One **Halton**

Place Based Plan

2019 - 2024

OneHalton
Working better together

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 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.

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.

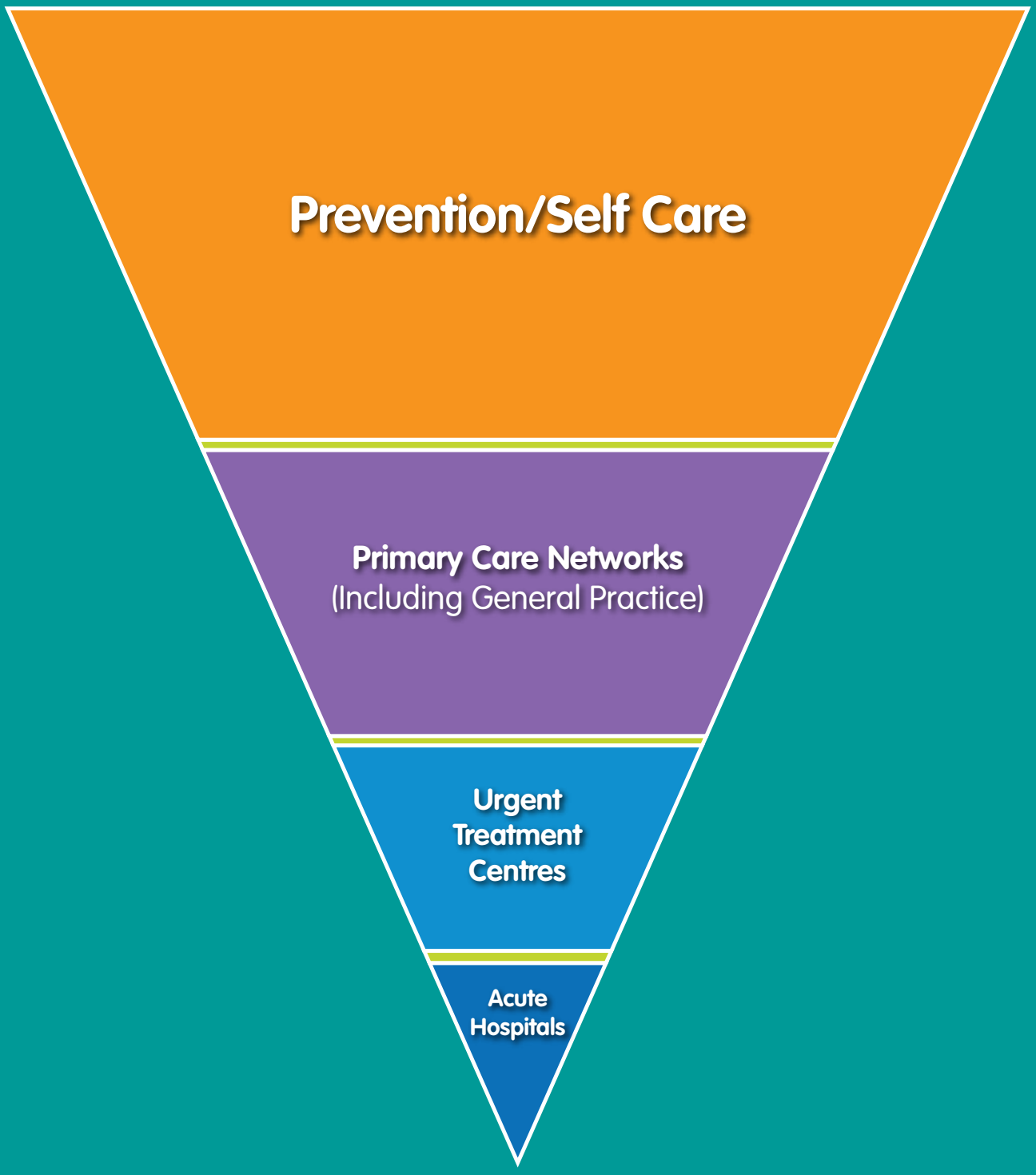
We want to support people to live well and healthily and we will do this by all working together.

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

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

Out of Hospital Model

With greater focus on prevention, in Halton we need a fundamental shift to provide more care in the community, meaning people can be treated closer to home without the need to go into a hospital.



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 North West 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 the 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

In 2017, the Health and Wellbeing Board published a "One Halton Health and Wellbeing Strategy". The Strategy was jointly developed after extensive consultation[1] 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**

These remain our priority areas today[2] 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.

1 See Appendix 1; Joint Health and Wellbeing Strategy Engagement Plan 2017
2 See Appendix 2; Healthwatch consultation

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 health challenges

LIFE EXPECTANCY & MORTALITY

Healthy life expectancy

4 6

years less than the England average

285 preventable deaths per year

MATERNITY & INFANT HEALTH

Low rates of breastfeeding

High rates of smoking at time of delivery

DEPRIVATION & INEQUALITIES

of Halton's residents live in areas among the 20% most deprived in England

The life expectancy gap between the most deprived and least deprived ward is:

13.7 years 9.3 years

Halton Lea vs Birchfield

HEALTHY LIFESTYLE

High rates of alcohol admissions for both adults and under 18s

MENTAL HEALTH

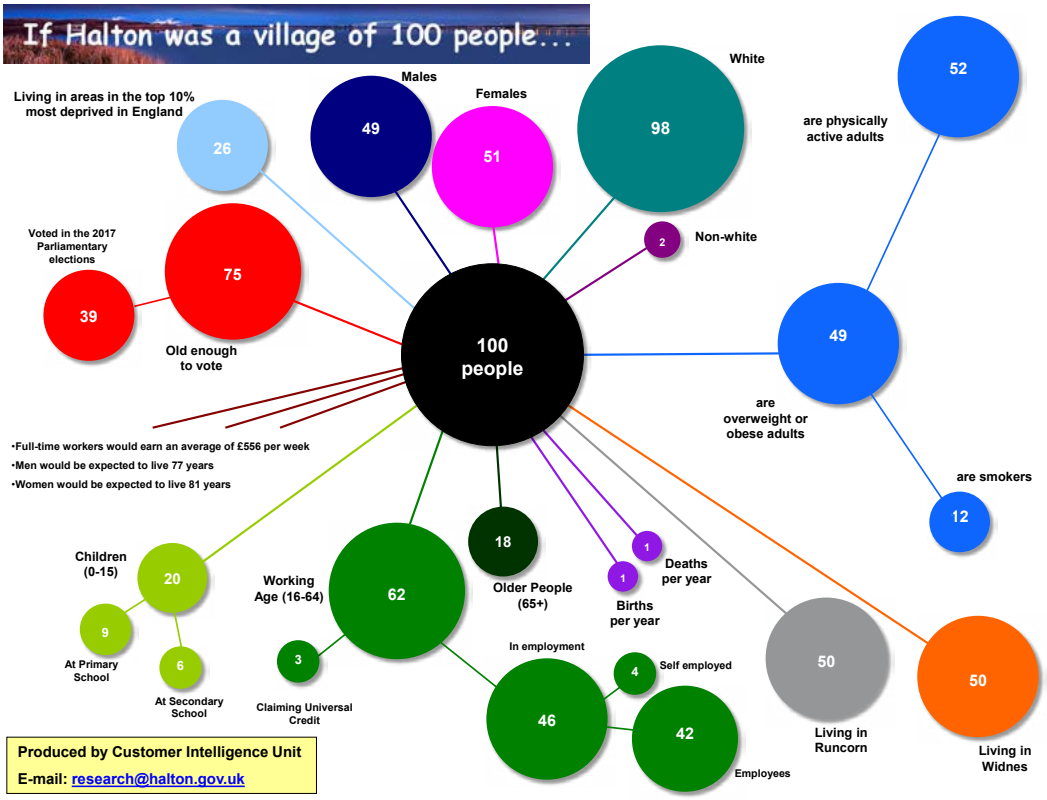
Mental & behavioural disorders account for more years of disability than any other cause

OLDER PEOPLE

Low flu vaccination coverage

High numbers of falls

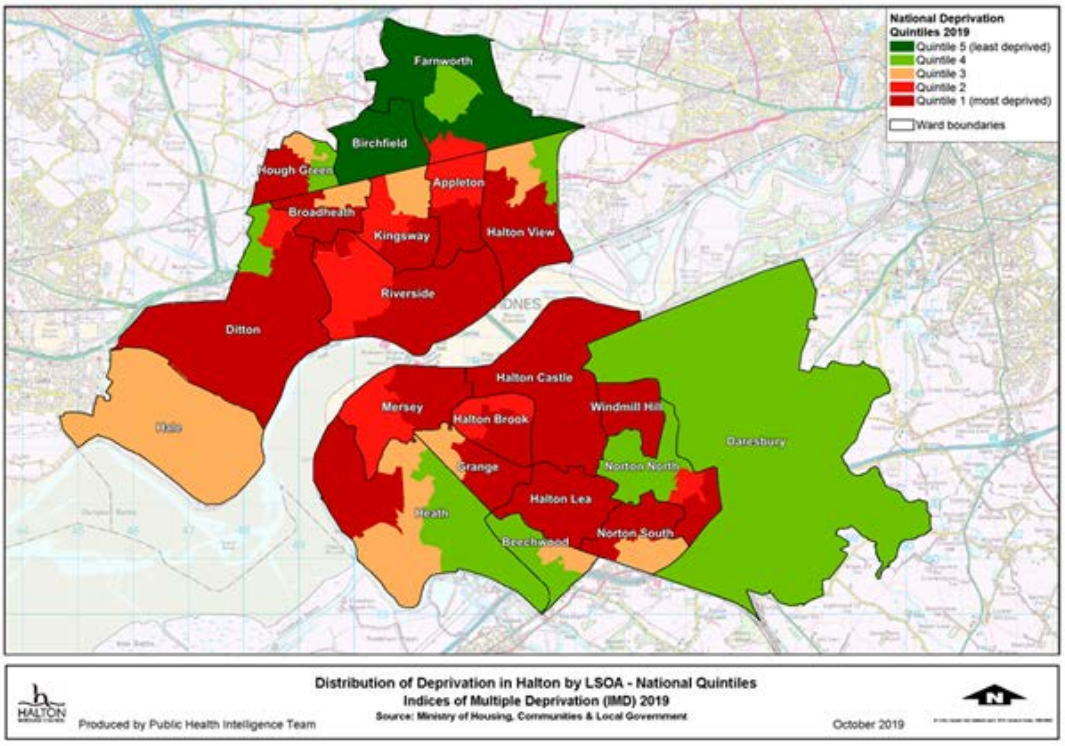
Our current population:



Halton is ranked as the 23rd most deprived area in England out of 317 Local Authorities[3].

Halton Deprivation Map:

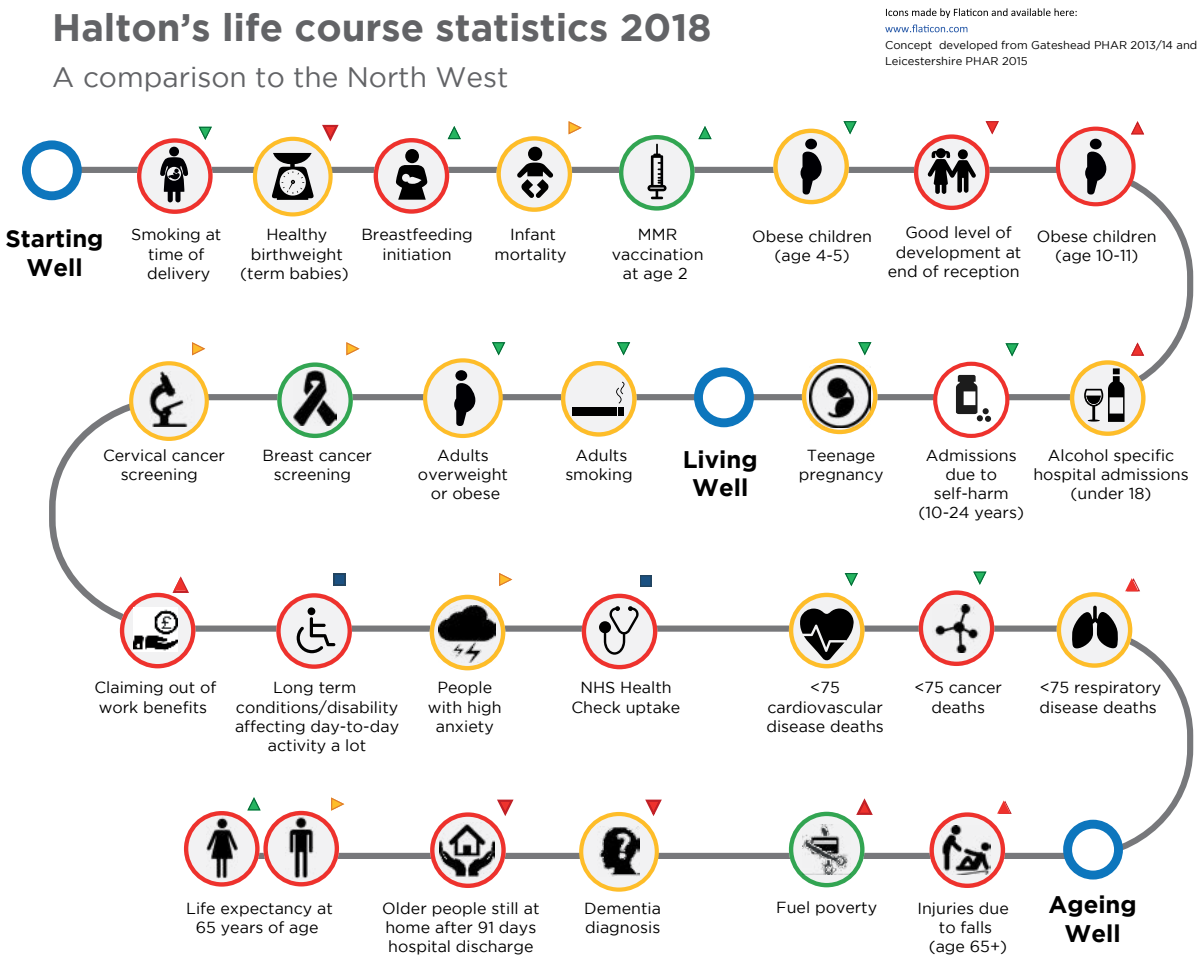
Higher levels of deprivation is related to poorer health outcomes. The map below shows the variances within Halton.



3 Based on The Index of Multiple Deprivation 2019

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.



HALTON FACTS

Population

About **127,600** people live in Halton. By 2030, this is projected to change:

age 0 - 14 ↓ 7.1%
age 15 - 64 ↓ 3.7%
age 65+ ↑ 30.3%

Deprivation

48.5% of Halton's population live in the top **20%** most deprived areas in England.

Child Poverty

21.7% of children aged 0 - 15 live in poverty in Halton

KEY

Direction of travel

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

Statistical significance to North West

- Better
- No different
- Worse

For more information & data sources

Please contact Halton Borough Council's Public Health Intelligence Team:
health.intelligence@halton.gcsx.gov.uk

Improvements so far: In the last 3 years Halton has made some improvements in Adult Obesity and Cervical Cancer Screening to bring these more into line with the North West average.

Work still to do: However there are some areas, where Halton has not improved or it has not improved as fast as other areas. These include Healthy Birthweight, Childhood Obesity (Aged 10-11) and Dementia Diagnosis. Together we will need to ensure these areas retain a high level of focus.

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[4]. However projections indicate a change in our demographics and by 2036 the population of 0-15 year olds will decrease by 7%, 16-64 will also decrease, but the number of people over 65 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, who 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 asylum 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.

4 (ONS, 2017)

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.

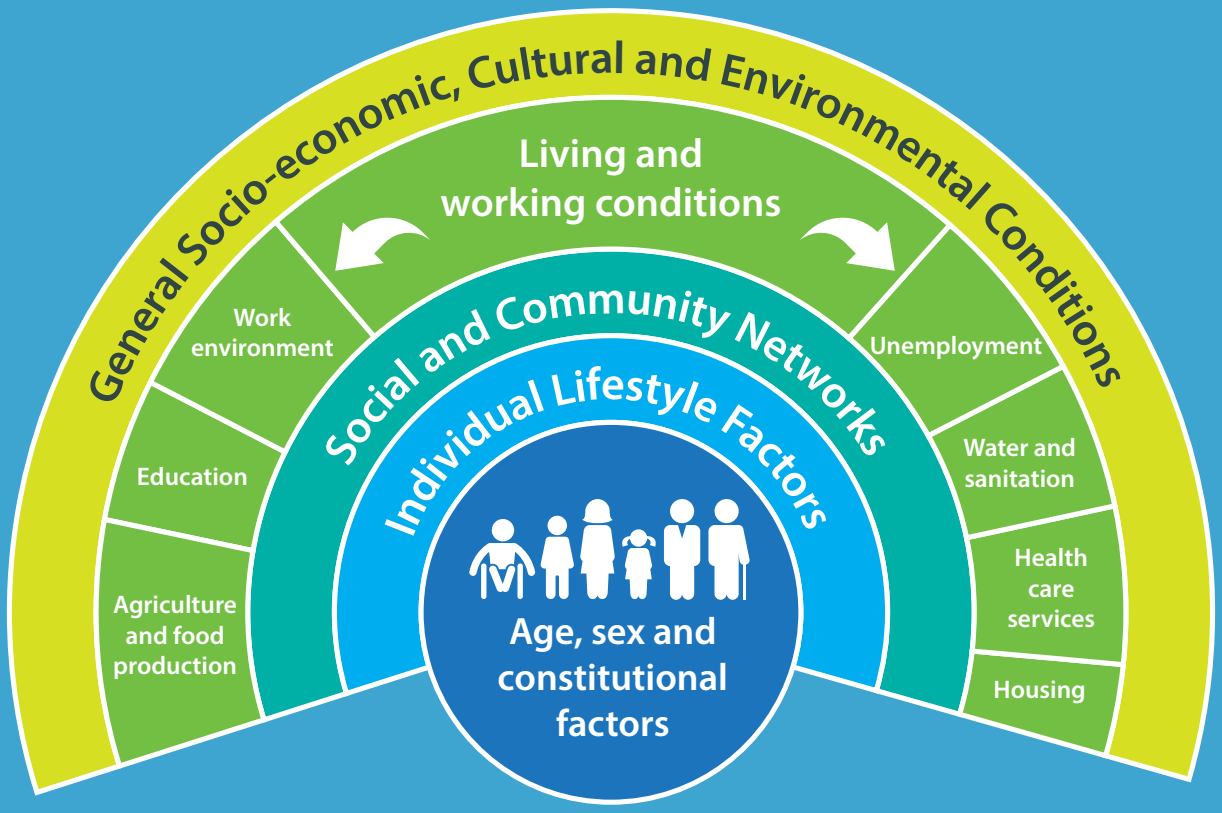
Wider determinants of health

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:

The Social Determinants of Health

Source: Dahlgren and Whitehead (1993)



- 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.

One **Halton** *Place Based Plan 2019-2024*

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 been making good progress in other areas too:

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
STFC Talking Science: Working in partnership with STFC Daresbury Labs to deliver a range of community science events aimed at Halton's young people.	This will help support our local workforce ambition, more Halton people in Halton jobs.
Partnership with Police Crime Commissioner: Well Halton has been working closely with the PCC on a number of projects, including some anti knife projects.	This helps to support our goal to reduce violent crime

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

Cheshire Fire and Rescue
Cheshire Fire and Rescue provide help towards the key local health priorities through Safe and Well visits. This service began in February 2017 and continues to provide value support to people living in Halton. In the six month period 1st April 2019 to 30th September 2019, they undertook 2,368 Safe and Well visits in Halton which resulted in;

1 alcohol reduction referral

81 Atrial Fibrillation screenings, **resulting in 5 GP referrals**

20 referrals to the local authority falls team

123 loneliness screenings, **resulting in 9 referrals.**

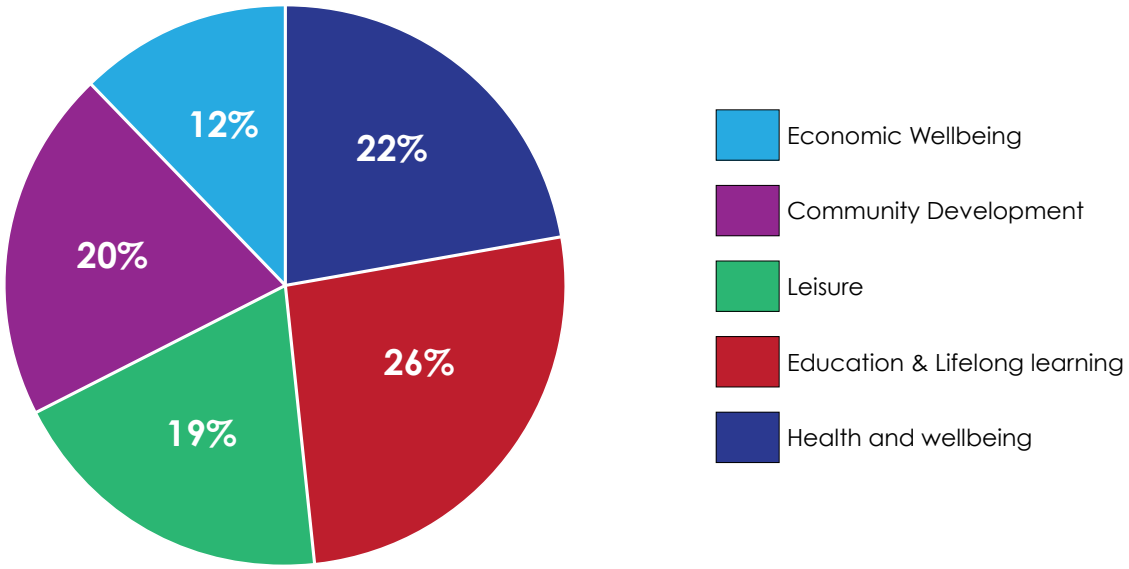
Voluntary sector

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[5]. **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

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.

The main areas of work the voluntary sector provides are:



Air Quality

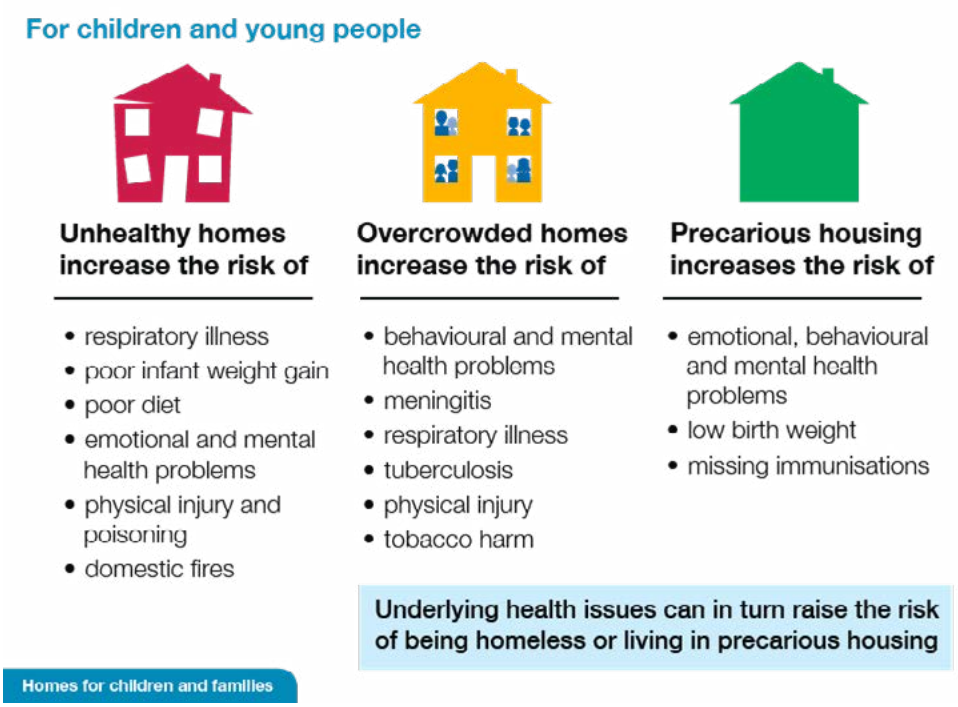
Air pollution particularly affects the most vulnerable in society – children and older people, and those with heart and lung conditions. In the last 20 years Halton has vastly improved its air quality and will continue to reduce air pollution.

Housing

5 According to the Money and Mental Health Policy Institute

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. [6]



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.

6 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.

Further detail on how Halton aims to deliver the NHS Long Term Plan is available as Appendix 3

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 and Merseyside Health and Care 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).

Cheshire and Merseyside Health and Care Partnership have created a five year strategy called "Better Lives Now"
They have a universal goal which is to reduce health inequalities across Cheshire and Merseyside. They have set four local priorities which are:

- Zero suicide
- Zero stroke
- No harm from alcohol
- No harm from violent crime

One Halton will work closely with Cheshire and Merseyside colleagues through the partnership programme to introduce changes and new services that support those priorities.

How the Cheshire and Merseyside Priorities link to One Halton Priorities	How we will implement
Zero suicides and no harm from violent 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. We also work closely with Cheshire Police reducing violent crime locally.
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. Specifically in Halton tackling the issues around cheap alcohol with the introduction of a Minimum Unit Pricing (MUP).
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.

Cheshire and Merseyside Health and Care Partnership help to deliver improvements at a greater paceand scale. They have a number of programmes that exist to implement a single approach across Cheshire and 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 4.

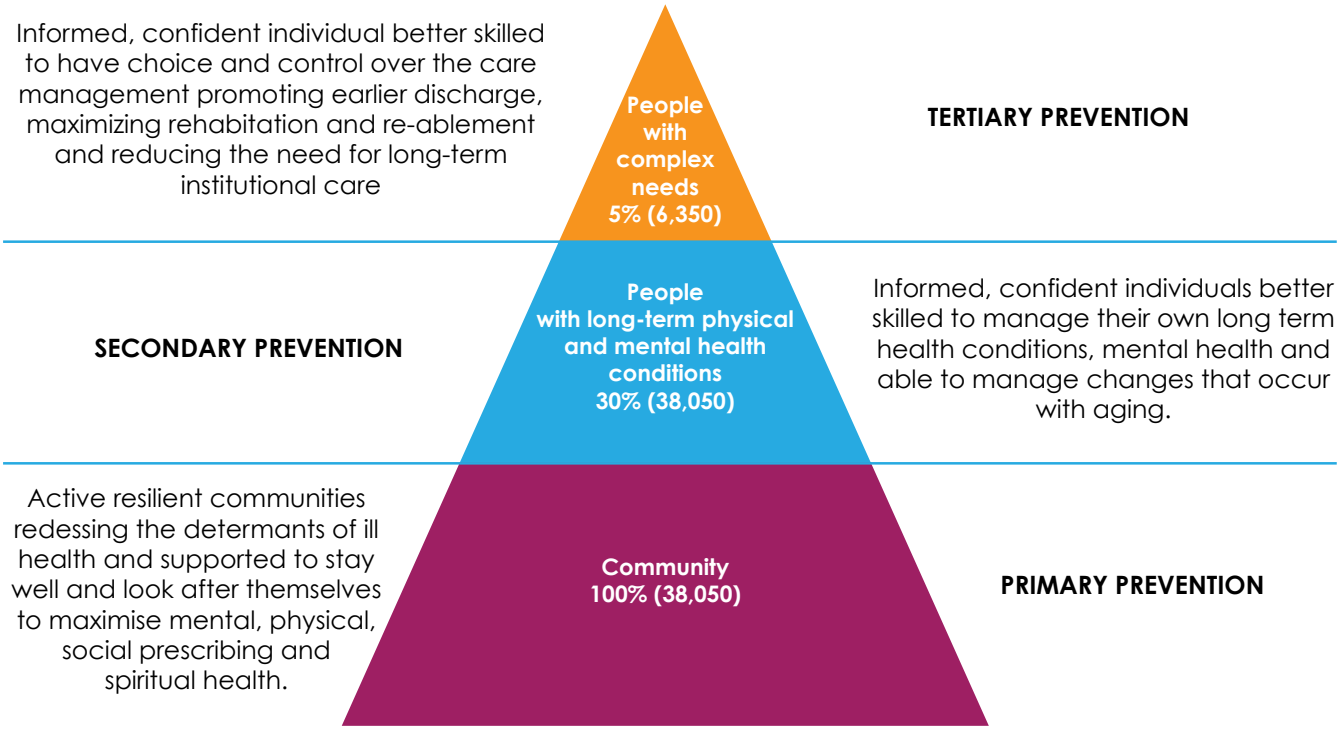
Empower people to take better control of their own health.

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 ONE HALTON PREVENTION & POPULATION HEALTH MODEL TARGET POPULATIONS AND OUTCOMES



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.

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 Programme including Healthitude and Fit4Life	Halton Health Improvement Team	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 Healthy 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
	Deliver specific Physical Activity Programmes such as "Active Me", a community wide project working with a wide range of partners to set up new physical activity sessions where need has been identified	Sports and Physical Activity Officer within Halton Borough Council.	2019/20
Prevent Diabetes	NHS Diabetes Prevention Programme	NHS England, Public Health England (PHE) and Diabetes UK	2019/20
Tackle Alcohol Admissions and Alcohol Harm in our Community – 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	2020/21
	Implement 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.	Local working group established, comprising of a range of Halton stakeholders.	ongoing
	Fibroscan Project Offering 'liver scans' in Primary Care, the community & hospitals as a new route into alcohol treatment	CHAMPs, led by Halton Public Health will prepare the proposed delivery	2019/20
	Consider the introduction of an alcohol Minimum Unit Pricing (MUP);	Halton Borough Council	2023/24
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

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. The CURE model will include all vulnerable groups.	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 Brooker 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
Manage Respiratory Disease	Implement a community based COPD team. Develop a holistic and multiple wrap around services for patients to access not only symptom management but disease management and lifestyle interventions where necessary.	Collaboratively between Primary Care and Acute Hospitals.	2020/21
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.	Everyone will be involved	2023/24
	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		

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	All Partners in One Halton	2020/21
10% reduction in suicides	Implement the local suicide reduction programme (NHS Long Term Plan)	Cheshire and Merseyside Health and Care Partnership	2023/24
	You're never too young to talk" mental health campaign, 5 Ways to Wellbeing Award	Health Improvement Team	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	Health Improvement Team	2024
	Training such as Self Harm and Basic Mental Health	Health Improvement Team	2024
	Named school link workers in community service settings and in primary and secondary schools across Halton.	Primary Care and Bridgewater Community Trust	2024
	IAPT services and co-location of therapists in primary care	Primary Care and Bridgewater Community Trust	
	Enhancing the psychological therapies to support adults with a personality disorder	Primary Care and Bridgewater Community Trust	
	Implementation of the Cheshire and Merseyside Crisis Care Model, to include Crisis Resolution Home Treatment Teams in place.	Ddelivering 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	2024
Access to Perinatal Mental Health extended to 24 months after birth and to include partners too.	C&M Wide Perinatal mental health service	Cheshire and Merseyside Health and Care Partnership	2020/21
All ages mental health liaison teams in place	Implement in all acute hospitals	St Helens and Knowsley Trust and Warrington and Halton Hospital	2020/21
Develop community services for children, young people and adults with Learning Disabilities and/ or Autism	Provision of risk stratification and crisis support, as well as the development of keyworker roles for children and young people with more complex needs.	All Partners in One Halton	2023/24
Improve GP medication reviews	Implementation of STOMP/STAMP agendas for people with Learning Disabilities and/ or Autism.	Primary Care Newtorks	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	Halton CCG	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
	Offer brief advice about bowel cancer and request bowel cancer screening kits as part of their Safe and Well visits	Cheshire Fire and Rescue	Ongoing
Improve Cancer treatments	Radiotherapy service	St Helens and Knowsley Trust and Warrington and Halton Hospital	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	All Partners in One Halton	2019
	Age Well exercise programme	Halton Health Improvement Team	Ongoing
Provide more services in the community for frail elderly patients	Halton Integrated Frailty Service	All Providers in One Halton	2019
Reduce Loneliness	Implement the Loneliness Strategy	All partners in Halton	Ongoing
	Increase awareness and offer therapeutic activities in Halton	Voluntary Sector	Ongoing
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.	Halton CCG and Halton Borough Council	Ongoing
Rooftop Garden	Physical space for community usage. Improved wellbeing. Opportunities for growing and education.	Well Halton	Q1 2020/21
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.	Warrington & Halton Hospital	Redeveloped hospital facilities: 2025; remaining campus facilities 2028
Focus on Dementia	Currently reviewing dementia care and support priorities. . A local delivery plan will be produced which will clearly define health and adult social care priorities going forward.	Halton Borough Council, supported by Halton Dementia Action Alliance	2019/20
	Promote Dementia Friendly Organisations and Increase the number of Dementia Friends	Halton Borough Council, through local libraries and leisure centres, supported by elected members becoming Dementia Friends	2019/20
	proving 1:1 information, service navigation, signposting and practical support to people living with dementia	Dementia Care Advisor service (Commissioned by Halton Borough Council)	2019/20

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.

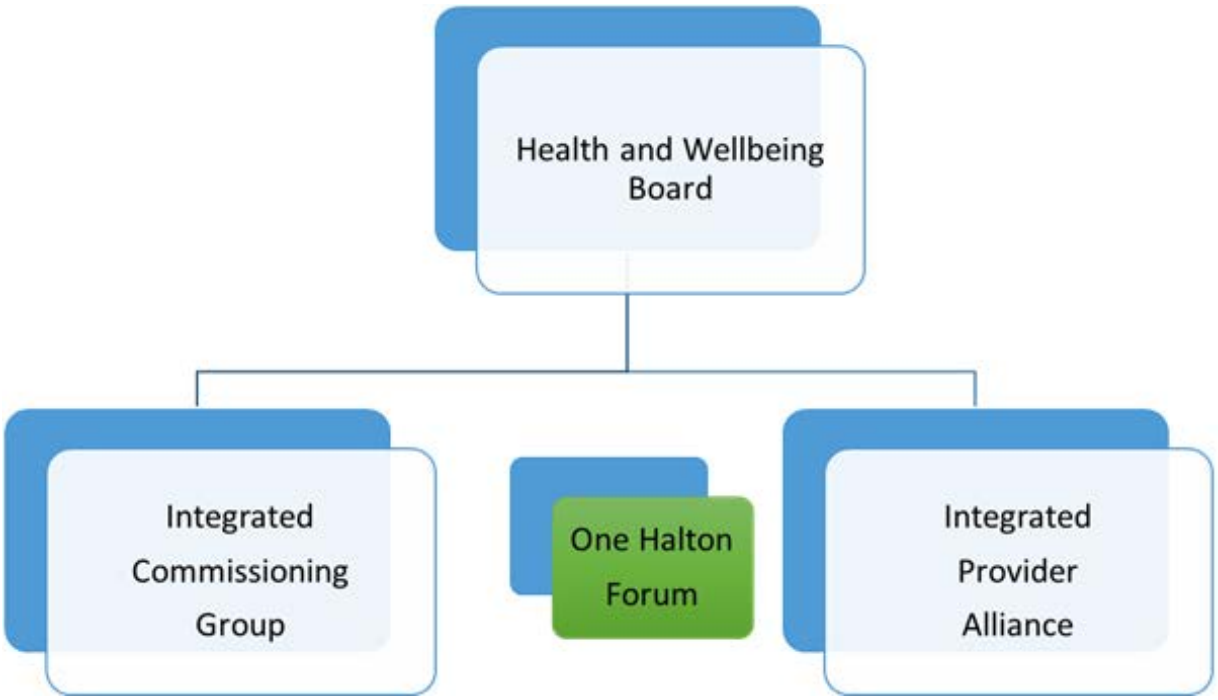
Through the One Halton model, we propose to radically change the way we do things so that by 2024 fewer people will be suffering from poor health.

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 and 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.

The development of PCNs will mean that patients 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.

Halton PCN vision
Halton 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 the vision is to maintain care continuity for those people who need it the most to provide more support for these people and their families.

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. It will reduce duplication. It will better coordinate how, when and where care and support is provided. To achieve this, capacity in the community will need to be created and delivered by changing the way 'acute on the day' services are provided. In Halton, it is the vision of the PCN to fully integrate and align General Practice with the Urgent Care/ Treatment Centres (UTCs). They will become one entity.

The aim is to create seamless service between the practices, teams in the communities and the UTCs, with standardised and common pathways and fully integrated, electronic health records. 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 to 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 for the 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, the PCNs 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).

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

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

Resources do not currently exist in the system to provide this fully integrated model in every practice. Therefore, the vision is to deliver this model across four community hubs. By working together in a more coordinated, more responsive and more integrated way, to change the way care is accessed and delivered in the community. This work has already commenced. General Practice and Community Services teams are integrating into the 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 complex case management. This will be overseen by the newly formed Provider Alliance. The teams and services will be 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.

Organisational boundaries will need to be removed and not be constrained by bureaucracy. PCNs will need to work with local partners and the public to re-design and implement the very best services and support resources can deliver. By getting this right, PCNs, are confident that they can create a workplace and career path that will be very attractive to both recruit and retain a workforce who share the same passion and vision. Working together, empowering front-line teams, utilising the collective skills of the workforce, rotating staff through different services, offering portfolio careers. A stable and highly motivated workforce will deliver the high-quality services that people in Halton communities deserve

PHASE 1	PHASE 2
General Practice	Third Sector
Social care	Housing
Bridgewater	Faith
North West Boroughs	Schools/Education
Warrington and Halton Hospitals NHS Foundation Trust / St Helens and Knowsley Teaching Hospitals NHS Trust	Employers
Wellbeing Enterprises	Youth Serives
Health Improvement team	Dental
Pharmacy	Optometry
North West Ambulance Service	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.

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 and 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'.

ACTION:

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.**

Communications/Engagement

Communication and Engagement is important in all that we do, whether with our stakeholders, service users, patients, residents or people working in Halton; we strive to ensure you are kept informed in the most suitable way.

The approach set out in our Communications and Engagement Strategy for One Halton is important in setting out how the diverse organisations/partners across Halton link together. Significantly, it will set our expectations on how we coproduce services with residents and patients and ensure all are kept informed.

- Expanding on the work already undertaken by Healthwatch (see Appendix 2), addressing the actions that arose from that.
- Closely working with the voluntary and community groups though the Engagement and Insight Group.
- Promoting achievements/successes/positive news stories
- Ensuring patients are engaged and informed about any changes in their care in Halton.

Using our resources more effectively

Workforce Transformation

Overview:
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.

Context:
In order to deliver the commitments identified from the NHS Long Term Plan it is essential to transform the way our entire workforce works together, this is outlined in the NHS People Plan. As One Halton we need to expand this wider than the NHS, and look at our whole system, this will include all our Partners recognised under One Halton.

There are a number of areas we need to address:

1. Making Halton the best place to work.
   - A lot of Halton residents work outside of the borough, by making improvements within Health and Social Care, we hope to attract local people to local jobs.
2. Improving our leadership culture.
   - Leaders play a key role in shaping the culture of their organisations, developing positive, inclusive and people centred cultures. The leaders of One Halton will ensure staff are motivated to work more efficiently and effectively, thus improving patient/service user experience.
3. Addressing urgent workforce shortages.
   - In particular there will be a greater focus on increasing the numbers of nurses.
   - However there are also shortages of other key roles within Health and Social Care.
4. Delivering 21st century care / A new operating model for Workforce
   - In Halton we require a fundamental shift from hospital centred care to providing collaborative, integrated community focused care. Therefore we need to ensure we have the Workforce capacity and capability in order to treat people closer to home within Halton.
   - Integration of Primary Care and community health services will mean that staff work in different ways with a greater focus on preventative care. There will be new roles that work across Health and Social Care.
   - We will need to ensure that staff have the right skills, education and training to realise their maximum potential.

Next Steps:
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.
- Implementation of the Healthy Workforce Programme.
- Career promotion in schools.
- Ensure Halton has sufficient workforce capacity to meet demand.
- Plans for how we will remove barriers to employment and financial independence through our local support programmes, including those with mental health issues or learning disabilities
- 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 will review our office space and where possible reduce and rationalise this to improve efficiencies.

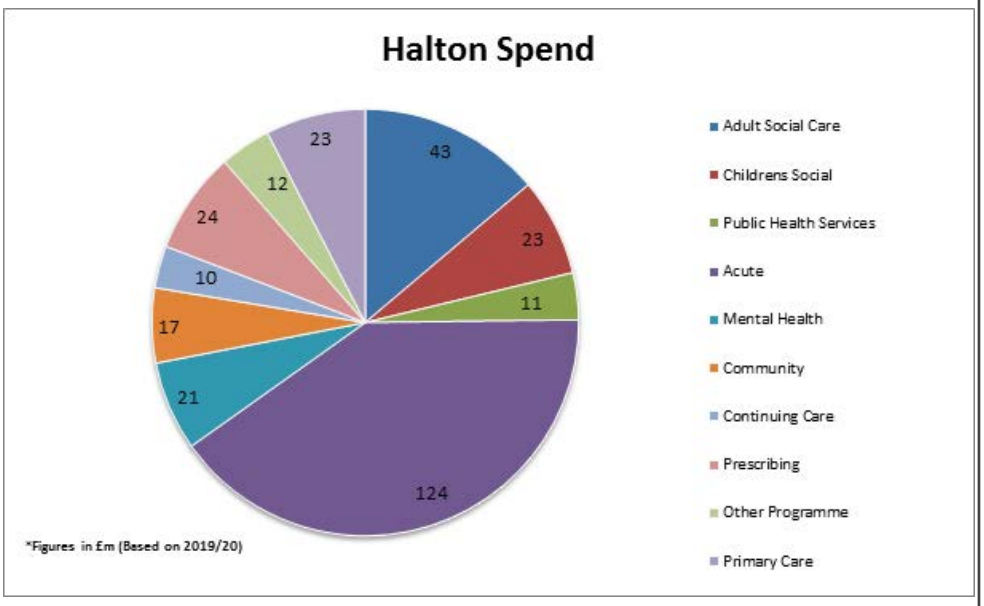
ACTION:

- **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.**

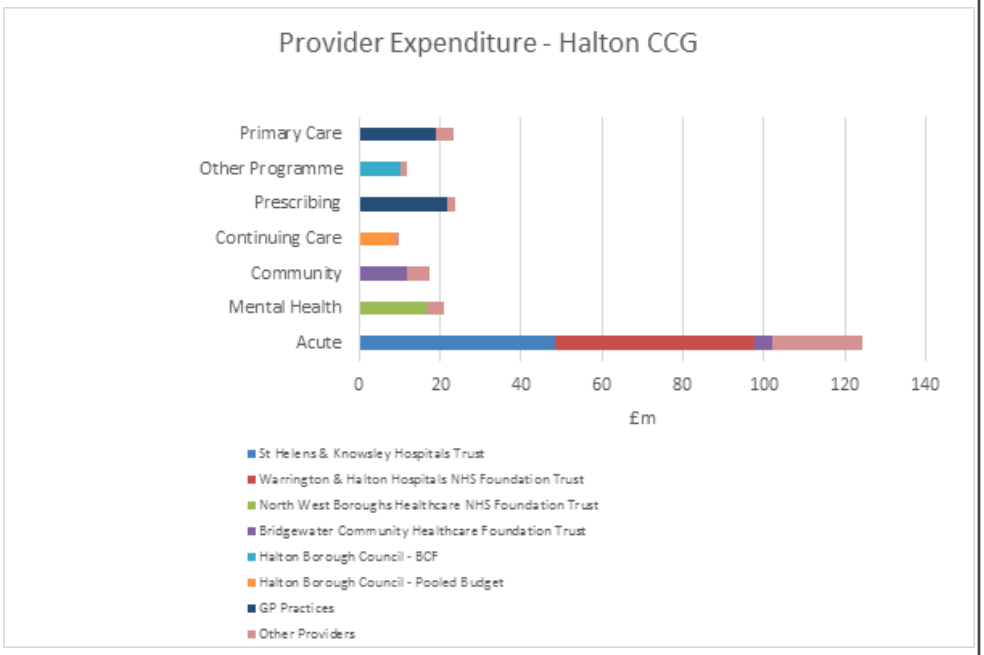
- **A heat map will be developed to show existing estate, what condition it is in, what clauses are in the lease, vacant space etc**

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



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.

7 2019/20 Budget

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 5).

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.

APPENDIX 1

Joint Health and Wellbeing Strategy Engagement Plan 2017

The following provides a summary of the key engagement activity that took place in 2016 to establish Halton's priorities as described in the Halton Health and Wellbeing Strategy 2017-2022. They are the foundation of the One Halton Plan 2019-2024 which builds on those priorities and takes into account more recent policies and guidance.

Message/ Activity	Audience	Timescales	By Whom
Defining Health and Wellbeing Priorities in Halton			
Public Health Event Halton Borough Council	Local Authority staff/ Public Health staff and Elected Members	7th Feb 2016	Halton BC/ Public Health
Stakeholder event at Halton Stadium on 28th February	Key stakeholders including: • Local Authority • CCG Staff • Halton and St Helens Local Involvement Networks (LINks)/Health Watch • Local Overview and Scrutiny Committees (OSC) • Media – general • MPs • Local Council Members • Third sector and patient support groups (via local CVS organisations • Health and Wellbeing Board members • CCG	28th Feb 2016	Halton CCG/ HWBB
Consulting local communities through use of local media: • Inside Halton • Websites e.g. Council, PCT, Voluntary sector, LinKsetc • Newsletters e.g. Health "e" times, staff newsletters, Links • Press releases	• General Public • Other interested groups as outlined above	Commenced – February 2016, ongoing throughout	HWBB/ CCG
Board Consultation	Elected Members through PPBs, Exec Board, HWBB, Children's Trust, PCT Board, CCG, LSP, LinKs	2016	HWBB
Communicating results of consultation and proposed strategy and engaging partners in identifying solutions	All key stakeholders via Boards, stakeholder events etc	May/ June 2016	HWBB
Ensuring accountability and ownership	All key stakeholders/ HWBB	June/ July 2016	HWBB
Ongoing Consultation by:			
Health and Wellbeing Board Stakeholder events	Key Stakeholders as outlined above	6 monthly events to be arranged as part of ongoing consultation on HWBB priorities	HWBB
Looking at ways in which priorities can be addressed by joint working and agreeing "pledges" with partners agencies		Actioned through the HWBB and subgroups	HWBB

APPENDIX 2

Healthwatch:
In May 2019 Halton Healthwatch undertook public engagement in response to the NHS Long Terms Plan. In total 259 surveys were received as well as 32 attendees across two specific focus events.

The key themes were:

- People wanted easier access to GP Appointments
- Longer GP Appointments
- Improvements to GP Practice phone systems
- People wanted to stay in their own home for longer, retaining their independence as they get older.
- Choosing treatment to be a joint decision between patient and clinician
- Technology and online services need to be more user friendly
- More joined up treatment plans to be treated as a whole person, not just focus on one condition at a time.
- Develop social care systems that encourage independence, including community activities.
- Consistency of clinician was important. Heavy reliance on locum clinicians means the patient loses continuity of care.
- Still a demand for paper, and people wanted this option, including appointment outcomes to be formally written and shared with the patient.
- Technology improvements needed between primary care and secondary care, additionally need interoperable data between the two main acutes serving Halton.

Cancer, Heart and Lung, Long Term Conditions like diabetes and arthritis received positive feedback overall.

However Autism and Mental Health are two areas that Halton needs to improve, particularly around waiting times and improving after diagnosis support for patient and carer.

The survey told us people still find it hard to access primary care, some can get same day GP appointments and others advise they cannot, meaning we have inequalities across the borough.

More work is needed to join up communications and technology between General Practice and Pharmacies, the survey highlighted inconsistencies with medicine reviews and local pharmacists not knowing when medication had been changed.

There was definite support that the NHS, Social Care and voluntary sector should work more collaboratively together to overcome some of these issues and offer integrated support services. One Halton strives to do this and supports the collaboration of organisations in Halton to achieve improved outcomes for all.

The full document is available to review on Healthwatch Halton's website.

APPENDIX 3

Smoking	Actions	Delivery Vehicle
By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.	The Cancer Alliance is trialling the CURE model in Cancer Care Hospitals across Cheshire/Merseyside with the intention that all Hospitals in the area will be on board by 2023/24. The CURE model is: 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: For all patients E.g. referral to NHS Stop Smoking Services. The CURE model will include all vulnerable groups with high levels of smoking prevalence e.g. pregnant smokers, smokers with mental health, smokers with alcohol/substance misuse, smokers with respiratory health and smokers from poorer communities. "Stop before the Op" programme to be developed and expanded to Whiston and Warrington/Halton Hospitals where the majority of Halton people attend will need to establish improved links with Halton local authority smoking cessation teams/ offer in community including community pharmacy in order to ensure that all patients on discharge are able to continue to access the smoking cessation products that they are discharged with. Plans should include consideration of IT and other communication links between acute trusts and community pharmacy and LA smoking cessation teams to ensure they meet IG requirements whilst being timely and meeting patient needs. Particularly transfers from hospital into community. Dedicated time and administrative procedures need to be put in place to effectively and appropriately manage any smoking cessation transfers out of secondary care Consider use of Transfers of Care Around Medicines (TCAM) service (The aims of this service are to improve the post-discharge support for patients by facilitating early medicine reconciliation thereby reducing re-admissions / emergency department attendances and reduce errors on medication prescribed and supplied in the community following changes instigated in hospital.) The CCG /Trusts will include Local Authority Public Health and Health Improvement Service within these discussions and the development of any service specifications / contracting arrangements. Halton Stop Smoking Services also offer training and advice to professionals who need support to deliver cessation, funding will be required to ensure that roll out to wider NHS / acute trusts is successful. Smoking cessation champions to be identified in each hospital ward / speciality/ clinic / practice Establish robust approach to achieving a Smokefree NHS (including the hospital estate) which includes both a positive environment and integrated support for people to quit. Acute, Community and Mental Health Providers will support this priority area during 2019/20 CCG CQUIN Programme by achieving 80% of patients will be screened for smoking use and achieve 90% of identified smokers given brief advice.	CM Cancer Alliance pilot using CURE model currently in place. Warrington/Halton and St Helens/Knowsley NHS Hosp Trusts Tobacco Control Alliance Halton Stop Smoking Service CCG 2019/20 Alcohol and Tobacco screening and brief advice

Smoking	Actions	Delivery Vehicle
The model will also be adapted for expectant mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments.	• NICE guidance (PH26) Smoking: stopping in pregnancy and after childbirth NHS England. • Saving Babies' Lives A care bundle for reducing stillbirth, 2016 National Maternity Review. • BETTER BIRTHS, Improving outcomes of maternity services in England. • A Five Year Forward View for maternity care, 2016 CCG Improvement and Assessment Framework – Maternity. Maternal smoking at time of delivery indicator 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. The CCG will work with the Maternity providers to ensure that the smoking cessation offer will be mainstreamed into the community midwifery contract, to include all elements of baby clear (or similar programme). Evidence suggests that one to one targeted intervention by the midwife ongoing through antenatal period, is most effective intervention. Ideally this is a core component of midwifery contract. The CCG will include Local Authority Public Health and Early Help Service within these discussions and the development of any Service Specifications/ Contracting arrangements. The Halton Health Improvement team, CCG and the local Maternity provider will continue to work directly within practices and in community to support healthy living advice. PH smoking offer would then complement and support this. Halton Stop Smoking Services also offer training and advice to professionals who need support to deliver cessation	Halton Stop Smoking Services./ HIS CCG Midwifery provider
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.	The MH provider will develop a universal offer.as part of core specialist mental health services, this will be as a corporate function (rather than a commissioned service) Halton Stop Smoking Service currently has a Stop Smoking Specialist in Mental Health who works with Booker Centre Staff and residents to support those wishing to stop smoking, as the PH grant will be further reduced this service will need to be supplementary to an approach to be developed by the MH provider, freeing the stop smoking service to provide needs based proportional interventions over and above the universal offer. The MH provider will train staff to identify and support individuals who want to stop smoking. This will be facilitated by the Halton Stop Smoking Service/HIS and roll out of MECC training	Halton Stop Smoking Services. MH Provider MECC training lead CCG 2019/20 Alcohol and Tobacco screening and

Obesity	Actions	Delivery Vehicle
Access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+	All patients with a BMI >30+ can be referred or self-refer into Halton Tier 3 weight management service. General practice to weigh/measure all patients as standard, offer low level advice and referral to service The CCG will support primary care to make more direct referral from Primary Care into the existing weight management service this includes direct referral into Tier 2 services (PH funded HIT Fresh Start) Tier 3 services (specialist) Additionally, the Primary Care team will continue to provide robust advice, and signposting to other opportunities within the community that can support individuals weight management including (but not limited to) the Physical Activity offer of HBC For capacity reasons (up to 70% Halton Population overweight or obese) offer all patients with a BMI in the overweight / obese category the opportunity to identify and develop their own action plan for weight loss which may include a commercial plan, offer follow up and referral into Funded Tier 2 and 3 services on review at 12 weeks if unsuccessful Key opportunities for referral occur at the times of annual reviews for chronic long term conditions, following NHS health Checks and at pre- diabetes reviews. Increasing Breastfeeding rates is critical to the obesity agenda. Need whole system leadership to support breastfeeding across the NHS, including strengthening contractual obligations for midwifery.	Halton Tier 3 Weight Management Service. Halton General Practices CCG HBC Physical Activity Lead Maternity services
NHS Diabetes Prevention Programme, including a new digital option	NHSE programme in place Digital options are being explored and a local offer is in development Existing diabetes prevention plan is also in place working in collaboration with DDP. CCG commissioner to continue to work with HIS to develop a robust pathway that ensures all people referred into the services benefit	Diabetes Prevention Programme. Halton Health Improvement service Halton General Practices CCG
Testing an NHS programme supporting very low calorie diets for obese people with type 2 diabetes.	Low calorie diets advised/supported by specialist dietetic provision via Halton Tier 3 weight management service. Specific testing programme for this cohort would need to be developed. NHSE will pilot for 5000 people but pilot sites are not yet known Has been discussed at HCP and would plan to apply for pilot status as an STP when this is available	Halton – Tier 3 Weight Management Service HCP Diabetes Programme/ NHSE
The NHS will continue to take action on healthy NHS premises	CCG to develop a workforce health programmes that offers all staff the opportunity to access healthy walks, food, rest breaks, and health advice related to their working environment This has been a CQUIN for 2017-19 with all providers. The C&M Prevention Pledge for provider trusts will maximise the delivery of this, supported by Food Active and the H&C partnership. MECC programme of work across providers.	CCG Warrington/Halton and St Helens/Knowsley NHS Hosp Trusts Halton Health Improvement service Food Active HCP. MECC Lead

Alcohol	Actions	Delivery Vehicle
Hospitals with the highest rate of alcohol dependence-related admissions will be supported to fully establish Alcohol Care Teams (ACTs)	Health and Wellbeing Boards has identified reducing alcohol-related harm as a core prevention priority. The C&M HCP Prevention Board has developed the 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. The development of hospital pathways and support and advice to clinicians has been shown to pay for itself. The single Alcohol Liaison Nurse has been decommissioned – Alcohol Care Teams funded by the hospital can gain better traction into all sections of secondary care and better connection back to community support for substance misuse. Alcohol Care teams can also maximise the Alcohol and Tobacco CQUIN by embedding Identification and Brief Advice ('IBA') across all areas of secondary care. Acute, Community and Mental Health Providers will support this priority area during 2019/20 CQUIN Programme by achieving 80% of patients will be screened for alcohol use and achieve 90% of patients identified as drinking above low risk levels given brief advice or offered a specialist referral NHS Halton CCG is implementing the RightCare model for High Intensity Users, offering targeted support to patients who are frequent users of ambulance and urgent care services with issues or conditions that have avoidance opportunities, including drug and alcohol dependant patients.	Health Care Partnership (HCP) CCG 2019/20 Alcohol and Tobacco screening and brief advice CQUIN Warrington & Halton Hospitals and St Helens & Knowsley NHS Hospitals Trusts

Air Pollution	Actions	Delivery Vehicle
While wider action on air pollution is for government to lead, the NHS will work to reduce air pollution from all sources. Specifically, we will cut business mileages and fleet air pollutant emissions by 20% by 2023/24.	Link with local active travel plans for staff, patients and visitors, maximising use of public transport, cycling and walking options. Promote use of electric vehicles and provide electric charging points at LA, Voluntary Sector and NHS premises. Consider waste, local supply chains and all contracted providers to reduce impact on the environment. Social value commitment across all NHS providers. Maximise the use of technology, where practical, to reduce the need to travel for face-face meetings Stipulate minimum environmental standards for all businesses that operate from NHS premises Work with NHS Sustainable Development Unit to spread best practice in sustainable development, including improving air quality, plastics and carbon reduction.	All partners in ICS

Antimicrobial resistance	Actions	Delivery Vehicle
The health service will continue to support implementation and delivery of the government's new five-year action plan on Antimicrobial Resistance.	NHS Halton CCG has continued to work with Primary Care prescribers and other providers regarding effective Antimicrobial Stewardship (AMS) and appropriate prescribing of antimicrobials. Inclusion of antimicrobial prescribing within the annual GP Prescribing Quality Initiative. All practices are required to have a practice specific action plan incorporating TARGET toolkit resources, strategies and audit. AMR is included in the Quality Contract Monitoring for GP Practices within Halton. The local AMR group has been re-established and has representation from CCG, LA Public Health, Community Microbiologist, GP and Infection Control. The group maintains the joint Halton AMR action plan, provides high level discussion and facilitates decision making with regards to the overall approach to appropriate use of antimicrobials and how to improve prescribing across the Halton locality. Activities to support effective AMS are included in all provider quality schedules, requiring evidence to support data analysis and audit, peer review, education and challenge. Introduction of the 'To Dip or Not to Dip' project within Halton care homes to improve management of urinary tract infections for care home patients by focussing on the symptoms and the patient rather than dipstick results in isolation. This is a joint approach between Infection Control and Medicines Management and its effectiveness continues to be reviewed with additional support where appropriate. Update of antimicrobial prescribing guidelines. NHS Halton CCG is part of the Pan Mersey Area Prescribing Committee and the Medicines Management Team (MMT) actively supports the development of the antimicrobial formulary and implementation with prescribers within the CCG. The MMT also attends: • Cheshire and Merseyside AMR formulary group to develop prescribing guidance across the wider area. • Mid-Mersey AMR leads group in relation to the practical approaches with providers, audit and local implementation of AMS/AMR strategies. Halton MMT is working closely with the HCP Mid Mersey AMR clinicians to target specific areas of improvement and to support education and peer support for 'red' practices. The MMT send out monthly Antimicrobial prescribing dashboards to all GP practices, this data is discussed at the local AMR Group and at practice level meetings. AMR is a Halton Health Protection priority and links in to all the work being done locally between the CCG and Public Health. Acute Providers will support this by 2019/20 CCG1 Antimicrobial Resistance (AMR) CQUIN monitoring Lower Urinary Tract Infections in Older People and Antibiotic prophylaxis in Colorectal Surgery	CCG Medicines Management team (MMT); Joint Local Antimicrobial Resistance (AMR) group; C&M Health & Care Partnership (HCP) AMR group; C&M Antimicrobial Formulary Group; Pan Mersey Area prescribing Committee. 2019/20 CCG1 Antimicrobial Resistance (AMR) CQUIN

Immunisation and Vaccination	Actions	Delivery Vehicle
Have a coherent plan with the local Public Health commissioning teams of NHS England to improve the quality, access to screening and immunisation programmes	CCG to actively engage in joint meetings across screening and immunisation agendas with PHE, NHSE Screening and Immunisation teams, LA PH and relevant partners to ensure co developed planning and activity	CCG PHE NHSE SCRIMMS teams LA PH
Support general practices to target at risk population groups to improve uptake and coverage of the flu vaccination, also having a named flu lead in place	Undertake joint practice visits with NHSE Screening and Immunisation teams to assess quality and assure improvements across screening and immunisation performance and practice Continue to identify and share best practice to support improvements in Flu uptake. Monitor uptake and share uptake figures during Flu season. Benchmark uptake across practices (via Primary Care Dashboard) and follow up with practices to identify support strategies. Named Flu lead in place at CCG – Head of Quality supported by Public Health and Primary Care Commissioning Team.	CCG NHSE SCRIMMS teams LA PH
CCGs need to ensure they have capacity to deliver: a) the additional colposcopies &cancer treatment for HPV primary screening; b) treatment of additional bowel cancer cases likely to follow the switch from FOBt to FIT 120ug	CCG receive assurance and input in to Trust and Cancer alliance partnerships regrading capacity and pathways	CCG Cancer Alliance
CCGS to ensure clear arrangements in place to support oversight of the flu programme between October with named lead	Undertake regular assurance monitoring and hold practices to account at regular intervals during the flu season, providing timely input to improve quality where practices are significantly behind anticipated activity Actively participate and input in to coordinated joint local flu planning and response meetings Benchmark uptake across practices and follow up with practices to identify support strategies	CCG Halton General Practices Halton flu planning meeting
CCGs will support general practices (subject to national funding) to sustain and improve uptake and coverage of the routine childhood vaccination to achieve WHO targets	Co-develop practice improvement plans alongside PHE screening and immunisation and screening team, LA PH Undertake regular targeted PLT events around immunisation Work closely with PCNs to explore alternative delivery mechanisms to improve uptake Continue to benchmark practices (via Primary Care Dashboard) discuss variation in uptake within annual Quality, Contracting & Transformation visits in order to identify areas for support and share best practice.	CCG PHE LA PH PCNs
CCGs will support the implementation of the flu programme, with particular emphasis on: supporting improvement in uptake and reducing variation, and ensuring the recommended vaccines are used	Undertake regular assurance monitoring and hold practices to account at regular intervals during the flu season, providing timely input to improve quality where practices are significantly behind anticipated activity Actively participate and input in to coordinated joint local flu planning and response meetings Undertake joint practice visits with NHSE Screening and Immunisation teams to assess quality and assure improvements across screening and immunisation performance and practice Benchmark uptake across practices (via Primary Care Dashboard) and follow up with practices to identify support strategies.	CCG Halton General Practices

Health Inequalities	Actions	Delivery Vehicle
To support local planning and ensure national programmes are focused on health inequality reduction, the NHS will set out specific, measurable goals for narrowing inequalities, including those relating to poverty, through the service improvements set out in this Long Term Plan	The integrated system will agree that every decision made we should consider how this impacts on inequality. This includes every commissioning/ decommissioning decision in order to prevent poor health and shorter lives. Continue to benchmark both actual prevalence (QOF disease registers) and QOF treatment and management indicators via Primary Care Dashboard. Discuss benchmarking and practice variation within annual Quality, Contracting & Transformation visits in order to identify areas for support and share best practice. Primary Care Networks are conducting quality improvement work on the disease conditions known to be the drivers of the gap in Life Expectancy locally: • circulatory diseases, respiratory diseases and cancer. These are also HWBB priorities. Intelligence reports enable focused targeting of effort. Work is targeted to improve the detection, and management of specific conditions including hypertension, pre-diabetes, COPD and clinical risk factors such as Smoking; prevalence varies widely between social classes. One in three people living in social housing smoke. Children living with smokers are more likely to become smokers themselves and may also be exposed to second hand smoke. Reducing smoking prevalence in these communities can reduce health inequalities and increase disposable income. Halton Stop Smoking Service is looking to work in partnership with Social Housing providers in Halton to reduce smoking prevalence in these communities. Halton Stop Smoking Service have Stop Smoking Specialists who target and work with those vulnerable groups with high smoking prevalence e.g. pregnant smokers, smokers with mental health, smokers with alcohol/substance misuse, smokers with respiratory health and smokers from poorer communities. CCG to identify a robust route into social prescribing – ie ensuring referrals to social welfare services such as CAB, Housing etc to 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. Social prescribing review currently being undertaken across borough to develop an agreed Halton model moving forward 2020 onwards . CCG working collaboratively with Local Authority Public Health and Primary Care Networks to ensure agreed model in place, building on Halton's early adopter status. This will ensure future commissioned services and the development of the PCN Social Prescribing Link Worker role is integrated around the agreed Halton model, Well Halton Programme working in 4 areas of greatest deprivation within Halton: Windmill Hill, Halton Brook, Halton Lea and Ditton (Inc Community Shop) – CCG will ensure that opportunities to reduce inequalities through inclusive recruitment practices and commissioning for social value are maximised. Working with public health on joint strategies for frailty, falls, loneliness and through partners in preventions. CCG looking at the use of technology to patients to access support through advice and guidance remotely e.g. health apps including the NHS app Staff Flu Vaccinations CQUIN: Acute, Community and Mental Health Providers will support this priority area during 2019/20 CQUIN Programme by achieving 80% uptake of flu vaccination by frontline clinical staff	Awaiting national indicators and datasets on health inequalities. Halton JSNA's and analysis. Population Health Management intelligence. Halton has GP Practice JSNAs in place and an analyst team with a wide range of data. HCP Prevention Board and Cross Cutting Themes work – CVD, Cancer. 2019/20 CCG2 Staff Flu Vaccination CQUIN

Health Inequalities	Actions	Delivery Vehicle
In maternity services, we will implement an enhanced and targeted continuity of carer model to help improve outcomes for the most vulnerable mothers and babies.	The CCG will work with its main providers of Maternity Services to ensure this requirement is included within Maternity Services Contracts and Service Specifications for 2019/20 onwards. The CCG will include Local Authority Public Health and Early Help Service within these discussions and the development of any future Service Specifications/Contracting arrangements.	
Offer all women who smoke during their pregnancy, specialist smoking cessation support to help them quit.	Halton Community Midwives follow: • NICE guidance (PH26) Smoking: stopping in pregnancy and after childbirth NHS England. • Saving Babies' Lives A care bundle for reducing stillbirth, 2016 National Maternity Review. • BETTER BIRTHS, Improving outcomes of maternity services in England. • A Five Year Forward View for maternity care, 2016 CCG Improvement and Assessment Framework – Maternity. Maternal smoking at time of delivery indicator 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. The CCG will work with the Maternity providers to ensure that the smoking cessation offer will be mainstreamed into the community midwifery contract, to include all elements of baby clear (or similar programme). Evidence suggests that one to one targeted intervention by the midwife ongoing through antenatal period, is most effective intervention. Ideally this is a core component of midwifery contract. The CCG will include Local Authority Public Health and Early Help Service within these discussions and the development of any Service Specifications/Contracting arrangements.	Halton Stop Smoking Service.
By 2023/24, further increase the number of people receiving physical health checks per year	Halton Health Improvement team work in partnership with Primary care to deliver NHS Health Checks. All practices are signed up and contracted to deliver these checks As a quality improvement action Runcorn practices have undertaken a project to increase uptake which will be rolled across all practices The CCG will work to ensure that people living with severe mental health problems have their physical health needs met. CCG Implementation of the CVD prevent tool C&M Health and Care Partnership Prevention Board Priority	Halton Health Checks Programme. CHAMPS priority High BP C&M Prevention Board Priority.
Across the NHS, we will do more to ensure that all people with a learning disability, autism, or both can live happier, healthier, longer lives	CCG will continue to monitor and benchmark health check uptake for patients on a Learning Disability register and ensure that all patients receive an annual health check by sharing good practice. CCG will also improve the quality of the healthy checks undertaken by promoting best practice, and ensuring that all clinical staff are trained and confident in undertaking a high quality health check. Adaptation of services to meet individual needs, with more bespoke multiagency delivery	G Halton general practices to support LD health checks. HCP cross cutting theme Learning Disabilities.

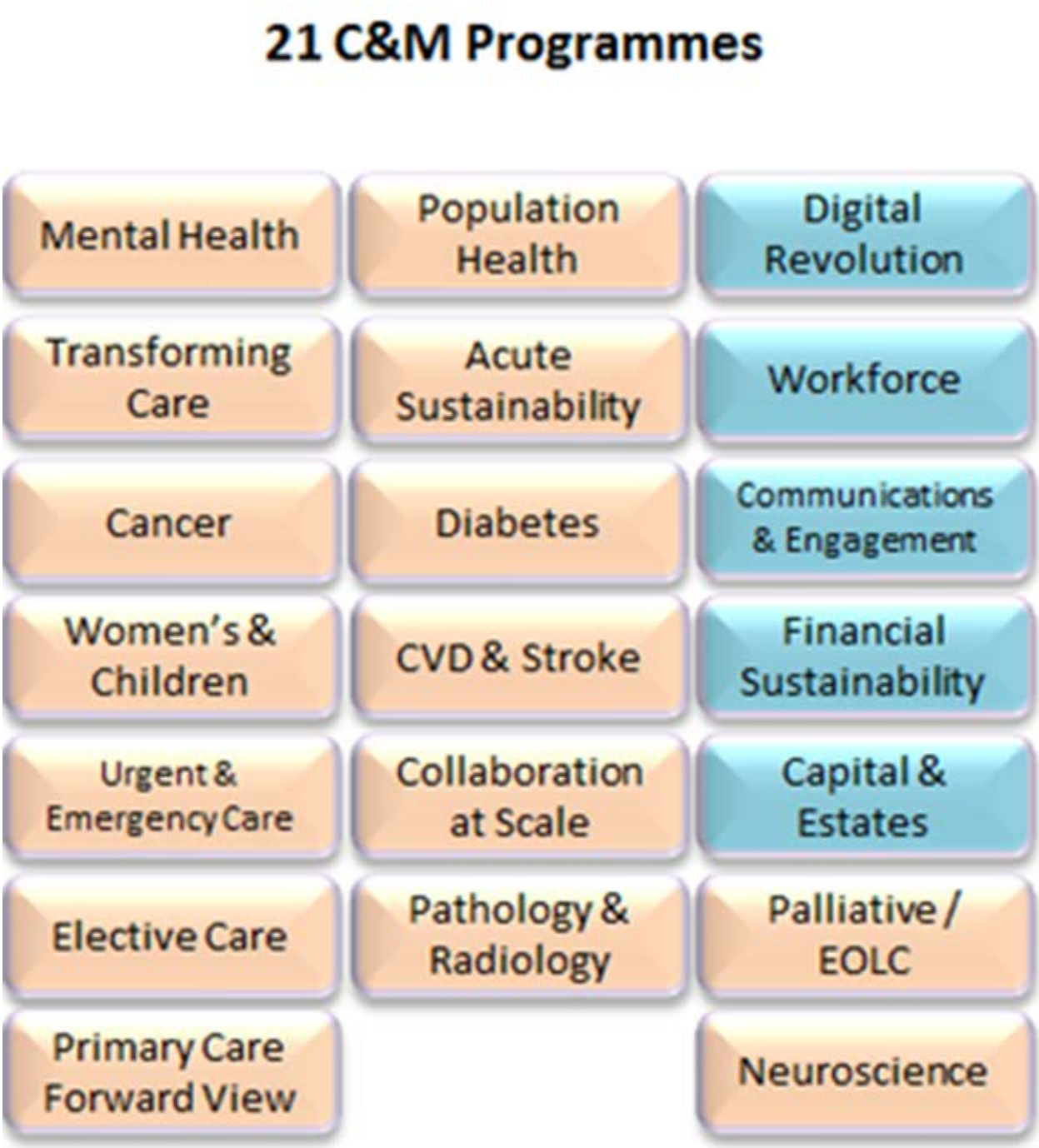
Health Inequalities	Actions	Delivery Vehicle
Meeting the needs of rough sleepers, to ensure that people rough sleeping will have better access to specialist homelessness NHS mental health support, integrated with existing outreach services.	Having a named GP practice champion In Halton there are very 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	Halton Housing support. HCP cross cutting theme Mental Health. Halton Mental Health Boards. PCN
We will continue to identify and support carers, particularly those from vulnerable communities	Development of Carers Strategy and Implementation plan has a focus on carer identification across the borough	Halton Population Health Framework – personalised care for carers.
Ensure that more carers understand the out-of-hours options that are available to them and have appropriate back-up support in place for when they need it.	Carers assessment process and outcomes to be reviewed as part of the carers strategy implementation. This includes contingency planning and out of hours support	
The NHS will roll out 'top tips' for general practice which have been developed by Young Carers, which include access to preventive health and social prescribing, and timely referral to local support services.	'Top tips' will be rolled out as part of the carers strategy implementation	Halton Prevention Services and social prescribing. Halton Population Health Framework.
We will invest in expanding NHS specialist clinics to help more people with serious gambling problems	All frontline staff will be trained to recognise gambling issues, including online and hidden gambling, and refer to appropriate support The CCG will use national guidance on roll-out of specialist services for people with serious gambling problems and seek to develop a local offer with partners including the voluntary sector.	Halton Prevention Services. VCS
The NHS will continue to commission, partner with and champion local charities, social enterprises and community interest companies providing services and support to vulnerable and at-risk groups.	CCG to continue the development of the One Halton system to include collaboration with wider partners, including third sector. Ensure the robust support and development of the One Halton Provider alliance to maximise opportunities for a variety of providers and maximise benefits and reach from a collaborative approach to commissioned services. Ensure service users from representative groups are included and involved in service design, planning and commissioning to best inform need based on lived experience learning.	CCG One Halton Provider Alliance

Mental Health	Actions	Delivery Vehicle
To ensure increased access to NICE concordant community-based specialist perinatal mental health services	Cheshire and Merseyside Perinatal mental health service is in place. Ensure continued quality and contractual arrangements. Continue to fund the NCT perinatal peer support programme. Implementation and engagement with the Cheshire and Merseyside Multiagency perinatal pathway	Cheshire and Merseyside Multiagency perinatal pathway
CCGs to ensure there is a crisis response that meets the needs of under 18 year olds.	Ensure sufficient capacity and easy access to services through the Thrive based model of provision. Facilitate and progress the development of a 24 hour access crisis response service for young people	CCG commissioning lead Children and Young people's mental health board for oversight
Deliver against multiagency suicide prevention plans, working towards a national 10% reduction in suicides by 2020/21	CCG to actively engage in multiagency Suicide prevention partnership and contribute to the delivery of the Suicide Prevention Strategy action plans. Actively engage within the CHAMPs Zero Suicide strategy and activities.	Halton Suicide Prevention Partnership
All CCGs must meet the Mental Health Investment Standard (MHIS).	CCG has committed additional investment to meet the requirements of Five Year Forward View	CCG
Additional CCG baseline funding to deliver commitments in Implementing the Five Year Forward View for Mental Health	CCG has committed additional investment to meet the requirements of Five Year Forward View	CCG
Use additional 2019/20 baseline funding to stabilise and bolster core adult community mental health teams and prepare for new integrated primary and community model as part of the Long Term Plan.	CCG has committed additional investment to meet the requirements of Five Year Forward View	CCG
Alongside the 66.7% Dementia Diagnosis Rate (measured via SDCS), improve postdiagnostic dementia care in line with published guidance	NHS Halton CCG commission a community pathway for patients diagnosed with dementia and their carers. Post diagnostic support includes signposting benefits advice, prognosis, support from Admiral Nurse Service. The new 6 week referral to diagnosis target to be monitored from April 2019 and a revised referral form for primary care to be implemented to deliver more timely access with appropriate diagnostic tests undertaken prior to referral memory clinic. Current diagnosis rate 77%.	CCG
Early Intervention in Psychosis (EIP): CCGs to meet NICE concordance for EIP 2018-19; deliver the further ambition for 50% of services to be graded at level 3 by the end of 2019/20	CCG to provide performance management and oversight of achievement	CCG
Crisis Resolution Home Treatment Teams CCGs to ensure by 2019/20 all adult population have access to services that are commissioned to meet the minimum functions set out.	CCG performance management and oversight of action, including dissemination to ensure that all adult population are aware of provision National funding secured to support development	CCG
Continued focus on improving access to psychology therapies (IAPT) services to meet core IAPT offer requirements, all areas commissioning IAPTLTC services, and colocation of therapists in primary care.	IAPT service currently on target to meet prevalence access target for 2019/20 Additional investment/business case to be developed for additional IAPT trained therapists and co-location with community based LTC teams e.g. heart failure and diabetes. This will facilitate achievement of 22% and 25% target by 2021. Targeted work with practices where referrals are less than expected and plan for co-location of therapy staff into 'hubs' to deliver assessment/therapy to patients from more than one practice.	CCG

Mental Health	Actions	Delivery Vehicle
Deliver liaison and diversion services to 100% of the population	CCG to continue to engage and support programmes such as CHAPS (Cheshire Autism Practical Support) attention card Ensuring provision and training of appropriate staff within the police and custody facilities, Mental Health services to link with probation and youth justice service	CCG
Secondary and tertiary prevention in primary care	Halton Health Improvement service is already well embedded in primary care providing a range of healthy advice and interventions that are targeted to population need. The Health Trainers provide NHS Health Checks; advice on diet, alcohol and smoking and signpost to specialist offers including weight management and physical activity opportunities. Working with the primary care networks bespoke lifestyle clinics will be developed to support individuals at risk from Diabetes, hypertension and a range of chronic long term conditions to reduce their personal risk as part of a personalised offer.	CCG CCG HIT
Deliver against multiagency suicide prevention plans, working towards a national 10% reduction in suicides by 2020/21	CCG to actively engage in multiagency Suicide prevention partnership and contribute to the delivery of the Suicide Prevention Strategy action plans. Actively engage within the CHAMPs Zero Suicide strategy and activities. Mental Health Providers will support this priority area during 2019/20 CQUIN Programme by achieving 80% of adult mental health inpatients receiving a follow up within 72hrs of discharge from a CCG commissioned service.	Halton Suicide Prevention Partnership 2019/20 CCG4 72 Hr Follow Up Post Discharge CQUIN

APPENDIX 4

Cheshire and Merseyside Health and Care Partnership



APPENDIX 5

How we will measure:

MENTAL HEALTH	15	Emergency self-harm admissions *Directly Standardised Rate per 100,000 population*	All	545.8	2010/11	540.0	183.5	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+	45.8%	2010/11	54.4%	45.1%	2017/18	-	-	
CANCER	18	Premature mortality from cancer *Directly Standardised Rate per 100,000 population*	<75	215.4	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	74.5%	2010	75.4%	75.4%	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	75.7%	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+	3564.9	2010/11	2957.1	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+	657.2	2010/11	574.5	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	19.5	20.2	2015-17	19.4	2016-18	
		CQC PRIORITIES									
A&E	29	A&E attendances *Directly Standardised Rate per 1,000 population*	All	559.0	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	97.5	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 cause*	All	15.5	2013/14	14.1%	13.8%	2017/18	-	-	

Health and Wellbeing Board Dashboard

**Target only available for QMR indicators, those without targets are not currently benchmarked locally*

Data correct as of: 08/09/2018

		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	

Contacts

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

One Halton Programme Management Office
Runcorn Town Hall
Heath Road
Runcorn
WA7 5TD
Email: onehalton@halton.gov.uk
website: www.onehalton.uk

Published 30th October 2019