One **Halton**

Place Based Plan

2019- 2024

PURPOSE

This One Halton Plan is building on our One Halton Health and Wellbeing Strategy 2017 – 2022, it will show our achievements to date as well as demonstrating the MUST DO's as part of the NHS Long Term Plan.

It is a direction setting document that outlines local need, health inequalities, current spend, trends, current and future targets and how we will monitor progress for the people of Halton for the next five years and beyond.

It highlights our ambition to work together in a new more integrated way to reduce the barriers between providers and commissioners allowing more flexible and innovative services that emphasise collaboration rather than competition. This will in turn improve health and wellbeing outcomes, manage demand and deliver efficiencies.

It will also set the strategic direction for how we can collectively achieve these ambitions.

POLICY CONTEXT

As well as working towards the priorities in the One Halton Joint Health and Wellbeing Strategy, our plans to support the better health and welfare of the people of Halton also falls within the context of a wider set of national and regional policies and plans.

At a national level the NHS Long Term Plan, published in January 2019, focuses on building an NHS fit for the future by:

- enabling everyone to get the best start in life;
- helping communities to live well and;
- helping people to age well

This is also supported by the Green Paper, Prevention is Better Than Cure, that outlines the importance of enabling people to stay healthy, happy and independent for as long as possible. This means reducing the chances of problems from arising in the first place and, when they do, supporting people to manage them as effectively as possible.

The Children and Families Act (2014) aims to ensure that all children, young people and their families are able to access the right support and provision to meet their needs. The Act outlines a new Code of Practice for children and young people with special educational needs and disabilities (SEND).

The Care Act 2014 introduced a number of reforms to the way that care and support for adults with care needs are met. It aims to achieve clearer, fairer care and support, promote the physical, mental and emotional wellbeing of both the person needing care and their carer, help prevent and delay the need for care and support and put people in control of their care.

The anticipated publication of the Adult Social Care Green Paper is expected to provide a comprehensive and thorough assessment of how recipients will pay for their social care in the future and also consider in detail other important factors relevant to a new, sustainable, funding model for Adult Social Care

VISION

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

CONTENTS

FOREWORD

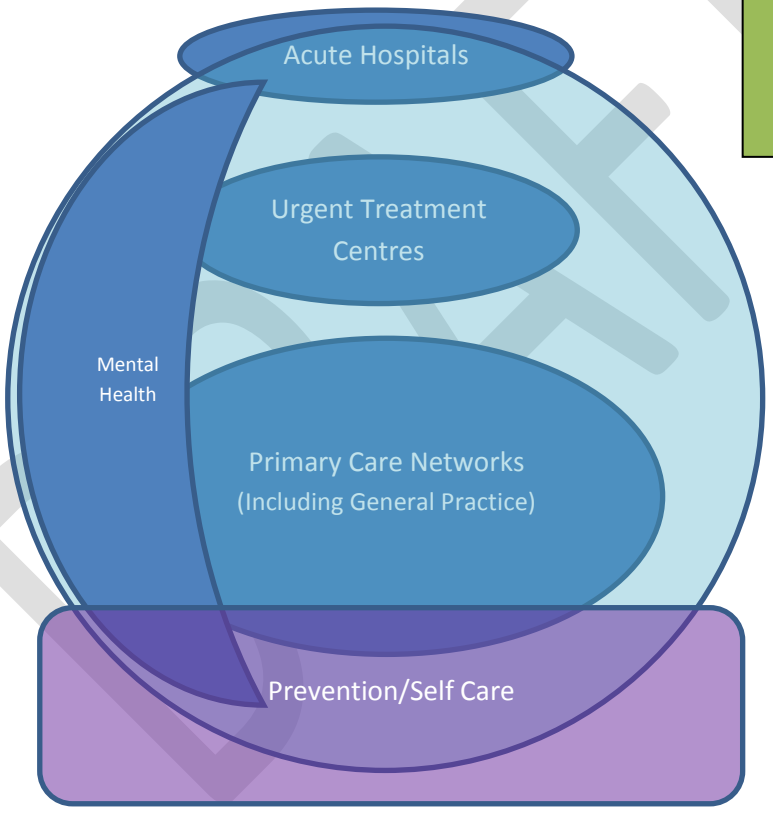
Putting your health and wellbeing first

Halton faces many challenges in common with the rest of the country, an increasingly challenging financial situation and a growing elderly population with increasing health and social care needs. However it also has distinct local issues, specifically inequality among local residents leading to significant health inequalities

To tackle the growing challenges faced by Halton's population, it requires a fundamental shift from hospital centred care to providing collaborative, integrated community focussed care meaning people can be treated closer to home within Halton.

Some people will still need specialist acute hospital care.

However where possible we want to move hospital services into the community. So patients can be treated closer to home within Halton.



We expect the majority of people to be treated within their community within Halton.

Linking the Urgent Treatment Centres and Primary Care so people can access a same day GP appointment

Integration is key to our strategic approach with all partners working together to deliver the vision of One Halton. It will demand strong relationships and collaboration amongst clinicians and communities and community leaders.

Improving the health of local people requires changes in behaviours and living conditions across Halton.

The challenge for the future of Halton's health and care economy is to reduce the costs of care with a particular focus on preventing unnecessary hospital admissions, reducing duplication and joining up health and social care.

There are numerous factors that impact on people's wellbeing, including employment, housing, education, environment and community safety.

The NHS Long Term Plan identities many priorities and through this One Halton Plan we will draw upon the priorities that matter locally, those areas that our patients and residents have said is important to them and where the data tells us we need to do further work to improve our outcomes for patients.

For the last 70 years we have concentrated on helping people to live longer. Now we must start to focus on healthy life span, increasing the number of years people can live a healthy, independent life free from illness or disability.

We want to support people to live well and healthily and we will do this by all working together.

Rob Polhill
Chair of Halton Health and Wellbeing Board
Leader of Halton Borough Council

David Parr
One Halton Senior Responsible Officer
Chief Executive Halton Borough Council

ONE HALTON *Place*

The term place based is becoming more frequently used. It describes the population served and the geographical boundaries that define a place, usually a Local Authority footprint.

We refer to our place as One Halton.

Place-based systems should be focused on the whole of the population that they serve – in other words, they should take responsibility for all the people living within a given area as is the case for Halton.

When we talk about Place Based Commissioning or Place Based Delivery, we are referring to services that are being delivered across Halton in a collaborative way.

One Halton is not a single entity. It is made up of a number of organisations, who work together to deliver the best outcomes for our community and patients.

Those Partners include:

- Halton Borough Council
- NHS Halton CCG
- NHS England
- NHS Bridgewater Community Healthcare NHS Foundation Trust
- NHS Warrington and Halton Hospitals NHS Foundation Trust
- NHS St Helens and Knowsley Teaching Hospitals NHS Trust
- NHS Northwest Boroughs Healthcare NHS Foundation Trust
- Healthwatch Halton
- Halton Housing
- Halton & St Helens Voluntary and Community Action
- Cheshire Fire & Rescue Service
- Cheshire Constabulary
- Halton Children's Trust
- Halton Children and Young People Safeguarding Partnership
- Halton Safeguarding Adults Board
- GP Health Connect Ltd
- Widnes Highfield Health Ltd

Working more effectively as one place, brings together the leadership, planning and delivery of health and local authority care services, working together without barriers and bureaucracy getting in way.

Additionally taking a place-based approach means working effectively with all the other areas that impact on wellbeing like education, housing, culture and leisure , employment and safety, with other public sector organisations, like the Police, Fire and Rescue, Department for Work and Pensions; and with the many community, voluntary and faith organisations.

Most importantly, it is means putting our community at the centre everything that we do.

Your priorities are our priorities

As One Halton we have made a commitment to work as one to deliver on the areas that you told us were most important to you*[1].

In 2017, the Health and Wellbeing Board published a "One Halton Health and Wellbeing Strategy". The Strategy was jointly developed after extensive consultation with a wide range of partners and stakeholders across the Borough, including; GPs, partners, providers, patients and public. It was supported by a strong evidence base.

The purpose of the strategy 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.

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.

The strategy identifies six priorities for Halton, they are:

- **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

[1] See Appendix XX Healthwatch consultation

These remain our priority areas today and form part of this One Halton Five Year Plan 2019-2024.

These priorities take a life course approach and have a strategic fit with the NHS Long Term Plan and the ambitions sought as a result of the Care Act 2014.

In Halton, we are also tackling many other issues, which may not be included in this document, that will contribute to the improvement of health and wellbeing of our community.

Halton, our community and the challenges we face

Our location:

The Borough of Halton is a unitary authority in the county of Cheshire.

Since 2014, Halton has been one of the six local authorites that make up the Liverpool City Region Combined Authority.

Straddling the River Mersey, Halton includes the two towns of Runcorn and Widnes as well as surrounding parishes of Hale, Moore, Daresbury and Preston Brook.

Halton is located in the middle of the economic triangle formed by Liverpool, Manchester and Chester. The borough is well connected by road, rail and air.

Our economy:

As the birthplace of the chemical industry, many of Halton's most challenging problems are rooted in the area's industrial past

With manufacturing and chemical sectors declining, considerable energy has been successfully put into broadening the range of employment opportunities available.

Major efforts have also been made to bring the industry's legacy of derelict and contaminated land back into productive use, to help create the right physical and social environment to attract new investment.

Our current population:

If Halton was a village of 100 people

Ward map deprivation

Halton is ranked as the 27th most deprived area in England out of 326 Local Authorities[2].

Halton Borough Council works closely with Liverpool City Region, the picture below shows how Halton compares with its neighbours in Liverpool City Region, North West and Nationally.

Halton's Life Course Statistics

The following infographic shows how Halton is performing against key health and wellbeing indicators and the current trend, which is denoted by the triangle above each indicator.

Our future population:

The population of Halton will gradually increase over the next five years and beyond, latest figures show Halton has a population of 127,595[3]. However projections indicate a change in our demographics and by 2036 the

2 Based on The Index of Multiple Deprivation 2015

3 (ONS, 2017)

population of 0-15 year olds will decrease by 7%, 16-64 will also decrease, but the number of people over 65s will increase by 44%.
Having an aging population will increase the use of health and social care resources in the borough.

The borough is fairly evenly split by gender, however the female population is growing, due to the fact that women are living longer than men.

In the 2011 census, the Black, Asian, and Minority Ethnic (BAME) population showed a percentage of less than three percent.

However Halton's population is changing and over the next five years it will continue to become more diverse with people moving into the borough who come from different cultures, practice different faiths and who don't have English as their first language.

We recognise the importance of ensuring all our population has their health and social care needs met and we do this by working closely with third sector organisations that work specifically with the BAME Communities.

Halton Providers offer a range of services and support to alyssum seekers and refugees living in Halton.

Life Expectancy

Halton's life expectancy at birth has improved since 2001, however, healthy life expectancy for men hasn't changed since 2010 and has worsened for females. Recent evidence indicates that increasing levels of deprivation, exacerbated by austerity, is causing it to stall.

Added to this, Halton has an unhealthy ageing population with an increasing number of people living with long term conditions, meaning those that are living longer are living out those years in poor health.

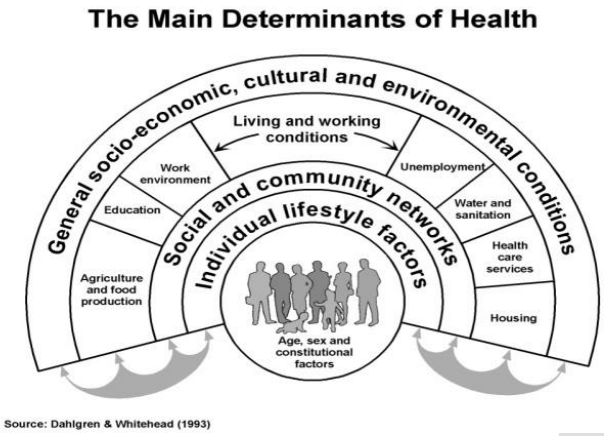
Why people are dying before 75

Our evidence shows us that the main causes of people dying before 75 in Halton are:

 **Long Term Conditions**	**Heart disease** is the second most common cause of death in the Borough leading to conditions such as heart attacks, strokes, heart failure, hardening of the arteries and vascular dementia. Similar to cancer, it is most often related to lifestyle.
	Respiratory Disease; Chronic Obstructive Pulmonary Disease (COPD), usually bronchitis and emphysema, is a major cause of premature death. Smoking is a leading contributory factor for COPD and although smoking rates have seen a decline over the last decade, the burden of disease caused by smoking is still of concern.
	Hypertension (High Blood Pressure) Despite improvements in the number of people with long term conditions diagnosed, there is still under diagnosis of hypertension, where only about 61% of Halton people thought to have the condition are diagnosed.
 **Mental Health**	**Mental Health;** Increases in dementia related deaths are linked to an increasing ageing population, however, vascular dementia, related to poor lifestyle has also added to the local burden of disease. Mental illness is a major contributor to ill health in Halton, often related to anxiety and depression. 1 in 4 people attend their GP in Halton to seek advice on mental health problems with 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
 **Cancer**	**Cancer** is the leading cause of death in Halton, particularly cancers of the stomach, digestive system and lungs. This increased burden of disease is predominantly linked to lifestyle factors such as smoking, poor diet and increased alcohol consumption. People in Halton also fail to spot the early signs of cancer or are afraid to go to the GP when they suspect something is wrong.
 **Older People**	**Unintentional injuries / Falls** Falls represent the most significant number of unintentional injuries. This is largely associated with older people and is linked to a range of factors including; medication (leading to dizziness and fainting), bone density (that decreases with age, particularly in women), cold homes and other environmental hazards. As well as the human costs of injuries associated with a fall, the cost to the NHS and Social Care can often be significant.

Wider determinants of health

There is an increased gap in health inequalities in Halton between the most deprived and most affluent areas of the borough but also between population groups.
The difference in health outcomes in different areas of the borough is often related to the wider determinants of health that can influence individual's choices and ability to remain healthy.



This diagram shows:
-At the core, are your personal characteristics, age, gender, hereditary factors which cannot be changed,
-Individual lifestyle factors such as smoking, alcohol, physical activities
-Social and community influence from family and friends
-Living and working conditions cause variants in health.
-General socio-economic factors include taxation, stability of country, environment.

Average life expectancy in Halton is lower than the North West and England averages, although there are massive variances in the borough.

The reduced life expectancy in the Riverside ward of Widnes means that residents living here can expect to live 5 years less than the general Halton population.

The inequalities are emphasised by the fact that Females living in Beechwood can expect to live for 9.8 years longer than the general female population of Halton; males in Beechwood have a 4.4 year greater life expectancy.

We are committed to supporting the range of interventions that are needed at different levels to address the root causes and the impact of inequalities as highlighted in our Health and Wellbeing Strategy. For example

- GP Practices conducting quality improvement work in disease conditions known to be the drivers in the gap in life expectancy
- Social Prescribing to ensure referrals are made to social welfare services such as Citizens Advice, Housing etc. This will ensure that those living in the poorest households are facilitated to maximise their income, maximise welfare benefits, minimise debts, access support such as foodbank, money advice.
- Well Halton Programme working directly with in the four areas of greatest deprivation within Halton: Windmill Hill, Halton Brook, Halton Lea and Ditton.
- Social Care in Practice (SCIP) – placing social care assessment staff in GP Surgeries has supported effective person-centred and integrated health and social care working. As a result of the relationships built the service has exceeded expectations and requests for referrals, along with the high level of complex case work.

Without behavioural change supported by targeted interventions and prevention these factors will continue to lead to poor health outcomes.

Progress we are making

For each of the six priorities identified in the One Halton Health and Wellbeing Strategy there were three specific actions that the partners and public felt were important to undertake. We have made good progress against these:

Priority Area	What is the Issue?	3 Key Actions our partners and public feel are important
Children & Young People 	• *Inequalities in school readiness* • *Significantly lower levels of good child development at aged 5 compared to the rest of England* • *Higher accidental injury levels*	• Enhancing school readiness programmes. ✓ • Additional action to prevent child accidents. ✓ • Expanding parenting programmes and local Home Start schemes ✓
Generally Well 	• *Obesity levels in early childhood and adults are above the national average.* • *Not eating at least 5 portions of fruit and vegetables a day* • *Not undertaking enough exercise*	• Mapping the public's access to fresh food. • Enhancing the infant feeding programme. • Promoting women's exercise programmes ✓
Long Term Conditions 	• *Undiagnosed hypertension is a concern.* • *Heart disease is the second biggest killer in Halton.* • *Although the number of people smoking is decreasing, Halton is still much higher than the national average.*	• Screening in the community for atrial fibrillation (irregular heartbeat). • Enhancing early diagnosis of heart disease and self-care programmes. • Increasing screening for hypertension (high blood pressure) in community pharmacies, general practice and other community settings.
Mental Health 	• *High levels of hospital admissions due to self harm* • *Higher rates of depression than national average* • *30% of people with dementia are not diagnosed.*	• Review the current Child and Adolescent Mental Health Services • Enhancing services for adults with personality disorders • Redesigning adult mental health services
Cancer 	• *The biggest cause of death locally, in particular lung, bowel and breast* • *Low cancer screening uptake, particularly for bowel screening.*	• Enhancing the public awareness of early detection programmes. • Developing a new Tobacco Control Strategy and Action Plan. • Enhancing support for bowel screening to improve uptake.
Older People 	• *Higher than average aging population* • *Life expectancy is lower than national average* • *Rise in dementia*	• Marketing campaign on how to prevent loneliness. • Develop an older people's transport group. • Develop a directory of services for older people.

We will continue to work on the remaining actions and they will be reported through our Halton Health and Wellbeing Board.

We have also been making good progress in other areas:

Well Halton

Well Halton is an initiative that focuses on the wider determinates of health such as poverty, isolation, unemployment, green spaces etc. Well Halton aims to support local areas, to inject some positivity, resilience and creativity to transform local neighbourhoods into dynamic communities where local people can live, learn, play, work, thrive and be happy.

Shopping City Roof Top Garden: The aim is to create a community garden on one of the disused carparks at Shopping City.	Green spaces, good for your physical and mental health
Community Shop: Well Halton has invested £50,000 in the development of the Northwest's first Community Shop. This model utilises surplus food as a platform to engage with people facing hardship. We expect the shop to be open before the end of 2019.	This will provide the opportunity for residents to eat healthily for less.
Veterans Garden Clearances: As part of our work in Ditton, Runcorn Veterans Association have been working with Halton Helps. The veterans are clearing gardens of local families who can't do it themselves. This is paid work and has helped the sustainability of the veterans.	Supporting people through work and families in need of help

Halton Healthy New Towns - Healthy Place to live and work

The Halton Healthy New Town is one of ten demonstrator sites across the UK chosen to represent cross-section of new housing developments in England as part of the Healthy New Towns Programme. These sites were chosen to rethink how health and care services can be delivered. The programme is an opportunity to re-link planning and health to create healthier places through good quality placemaking, uniting public health, NHS providers, commissioners, planning and housing development. It demonstrates collaborative working across a number of providers in Halton.

Halton Healthy New Town Vision: A thriving vibrant town centre that provides for the needs of the community and supports a wider area where all people can enjoy a good quality of life in a healthy, sustainable, modern urban environment.

It will offer opportunities for the local community to learn and develop their skills in order to help them fulfil their potential. It will create opportunities for the community to increase local wealth and equality, supported by a thriving business community within a safer, stronger and more attractive neighbourhood.

Scheme	Expected Outcomes	Expected Timetable	One Halton Priority Areas
Youth Zone	Physical space for community usage. Improved wellbeing and educational attainment for 12-17 year olds	Complete– delivering sessions twice weekly	Young Children and Young People
Riverside "Quick Wins"	Local improvements for residents of Hallwood Park, Uplands, and Palacefields Estates. Projects TBC Q3 2019/20 following consultation.	Q3 – Q4 2019/20	Generally Well, Long-term Conditions, Mental Health, Older People
Rooftop Garden	Physical space for community usage. Improved wellbeing. Opportunities for growing and education.	Q1 2020/21	Generally Well, Long-Term Conditions, Mental Health, Older People

The voluntary sector is supporting the One Halton Priorities providing services that reduce the demand for more costly clinical interventions.

People experiencing debt problems are three times more likely to have considered suicide[4]. **Citizens Advice Halton (CAH)** helps over 1,500 local people struggling with problem debt by offering a wide range of support	They have trained their staff in suicide awareness so that they can have supportive conversations with service users who are at risk of self-harm and help them to access specialist help.
	They employ an accredited team of money advisors who can help patients to address their debt problems and many of the other social welfare issues (e.g. debt, relationship breakdown, unemployment, poor housing, poverty) that are impacting on their mental health and wellbeing
	They offer ongoing support to help people get their lives back on track e.g. confidence building courses, employability support, money management courses, help with applications for grants for respite holidays.
Halton Disability Partnership provides an advice and brokerage service and help local people with a disability to access support and care that fully reflects their choice and wishes	HDP has a small store of independent living aids which are available for short term or an emergency loan which can make all the difference between being able to be discharged from hospital on a Friday and return home safely rather than be held back for several days while waiting for an available assessment to unlock equipment through conventional channels

Air Quality

Air pollution particularly affects the most vulnerable in society – children and older people, and those with heart and lung conditions.

In the last 20 years Halton has vastly improved its air quality and will continue to reduce air pollution.

Housing

Having a decent home is fundamental to physical and mental health. Housing is particularly important for our vulnerable groups. Poor housing can result in poor health and wellbeing..

Halton Borough Council is currently updating their affordable housing plan policy which set out the ambition to provide more affordable homes in Halton, in order to positively impact on homelessness and improve quality of life for those most in need.

- 1,335 – Estimated Number of Houses that will be built in Halton in the next 5 years.
- 335 – Approx number of affordable homes that will be built.5

We also need to ensure that local housing meets the specific needs of people with learning disabilities, including those people who have their own home but require additional support.

We aim to secure funding from NHS England to refurbish a property into two ground floor apartments for those people who require additional support in the community.

Voluntary Sector organisations are committed to ensuring that everyone in Halton has a decent home to live in.

4 According to the Money and Mental Health Policy Institute

5 Based on 25% of new homes being affordable homes. Percentage can vary depending on the site used.

Why we need to change

Health needs and society are constantly changing which means that organisations have to respond to meet the demands of the population they serve.
It's not just Halton that needs to change, nationally things must change too because:

- many of us are now living longer, with more long term conditions,
- people are more digitally enabled, services need to adapt and make the best use of technology available,
- we live and work very differently and this continues to evolve, and
- the current model is financially unsustainable.

The NHS Long Term Plan was published in January 2019 and set out its ambition to transform the NHS to make it fit for the 21st century.
The NHS Long Term Plan sets out five major, practical changes it expects to bring about over the next five years, they include:

1. Boosting out of hospital care
2. Redesigning and reducing pressure on emergency hospital services
3. More personalised care
4. Digitally enabled primary and outpatient care
5. Focus on population health: this means focusing on you, rather than managing each disease you may have, separately.

The NHS Long Term Plan is about changing the balance between acute hospital care and care in the community so more people are treated closer to home. With more focus on prevention we need to increase the range and choices of care in the community.
This will then reduce pressure on our hospitals, keeping people well enough so they do not need to go to hospital and can be treated in the community instead when appropriate.

Getting this right will reduce the call on our overstretched NHS and social care services. By taking services into the community and redirecting resources towards the wider determinants of wellbeing, we will not only have a healthier, happier workforce, but we will be able to provide better care and create a sustainable Halton.

In local authorities, there has been an increase in demand for adults and childrens social care. There have been delays with the government publishing the Adult Social Care Green paper which is expected to have national changes that will need to be implemented locally. In addition to the anticipated Adult Social Care Green paper we have the statutory requirements outlined in the Care Act 2014 which have to be delivered. The current provision is unsustainable, there is insufficient funding to keep up with the demands of an aging population. Through Health and Social Care working closer together they can focus on building a sustainable model for the future.

By doing things differently we will be able to protect and stabilise those organisations in Halton. By working together we can:

- Improve early prevention of avoidable illness.
- Get the right service in the right place
- Ensure health and care services are shaped around the person. (Population Health)
- Access more and better paid jobs
- Have healthier environments
- Have safer streets
- Ensure children gain a better education
- Offer more choice in eating healthy

Cheshire & Merseyside Healthcare Partnership

One Halton is one of nine places that forms part of Cheshire and Merseyside Healthcare Partnership who are working towards becoming an Integrated Care System (ICS).

In addition to the mandated priorities in the NHS Long Term plan the Cheshire & Merseyside Healthcare Partnership have agreed a number of audacious goals, these are:

- Starting well – 100% vaccination and immunisation rates for children.
- Living Well – no more suicide, reduce violent crime and alcohol harm.
- Aging Well- zero stroke and reducing falls in the elderly.

One Halton supports the delivery of these audacious goals and will work closely with Cheshire & Merseyside colleagues through the partnership programme to introduce changes and new services as developed and agreed.

How the audacious goals link to One Halton Priorities	How we will implement
In Halton if we achieve 100% vaccination and immunisations rates for children, they are less likely to miss school due to ill health, thus supporting them to reach a good level of development	We will work closely with Primary Care Networks to explore alternative delivery mechanisms to improve uptake.
No more suicides and reduction in violent crime are closely linked to the work we undertake in Mental Health	Support through our Halton Suicide Prevention Partnership , including the Mental Health Outreach Team which provides support to adults with severe and enduring mental health problems to live independently and inclusively within the local community. Implement through our Halton Suicide Prevention Partnership
Reduction in alcohol harm is a One Halton priority outcome, particularly in those under aged under 18	Because of high levels of preventable alcohol-related harm in the region, all Health and Wellbeing Boards across C&M have identified reducing alcohol-related harm as a core prevention priority.
Reduction in stroke is a One Halton Priority and we are working to ensure that there are no preventable strokes in Halton	Improving High Blood pressure checks, deliver education sessions, increase the number of the NHS health checks, working with local pharmacies and improve information technologies between them and General Practice so the blood pressure data can be transferred seamlessly between the two. Utilise BP/ Health kiosks in community & workplace settings to increase access to BP testing.
Reducing falls in the elderly is a Priority for One Halton and work is well on the way in this area.	Implementation of the Halton Falls Strategy

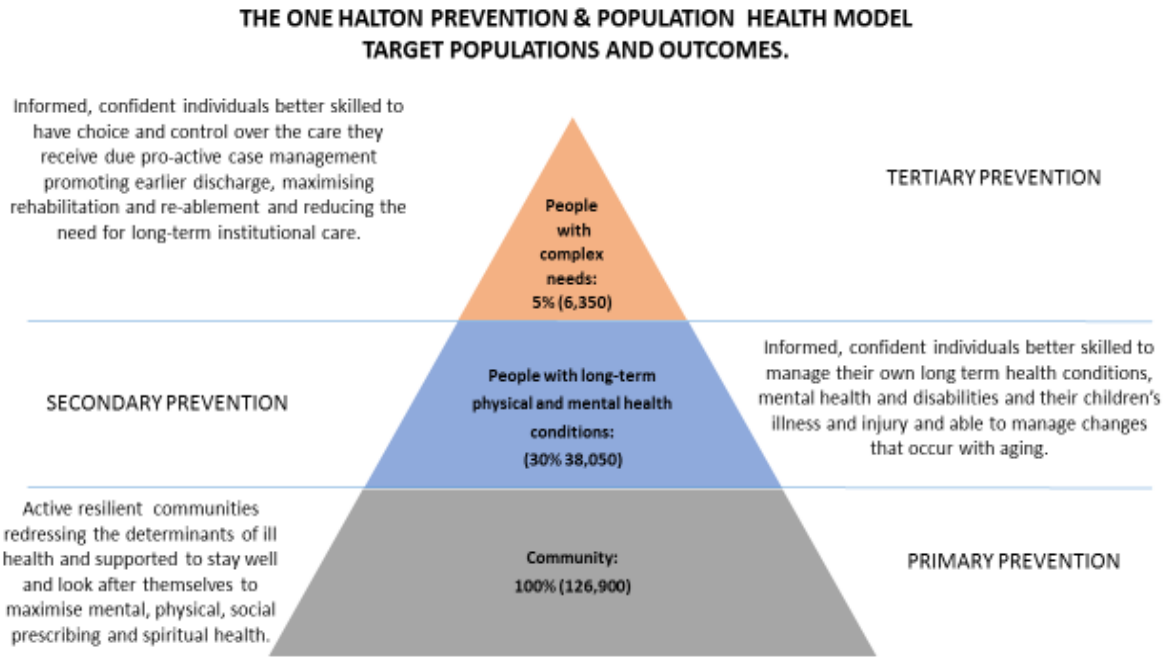
Cheshire & Merseyside Healthcare Partnership help to deliver improvements at a greater pace and scale. They have a number of programmes that exist to implement a single approach across Cheshire & Merseyside and they work with each of the nine "places" to help deliver those programmes in a cohesive way. Those Programmes are included as Appendix 1

Empower people to take better control of their own health.

What is Population Health?

A population health management approach moves away from managing disease in silos to an approach based on defined populations of people, who may have multiple conditions. Whilst primary care will play a crucial role in supporting population health management, a wider group of providers other than the GP will be necessary for accountability of the defined population.

Prevention is inherent with consideration of the person's holistic health and care needs with a particular focus on improvements to wellbeing and on keeping people healthy. One Halton Population Health Framework promotes the integration of health, mental health and social care services.



The 2020s will be the decade of proactive, predictive and personalised prevention. This means:

- Targeted support
- Tailored lifestyle advice
- Personalised care
- Greater protection against future threats

This will enable us to shift from a system that just treats illness, towards preventing problems in the first place.

What do we want to achieve

For each of our 6 priorities we have identified a number of measurable outcomes that are monitored by the Health and Wellbeing Board.
These outcomes are:

Children and Young People: Improved Levels of early child development

- 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.

What are we going to do?	How are we going to do it?	Who will do it?	When?
Ensuring children get a good start in life.	Halton Healthy Schools	We all must take a responsibility.	2023/24
Improve our Immunisations and Vaccination rates	Support general practice to target at risk population groups to improve update of flu vaccine, routine childhood vaccinations	Primary Care Networks	2023/24
Enhance Parent and Child Bonding	Baby and Infant Bonding Service (BIBS)	Providers in Halton	2023/24

Generally Well – Increased Levels of Physical Activity and Health Eating and Reduction in harm from alcohol.

- 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

What are we going to do?	How are we going to do it?	Who will do it?	When?
Tackle Obesity	Access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+	BMI> 30 can self-refer to Halton Tier 3 Weight Management Service	2022/23
	Healthy NHS premises	North Mersey Food Pledge with providers	2023/24
	Physical Activity Programmes		ongoing
Prevent Diabetes	NHS Diabetes Prevention Programme	NHS England, Public Health England (PHE) and Diabetes UK	2019/20
	Testing an NHS programme supporting very low calorie diets for obese people with type 2 diabetes		2019/20
	Glucose monitoring for pregnant women with type 1 diabetes		2020/21
Tackle Alcohol Admissions – Alcohol has a big impact on A&E figures: 70% at peak times.	Hospitals with the highest rate of alcohol dependence-related admissions will be supported to fully establish Alcohol Care Teams (ACTs)	St Helens & Knowlsey NHS Trust and Warrington and Halton Hospitals NHS Foundation Trust	2023/24
	C&M Alcohol Prevention Plan which provides a focus on actions across the health and social care system which will support both the reduction and prevention of alcohol-related harm.		
	Fibroscan Project Offering 'liver scans' in Primary Care, the community & hospitals as a new route into alcohol treatment		
Increase the number of people receiving physical health checks	Halton Health Improvement team work in partnership with Primary Care to deliver NHS Health Checks.	Halton Health Improvement Team and Primary Care Networks	2023/24
	Ensuring patients register on a Learning Disabilities register and improve uptake of the annual health check.(Above 75% for aged 14+)	Primary Care Networks	2023/24
Homeless: Meeting the needs of rough sleepers and ensure people have better access to services.	Having a named GP practice champion In Halton there are very low rough sleeper numbers locally but a hidden homeless sofa surfing population	Identification of a PCN lead practice to act as a dedicated access to enable improved access	
	Offering bespoke flu programmes for homeless people who use drug and alcohol services.		

Long Term Conditions: Reduction in levels of Heart Disease and Stroke

- 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

What are we going to do?	How are we going to do it?	Who will do it?	When?
Reduce Smoking in Halton	All people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services	C Conversation: Have the right conversation every time U Understand: Understand the level of addiction R Replace: Replace nicotine to prevent withdrawal E Experts and evidence based treatments The CURE model will include all vulnerable groups with high levels of smoking prevalence Halton Stop Smoking Services also offer training and advice to professionals who need support to deliver cessation Smoking cessation champions to be identified	2023/24
	Smoke Free Pregnancy for Mum and Partner	Halton Community Midwives offer CO monitoring to all pregnant women and refer smokers into the Halton Stop Smoking Service. On receipt of referrals the Stop Smoking Service offer all pregnant smokers' home visits, financial incentives, stress management techniques and intensive behaviour support alongside NRT if required. Halton Stop Smoking Services also offer training and advice to professionals who need support to deliver cessation	2023/24
	A new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services.	Halton Stop Smoking Service has a Stop Smoking Specialist in Mental Health who works with Booker Centre Staff and residents to support those wishing to stop smoking.	2023/24
Prevent Cardiovascular disease (CVD)	Implement schemes relating to Atrial Fibrillation Blood Pressure – Hypertension Cholesterol (Lipids)	Cheshire and Merseyside CVD Prevention Board	2028
Respiratory disease	To follow		
More People will be independent after a stroke.	Increase the number of people who have a thrombectomy after a stroke.		2022

Reduce air pollution	-Organisations in One Halton supporting and encouraging their staff to think about sustainable travel, making use of public transport, cycling, walking or car sharing. -Maximising the use of technology to reduce the need to travel to have face to face meetings. -Providing electric car charging points at all NHS, public sector and voluntary sector premises	Everyone will be involved	2023/24.

Mental Health: Improved Prevention, early detection and treatment

- 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

What are we going to do?	How are we going to do it?	Who will do it?	When?
Develop a system approach to support Children and Young Peoples Mental Health	Utilising the THRIVE model	Everyone	2020/21
10% reduction in suicides	You're never too young to talk" mental health campaign 5 Ways to Wellbeing Award		2020/21.
	Improve the mental health and wellbeing of Halton people through prevention and early detection via the work of our adult social care mental health teams		
	Basic Mental Health Awareness		2024
	Self Harm Awareness training		

	Suicide prevention training	Halton Suicide Prevention Partnership	
	Named school link workers in community service settings and in primary and secondary schools across Halton.		
	IAPT services and co-location of therapists in primary care		
	Enhancing the psychological therapies to support adults with a personality disorder		
	Crisis Resolution Home Treatment Teams in place	Delivering a 24/7 community-based crisis response and intensive home treatment as an alternative to acute in-patient admissions.	2020/21
	Implement Mental Health and Resilience in Schools (MHARS) framework	Mental Health Champions	
Access to Perinatal Mental Health	C&M Wide Perinatal mental health service		2020/21
All ages mental health liaison teams in place	Implement in all acute hospitals		2020/21

Cancer: Reduced level of premature death

- 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.

What are we going to do?	How are we going to do it?	Who will do it?	When?
Early Diagnosis	Implement Rapid Diagnostic Centres	Work with C&M Cancer Alliance to roll out Rapid Diagnostic Centres	2020
	Targeted Lung Health Checks		2023
Improve uptake of screening	Faecal Immunochemical Test Bowel Screening Programme	Public Health England	2019

	Implement HPV primary screening for cervical cancer	Public Health England	2020
Improve Cancer treatments	Radiotherapy service		2021/22
Access to Personalised Care Plans	Personalised care interventions including needs assessment, a care plan and health and wellbeing information and support.	C&M Cancer Alliance	2021

Older People: Improved quality of life

- 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

What are we going to do?	**How are we going to do it?**	**Who will do it?**	**When?**
Prevent Falls	Falls Prevention Strategy		2019
Provide more services in the community for frail elderly patients	Halton Integrated Frailty Service		2019
Reduce Loneliness	Implement the Loneliness Strategy		2019-2024

Provide care and support to enable older people to live an independent life	Commission high quality care services, including domiciliary care and care home provision, from the independent and voluntary sector. Ensure that there are robust contract monitoring processes in place to ensure high quality services are in place to ensure that service users receive the outcomes that they want.		

Riverside "Quick Wins"	Local improvements for residents of Hallwood Park, Uplands, and Palacefields Estates. Projects TBC Q3 2019/20 following consultation.	Q3 – Q4 2019/20	Generally Well, Long-term Conditions, Mental Health, Older People
Rooftop Garden	Physical space for community usage. Improved wellbeing. Opportunities for growing and education.	Q1 2020/21	Generally Well, Long-Term Conditions, Mental Health, Older People
Halton Hospital and Wellbeing Campus	Physical space for community usage. Redeveloped health infrastructure, including provision of expanded step up and step down care facilities, alongside housing, leisure and health opportunities. Increased job opportunities.	Redeveloped hospital facilities: 2025; remaining campus facilities 2028	All
East Lane House Redevelopment	Improved physical infrastructure. Demolition of East Lane house and construction of hotel and care home facilities. Increased job opportunities.	TBC	Older People

One approach

One Halton describes how all organisations across Health and Care will work together at a Place level to deliver the best outcomes for the people of Halton.

It is recognised that there are increasing demands on all services. The difference that One Halton will make is to place people at the centre of care and wellbeing so the emphasis is based on them rather than targets and outcomes.

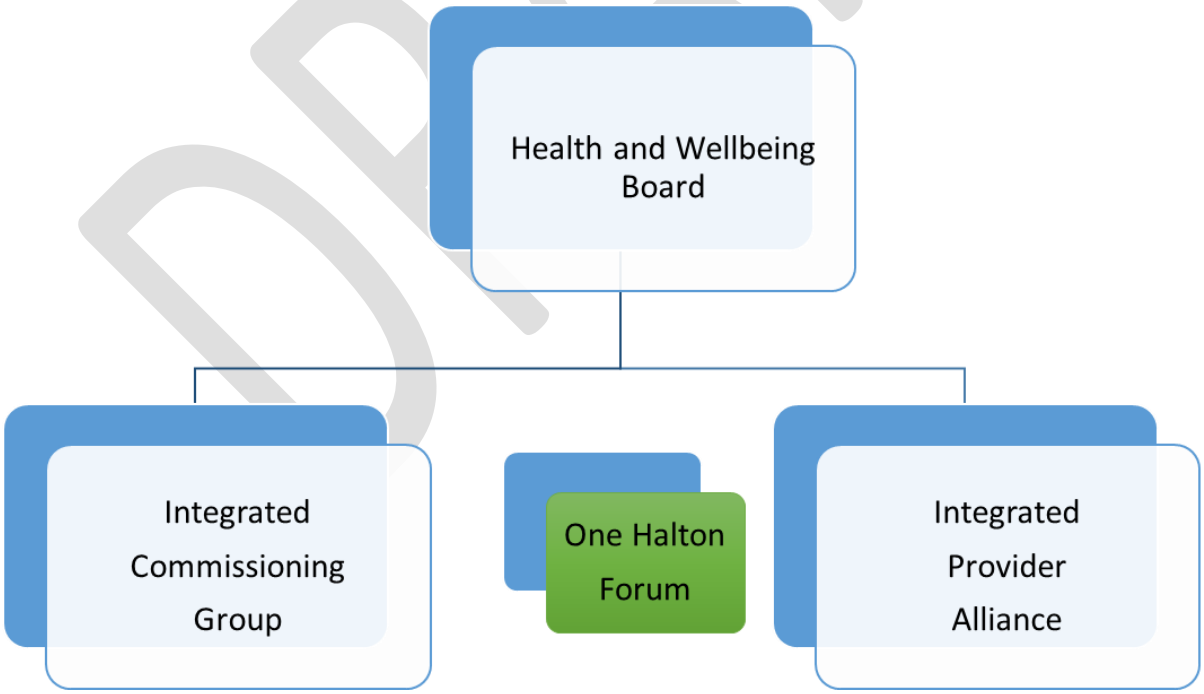
Through the One Halton model, we propose to radically change the way we do things so that by 2024 fewer people will be suffering from poor health.

We know that people who have jobs, good housing, undertake 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.

Governance

Ultimate responsibility for the implementation of the One Halton Health and Wellbeing Strategy and the One Halton Plan lies with the Halton Health and Wellbeing Board. However we need everyone who works and lives in Halton to take an active role in improving their Health and Wellbeing.

The governance structure for One Halton is demonstrated below:



Roles and Responsibilities:

Health and Wellbeing Board: Responsible for guiding and overseeing the implementation of the ambitions outlined in the One Halton Health and Wellbeing Strategy, The NHS Long Term Plan, health strategies for England, national operational plans and local health strategies and action plans.

It also provides a voice for Halton residents on all matters relating to the commissioning, provision and scrutiny of health and social care in Halton.
It is the decision making body for One Halton.

Integrated Commissioning Group: To create joint commissioning intentions for Halton.
To provide oversight of commissioned services. Where it is appropriate to do so, pool funding and jointly commission services across Health and Social Care.

Provider Alliance: To bring about real and effective collaboration across the whole of the health and social care system in Halton and to support an end to competitive behaviour between providers.

One Halton Forum: An informal meeting which allows Commissioners and Providers to come together to discuss, challenge and clarify prior to the Health and Wellbeing Board. The Forum is not a formal decision making group.

Collaborative Approach

Collaboration and Integration are key to our approach. All organisations will work together to redesign care and improve population health, creating shared leadership and action.

Currently we have a Provider Group and a Commissioner Group reporting into the Health and Wellbeing Board. However Commissioners and Providers will have the biggest impact by working together to make shared decisions about population health, service redesign and implementation of the NHS Long Term Plan.

There are some areas, like Procurement and contract award whereby only the Commissioner can undertake this duty and Service Delivery will be provided by the Providers. However all other stages within the Commissioning Cycle should be undertaken jointly to achieve the best outcomes.

Provider Collaborations

NHS Foundation Trusts will be able to create joint committees with others, they will be able to create integrated care trusts to be able to deliver primary and community care for the first time under one single contract. It will be easier for organisational mergers to progress without diluting the current safeguards on frontline services.

There are other options available for Providers to work collaboratively together, through Alliance Contracts or through Integrated Care Provider (ICP) contracts which will be developed over the coming years.

Currently the Providers in Halton have come together and identified four specific workstreams that will contribute to the One Halton priorities:

1. **Place Based Integration**
2. **Prevention / Population Health**
3. **Workforce**
4. **Information/Digital**

They will work collaboratively with Commissioners to develop these workstreams further supporting the overall aim and outcomes for One Halton.

Primary Care Networks (PCNs)

Primary Care Networks will be delivered in the local area by the GP Practices and multidisciplinary teams employed by the network. PCNs need strong relationships, trust, collaboration and innovation.

PCNs are central to the provision of integrated, at scale primary care, encompassing services beyond core general practice and working closely with acute, community and mental health trusts, as well as with pharmacy, voluntary and local authority services.

PCNs will interact at different levels;

- **Neighbourhood**; will be based on Runcorn and Widnes, working with voluntary, social care and community sectors to deliver services at scale.
- **Place;** refers to Halton, will interact with hospitals, mental health trusts, local authorities and community providers.
- **System;** Cheshire & Merseyside, the PCNs will be involved in at scale decisions involving strategy decisions and resource allocation.

The aim of the PCN is to deliver integrated primary and community health care services supported by an integrated workforce team.

Networks will have a host of new roles available; initially there will be a pharmacist and a social prescriber. In the next five years they will have first contact physiotherapists, physician associates and community paramedics.

Appendix 2 shares the local of vision of the Halton PCNs.

The development of PCNs will mean that you will be able to access:

- resilient high quality care from local clinicians and health and care practitioners, with more services provided out of hospital and closer to home.
- A more comprehensive and integrated set of services, that anticipate rising demand and support higher levels of self care
- Appropriate referrals and more 'one stop shop' services where all health and care needs can be met at the same time
- Different care models for different populations group – meaning that they are person centred rather than disease-centred.

Benefits of PCNs

- You will be able to consult with a pharmacist for two or three times longer than a GP.
- Capacity will increase to undertaken more frequent medicine review, reducing the likelihood of conditions worsening or leading to other complications or side effects.
- Social prescribers will undertake specific activities such as referring patients to appropriate voluntary and community groups, acting as a first point of call for nursing homes, supporting and spending time with patients and their carers, in particular for those who are frail and vulnerable, those that are at risk of frequent hospital admission

and those coming towards the end of their lives.

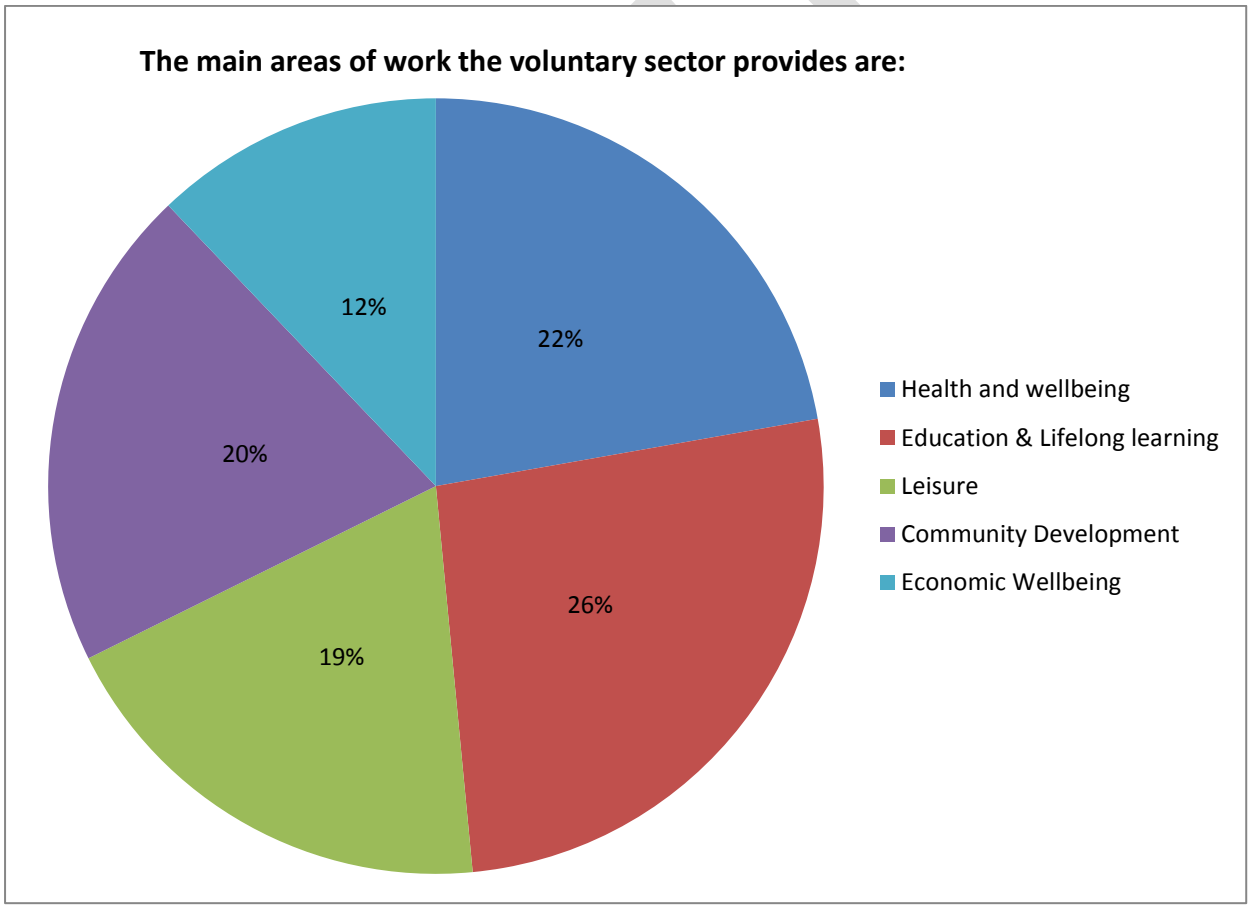
- People with long term conditions and their carers can benefit from access to non-clinical support, increase the patient experience and positive outcomes, enable patients to become less socially isolated and more independent.

Voluntary Sector

In Halton there are over 700 organisations and groups that make up the voluntary sector. 487 of these are registered with Halton & St Helens Community and Voluntary Action.

Across Halton there are over 15,000 volunteers providing over 45,000 hours of capacity each week.

It is estimated that the voluntary sector contribute £57m worth of gross added value to the Halton economy. The contribution of the voluntary sector can be increased through collaboration.



Driving improvements by working smarter

Digital:

Technology is now a fundamental part of every aspect of our lives. The way we access and share information, interact with each other and use services all rely on technology working well and in a way that suits our lives. Organisations need to be able talk to each other more easily so that people can use technology to find out more about health and social care.

The aim is to deliver barrier free health and social care experiences through new ways of data capture, recording and apps integration, secure citizen access and ultimately ownership of one's own record. This will mean that you only need to tell your story once and that data is consistent across organisations.

In order to achieve the digital ambitions of 'The NHS Long Term Plan' organisations will continue to embrace and build upon the emerging national, regional and locality initiatives and workstreams.

Delivering Digital within Halton will be built upon our continued engagement with the Cheshire & Merseyside Health Care Partnership Digit@LL Strategy. This will be a key enabler to allow us to deliver digital change locally whilst delivering efficiencies by collaborating at scale.

Empowering People

Technology can be a key asset for communities, helping to support local business opportunities, improving educational experiences across all age groups, providing everyone with better ways of communicating with the outside world and offering the opportunity to learn from others. We want to work with partners and the wider community to make sure we are making the best use of the technology that is available to individuals and communities.

By making better use of data and digital technology we will provide more convenient access to services and health information for patients, with the new NHS App as a digital 'front door', better access to digital tools and patient records for staff, and improvements to the planning and delivery of services based on the analysis of patient and population data.

Prevention and early intervention will require effective use of new technology. We will explore how we can use telemedicine and continue to develop our approach to assistive technology to keep people safe and give them rapid access to support. We will use connected home technologies to allow patients with long-term conditions access their health records, care plans and where they choose share information with the NHS via digital monitoring devices.

Supporting health and care professionals

We will support our health and care professionals by providing them with timely access to the information they require in the location they require it. This will include a continued roll out of mobile devices for our staff working in the community, visiting people in their own home including care and residential homes.

We will implement and develop a local shared care record to ensure professionals directly involved in health and social care have access to the most up-to date information. We also want people to have access to, and control over, their personal health and social care records which will be enabled through our Care Record programme. We want to help people take responsibility for self-managing their care, and technology has a role to play in offering easy ways to access advice and information.

We will ensure that our local shared care record programme is fully aligned and takes advantage of the collaborative Share2Care programme. Share2Care is a collaborative programme between Cheshire and Merseyside Health Care Partnership and Healthier Lancashire and South Cumbria to deliver electronic shared health and care records.

Digital transformation will require all staff to make adjustments in how they work. Our aligned workforce plans will address the need for an increase in the technical skills of both specialist and non-specialist staff. Through the NHS Digital Academy we will support an increase in capability among senior technology and digital leadership enabling further cohorts of NHS staff to become digital change leaders and we will ensure that by 2021/22, all local NHS organisations will have a CCIO or CIO on the Board.

Supporting clinical care

Our ambition to achieve a paperless health and social care system will focus upon optimisation and interoperability of electronic patient records used and to support our staff, patients and carers in embracing digital solutions for seamless but complex health and care services.

It is our intent to develop ever more impactful and accessible decision tools and insights for clinicians and patients in pursuit of the right advice, decision and support every time. We will increase the digital options available to people of their care. These will include, where appropriate, online consultations and digital advice across all services in health and social care. We will continue to develop the digital capability available to our GP practices through the GP IT Futures Framework whilst ensuring these systems support our ambitions when redesigning clinical pathways.

We will ensure that our digital programmes make a direct contribution to the delivery of wider system transformation objectives and specific priorities such as improved cancer care and mental health services.

Improving population health

New ways of assessing health risks, early diagnosis and providing preventative care are being created by new digital technology and information analysis. We want to make those benefits available to people in our communities. Our aim is to use technology to support population health management. This is the identification of people at risk of illness and those who would benefit from early intervention to help reduce illness and premature death.

Improving clinical efficiency and safety

Security & confidentiality, accessibility & availability, accuracy & comprehensiveness are all key facets of outstanding digitised care. We will ensure that any locally developed or procured services comply with the published open standards, ensuring full interoperability with the national infrastructure and other local services. In addition We will ensure local systems and data are secure through the implementation of security and monitoring systems across the whole estate, the education of all staff, and the design of systems and services to be resilient and recoverable.

Our ambition is to drive forward digitisation focussed on the user need whilst engaging with our staff and our patients in its development. Digital skills are no longer exclusive to our information technology service providers. We are committed to mobilising the skills of our entire workforce and inclusiveness of all our citizens to aid our ambition for 'digital first'.

We are currently developing a digital strategy for Halton, specifics will include:

- *Create a Health and Care shared record that is accessible by the patient and health care professionals.*
- *Interoperable IT, to allow ease of data sharing across providers.*
- *Consistency of data sets to allow a system/Halton response to statistics.*
- *Improved data/information flows*
- *Engage with the public to establish how they want this to look and explain how it will achieve better outcomes.*

Using our resources more effectively

Workforce:

Our joint health and care workforce is one of our biggest assets. However, across Halton, and indeed the whole country, workforce shortages are currently the biggest challenge facing health and care services. This poses a threat to the delivery and quality of care. Current workforce shortages are taking a significant toll on the health and wellbeing of staff.

People's rapidly changing health and care needs, alongside medical and technological advances, requires all frontline staff to acquire new skills
and adopt new ways of working over the next decade. We want to make sure our health and care workforce supports a strong, safe and sustainable health and care system that is fit for the future.

A workforce strategy for Halton is currently in development, not only to ensure we have the workforce capacity we need for the next five years but to ensure the current staff are well looked after. It will include:

- Developing a workforce with new roles and new ways of working that are focussed on One
- Implementation of the Healthy Workforce Programme.
- Career promotion in schools.
- Ensure Halton has sufficient workforce capacity to meet demand
- One Halton rotational roles. Ability for some roles to work across multiple providers in health and social care, taking away any contractual barriers, optimising pay and conditions to promote Halton as the preferred place to work.

Action: Create a workforce strategy for Halton

Estate:

We need to ensure that our collective estate is utilised in the most effective way both in the short and long term. This means making sure that we make best use of our land and property assets now; facilitating joint working or alternative uses where appropriate.

We will improve the way we use our land, buildings and equipment. This will mean we improve quality and productivity, energy efficiency and dispose of unnecessary land to enable reinvestment. We will work with all providers to reduce the amount of non-clinical space, as well as reducing our carbon footprint by improving energy efficiency through widespread implementation smart energy management.

We can help improve the use of our community facilities, such as libraries and GP Practices, by ensuring they are multi-purpose and can support health and wellbeing. It also means we need to ensure that our estates support the health and social care transformation and integration agenda and can respond to developing service models.

Looking forward, we also need to inform long-term regeneration plans for the borough with regard to changing need and demographics to ensure that future estate is planned appropriately. This includes working with all partners to help secure commitment for a new purpose-built modern hospital which will be flexible and able to support the delivery of new models of care as they evolve.

We will maximise utilisation of existing estate to reduce void space and increase utilisation of bookable spaces through the reconfiguration and relocation of services. We will dispose of old or surplus property wherever possible and end leases for properties that are no longer required. We review our office space and where possible reduce and rationalise this to improve efficiencies.

Action:

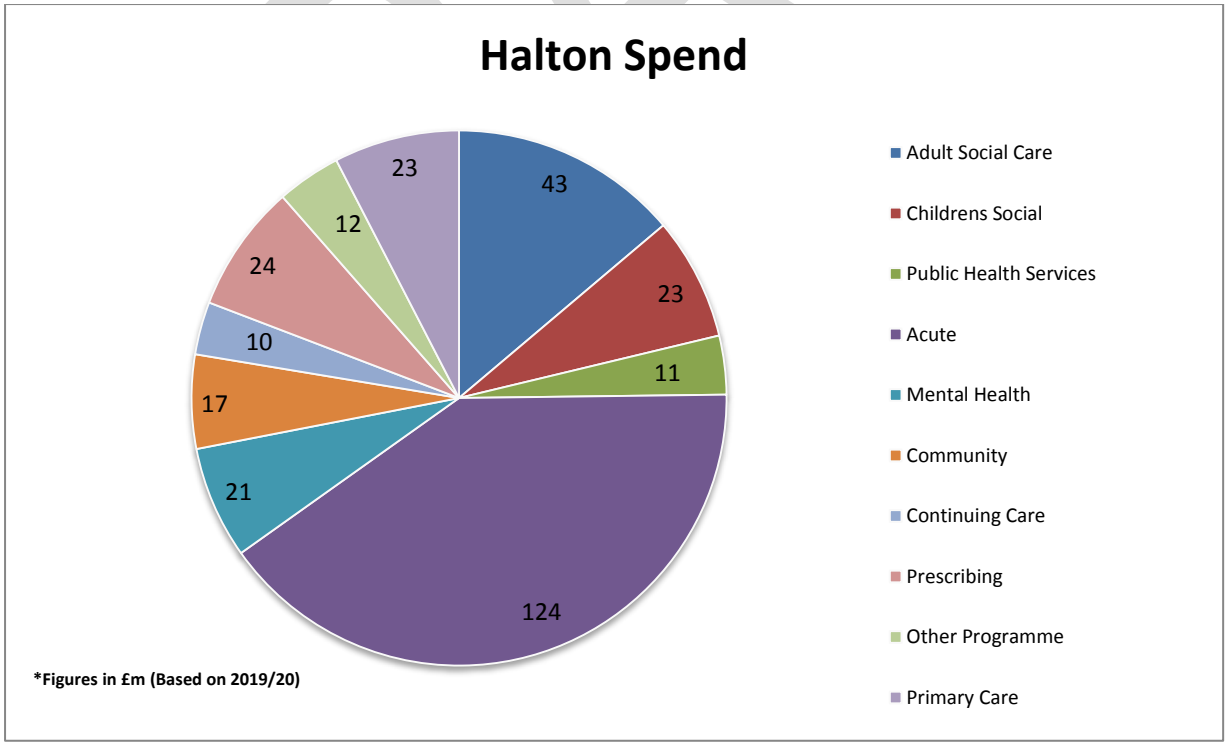
- *Develop an overarching estates strategy for Halton to ensure that the current estate in Halton is being utilised to its maximum potential and that when new services are proposed there is local availability of land/buildings to provide these.*
- *A heat map will be developed to show existing estate, what condition it is in, what clauses are in the lease, vacant space etc*

Making tax-payers money work harder

Across Halton over £300 million a year is spent on Health and Social Care.

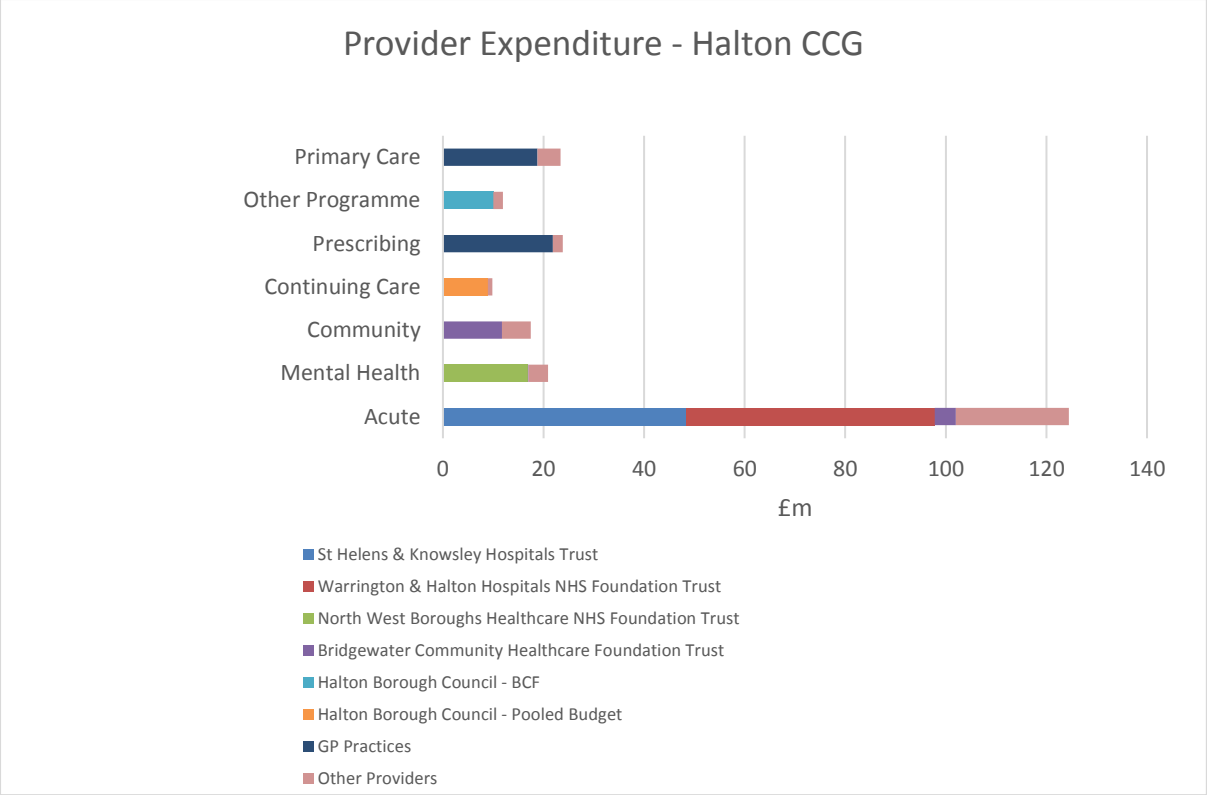
NHS Halton CCG spends £231m on services such as Acute Care, Primary Care, Community Services, Mental Health and Prescribing[6].

Halton Borough Council £76m on Adult Social Care, Children's Social care and Public Health[7]. This includes many services such as community services, complex care, mental health and family services.



6 2019/20 Budget

7 2019/20 Budget



All commissioners in Halton (NHS Halton CCG and Halton Borough Council) are experiencing financial difficulties as demand has grown faster than nationally allocated budgets.

The Local Authority already has to demonstrate a balanced budget annually; there is now a national mandate for all NHS organisations to be in financial balance by 2023/24.

Funding reforms will lead to changes for providers with more of an emphasis on incentives for improving quality and patient experience. By reducing duplication and commissioning services in a more integrated joined up way we can save money.

To get the most out of taxpayer's investment we will work as a partnership to reduce duplication and work at scale to combine buying power to ensure cheaper costs,
We will make sure the Halton pound is invested efficiently and effectively to achieve the best outcomes.

What does it mean for me?

One Halton has already made a commitment to deliver on the outcome described above.
The organisations in Halton that provide your services have made a commitment to work collaboratively together so you only have to tell your story once and the care you receive is more joined up and focussed on your needs.

The commissioners in Halton have agreed to streamline and integrate their services where possible; as well as work with Providers to ensure those services are designed around your needs.

As a patient, resident or someone who works in Halton you also need to make a commitment to do things differently and take an active role in prevention.

Eating healthy, getting more active and most importantly asking for help when you need it.

Health is a shared responsibility and only by working together can we achieve our vision of healthier, happier lives for everyone.

For prevention to succeed we need individuals and communities to play their part too. This involves making healthier choices for ourselves and our families, eating well, staying active, being smoke free and taking care of our mental health. Health is a shared responsibility and only by working together can we achieve our vision of healthier, happier lives for everyone.

Together, we will:

- Focus on people and places not organisations.
- Take a life course approach
- Work in partnership to co-produce
- Be financially sustainable
- Align budgets
- Be fair
- Be innovative
- Strive for best quality services.
- Safeguarding commissioning landscape as it changes
- Be accountable and hold to account to offer assurance (system oversight)

Our Priorities are:

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

How will we measure success?

Ultimate responsibility for the implementation of the One Halton Health and Wellbeing Strategy and the One Halton Plan lies with the Halton Health and Wellbeing Board.

The outcomes are monitored and reported quarterly through the Health and Wellbeing Dashboard (see appendix X).

The Health and Wellbeing Board is a public meeting and residents are encouraged to attend to find out more about what is going on across Health and Social Care in Halton.

CONTACTS

If you have any queries relating to One Halton, in first instance please contact:

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Runcorn Town Hall
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Email xxxx

Alternatively you can contact;

Councillor Rob Polhil
Chair of Halton Health and Wellbeing Board
Leader of Halton Borough Council
xxx
David Parr
Senior Responsible Officer – One Halton
Chief Executive – Halton Borough Council
Xxxx

APPENDIX 1

Cheshire & Merseyside Healthcare Partnership

APPENDIX 2

Halton PCN vision

Our PCN vision has three elements:

1. Keep local people healthy.
2. Deliver high quality, responsive care by working together in an integrated, multi-disciplinary way across our community.
3. Create a great place to work

A key aspect of our vision is to maintain care continuity for those people who need it the most. We want to provide more support for these people and their families. We believe the best way to achieve this is by working in a more integrated and team-based way across partners, working together in the community to better support these people and their on-going needs. By doing this, the 'system' can respond quicker in the community, providing care closer to home, meaning people only need to go to hospital when specialist intervention is required. We can reduce duplication. We can better coordinate how, when and where care and support is provided.

To achieve this, we need to create the capacity in the community and our plan to deliver this to change the way we provide 'acute on the day' services. Our vision is to fully integrate and align General Practice with the Urgent Care/Treatment Centres (UTCs). They will become one entity.

Our vision is to create seamless services between the practices, teams in our communities and the UTCs, with standardised and common pathways and fully integrated, electronic health records.

When we achieve this, people seeking an 'on the day' acute appointment in General Practice will be offered, where appropriate, pre-bookable appointments in the UTC where they will see a clinician appropriate for their need. The UTCs will provide multi-disciplinary services that go beyond the traditional clinical offer. People and staff will have direct access Well Being, Social Care and Third Sector services, all co-located in the same place, offering one-stop services and support.

By approaching acute on the day demand in this way and working together, it will free up capacity in the community to deliver the level of high-quality, responsive care continuity we strive to for our most vulnerable people. Those with on-going and complex health and social needs, those who are in the palliative care stage of life and their loved ones, those with learning disabilities, those with mental health challenges and those who are frail.

To provide the very best care continuity, we will adopt a fully integrated multi-agency approach that includes community teams, social care, mental health, well-being, hospital services, public health, third sector and housing (list not exhaustive).

Where rapid intervention and support in the community will prevent individuals from needing to be admitted into one of our local hospitals.

Where on-going support and education will help to keep people and families healthier.

We also recognise that the resource does not exist in the system to provide this fully integrated model in every practice. Therefore, our vision is to deliver this model across our four community hubs. By working together in a more coordinated, more responsive and more integrated way, we are confident we can change the way care is accessed and delivered in our community.

We have already started this work. We are integrating General Practice and Community Services teams into our Community Hub model. Clinically led work is underway to develop and implement this new model that focuses on multi-disciplinary working, communication, risk stratification and escalation and complex case management.

We are adopting a phased approach, bringing in teams and services one by one. This will be coordinated and overseen by the newly formed Provider Alliance. The teams and services we see being essential to this community based multi-agency model include social workers, mental health, third sector, well-being, health improvement, pharmacy and housing.

This change is about putting the patient at the centre of everything we do. To learn from each other and evidence-based best practice. We need to remove the organisational boundaries and not be constrained by bureaucracy. We need to work with our partners and the public to re-design and implement the very best services and support our resources can deliver.

If we do this, we are also confident that we can create a work place and career path that will be very attractive to both recruit and retain a workforce who share this passion and vision. Working together, empowering our front-line teams, utilising the collective skills of our workforce, rotating staff through different services, offering portfolio careers, our view is that a stable and highly motivated workforce will deliver the high-quality services that people in our local communities deserve.

Phase 1	Phase 2
General Practice	3rd sector rep.
Social Care	Housing
Bridgewater	Faith
NWB	Schools/education
W&H/StHK	Employers
WellBeing Enterprises	Youth services
Health Improvement Team	Dental
Pharmacy	Optometry
NWAS	Leisure/libraries

PCN Strategic goals

Building on previous engagement work through the One Halton Programme, ten Strategic Goals were developed by system partners to ensure Halton residents benefit from a sustainable, safe and effective out of hospital delivery system:

1. Manage demand for services by promoting self-care independence and prevention;
2. Enable health and social care service integration wherever possible and appropriate;
3. Design services around users and not organisations;
4. Treat people in the home and community for as long as it is appropriate and possible;
5. Reduce dependence on oversubscribed specialist resources such as emergency services, non-elective admissions and care homes;
6. Manage length of stay in hospitals, avoid delays to discharge and prevent readmissions where possible;
7. Allow system efficiencies to be realised – duplication and over supply is eliminated while "cost shift" from one service line or organisation to another is avoided;
8. Create the climate for staff from different professional backgrounds to work together in a positive, open and trusting multi-disciplinary climate;
9. Allow every member of staff to be trained in having new conversations with residents that focus on assets rather than need; and
10. Make full use of digital technology, including development of a joined-up electronic record.

MENTAL HEALTH	15	Emergency self-harm admissions *Directly Standardised Rate per 100,000 population*	All	343.8	2010/11	340.0	185.5	2017/18	337.7	2018/19	
	16	Self reported wellbeing: low happiness *% of adults reporting low happiness*	16+	11.1%	2011/12	9.7%	8.8%	2017/18	9.4%	2018/19	
	17	Social isolation *% of adult social care users who have as much social contact as they would like*	18+	43.8%	2010/11	54.4%	48.1%	2017/18	-	-	
CANCER	18	Premature mortality from cancer *Directly Standardised Rate per 100,000 population*	<75	213.4	2001-03	169.1	148.5	2015-17	170.9	2016-18	
	19	Cancer screening coverage: bowel *% eligible people invited for screening with a FOBt screening result in last 30 months*	60-74	52.2%	2015	57.0%	58.9%	2018	60%	National standard	
	20	Cancer screening coverage: breast *% women eligible for screening with a test with a recorded result once in previous 36 months*	53-70	74.3%	2010	73.4%	73.4%	2018	70%	National standard	
	21	Cancer screening coverage: cervical *% eligible women screened adequately in previous 3.5 years*	25-64	70.2%	2010	71.8%	71.8%	2018	80%	National standard	
QUALITY OF LIFE FOR OLDER PEOPLE	22	Flu vaccination uptake *% of eligible adults aged 65+ who received the flu vaccine, GP registered population*	65+	74.8%	2010/11	73.7%	75.3%	2017/18	75.0%	2018/19	
	23	Emergency admissions to hospital due to injuries from falls *Directly Standardised Rate per 100,000 population*	65+	3864.9	2010/11	2937.1	2398.5	2017/18	2900.0	2018/19	
	24	Emergency admissions to hospital due to hip fractures *Directly Standardised Rate per 100,000 population*	65+	637.2	2010/11	674.5	617.2	2017/18	665.0	2018/19	
	25	Health-related quality of life for older people *Average health status score for adults*	65+	0.662	2011/12	0.689	0.716	2016/17	-	-	
	26	Permanent admissions to residential/nursing care homes *Crude rate per 100,000 population*	65+	575.9	2010/11	562.0	756.0	2017/18	-	-	
	27	Male life expectancy at 65 *Avg. no. of years males would expect to live based on contemporary mortality rates*	65+	14.8	2001-03	17.5	18.0	2015-17	17.6	2016-18	
	28	Female life expectancy at 65 *Avg. no. of years females would expect to live based on contemporary mortality rates*	65+	17.5	2001-03	19.3	20.2	2015-17	19.4	2016-18	
A&E		**CQC PRIORITIES**									
	29	A&E attendances *Directly Standardised Rate per 1,000 population*	All	359.0	2011/12	746.2	-	2017/18	-	-	
	30	A&E attendances *Directly Standardised Rate per 1,000 population*	0-19	420.8	2010/11	942.1	499.2	2016/17	-	-	
	31	A&E attendances *Directly Standardised Rate per 1,000 population*	65+	422.8	2011/12	734.5	-	2017/18	-	-	
HOSPITAL ADMISSIONS / READMISSIONS	32	Emergency admissions to hospital *Directly Standardised Rate per 1,000 population*	0-19	104.5	2010/11	110.4	97.3	2016/17	-	-	
	33	Emergency admissions to hospital *Directly Standardised Rate per 1,000 population*	65+	590.0	2011/12	574.4	-	2017/18	-	-	
	34	Length of hospital stay *Percentage of emergency admissions among those aged 65+ lasting longer than 7 days*	All	32%	Q3 17/18	32%	-	Q4 17/18	-	-	
	35	Emergency readmissions to hospital from care homes *% of emergency readmissions from care home within 30 days of discharge*		29%	Q3 17/18	17%	-	Q4 17/18	-	-	
	36	Emergency readmissions to hospital (30 days) *% of patients readmitted to hospital within 30 days of discharge for all causes*	All	13.5	2013/14	14.1%	13.8%	2017/18	-	-	

Health and Wellbeing Board Dashboard

**Targets only available for QMR indicators, those without target are not currently benchmarked locally*

Data correct as of: 08/05/2019

			Ages	Baseline	Period	Current	NW	Period	Target	Year	Trendline
		HEALTH & WELLBEING BOARD PRIORITIES									
CHILD DEVELOPMENT	1	Child development at age 5 *% of eligible children achieving a good level of development at the end of reception*	5	37.0%	2012/13	64.5%	68.9%	2017/18	66.5%	2018/19	
	2	A&E attendances *Crude rate per 1,000*	0-4	535	2010/11	1627.2	766.6	2017/18	-	-	
	3	Children in care *Crude rate per 10,000 children*	0-17	47.0	2011	92.2	91.2	2018	-	-	
	4	Obese children - Reception *% of children who are obese*	4-5	11.6%	2006/07	11.4%	10.2%	2017/18	*Awaiting*		
	5	Obese children - Year 6 *% of children who are obese*	10-11	21.7%	2006/07	23.4%	21.0%	2017/18	*Awaiting*		
	6	Hospital admissions for mental health conditions *Crude rate per 100,000*	0-17	179.5	2010/11	137.3	105.6	2017/18	-	-	
GENERALLY WELL	7	Adults achieving recommended levels of physical activity *% of adults achieving 150+ minutes of moderate intensity equivalent per week*	19+	59.0%	2015/16	65.2%	53.7%	2016/17	67.0%	2017/18	
	8	Adults with excess weight *% of adults classified as overweight or obese*	18+	70.5%	2015/16	61.1%	64.3%	2016/17	58.0%	2017/18	
	9	Under-18 alcohol-specific admission episodes *Crude rate per 100,000 population*	<18	201.8	06/07-08/09	57.6	47.6	15/16-17/18	55.6	16/17-18/19	
	10	Alcohol-related admissions episodes (narrow definition) *Directly Standardised Rate per 100,000 population*	All	754.4	2008/09	830.2	699.9	2017/18	827.7	2018/19	
	11	Premature mortality from liver disease *Directly Standardised Rate per 100,000 population*	<75	23.4	2001-03	31.4	26.3	2015/17	-	-	
LONG TERM CONDITIONS	12	Smoking prevalence *% of adults who currently smoke*	18+	22.9%	2011	15.0%	16.1%	2017	14.8%	2018	
	13	Premature mortality from cardiovascular disease *Directly Standardised Rate per 100,000 population*	<75	177.4	2001-03	91.3	87	2015-17	88.9	2016-18	
	14	Premature mortality from respiratory disease *Directly Standardised Rate per 100,000 population*	<75	50.7	2001-03	50.3	45.8	2015-17	50.5	2016-18	