ONE Halton

Place based care

ONE Halton

What is it all about

- The right care, in the right place, at the right time, from the right person

- Helping people to help themselves stay well longer and get well quicker

What is the aim of ONE HALTON?

To deliver a single fully integrated place based health, well being and social care system for the people of Halton, that has wellness at it's heart but also addresses the health and social care needs of the local community of Halton, where ever possible from within Halton; is easy to access, cost effective, of high quality and clinically robust.

Delivered through

- Innovative and locally driven provision in the community - in Halton
- Easily accessed and high quality specialist/acute care where ever it may be located when it is needed
- With an emphasis on illness prevention and “self health”

And supported by

- Strong strategic leadership
- Strong operational leadership
- Strong financial performance and leadership
- Strong clinical performance and leadership
- Strong integrated commissioning
- Strong performance management and monitoring

Building on

- **the illness prevention, health and social care expertise that already exists in Halton**
  - Halton Council (incl Public Health)
  - Halton CCG
  - Our Local GPs
  - Community health and social care providers
  - Acute and specialist providers
  - The voluntary sector

IT IS "**WORK IN PROGRESS**"

- WILL NEED TO BE CONSIDERED and SIGNED OFF BY
  - MEMBERS (HBC)
  - CCG (GOVERNING BODY)
  - NHSE (C&M NHS)
  - PROVIDERS (GOVERNING BODIES)

- DEVELOPMENT PHASE
- ALL COMMENTS ARE WELCOME

We are developing the <u>ONE HALTON PLAN</u>

This Plan will tell us, and most importantly you

- How we will deliver the right care, in the right place, at the right time, by the right person.

AND

- How a member of the public in Halton can stay healthy and when necessary access health and social care services quickly and easily

ONE HALTON PROVIDER PLAN

This work is being lead by our **GPs and Bridgewater** Community Care NHS Trust.

They will lead a number of workshops to develop our **ONE HALTON LOCAL CARE PARTNERSHIP**

They will engage with the following to build on their experience

- Social care providers
- Adult Social Care
- Children & Young People Services
- Public Health
- Our voluntary sector
- GPs
- Community care and health providers – general and specialist
- Acute care and health providers – including Consultants
- Specialist care and health providers
- The wider system such as Housing, DWP etc

AND WITH MEMBERS

ONE HALTON MODEL OF CARE

ONE HALTON MODEL OF CARE - that has 'self health" as a priority but also delivers, where ever possible, health and social care close to home in Halton and where this is not possible easily accessed and high quality specialist/acute care outside Halton

Our **ONE HALTON MODEL OF CARE** will maximize the opportunities presented by our proposed

- **multi-discpline GP Hubs** – that will address ongoing complex conditions and deliver proactive and early interventions in the community
- **community based assets** – that will address specialist provision when required close to home
- **Urgent Care Centres** – that will meet urgent care needs that present "on the day" in the community
- **Hospitals** etc – that will continue to address specialist urgent care needs that present "on the day" (including A&E presentations) that can only by provided in provision outside Halton

ONE HALTON COMMISSIONING PLAN

This work will be lead by **commissioners** from Halton Council, Halton CCG and Public Health.

- They will lead a number of workshops to develop and establish a single, integrated **ONE HALTON COMMISSIONING ALLIANCE**
- They will engage with the following to build on their experience
- Social care providers
- Children & Young People Services
- Public Health
- Our voluntary sector
- GPs
- Community care and health providers – general and specialist
- Acute care and health providers – including Consultants
- Specialist care and health providers
- Etc

- **AND WITH MEMBERS**

ONE HALTON MODEL OF COMMISSIONING

- To produce a single, integrated light-touch ONE HALTON MODEL OF COMMISSIONING that is based on need/evidence, supports the ONE HALTON MODEL OF CARE

- Holds to account the activities carried out through the ONE HALTON LOCAL CARE PARTNERSHIPS

CARE PATHWAYS

As part of the development of our ONE HALTON MODEL OF CARE we will develop simple and easily understood **CARE FLOW PATHWAYS** with a "**single point of access**" to deliver the right care, in the right place, at the right time, by the right person

CARE NAVIGATORS

As part of the development of our ONE HALTON MODEL OF CARE we will explore the opportunities presented by **CARE NAVIGATORS** to help navigate the public through our care flow pathways, to take away any uncertainty about our new model of care

NEW WAYS OF ACCESSING
OUR ONE HALTON MODEL OF CARE

As part of the development of our ONE HALTON MODEL OF CARE we will explore the opportunities presented by **technology and ICT** to improve access to services and information remotely, including the use of online, telephone, ”App” and web technology etc

WORKFORCE PLANNING and INTEGRATION

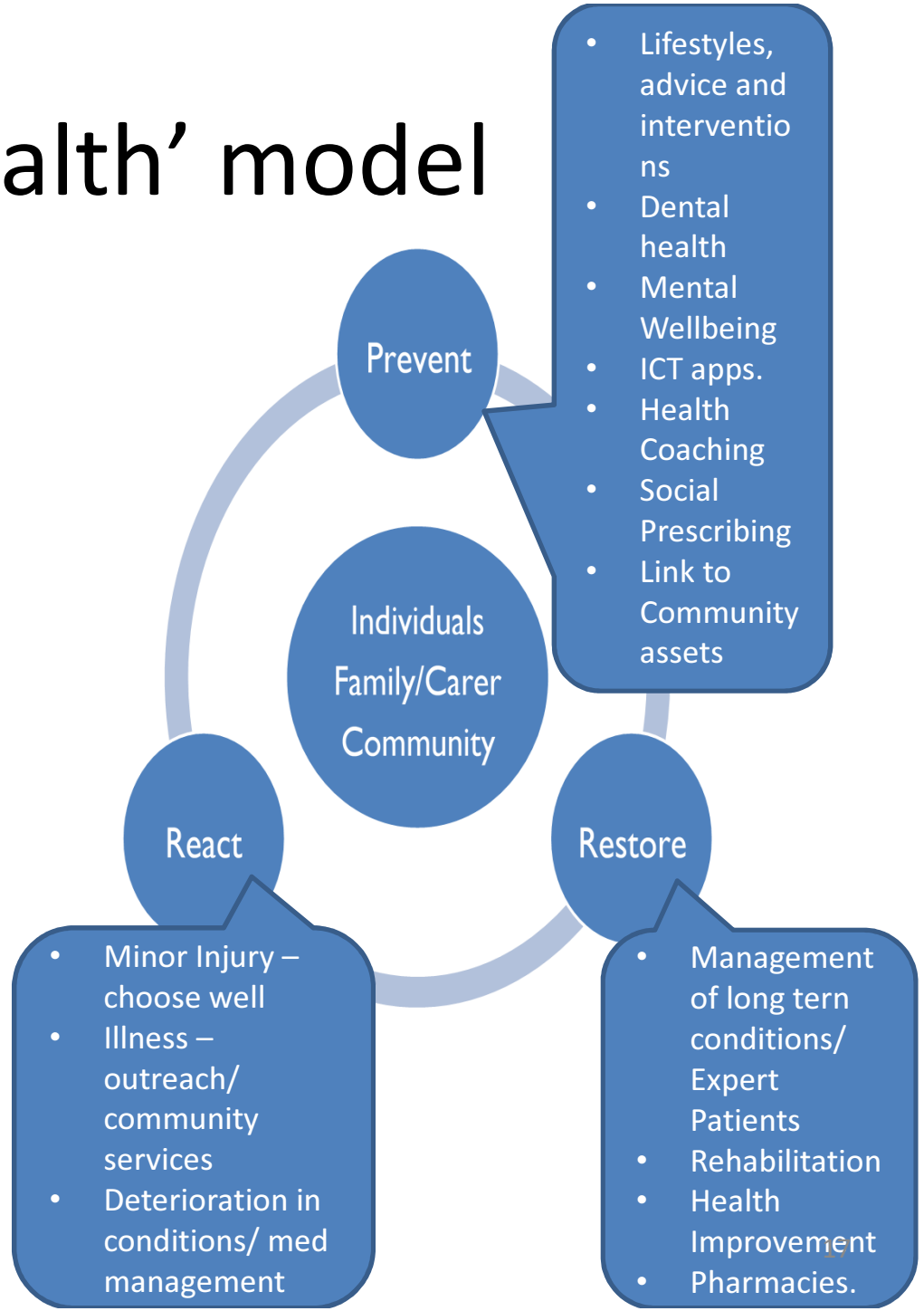
Our ONE HALTON MODEL OF CARE will also explore opportunities to integrate our collective workforce to maximize their impact, ensure they connect across the system and provide positive development opportunities for all employees

REVIEW HOW WE FUND ONE HALTON MODEL OF CARE

We will review how we currently fund the provision of health, well-being and social care to ensure we get the most from the funding available and drive efficiencies within the system

‘Self Health’ model

- **‘Self health’** is key in managing future demand and capacity
- Building community confidence in managing acute and long term health
  - Parent confidence to manage children's illness and injury
  - Confidence to manage long term health conditions
  - Confidence to manage changes that happen with age
  - Confidence to navigate and access right point in health and care system



DEVELOPING MODEL

HOSPITAL CARE

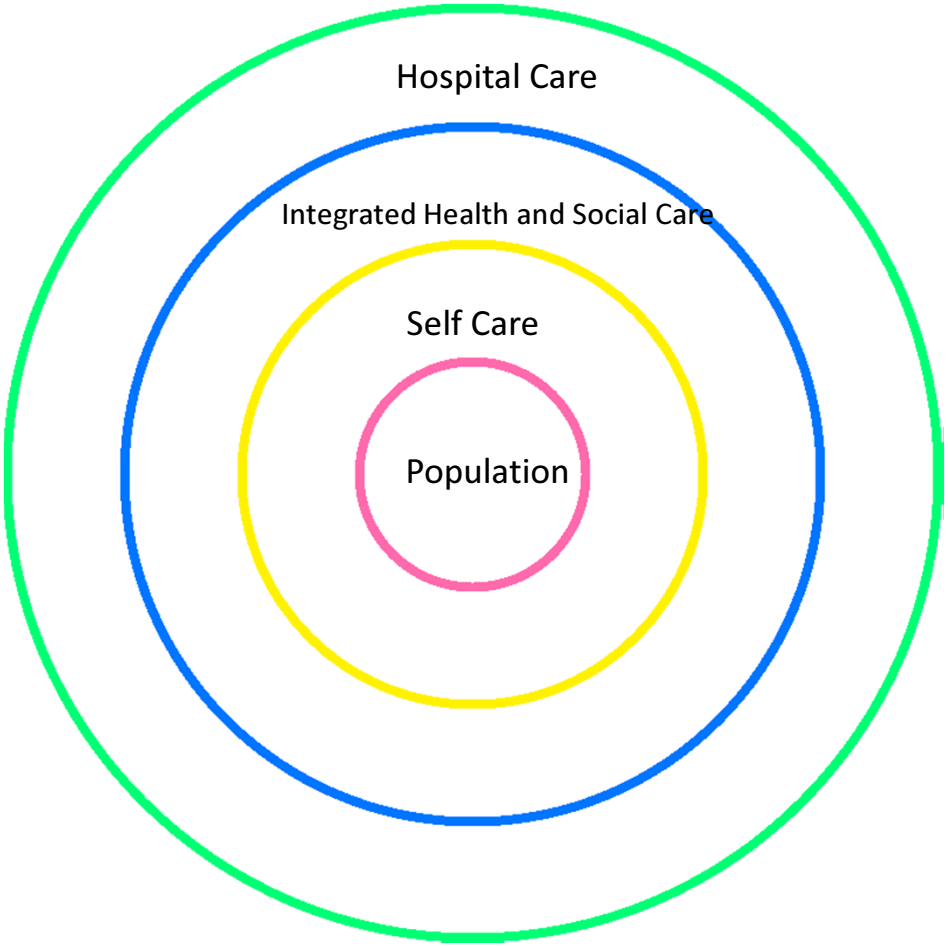
Specialist care that can't be provided in a community setting or home.

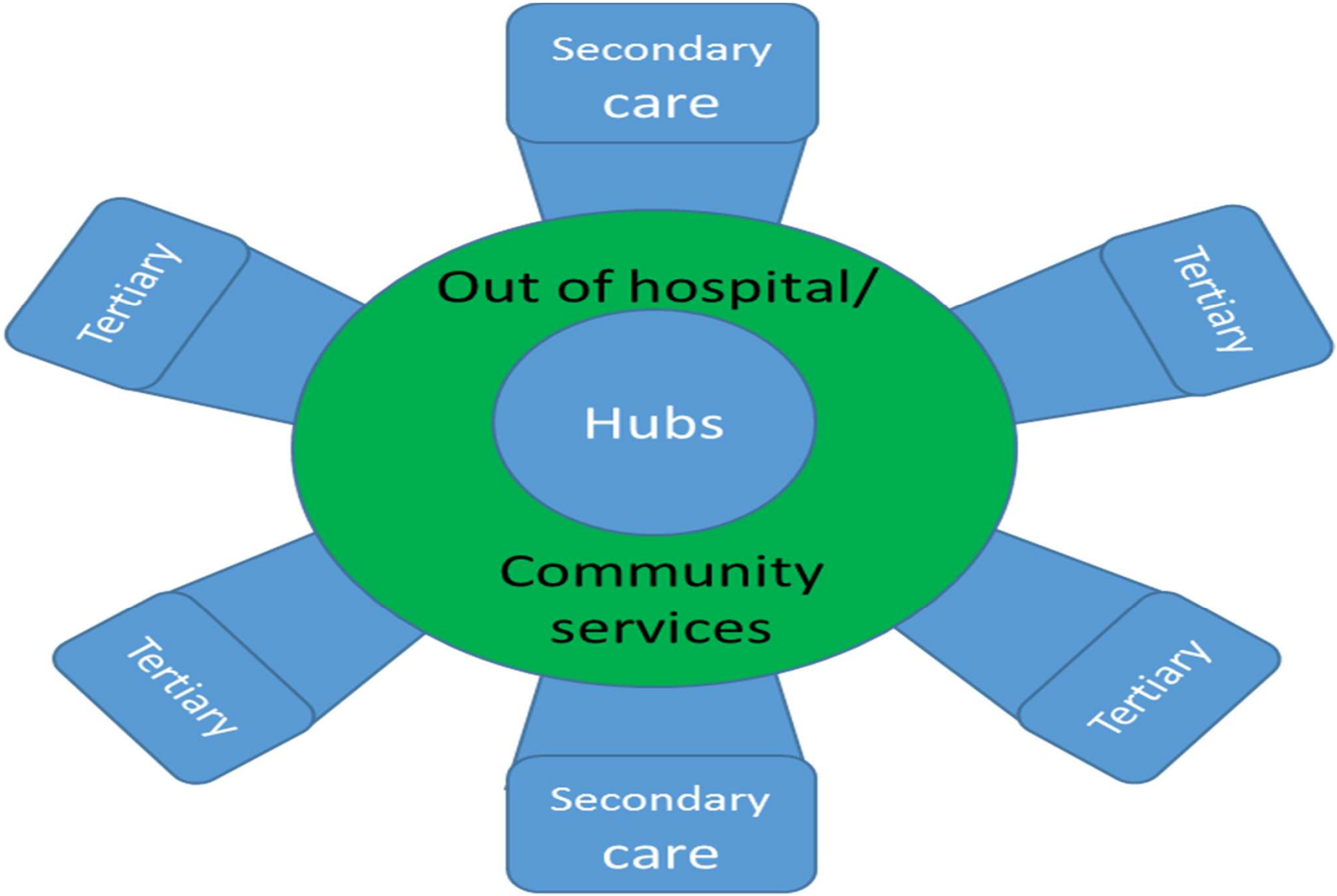
INTEGRATED HEALTH AND SOCIAL CARE

Multi-disciplinary teams with co-ordinated care plans delivering health and social care, centred around the population's needs. Commitment to new ways of working to manage long-term conditions.

SELF CARE

Delivery of care packages which includes support from a variety of agencies, formed by building relationships with Local Authorities, Pharmacies and Voluntary Sector organisations and other community providers. Champion health ambassadors within our teams.



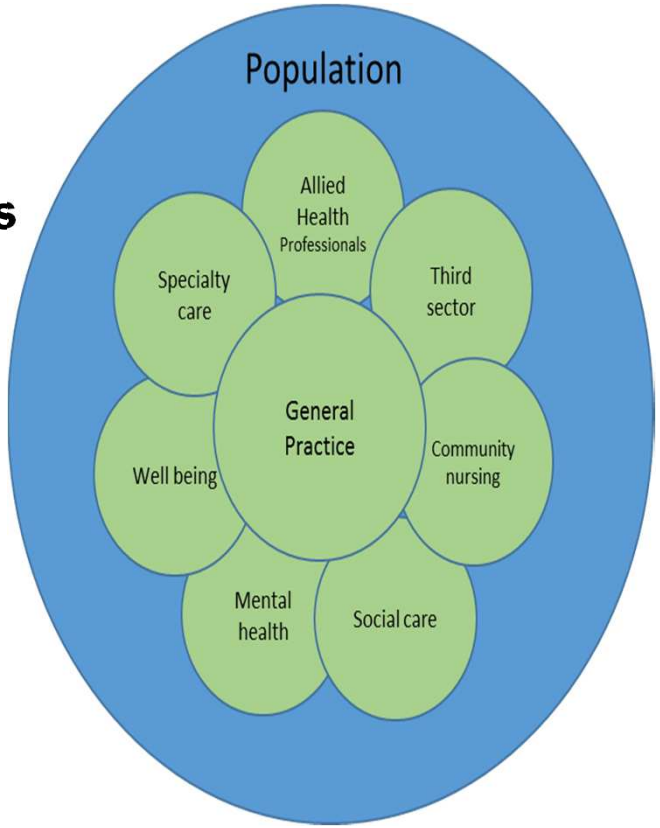

Secondary care
Tertiary
Tertiary
Out of hospital/
Hubs
Community services
Tertiary
Tertiary
Secondary care

Halton Neighbourhood Hub Model

Widnes	Runcorn
Hub 1 • Appleton • Beeches • Hough Green • Peelhouse *Population size – 37,200*	Hub 1 • Grove House Partnership • Tower House *Population size – 26,850*
Hub 2 • Bevan • Newtown • Oaks Place • Upton Rocks *Population size – 28,800*	Hub 2 • Brookvale • Castlefields • Murdishaw • Weavervale *Population size – 37,900*

Halton Hub Model

- We recognise the **need to change the model of General Practice** in Halton – but this must be done as **part of a wider system change**.
- The new 'out of hospital' model will see **more collaboration between practices and providers** and the establishment of the **four community hubs with integrated teams wrapped around** defined patient populations.
- These teams will operate as a **single, multi-disciplinary team, accessing a single care record**. The teams must **focus on the physical health, mental health and social needs** of their populations.
- They need to act as **one team**, **without organisational, contractual or financial constraints or barriers**.
- To underpin, strengthen and sustain the new approach, we need a **new workforce model**. One that **maximises the skills, experience and knowledge of our workforce**.



ONE HALTON PLACE BASED PRIMARY CARE HUB MODEL.