REPORT TO:	Halton Health and Wellbeing Board
DATE:	8th October 2025
REPORTING OFFICER:	Director of Public Health
PORTFOLIO:	Health and Wellbeing
SUBJECT:	Stronger for Longer Service
WARD(S)	All Wards

1.0 PURPOSE OF THE REPORT

1.1 To inform Health and Wellbeing Board members about the launch of a new service aimed at supporting adults in Halton over the age of 55 'Stronger for Longer'.

2.0 RECOMMENDED: That

1) **the report be noted; and**
2) **the Board agrees to engage with promotion of the new service and to look for opportunities for partnership working between organisations working with the older population in Halton.**

3.0 SUPPORTING INFORMATION

3.1 Stronger for Longer Service Development Process

For a number of years the Halton Borough Council (HBC) Public Health Ageing Well offer, has provided a range of in community services to support residents over 55 years of age to remain healthy, connected and independent in Halton. This includes Get Together social events, regular chats with the team afternoons and the 1:1 information and advice service know as Sure Start to Later Life.

Previously the 1:1 service was limited to the sharing of information and resources with the expectation that clients would act independently to access services. The team of Information Officers would carry out an in-person visits to a clients home, getting to know the client and their needs, providing information on local services. Clients would then be followed to review their progress. Although this was sufficient for some clients, it is clear that most of those referred to the service required a more intensive approach in order to support them to access the local community.

3.2 Following a full review of client feedback, service level data and local health priorities a new model of service delivery was required. The result of this development work is the Stronger for Longer Service.
Stronger for Longer will focus on closer collaboration with the clients over the age of 55 to break down barriers to accessing groups that will improve health and wellbeing. This change brings the service in line with the full holistic offer of the Health Improvement Team (HIT), integrating our service with the range of preventative services the team specialises in.

3.3 The Stronger for Longer Service is a structured 12 week programme with the intensity of support tailored to the individual in question. Once referred into the service a client will be visited in their home for an initial assessment. The assessment is broken down into four sections.

1. The team will get to know the client and make them comfortable with the service. Discuss their current routine, how often they access the community and attend social activities, getting to know what interests they could be supported in pursuing.

2. Assessment of the clients current support network, for example who they live with, do they use public transport, do they have the support of a carer.

3. Assessment of a clients health and wellbeing including taking blood pressure and checking for risks of falls. This is in line with the wider preventative aims of the HIT and clients will be supported to access the wider offer of the team.

4. Goal Setting. Together with the client, a handful of clear goals will be agreed to work towards over the following 12 weeks. A level of support needed to achieve these goals will also be agreed upon. This is broken down into 3 tiers.

   Tier 1: For those clients who only require some information and advice and would prefer to access these independently.
   Tier 2: For clients requiring more of a connection with the team, following up on availability of local services and making referrals on behalf of the client.
   Tier 3: For clients requiring in person support from the team. Accompanying clients to events in the community they are currently missing out on. For example, this could be to attend a HIT Weight Management class or a knit and natter group to pick up a new hobby and meet new friends in the community. The Stronger for Longer Team will provide 1:1 support to the client over the 12 week programme to attend classes with them, overcoming barriers to access and make

sure they are comfortable making new connections in the community.

3.4 Over the course of the programme a clients progress will be reviewed after 6 weeks and at the end of the 12 week course. Adjustments will be made to goals after 6 weeks if required with support tailored to a clients needs. On completing the course after 12 weeks a reassessment of the clients situation and the improvements that have been made to reduce their social isolation will take place.

3.5 The Stronger for Longer Service launched in early August 2025 and one of the first clients was Irene, a 64-year-old woman from Widnes. During the initial assessment, she shared that she hadn't been out socially in over two years and often couldn't find the motivation to get dressed in the mornings.

She was introduced to a range of local community activities and showed a particular interest in the Upton Get Together Group, held close to her home. With her consent, staff provided level 2 barrier breaking support and supported her to book and pay for the next session, which was taking place just a few days later.

She attended the event independently, armed with the knowledge that her Age Well worker would be there to greet her and integrate her in to the session. Irene engaged with others, enjoyed making conversation, taking part in activities and even got up to dance. She was delighted to win a raffle prize and told staff how much she was enjoying herself. By the end of the afternoon, she had made a connection with another attendee and arranged to go to an aqua exercise class together the following week. The two have since become close friends and are regularly enjoying attending the new leisure centre pool.

This simple but timely support led to meaningful change, helping her reconnect socially, improve her confidence, and take steps to become more physically active, all of which contribute positively to her health and wellbeing.

3.6 To promote the new service a launch event was held in July at the DCBL Stadium. At the event the new service model was outlined to attendees, with information on how local groups and individuals can refer into the service (including the criteria the service will apply to determine suitability for the program), and how services can work in partnership with the Stronger for Longer team and wider HIT services in the future.
Attendees at the launch event came from a range of organisations and services including HBC Adult Social Care, Community Development and Library Services as well as representation from

the NHS and 3rd sector organisations such as the Red Cross and Age UK.
For further information on the service model including referral criteria please email the HIT Ageing Well Team at age.well@halton.gov.uk.
Referrals into the service can be done using the general HIT referral form and emailed to HIT@halton.gov.uk

4.0 POLICY IMPLICATIONS

4.1 The support of the older population in Halton is a consideration in a wide variety of policy decisions, including housing policy, Adult social care policy, transport policy.

4.2 A preventative approach to health services across Halton will support local residents to live longer lives, and crucially to live longer of their lives in good health

5.0 FINANCIAL IMPLICATIONS

5.1 Adult Social care remains one of the local authorities largest areas of expenditure with demand rising with an ageing population. As such, preventative support to keep residents in good health is an essential part of reducing the costs of expensive intervention for residents whose health has deteriorated.

6.0 IMPLICATIONS FOR THE COUNCIL'S PRIORITIES

6.1 Improving Health, Promoting Wellbeing and Supporting Greater Independence

The change to the service will prioritise intense support to residents to sustainably access community groups and improve their independence in the community.

6.2 Building a Strong, Sustainable Local Economy

As our service supports residents 55+ to improve their health and wellbeing we can support those still able to work to remain in good health.

6.3 Supporting Children, Young People and Families

The service will continue to look into the opportunities to promote intergenerational work within care settings with some early work in this area well received by residents and staff.

6.4 Tackling Inequality and Helping Those Who Are Most In Need

Residents isolated from the community are unable to access local health services or essential support services in a timely manner.

The team will be helping residents in their assessments access support for cost of living issues and housing support if required.

6.5 Working Towards a Greener Future

We will be promoting health classes such as local walking groups, encouraging residents to continue with active travel as a means of transport.

6.6 Valuing and Appreciating Halton and Our Community

As part of helping connect residents locally we will be building a portfolio of local activities to inform groups and residents what is available in Halton from both council offers and the 3rd sector.

6.7 Resilient and Reliable Organisation

By enhancing the prevention offer we hope to keep residents healthy and independent for longer reducing the pressure of demand on Adult Social Care services.

7.0 RISK ANALYSIS

7.1 Introduction of this service presents no additional risk to the Local Authority.

8.0 EQUALITY AND DIVERSITY ISSUES

8.1 Through monitoring referral patterns and client database the Stronger for Longer Service will develop approaches to ensure equitable access to the service across different populations of local residents.

9.0 CLIMATE CHANGE IMPLICATIONS

9.1 The service aims to keep residents mobile whether its through falls prevention work, fresh start classes aimed at weight loss and exercise or walk and talk groups that meet locally on a weekly basis. All of this will keep residents engaged with active travel and reduce the need to for short travel using cars or taxis.

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

All reports must contain this heading. Background papers are described as those upon which you have relied to write your report. They could for example be Government legislation,

previous Board reports or Strategies. State the title of the document(s), where they can be inspected and a contact officer. **‘None under the meaning of the Act.**’