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Town Hall
Trinity Road
Bootle
L20 7AE

Date:

Contact: Amy Dyson
Contact Number: 0151 934 2045

e-mail:
amy.dyson@sefton.gov.uk

Dear Member,

HEALTH AND WELLBEING BOARD - WEDNESDAY 7TH JUNE, 2023

I refer to the agenda for the above meeting and now enclose the following documents which were unavailable when the agenda was published.

Agenda No.	Item
5	**Sefton Plan 2023-25** (Pages 3 - 130) Report of the Associate Director of Transformation and Partnerships (Sefton) – NHS Cheshire and Merseyside
7	**Special Educational Needs and Disabilities Joint Commissioning Plan** (Pages 131 - 196) Report of the Executive Director of Children's Social Care and Education and Executive Director for Adult Social Care and Health/NHS Place Director

Yours faithfully,

Democratic Services

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Report to:	Health and Wellbeing Board	**Date of Meeting:**	7 June 2023
Subject:	Sefton Plan 2023-25		
Report of:	Executive Director Adult Social Care and Health (DASS) and NHS Place Director (Sefton)	**Wards Affected:**	(All Wards);
Portfolio:	Health and Wellbeing		
Is this a Key Decision:	No	**Included in Forward Plan:**	No
Exempt / Confidential Report:	This report does note contain information which is confidential or exempt.		

Summary:
The Sefton Plan 2023-25 has been developed collaboratively with partners to support the delivery of:

- The Joint Health and Wellbeing Strategy, Living Well in Sefton.
- The Cheshire and Merseyside Health and Care Partnership strategy.
- The NHS Cheshire and Merseyside Joint Forward Plan (JFP).
- The NHS Operational Guidance for 2023/24.

It is a strategic document that sets out key objectives across the life-course, together with their intended impact and timeframe for implementation. It is intended the plan is a "live" document that can respond to the changing needs of Sefton's communities.

Recommendation(s):
The Board is asked to:

1) Note the purpose of, and collaborative approach and engagement undertaken in developing, the Sefton Plan.
2) Provide feedback on the content and offer comments in terms of how best to advance delivery in collaboration with partners and communities.
3) Approve the plan and endorse the approach of it being a "live" document that can respond to the changing needs of Sefton's communities.

Reasons for the Recommendation(s):
Although not a statutory document or requirement, the support of the Board is considered a strong statement of intent in supporting partnership delivery.

Alternative Options Considered and Rejected: (including any Risk Implications)
No alternative options were considered given the plan has been developed following extensive engagement and is an important document for setting out how partners will work together to improve the health and wellbeing of Sefton's residents.

What will it cost and how will it be financed?

(A) Revenue Costs

The plan will be financed through NHS financial allocations and the commitment of all partners to pooling resources (where possible) in support of maximising the impact of the Sefton pound in transforming health and care outcomes for residents.

(B) Capital Costs

N/A

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets):
The plan will need to be delivered in line with NHS England funding allocations and partner affordability.

Legal Implications:
There are no direct legal implications.

Equality Implications:
There are no direct implications at this stage given the document is a strategic plan. Individual equality impact assessments will need to be developed to support implementation. An easy-read and accessible version of the plan will also be developed once approved. In support of care experience as a protected characteristic, colleagues within Sefton are leading implementation of the NHS Universal Family (Care Leaver Covenant) Programme. The target date to advertise the offer to care experienced young people is October 2023. This is reflected in the plan.

Impact on Children and Young People: Yes
The Sefton plan includes key objectives across the life-course. Children and Young People, Early Help and Maternity are priority areas under Start Well. The plan specifies the impact each objective will have on Children and Young People together with timeframes for delivery.

Climate Emergency Implications:

The recommendations within this report will

Have a positive impact	Yes
Have a neutral impact	
Have a negative impact	
The Author has undertaken the Climate Emergency training for report authors	N/A

The author has completed NHS Net Zero Training.
Community first is one of three cross-cutting priorities outlined in the Sefton plan. This includes objectives relating to social value and the role of partners as anchor institutions, with reducing environmental impact a key element of this approach. The Sefton plan will also support delivery of the JFP and its objectives in relation the delivery of the NHS Cheshire and Merseyside Green Plan.

Contribution to the Council's Core Purpose:

Protect the most vulnerable: The Sefton plan includes reducing health inequalities as one of three cross-cutting themes. Local implementation of the Core20PLUS5 initiative, which is focused on the 20% most deprived communities and those who are most susceptible to poor access, outcomes and/or experience, will support partners in protecting the most vulnerable across the borough.
Facilitate confident and resilient communities: The Sefton plan includes community first as one of three cross-cutting themes. All partners are committed to co-producing with communities and ensuring their voice informs future plans. This is strongly reflected in objectives relating to enabling functions in particular, including communications and engagement and population health management (PHM).
Commission, broker and provide core services: The Sefton plan is a partnership plan that will help to drive forward the integrated commissioning agenda and result in more jointly commissioned services through use of the Better Care Fund (BCF).
Place – leadership and influencer: The Sefton plan sets out how partners will deliver improved health outcomes for residents working under the umbrella of the Sefton Partnership. It is also acknowledged the Partnership need to work in conjunction with other places to influence the NHS Cheshire and Merseyside agenda, particularly in relation to themes that impact residents across Cheshire and Merseyside e.g., the provision of acute and specialist services.
Drivers of change and reform: The Sefton plan has been developed on the premise that all partners must change how they work as part of an integrated health, care and wellbeing system to drive improved health outcomes for residents. This means working in partnership and breaking-down traditional provider-commissioner barriers.
Facilitate sustainable economic prosperity: The Sefton plan supports delivery of the Cheshire and Merseyside Health and Care Partnership strategy, with one of its key objectives being to support social and economic development. This is also reflected in the community first cross-cutting theme which has an objective to support more Sefton organisations to become anchor institutions – spending more money locally and employing local people.
Greater income for social investment: As above while also noting the Sefton plan includes a number of joint initiatives that will support social investment including, for example, the health-on-the-high-street proposal to support the redevelopment of The Strand in Bootle.
Cleaner Greener As above while noting the Sefton plan supports delivery of the JFP and its objectives in relation the delivery of the NHS Cheshire and Merseyside Green Plan.

What consultations have taken place on the proposals and when?

No formal consultations have been required or undertaken but extensive partner engagement has been completed to develop the plan, including:

- **Monthly updates to the Sefton Partnership Board** in March, April and May setting out the approach, key objectives and inviting opportunities for partner input.

- **A draft copy of the Sefton Plan was shared with partners in April for feedback**, which has been reflected in subsequent versions. The feedback that was collated and the responses were also shared at May's Partnership Board meeting to ensure transparency.

- **Four multi-agency workshops have been held with wide-ranging partners**, including NHS providers, the voluntary, community and faith sector and Sefton Council between February and April to ensure co-design and that the plan reflected partner-wide priorities. The workshops have showcased a range of evidence from different sources, including:

    - Sefton's Joint Strategic Needs Assessment (JSNA)
    - Fingertips
    - RightCare and Model Hospital
    - System P
    - Healthwatch
    - Quality and performance Indicators
    - Global Burden of Disease
    - VCF community insights tool

- **A joint Health & Social Care Forum, Every Child Matters and Healthwatch event was held in May** with approximately fifty attendees from across the VCF sector and service users in attendance. The feedback has already resulted in changes to the plan, with one notable change being re-naming one of the three cross-cutting themes, from community "resourcefulness" to community "first".

- **Members of the Sefton ICB team have supported development of the JFP through planning meetings since February** and engaged with Cheshire & Merseyside programmes of work including, for example, Mental Health, to ensure connectivity (where relevant, based on population need) between Sefton's objectives and those of NHS Cheshire and Merseyside.

Contact Officer:	Stephen Williams
Telephone Number:	07876 100472
Email Address:	stephen.williams@southseftonccg.nhs.uk

Appendices:

The following appendices are attached to this report:

- The Sefton Plan 2023-25

Sefton Partnership

NHS
Cheshire and Merseyside

Sefton Plan

2023 - 2025

Contents

Introduction

The Sefton Partnership was established in 2022 and includes **partners who have agreed to work together to respond to the health, care and wellbeing needs of the people of Sefton.**

This document – **our Sefton Partnership plan for 2023-25** – sets out our objectives as well as how we will deliver them so that we can improve the health of our residents over the next two years.

We have already made significant progress as a Partnership, with our achievements including being shortlisted for two prestigious national awards, while we have also launched innovative new services that are **already making a real difference to transforming the lives of local people of all ages**. These include:

New funding for our baby attachment and bonding service (BABS), which provides specialist mental health support for new mums during pregnancy and in the postnatal period, helping them to secure attachments and loving bonds with their babies

The launch of crisis cafés in Southport and Crosby that provide a safe space for anyone experiencing a mental health crisis, with 1:1 support available to help manage crisis situations

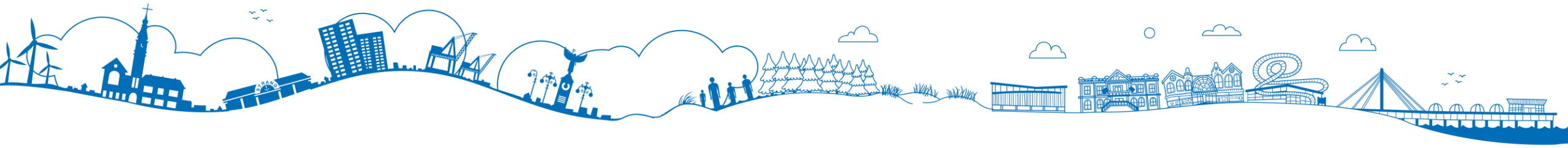
A new two-hour urgent community response service that has been highly effective in reducing the need for our most vulnerable patients to be admitted to hospital

Introduction

We have **adopted a collaborative approach to developing this plan**, working with all our partners to gain their unique knowledge, learning and experience from working with local people.

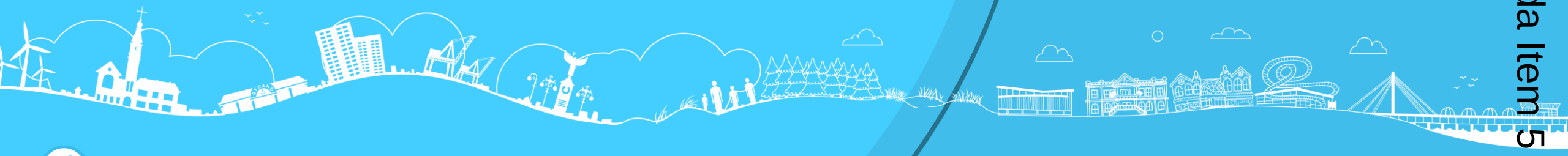
Given that health and life chances are impacted by a wide range of factors, **we know that we will only achieve our objectives by strengthening how we work together as a Partnership over the next two years.**

This document describes our starting point in 2023, our objectives for 2025 and, importantly, how we will deliver them together as a Partnership.

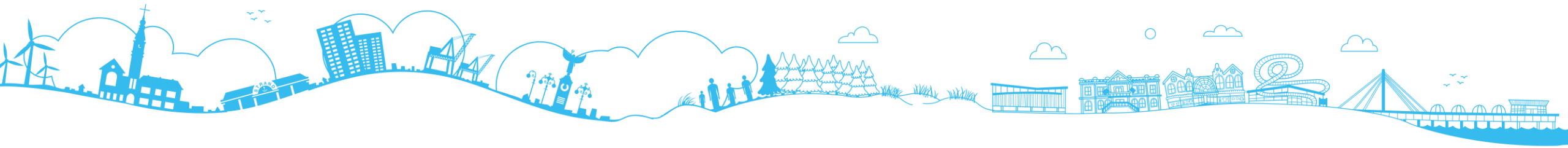


Our starting point in 2023

1. Our vision
2. Cross cutting themes
3. Life-course priorities
4. Enablers



Our vision

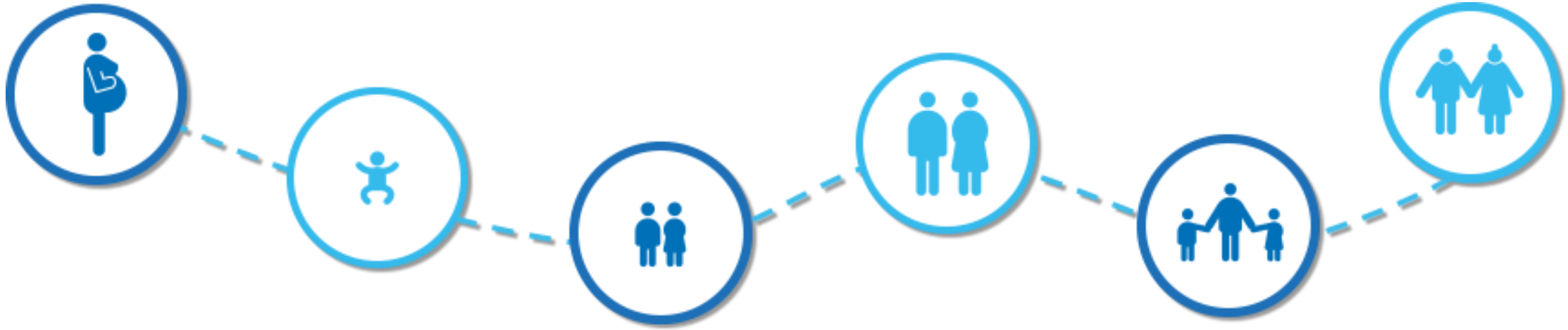


Our vision

Our Partnership plan **supports delivery of the borough's health and wellbeing strategy**, Living Well in Sefton. **We share a single vision**, namely that Sefton will be:

"A confident and connected borough that offers the things we all need to start, live and age well, where everyone has a fair chance of a positive and healthier future"

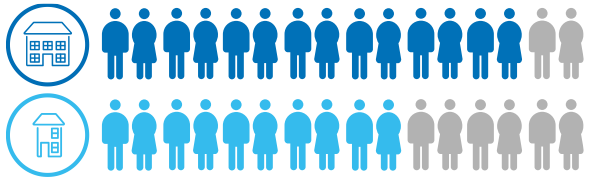
Our vision



Our plan sets out our objectives across the life-course, starting from pregnancy and continuing right through to supporting those who are nearing the end of their life. This underpins our **shared commitment to adopting a "*whole population, whole partnership*"** approach to delivery. In order to realise both our vision and shared commitment, **we have identified three cross-cutting themes: reducing health inequalities, service transformation and community first.**

Our vision

Theme 1
Health inequalities



We recognise there are stark differences in the quality and length of life across Sefton and that we need to work together to prioritise those who stand to gain the most.

Theme 2
Service transformation

We know our provider partners are under increasing pressure and that we have to radically transform how we deliver services to local people.

Theme 3
Community first

We recognise our communities have a vital role in improving their health and wellbeing and we are committed to working with them and co-producing together.

Our vision

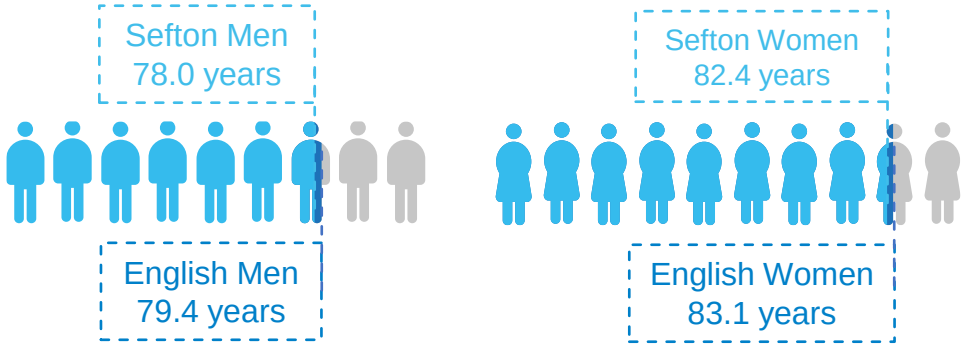
The Sefton Partnership is proud to be part of NHS Cheshire and Merseyside with our plan also supporting delivery of the Cheshire and Merseyside Health and Care Partnership Strategy and the Cheshire and Merseyside Integrated Care Board's Joint Forward Plan, which includes key NHS priorities for 2023-2025.

Our population

Our population

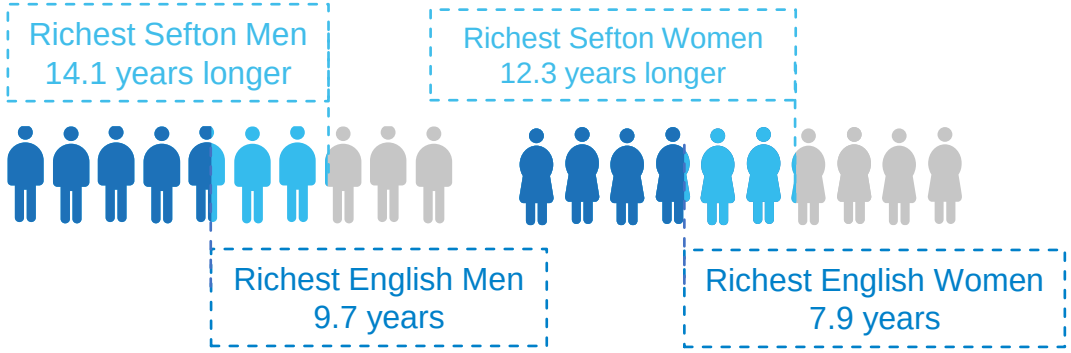
Sefton is unhealthier than England

Over two thirds of local authorities in England have a **longer average life span than Sefton**



Sefton is much more unequal than England

Almost nowhere in England has a **bigger gap** between the **expected lifespan of richest and poorest residents** than Sefton.



Our population

Why?

On average, residents of Sefton's most well off areas live even longer compared to other wealthy places in England (84 years for men and 88 years for women.)

The reverse is true in **our least well off areas** where **the average lifespan is lower** compared to other poor areas in England (71 years for men and 76 years for women.)

Big differences in living standards and life chances cause big differences in health, including how long someone can expect to live in good health. Sefton has the **second most divided distribution of wealth and poverty in England**, just behind Kensington and Chelsea.

Our population

Sefton has a larger than average population of senior residents.

Getting older increases the chances of developing a long-term condition, but living with poor health for a long time is not a guaranteed part of ageing.

The biggest causes of poor health in Sefton

Diseased affecting the heart, brain and blood vessels, lung disease, cancers, mental illness and injury. **About half of this ill-health can be prevented**.

The biggest risks for long-term illness in Sefton

The big causes of long-term illness in Sefton are **smoking, obesity, poor quality food, not being active, and alcohol use.**

Our population

The big root causes of poor health in Sefton

Poverty
Too high cost of living

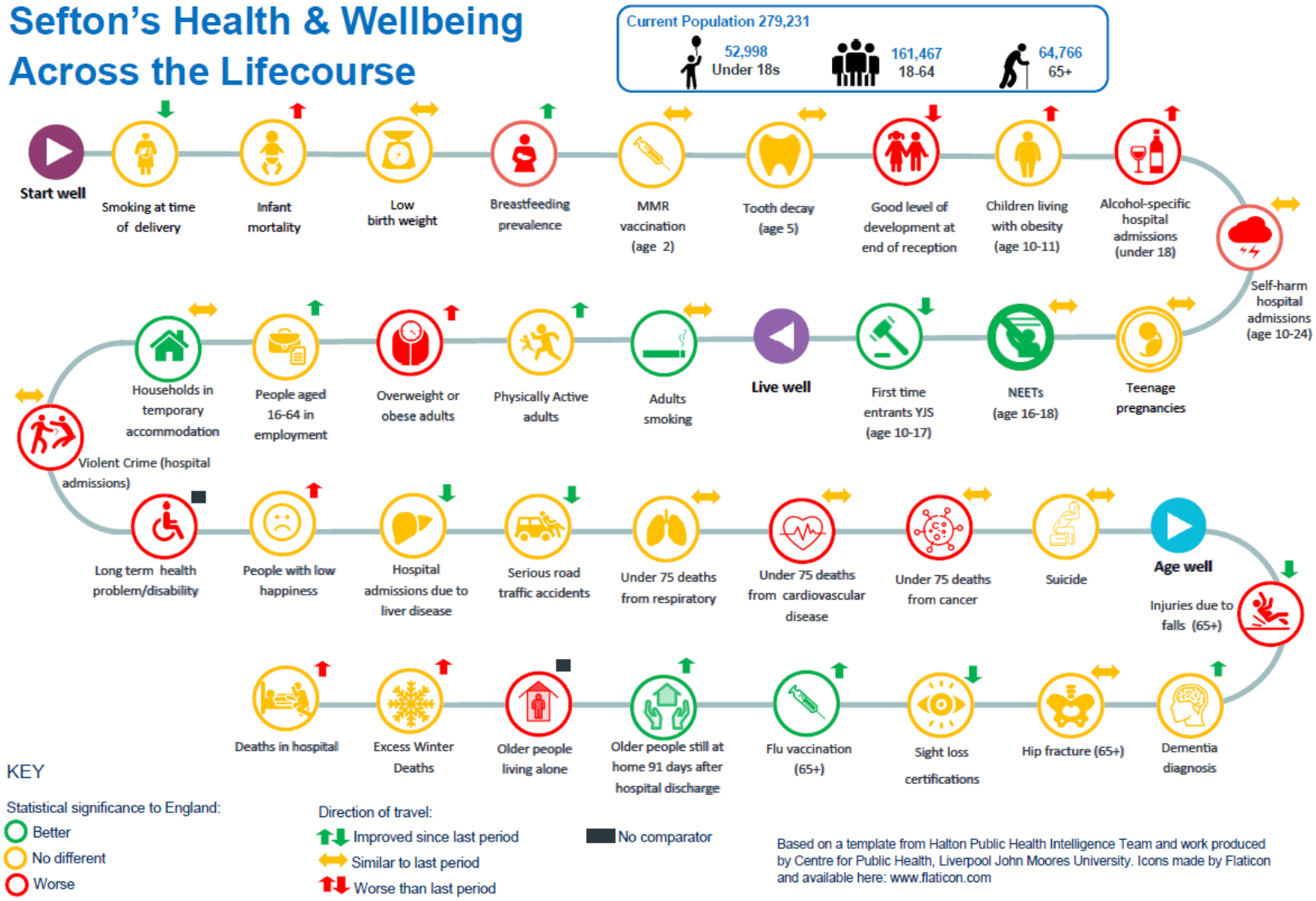
Social
Isolation, loneliness

Housing
Problems with poor housing, neighbourhood environment, transport

Education
Disadvantages in education and employment

In Sefton, 40% to 50% of poor health and premature death is **linked to known risk factors**. Common behavioural risk factors which impact health chances **across the life-course** include **tobacco, obesity, poor nutrition, sedentary living and alcohol use**.

Early health changes can often **be halted or reversed before lasting long-term conditions develop**. Primary, secondary and tertiary prevention are **all needed to extend life, healthy life and quality of life.**



Our achievements

Our achievements

The High Intensity User (HIU) service was named as a finalist in the 'best not for profit working in partnership with the NHS' category of the HSJ Partnership Awards 2023.

Sefton Partnership was a finalist in the 'care and health integration' category of the MJ Achievement Awards 2023.

Our Crisis Cafes in Southport and Crosby are offering out of hours support to anyone experiencing a mental health crisis.

They give adults in Sefton a safe place to go as an alternative to A&E, and demonstrate the huge benefits that working in partnership can achieve.

We have commissioned additional support for parents and carers who are pregnant or who have a baby and are struggling to develop a relationship and bond with their baby.

BABS, the Building Attachment and Bonds Service, is gaining national attention for its work.

Our achievements

We have two mature and innovative primary care networks (PCNs) who work collaboratively with a range of partners.

Examples of PCN-led initiatives that are making a difference to the lives of residents include the enhanced health at home programme, social prescribing, cancer care navigation and winter respiratory hubs.

PCNs are also reducing health inequalities through focused programmes on homelessness, mental health, and vaccination and immunisation uptake.

Our pioneering medicines management hub continues to go from strength to strength, supporting patients, GP practices, pharmacies and hospital services in improving patient care.

The team deals with thousands of queries each year from medical professionals as well as speaking directly with patients on discharge from hospital and beyond to improve their care.

Our work has been acknowledged nationally through various awards with the model shared with other areas.

Our achievements

Sefton Council has been successful in a bid for government levelling up funding for the redevelopment of the Bootle Strand, which presents the possibility of progressing our ambition for a 'health on the high street' hub that brings together a range of services.

This forms one part of our work with Liverpool City Region to develop a wider One Public Estate Strategy.

With the support of our partners we developed a new delivery model that provides an integrated frailty unit with intensive reablement at our Chase Heys service.

The service launched in January 2023 with an additional 14 beds and has already **achieved some impressive outcomes, supporting patients to return home more quickly and releasing hospital beds.**

Our new 2hr Urgent Community Response (2hr UCR) service has been highly effective in reducing the need for our most vulnerable patients to be admitted to hospital.

We have seen referrals jump with performance rates averaging **80-90% against a 70% target**. We continue to develop the service, to support more admission avoidance, as well as ensuring its integration with wider developments.

Our achievements

We have been working together with Knowsley and Liverpool to improve interpreter services for D/deaf patients.

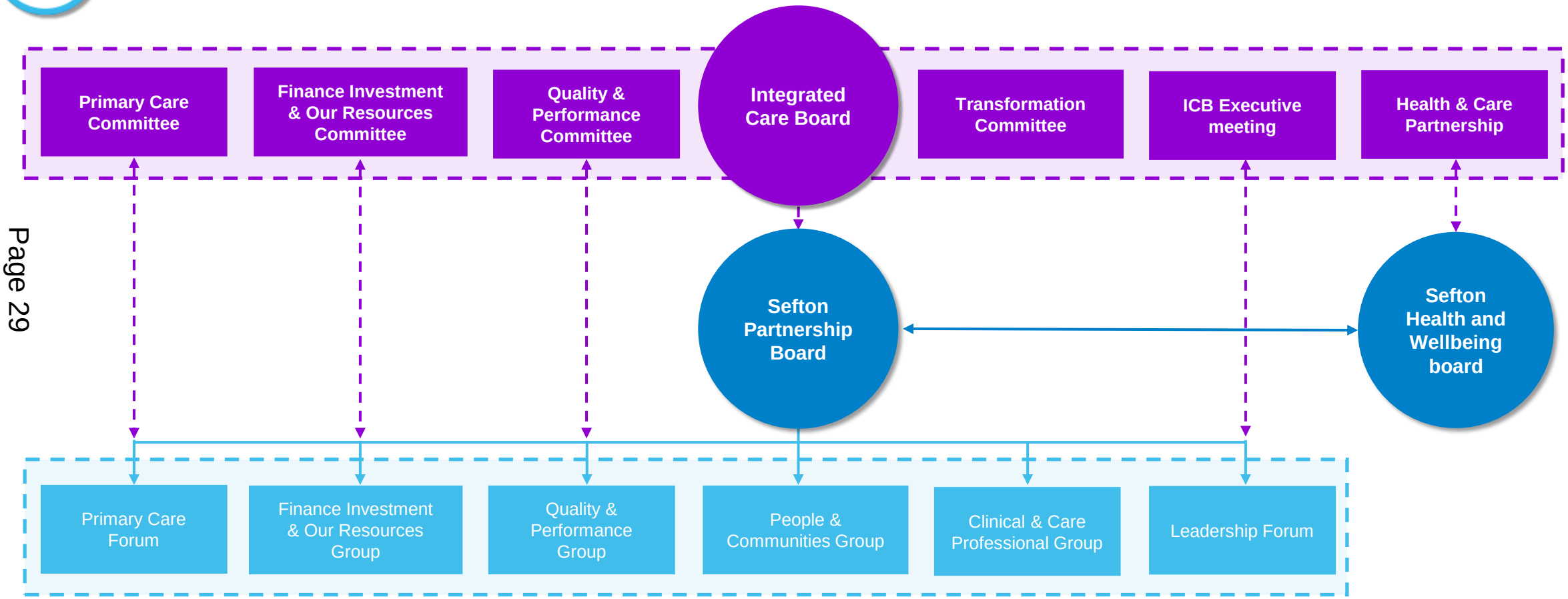
Following engagement with patients highlighting the need for more responsive interpreter services, a new contract was awarded to Signalise Co-op to provide sign language and deaf blind services to the local NHS, including GP practices, hospitals and community health services

We are working with our local GP practices to improve access based on their views and experiences of their patients. More than 10,500 Sefton residents responded to our initial GP access survey.

These results are now being examined by practices, working together their patient participation groups, to develop action plans around possible improvements.

Our governance

Our governance



Our governance

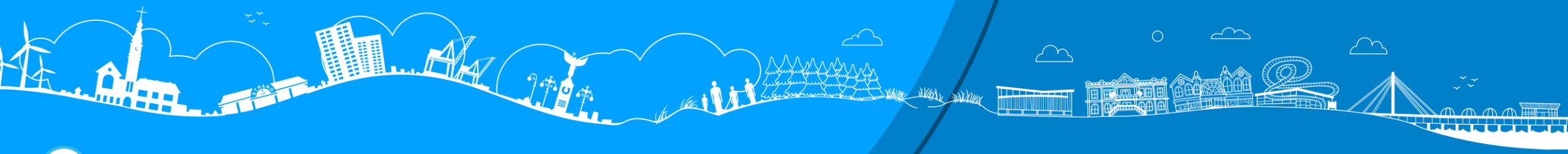
Board, Group or Forum	Role
Health and Wellbeing Board	• A statutory committee of Sefton Council that provides a basis for joint working where political, clinical, professional and community leaders come together to improve the health and wellbeing of local people and reduce health inequalities. • Sets strategic direction through the development and delivery of the Health and Wellbeing Strategy (HWBS).
Sefton Partnership Board	• A consultative forum that provides strategic oversight of the work of the Partnership. • Oversees the development of all key strategic plans, including the Sefton Plan, and is responsible for ensuring the plan is aligned with both the ICB Joint Forward Plan and the HWBS. • Provides assurance in relation to progress, raises concerns in respect of key risks to delivery, and provides a forum for discussion on key strategic developments.
Finance Investment and Our Resources Group	• Supports the development and delivery of the Partnership's financial plan and provides advice to the Board to support effective decision making. • Provides assurance on financial control and value for money. • Provides strategic oversight of the combined financial resources of partner organisations.

Our governance

Board, Group or Forum	Role
Clinical and Care Professional Forum	• Brings together clinical leaders from across Sefton to discus key programmes of work. • Provides a mechanism for review and challenge from a clinical perspective.
Quality and Performance Group	• Brings together partners to discuss quality and performance insights and intelligence. • Identifies opportunities for improvement based on key risks and issues, and develops place-based responses to support quality and performance improvement.
Primary Care Forum	• Oversees functions relating to the commissioning of primary medical services in relation to general practice (GP) primary medical services and community pharmacy. • Supports the ICB's Primary Care Commissioning Committee that has specific NHS England duties delegated to it in respect of GP practice commissioning.
People and Communities Group	• Ensures that local people's voices are heard and that patient experience shapes priorities related to health and wellbeing. • Ensures there are effective channels of communication and networks for local engagement and receives the priorities emerging from local groups and communities.

Our objectives for 2025

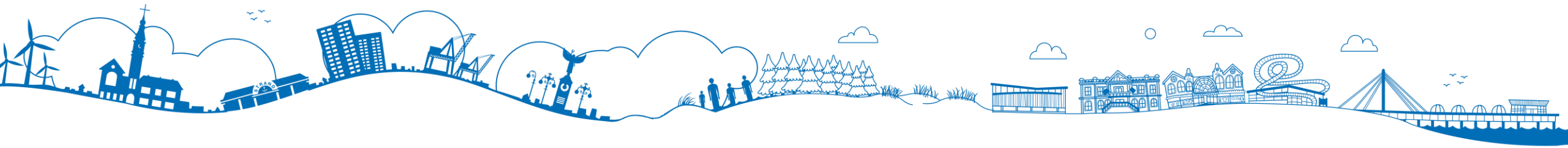
1. Cross cutting themes
2. Life-course priorities
3. Enablers



1. Cross cutting themes

- Reducing health inequalities
- Service transformation
- Community first

Reducing health inequalities



Reducing health inequalities

Health inequalities are avoidable, unfair and unjust. They lead to differences in the quality and length of life Sefton residents will experience. Our most vulnerable residents suffer most as a result of these inequalities, including those who live in our most deprived communities.

The principles behind our approach to reducing inequalities are twofold:

1.
To improve the health of the whole population:
all residents should benefit from our shared actions

2.
To make the gap smaller in health inequalities:
giving more help where there is more need based on our intelligence

Reducing health inequalities

This demonstrates our commitment to:

Proportionate universalism

The resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need.

Services are universally available, not only for the most disadvantaged, and are able to respond to the level of presenting need. This aims to improve the health of the whole population, across the social gradient, while simultaneously improving the health of the most disadvantaged fastest.

Core20PLUS5

A national NHS England approach to reducing inequalities that is focused on the most 20% deprived communities, those groups who suffer particular disadvantage, and across priority areas for action and for both adults and children.

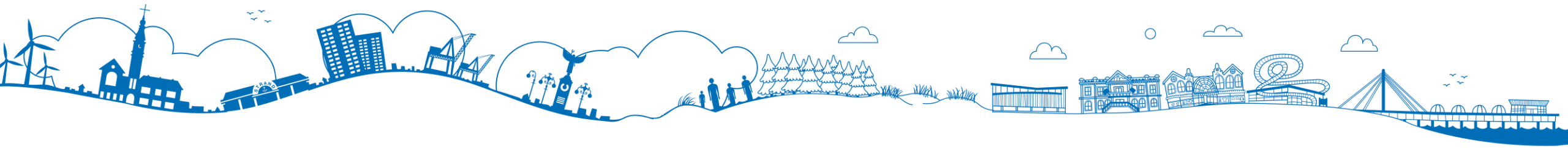
We know that Sefton is more unequal than most of England with large gaps between the expected lifespan of residents who live in the richest and poorest parts of the borough.

Reducing health inequalities

There will be cumulative benefits beyond health outcomes of our adopting both approaches, and by prioritising and targeting resources in a joined-up, evidence-based way. For example, this should help to reduce future demand on heath and care services, which ties in with the role all partners have in supporting early intervention and prevention.

We are therefore embracing a "*whole population, whole partnership*" approach to reducing health inequalities as part of our plan

Service transformation



Service transformation – Shaping Care Together

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Through an established Programme Board with system partners, and through engagement with local residents and clinicians, we are working to develop potential options to ensure the sustainability of acute services provided by Southport and Ormskirk Hospital NHS Trust. Any options or proposals for significant service change will be subject to full public engagement and consultation, managed in line with national policy and will meet the requirements of the assurance process led by NHS England.	• A programme approach to any proposed changes to ensure they have full ownership and involvement from all system partners across Cheshire and Merseyside and Lancashire and South Cumbria. • Improved quality and safety of services for local residents through evidence-based service change where appropriate.	Timescales are under review due to the proposal for Southport and Ormskirk Hospital NHS Trust and St Helens and Knowsley Teaching Hospitals NHS Trust to become one organisation although a full programme plan has been developed to follow the outcome of this process.

Service transformation – Shaping Care Together

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Realise opportunities for greater collaboration between acute and specialised trusts in order to optimise clinical pathways in acute care across Liverpool and neighbouring places, which will impact upon Sefton residents.	• The objective of the review is to identify ways in which to improve outcomes and ensure clinical and financial sustainability of acute and specialist services delivered by NHS providers in Liverpool. • For Sefton, our role is to ensure strong connectivity with the review so that the impact on Sefton residents is fully considered as part of any proposals.	Joint Committees are being tasked with taking forward key recommendations and will determine the timescales.

Community first

Community first

Positive health outcomes can only be achieved by addressing the factors that protect and create health and wellbeing.

Many of these are found at a community level. Community life, social connections and having a voice in local decisions are all factors that make a vital contribution to health and wellbeing. Communities have a vital role in improving health and wellbeing:

1. The communities where people are born, live, work and socialise have a significant influence on how healthy they are.

2. The ‘assets’ in communities, such as skills, knowledge and volunteers, which can be mobilised to promote health and wellbeing.

3. Communities have great insight and intelligence about what they need from services and what works to improve health.

4. Communities are often best placed to engage and reach marginalised groups and those most likely to be affected by health inequalities.

Community first

Sefton's **community first** approach recognises the importance of community-centred approaches as well as the need to mobile assets, empower communities, promote equity and increase people's control over their health and lives.

Voluntary, community and faith (VCF) sector organisations are essential to the planning of care and supporting a greater shift towards prevention and self-care. They are key system transformation, innovation and integration partners. Organisations across the sector are uniquely placed to support people and communities and are vital to supporting population health and reducing health inequalities.

Sefton is home to a rich and varied VCF sector that is dedicated to supporting communities through a range of services and organisations. These organisations benefit from infrastructure support and key sector networks, collaborations and user voice groups, which provide solid platforms for embedding and realising opportunities on multiple agendas, providing a comprehensive social infrastructure for Sefton.

Community first

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Encourage, promote and strengthen VCF sector initiatives which improve people's health and wellbeing.	• Increased opportunities for communities in Sefton to improve their own health and wellbeing.	**March 2025**
Increase capacity and sustainability of Sefton's VCF sector.	• Sefton's communities benefit from trusted relationships and lasting positive social action created by a stable, vibrant and collaborative VCF sector.	**March 2025**
Ensure Sefton's VCF sector is firmly embedded as a key partner in health and care transformation and enabled to continue to innovate in collaboration with communities and partners (as articulated in Sefton's VCF Transformation Narrative)	• Increased cross-sector collaboration to improve health outcomes for local communities.	**March 2025**

Community first

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Recognise and create opportunities to further enhance social value with more organisations becoming “anchor institutions.”	• Increased opportunities for communities in Sefton to improve their own health and wellbeing.	**March 2025**
Involve communities in pathways of care to expand the scope of services that health and social care services provide.	• Pathways of care include additional social as well as medical models of care.	**March 2025**
Explore new opportunities to collaborate with local communities and the VCF sector, particularly in relation to ill-health prevention and providing care closer to home.	• Increased collaboration and integration between VCF sector and Sefton partners.	**March 2025**

2. Life-course priorities

- Start well
- Live well
- Age well
- All age

Start well

1. Children & Young People (CYP)
2. Early Help
3. Maternity

Start Well – Children & Young People (CYP)

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Developed an expanded offer for CYP and their families/carers with emotional health and well-being needs, with a specific focus on children in care that reflects a partnership approach to the role of corporate parent, and development of support for those aged 19-25.	• More CYP will access timely support to meet their mental health needs. • The mental health needs of children in care will be better managed, which will help promote placement stability and management of risk. • The specific needs and challenges faced by 19-25 year olds will be more effectively met.	**March 2024**
Improved understanding of the reasons why CYP attend accident & emergency (A&E) to inform how the management of health conditions by universal services, primary care and community services can improve outcomes and reduce urgent care presentations and admissions.	• Health conditions better managed leading to a reduction in the number of CYP people using urgent care when their needs could be met more effectively elsewhere.	**March 2024**

Start Well – Children & Young People (CYP)

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Developed and expanded offer CYP and their families/carers with neurodevelopmental needs as part of the Special Educational Needs and Disabilities (SEND) Joint Commissioning Plan.	• CYP's needs will be met earlier • CYP and their families/carers will be accessing support that is less reliant on a formal diagnosis.	**March 2024**

Start Well – Early Help

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Actively listening to children, young people and their families to co-create solutions that work for them.	• Co-producing and co-creating with children, young people and families will ensure services evolve and meet community need.	**April 2024**

Start Well – Early Help

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Integrated practice that is supported by co-location, with opportunities for integrated induction of staff, strengthened through shared training, shadowing and observation across partners, team meetings, case management discussions and matrix management approaches.	• Address silo working, ensuring children, young people and families receive the right support at the right time by the right person. • The workforce will be knowledgeable about what each service provides and work with children, young people and families will be seamless.	**March 2025**
Shared access to data and IT systems in order to collate evidence of early help across Sefton Partnership, ensuring it is utilised to target and identify genuine gaps in provision. Such gaps will be prioritised for service investment through adopting a whole pathway approach, within a shared outcomes framework.	• Integrated data collection, collation and analysis will identify areas for preventative work to be targeted, identify gaps in service delivery so early action can be taken. • Effectively capturing outcomes across the partnership will ensure a shared understanding from all partners.	**March 2025**

Start Well – Maternity

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Develop a perinatal pelvic health service to address the specific needs of women during the perinatal period.	• Increased mental and physical recovery. • Improved access to services. • Empowered women who are able to take control of decisions about the care they receive to better meet their needs.	**March 2024**

Start Well – Maternity

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
The delivery of timely, safe and efficient services for women and children across the whole maternity pathway that meets their needs, by engaging in genuine co-production This will be achieved by working closely with the Maternity Voices Partnership (MVP) to co-design solutions and overcome barriers to accessing services.	• Ensure the patient voice is heard with services including the needs of women, children and families. • Deliver more timely, safer and personalised care to improve outcomes. • Improve patient access, experience and satisfaction levels, as well as quality and efficiency. • Reduce health inequalities and strengthen diversity and inclusion e.g. hard to reach populations, language barriers, poverty and exclusion.	**March 2025**

Start Well – Maternity

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
New opportunities to work more closely with the VCF sector and wider partners to: • Provide more effective support to women and families affected by birth trauma and mental health issues. • Ensure families are aware of the support that is available, including new developments such as the baby attachment and bonding service (BABS).	• Provide support to families experiencing difficulties in early relationships to help prevent mental health difficulties in the future. • Improve families emotional wellbeing and resilience. • Reduce numbers accessing secondary care and promote seamless pathways. • Build partnerships beyond health to improve life chances and wellbeing for families.	**March 2025**

Start Well – Maternity

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Embed measures to improve health and reduce inequalities, including a continued focus on CVD, obesity, diabetes and smoking cessation Accelerate preventative programmes that engage those at greatest risk of poor health outcomes using the pregnancy register to target immunisations and other health messages, including the rollout of a Treating Tobacco Dependency programme at providers accessed by Sefton women and the mobilisation of a Sefton Stop Smoking in Pregnancy Group.	• Prevent uptake of smoking, promoting quitting and treating dependency. • Reduce stillbirth, maternal mortality, neonatal mortality and serious brain injury. • Increase vaccinations uptake for mothers and their babies. • Improve health outcomes for mothers and babies.	**March 2025**

Live well

1. Cancer
2. Complex lives
3. Diagnostics
4. Learning Disabilities & Autism
5. Long Term Conditions (LTC)
6. Mental Health
7. Planned Care
8. Women's Health

Live Well - Cancer

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Implement primary care managed Faecal Immunochemical Testing (FIT)/new colorectal suspected cancer pathway	• Earlier stage diagnosis of colorectal cancer for all ages. • Quicker diagnosis and treatment of colorectal cancer. • Improved cancer survival and quality of life • Reduction in urgent presentations associated with later stage cancer. • Creation of secondary care capacity to support effective prioritisation. • Support reduction in 62 day cancer backlog.	**June 2023** To achieve 75% faster diagnosis standard by March 2024 To support detection of 75% of early stage cancer by 2028
Roll out Targeted Lung Health Checks (TLHC)	• Earlier stage diagnosis of lung cancer. • Improved cancer survival and quality of life. • Reduction in urgent presentations associated with later stage cancer. • Earlier detection of other respiratory and cardiac conditions.	**March 2024** To support detection of 75% of early stage cancer by 2028

Live Well - Cancer

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Implement tele-dermatology for suspected skin cancer	• Earlier stage diagnosis of skin cancer. • Quicker diagnosis and treatment of skin cancer. • Improved cancer survival and quality of life. • Creation of secondary care capacity to support effective prioritisation. • Support reduction in 62 day cancer backlog.	**March 2025** To achieve 75% faster diagnosis standard by March 2024 To support detection of 75% of early stage cancer by 2028
Improve access to, and uptake of, cancer screening programmes	• Earlier stage diagnosis of cancer (breast, cervical, colorectal). • Improved cancer survival and quality of life. • Reduction in urgent presentations associated with later stage cancer.	**March 2025** To support detection of 75% of early stage cancer by 2028

Live Well – Complex Lives

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Develop supported accommodation for individuals with complex mental health (dual diagnosis) linked to an expanded High Intensity User (HIU) service, which will enable timely discharge from an acute setting, supporting capacity and flow. Direct referrals to psychological and in-reach support working in partnership with Housing, Adult Social Care, Mersey Care and VCF sector.	• Support timely discharge from an acute setting. • Reduce delayed transfer of care. • Settled accommodation. • Improved health and wellbeing. • Trauma informed care. • Improved resilience. • Increased independence.	**March 2024**

Live Well – Complex Lives

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Development of Integrated Care Teams (ICT) that encompass a 'Whole Family Approach' working in partnership with Mersey Care, Alder Hey, Adult Social Care, Children's Social Care and the VCF sector to develop and enhance the existing model to reflect an all-age focus	• Improve the co-ordination of care and support at locality level. • Predict and prevent the increasing acuity of people's needs by ensuring that people receive the right targeted support. • Improve signposting to community services and through a single point of access.	**March 2024**
Expansion of Crisis Cafés and the High Intensity User Service, supported by the development of an alternative model of support for CYP as a place of safety, working in partnership to support the development of seamless pathways	• Alternative to A&E attendance for people in crisis. • Reduced pressure on child and adolescent mental health services (CAMHS). • Improved health and wellbeing.	**March 2024**

Live Well – Diagnostics

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Development of capacity to support diagnosis and monitoring of cardiovascular diseases (CVD) and long-term conditions, in order to reduce the gap between observed and expected prevalence and support self management and optimisation of patients	• Improve timely diagnosis of cardiac conditions • Reduce the gap between expected and actual prevalence. • Improved quality of life. • Improved efficiency with a reduction in non-elective activity. • Provide additional social value.	**March 2025**
Support the diagnostic programme to deliver the aims of the programme, including a target of 90% of patients being treated within 6 weeks and meeting demand for the faster diagnosis cancer 28 day standard.	• Improve timely access to diagnostics. • Improved earlier and faster diagnosis of cancer. • Improved quality of life. • Improved efficiency with a reduction in non-elective activity. • Provide additional social value.	**March 2025**

Live Well – Diagnostics

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Development of additional capacity to support diagnosis and management of respiratory long-term conditions, in order to reduce the gap between observed and expected prevalence, supporting self management and optimisation of patients with a respiratory long term condition.	• Improve timely diagnosis of respiratory conditions • Reduce the gap between expected and actual prevalence. • Improved quality of life. • Improved efficiency with a reduction in non-elective activity. • Support validation of current registers to ensure accurate diagnosis with appropriate treatment and reduction in avoidable admissions. • Support optimisation of patients with respiratory conditions. • Provide additional social value.	**March 2025**

Live Well – Diagnostics

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Greater understanding of the behavioural and accessibility barriers that are impacting the uptake of diagnostic testing across Sefton's communities, including the impact of the social determinants that could be preventing access to diagnostic services	• Targeted offers focused on areas of greater deprivation, higher expected prevalence and higher numbers of co-morbidities to support identification of individuals with a higher likelihood of disease and better use of resources. • Delayed disease progression. • Support narrowing of health inequalities, in line with proportionate universalism and the Core20PLUS5 approach.	**March 2025**

Live Well – Learning Disabilities & Autism

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Ensure 75% of people aged over 14 on GP Learning Disability (LD) registers receive an annual health check and health action plan by March 2024, by working in partnership to ensure that people are educated and supported to attend their annual health check appointments.	• Earlier identification of undetected health conditions. • Improved health and wellbeing.	**March 2024**

Live Well – Learning Disabilities & Autism

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Reduce reliance on inpatient care, while improving quality in line with national objectives. Sefton currently has eight adults and two CYP in inpatient care, which should reduce to six and one respectively by March 2024. A seamless pathway of care with appropriate accommodation that meets individual needs, underpinned by a housing strategy.	• Increased community services to support individuals with a diagnosis of a learning disability and/or autism. • Care provided closer to home enabling individuals to maintain relationships and connections with their local community. • Settled accommodation that is of a high standard • Improved health and wellbeing.	**March 2024**

Live Well – Learning Disabilities & Autism

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Co-produce an employment pathway that provides individuals with meaningful training, volunteering and employment opportunities that lead to paid employment, working in partnership with Department of Work and Pensions, colleges, advocacy organisations, Get Involved Group, and VCF sector.	• Increased employment, volunteering and/or training opportunities for individuals with a learning disability and/or autism. • Improved health and wellbeing. • Increased resilience.	**March 2024**
Development of autism and attention deficit hyperactivity disorder (ADHD) pathways that include pre and post diagnostic services that are NICE compliant and underpinned by shared care arrangements with primary care.	• Improved access. • Improved mental and physical wellbeing. • Increased resilience.	**March 2024**

Live Well – Long Term Conditions (LTCs)

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Optimise management of LTCs, including supported self-management, by reviewing the model of provision to deliver efficiencies and improve patient compliance and experience Scope the development of a LTC hub, to support optimisation and the delivery of targets.	• Reduced rates of complications and exacerbations. • Reduced demand for urgent and emergency care services. • Reduced inequalities in line with the priorities identified in the Core20PLUS5 approach. • Improved clinical outcomes, quality of life and patient experience.	**March 2024**
Reduce the number of non elective admissions by offering alternative treatment options as close to home as possible.	• Reduced demand for urgent and emergency care services. • Improved clinical outcomes and patient experience. • Improved access to care.	**March 2025**

Live Well – Long Term Conditions (LTCs)

Objective What are we trying to achieve?	**Impact** What difference will it make?	**Timeframe** Our target date?
Primary prevention of LTCs by working with partners to promote a range of lifestyle initiatives that support people to live well in the community.	• Avoid or delay onset of long term health conditions. • Slower rate of increase in demand for health and care. • Improved happiness and quality of life.	**March 2025**
Narrow the gap between predicted and recorded prevalence of key LTCs across Sefton through case finding including health checks, access to diagnostics and the offer of CVD prevention within Targeted Lung Health checks and underpinned by an evidence-based approach using population health management principles.	• Earlier diagnosis supported by improved access • Reduced inequalities supported by a focus on hard to reach groups. • Improved clinical outcomes and patient experience. • Reduced diagnoses of LTCs made in urgent settings. • Reduced rates of complications and exacerbations. • Reduced demand for urgent and emergency care services.	**March 2025** (although recognising a five-year timeframe for the national strategy)

Live Well – Mental Health

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Increase the number of adults and older adults accessing IAPT (Improving Access to Psychological Therapy) treatment, working to promote and develop seamless pathways in partnership with Mersey Care's Step Forward service and commissioned VCF sector providers Promote the service to young people in schools and colleges, particularly at exam times to equip them with the skills to cope at what can be a stressful and anxious time.	• Increased recovery. • Improved mental wellbeing. • Increased resilience. • Improved employment opportunities. • Reduction in people accessing secondary care services.	**March 2024**

Live Well – Mental Health

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Work towards eliminating inappropriate adult acute out of area placements by working in partnership with Mersey Care, Adult Social Care, Housing and the Criminal Justice Liaison Service to develop a seamless pathway of accommodation and support that will be underpinned by an accommodation strategy.	• Development of quality community provision that will support timely discharge from an acute setting and prevent hospital admission, supporting flow. • Improved mental wellbeing. • Increased recovery. • Increased resilience.	**March 2024**
Development of eating disorder services (EDS) that offer a range of NICE compliant interventions, including enhanced medical monitoring within primary care.	• Improved mental and physical wellbeing. • Increased recovery. • Increased resilience.	**March 2024**

Live Well – Planned Care

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Ophthalmology Support the ophthalmology programme to deliver the principles of the eye care roadmap including implementation of the optometry first pilot project.	Transfer activity that can be delivered safely in the community: • Free up clinical resource in secondary care supporting reprioritisation. • Improve quality of life. • Improve efficiency. • Support reduction of elective waiting lists. • Support and educate primary care to manage activity in primary care. • Improve timely access to diagnostic tests • Reduce inequalities. • Improve clinical outcomes, quality of life and patient experience.	**March 2024**
Ophthalmology Support the ophthalmology programme to deliver the principles of the eye care roadmap including implementation of the optometry first pilot project.		**March 2025**

Live Well – Planned Care

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Dermatology Support the dermatology programme to deliver the principles of the transformation programme including development of teledermatology for routine/urgent referrals, supporting repatriation of routine activity into the community and ensuring robust pathways that maximise community delivery	Transfer activity that can be delivered safely in the community: • Free up clinical resource in secondary care supporting reprioritisation. • Improve quality of life. • Improve efficiency. • Support reduction of elective waiting lists. • Support and educate primary care to manage activity in primary care. • Improve timely access to diagnostic tests • Reduce inequalities. • Improve clinical outcomes, quality of life and patient experience.	**March 2025**

Live Well – Women's Health

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Explore women's health services that could be safely delivered in a 'Community Hub model', engaging women in the design through co-production. At present, women often need to attend multiple appointments in different places to access essential services.	• Community hubs will aim to address fragmentation in provision and provide equitable access to better healthcare. • Hubs will focus on delivering services that better fit around women's lives, including ways to streamline access and overcome barriers.	**March 2025**
Develop special interest groups to look at the current referral mechanisms between primary and secondary care, in order to address waiting lists, strengthen advice & guidance mechanisms and develop training opportunities.	• Reduce waiting lists for specialist care. • Provide equitable access to high-quality women's healthcare. • Strengthen advice and guidance mechanisms for primary care. • New training opportunities for clinical staff.	**March 2025**

Live Well – Women's Health

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Improve education and management of women's conditions by upskilling clinicians and trainees to allow women more equitable access to high quality specialised health care.	• Primary care will be better equipped to provide on-going support for patients and their gynaecological conditions.	**March 2025**

Sefton Partnership

NHS
Cheshire and Merseyside

Age well

1. Community Services
2. Dementia
3. Urgent & Emergency Care (UEC)

Age Well – Community Services

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Develop proactive all age Integrated Care Teams (ICTs) across each of the eight localities in Sefton, each serving a population of 30-50,000 population (This will also form the anticipatory care element of the Ageing Well programme for proactive care).	• Increased percentage of the population supported to live in their own home/care home for longer, including the identification of those at risk of frailty, with complex needs and/or multiple long term conditions. • Reduced numbers of the population requiring crisis intervention or support. • Increased numbers of people who are supported in restoration of skills, function, physical and emotional resilience (promoting independence.) • Increased identification of people who are most at risk of health deterioration. • Resources targeted to those most in need and used effectively. • Improved outcomes for people who receive integrated care and support. • One model able to support CYP and adults using 'think family' approaches.	**December 2024:** The Integrated Care Team Programme is a 2 year programme of work that started in December 2022. There is a high level road map and a developing programme plan. There is also a performance dashboard that is currently being updated to reflect the needs of the programme

Age Well – Community Services

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Embed PCN's and primary care as key system partners in the delivery of integrated care, as recommended in the Fuller Stocktake Report.	• Enabled PCN's and primary care taking shared ownership within the integrated teams for improving health and wellbeing. • Clear development plan to support primary care sustainability. • Primary care enabled to act as system improvement leaders.	**December 2024:** The Integrated Care Team Programme is a 2 year programme of work that started in December 2022. There is a high level road map and a developing programme plan. There is also a performance dashboard that is currently being updated to reflect the needs of the programme

Age Well – Community Services

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Level up the current inequity in the Integrated Care Team (ICT) service offer across Sefton.	• Reduced health inequalities across Sefton. • Targeted resources on specific population cohorts (complex lives, long term conditions, disability, frailty/dementia, children & families.) • Effective co-ordinated care and support provided for all.	**December 2024:** The Integrated Care Team Programme is a 2 year programme of work that started in December 2022. There is a high level road map and a developing programme plan. There is also a performance dashboard that is currently being updated to reflect the needs of the programme.
Develop our ICT workforce and leadership arrangements so that staff feel supported, valued and able to effectively respond to the needs of Sefton population.	• Flexible and future-proofed workforce • Integrated leadership arrangements which reflect the needs of each locality, its community, and the staff who work there with a strong commitment to collective leadership and a psychologically safe culture. • There is a look and feel of one integrated service workforce functioning together, unrestricted by role titles or organisational boundaries, working together for the people of Sefton. • Common culture across organisations displayed through shared assumptions, values and beliefs, enabled through this way of integrated working.	

Age Well – Dementia

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Recover the dementia diagnosis rate to 66.7%, although recognising an ambition to further improve performance, in line with available resources.	• Residents in Sefton having a firm and timely diagnosis of dementia. • Additional advice and guidance for patients who decide they don't want to proceed with a diagnosis, as well as a greater understanding of the barriers impacting target recovery as part of a whole pathway approach.	**September 2023**
Establish wellbeing hubs at Strand By Me and the Atkinson Centre to contribute towards improved diagnosis rates – raising awareness of dementia within the community and providing a one stop shop for residents of Sefton.	• Increased awareness of dementia, help and advice for people worried about memory issues, one stop shop for information relating to dementia enabling people to make informed decisions to move forward to diagnosis. • Various providers will be on hand to offer help and support Sefton residents worried about their memory.	**June 2023**

Age Well – Dementia

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Improve support for early onset dementia Undertake a scoping exercise to look at available support groups, which are currently only offered to patients accessing secondary care, presenting an opportunity for a VCF sector pilot.	• Better support for younger residents with peer groups, workplace advice and guidance, and links with other services and benefit advice.	**March 2024**

Age Well – Urgent & Emergency Care (UEC)

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Sustain additional bed capacity to support step up and step down provision to maximise hospital bed capacity.	• Reduce non-criteria to reside (NCTR) patients. • Support admission avoidance.	**September 2023**
Develop complex care & advanced care planning to support high costs packages of care and 1:1 provision for dementia.	• Support provision of complex case management of patients wishing to remain at home. • Improve discharge and flow, reducing long length of stay (LLOS).	**September 2023**
Establish a transfer of care hub that incorporates bed brokerage, pathway management and improved navigation of services. Work towards seven day service provision, inclusive of GP appointments.	• Improved navigation of services to enable patients to access services in the right place and at the right time. • More effective management of capacity, demand and system flow into step down and step up services. • Improved integration of wrap around support services to reduce admissions and expedite discharges.	**September 2023**

Age Well – Urgent & Emergency Care (UEC)

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Enhance reablement and domiciliary care provision as well as wider approaches as part of an Enhanced Home First offer, including for those patients with a mental health condition and/or a learning disability.	• Increase the number of patients discharged directly to their own homes. • Support discharge and hospital avoidance. • Reduction in long term placements and high cost packages of care.	**March 2024**
Develop an enhanced workforce strategy that enables 7 day provision, recruitment and retention to level up resource, supported by a revised training offer.	• Improved access to services. • Reduced conveyance, admissions, and expedited discharge.	**March 2024**

All age

1. Carers
2. Obesity
3. Primary Care
4. End of Life Care (PEoLC)

All age – Carers

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
For carers to receive appropriate recognition and support through sustainable and integrated services that ensure support for as many carers and their families as possible. All statutory duties relating to carers including the enhanced obligations to include carers in discharge hubs as set out in the Health and Social Care Bill, and Care Act responsibilities. Effective partnerships with the Carers Centre and co-production with carers in support of an all-age strategy and model of delivery.	• Carers are able to access the right level of resources in a timely manner and in a way which empowers and enables them to meet the needs of the those they care for. • Carers and the cared for have the support they need to improve their health and wellbeing. • Carers and the cared for have the support they need when receiving end of life care. • Sefton Partners acknowledge the invaluable role of carers through, for example, discharge and assessment processes.	**March 2025**

All age – Obesity

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Start Well Develop a CYP Integrated Wellness Programme across all 0-19 public health services, which will promote a holistic approach to CYP health through improved integration between services that provide support on healthy eating, physical activity, smoking, substance misuse, mental health and healthy weight.	• Ensure a fully integrated service is available, operating through the Happy 'N' Healthy Hub, which will provide access, support and advice to CYP on a range of health and wellbeing areas including healthy weight.	**June 2023**
Live Well Achieve all 16 competencies as outlined in the Healthy Weight Declaration	• The declaration allows for a broad range of deliverables, ranging from healthy catering to proactive lobbying against unhealthy food provided by anchor institutions (e.g. vending machines and school catering), and enhancing collaboration and partnership. • Demonstrate commitment to the healthy weight agenda.	To assign ownership of actions by the end of **June 2023**. It is envisaged that accreditation for the declaration will be achieved by **March 2025.**

All age – Obesity

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Age Well Develop a healthy weight pathway.	• It will provide a defined pathway for health care professionals and individuals to access appropriate services, from low level intervention to treatment services, with relevant support ranging from behaviour change to clinical treatment programmes.	Subject to confirmation: draft pathway for Tier 0-4 has already been developed. Tiers 0-3 are already operational. Tier 4 is out for re-procurement.

All age – Primary Care

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Make it easier for people to contact a GP practice, by supporting general practice to transition to digital telephony. This will help to ensure that everyone who needs an appointment gets one within two weeks, and those who need an urgent appointment are assessed by the following day according to need.	• Improve patient experience and satisfaction. • Potential to manage workflow and routine/urgent demand within practice. • Assist with new models of care to stream on the day urgent activity. • Expansion of workforce through ARRS. • Reduce health inequalities through PCN led service provision targeting hard to reach groups/priority conditions.	**March 2024**
Increase the resilience of general practice in Sefton through delivery of the Evolution of General Practice Programme (Evo GP) and support for PCN development.	• Exploration of new models for the organisation and delivery of primary medical care services to ensure stability and continuity of provision. • PCNs continue to develop their organisational form and portfolios. • Expansion of services across localities to provide accessible services, expanding appointments and shifting workload to the most appropriate clinician.	**March 2024**

All age – Primary Care

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Ensure that improvements to dental services are targeted at priority cohorts.	• Improved access to general dental services. • Improved access to urgent dental services. • Reduction in health inequalities through targeted access.	**March 2025**

All age – Palliative & End of Life Care (PEoLC)

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Map all specialist palliative care services against the core specification. Contribute to a Cheshire & Merseyside place-based needs assessment and establish links with system-wide services to ensure provision of services to support CYP. Identify key metrics and intelligence support. Provide 24/7 specialist advice for healthcare professionals, patients and carers.	• Partner organisations will work collaboratively to provide equitable care for those likely to be in the last year of their life across Sefton. • Demonstrate the need for specialist PEoLC services and identify gaps in provision against the core specification, informing plans for service development and sustainable investment in core services. • Ensure there are common metrics to enable measurement and to assess progress against key objectives, informing plans for service development and sustainable investment in core services.	**March 2024**

All age – Palliative & End of Life Care (PEoLC)

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Increase the identification of adults who are likely to be in the last year of life across all care settings (community, care homes, hospice and hospital) More adults receiving coordinated care and offered future care planning An agreed system-wide approach to anticipatory clinical management planning with resources enabling implementation across all care settings More patients in the last year of life having a holistic assessment of their care needs.	• Increased number of patients who are identified as being in the last year of life and included on a GP register using nationally agreed codes (minimum of 0.6% of population). • Improved patient involvement in shared care planning • Increased anticipatory clinical management planning across all care settings (including increased used of personalised care support plans, treatment escalation plans and others). • Increased number of patients who die in their usual place of residence who have had a cardiopulmonary resuscitation (CPR) discussion and/or decision recorded in the primary care record at the time of death • Reduced admissions to hospital in the last 90 days of life. • More people dying in their usual place of residence (if they choose). • Increased number of carers who have had a carers assessment.	**March 2025**

All age – Palliative & End of Life Care (PEoLC)

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Enable timely and responsive PEoLC supported by information that can be transferred electronically across all care settings.	• Improved care by allowing staff to view important information. • Improved communication between professionals across all care settings to ensure patients receive coordinated care that reflects their wishes. • Consistent use of coding across all care settings to support sharing of information and data collection.	**March 2025**

All age – Palliative & End of Life Care (PEoLC)

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Upskill all health and social care staff (including care home) so they can recognise when people are approaching end of life, and work together to co-ordinate and provide high quality care. Support with enhanced provision for network and system-wide education programs. Respond to a system-wide workforce scoping report.	• All health and care staff will have undertaken appropriate training suitable to their role, leading to increased staff confidence and skill-level. • Ensure there is an appropriately resourced and skilled specialist PEoLC workforce. • Ensure sufficient resources are available for the development of a multi-professional PEoLC workforce at all levels. • Consistent standards of education to improve quality across all settings. • Provide essential support to patients, carers and those important to the individual. • Ensure a joined up system-wide approach.	**March 2025**

3. Enablers

1. Clinical & Care Leadership
2. Communications & Engagement
3. Digital
4. Estates
5. Medicines Optimisation
6. Organisational Development (OD)
7. Population Health Management (PHM)
8. Workforce

Enablers – Clinical & Care Leadership

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Evolve the former Clinical Advisory Group into a Clinical and Care Professional Forum to ensure the Partnership benefits from a strong clinical and professional.	• Ensure engagement with a wider range of clinical and care professionals to "sense-check" and advise on the work of the Sefton Partnership. • Avoid unintended consequences from any proposed changes through effective engagement with colleagues who deliver frontline services.	**July 2023**
Effective clinical leadership that is able to work collaboratively on Sefton's objectives – through the retention of experienced clinical leaders, including the Clinical Director.	• Our work will be clinically led through utilising the skills, knowledge and experience of local clinicians to improve the quality of care. • Greater clinical engagement in the work of the Sefton Partnership.	**September 2023**
Align clinical leads to key Sefton Plan objectives to ensure focused input and to maximise impact.	• Improvements to patient care through smoother clinical pathways. • Maximise opportunities for closer working between partners and clinical leads to ensure relevant developments are clinically-led.	**March 2025**

Enablers – Communications & Engagement

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Establish People and Communities Group (PCG) as part of reviewed and strengthened governance arrangements.	• Ensure statutory requirements for public involvement are considered at, and reported to, the highest levels of the Partnership to build ownership and provide assurance.	**June 2023**
Develop the PCG into a key forum for co-production in line with relevant guidance, the place maturity framework and the Sefton Public Engagement and Consultation Framework and Standards Panel.	• Support the Partnership in meeting it's public involvement duties and the 'triple aim' of better health and wellbeing, improved quality of services and the sustainable use of resources.	**March 2024**
Further develop Sefton's Communications and Engagement Group to coordinate joint activities supporting the delivery of relevant Partnership objectives, as outlined in this plan.	• Maximise efforts and resources across health and care to ensure integrated and effective communications and public involvement activities, to better support the objectives of the Partnership plan	**March 2024**

Enablers – Communications & Engagement

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Commissioners and providers routinely consider public involvement, and particularly co-production, at all stages of the design of their delivery plans.	• Considering public involvement early will ensure better decisions about service changes and help to shape a sustainable future for health and care services that better meets people's needs.	**March 2024**

Enablers – Digital

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Review and implement opportunities to utilise technology enabled care (Telehealth, Telecare and Remote Monitoring) solutions to support health and wellbeing at scale.	• Enhance the independence of citizens and improve experience. • Avoid GP appointments and hospital attendances and admissions, supporting the delivery of care as close to home as possible. • Supports pro-active self-monitoring of health and wellbeing.	**March 2024**
Support our health and care workforce to maximise the potential of digital solutions.	• Enhance collaboration between health and care staff and patients. • Improve the delivery o safe, effective and efficient health and care services through enhanced access to technology and data. • Develop and retain a highly skilled workforce that is data and digital competent and confident.	**March 2024**

Enablers – Digital

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Establish strong digital and data foundations, delivering reliable, seamless and secure digital and data infrastructure and associated support services.	• Ensure access to reliable, seamless and secure network infrastructure and fit for purpose devices. • Enhance delivery of health and care services.	**March 2025**
Implement 'at scale' digital and data platforms which are embedded in health and care service delivery.	• Enable platforms for shared care records, remote care, intelligence delivery and patient empowerment. • Improve the productivity and efficiency of service delivery.	**March 2025**
Maximise the utilisation of shared records for the purposes of direct care.	• Improve access to real time information at the point of care. • Improve patient safety and reduce clinical risk. • Improve patient experience and empowerment by reducing duplication and deliver improved outcomes for staff and public.	**March 2025**

Enablers – Digital

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Improve digital inclusion to enable the greater use of digital tools and solutions.	• Empower citizens to take increased control of their physical and mental health and wellbeing. • Enhance clinical care through greater use of patient expertise in the management of their own conditions.	**March 2025**

Enablers – Estates

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Finalisation of the One Public Estate Sefton Plan.	• System-wide view of assets, opportunities and agreed priorities. • Support discussions regarding availability of capital to progress developments.	**June 2023**
Refresh the Sefton Property and Estates Group (with reporting from primary care, connectivity with One Public Estate and the wider system) and with sufficient capacity to deliver the programme.	• Streamlined governance to enable effective working at locality, Sefton, City Region and Cheshire & Merseyside levels.	**July 2023**
Develop the Bootle Strand "Health on the High Street" Hub with an agreed vision and plan, with a view to securing investment and delivery.	• Integrated service delivery will improve the health and wellbeing of local residents, as well as contributing to the regeneration of the town centre.	**Local outline plans by October 2023**

Enablers – Estates

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Increase co-location and utilisation of estates across Sefton in both the short-term, through identification of current opportunities, and in the longer-term through co-design of fit for purpose premises.	• Improved integrated working, with co-delivery for patients. • More effective utilisation of current estate. • Co-designed plans for future requirements in each locality with key partners e.g. Crosby Village, Maghull Health Centre, Southport, Formby. • Enable full utilisation of PCN additional role funding.	**March 2024**

Enablers – Medicines Optimisation

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?

Quality
Work with the Council to improve quality within care homes.
 	
Optimise prescribing of medicines associated with dependence, utilising the good practice shared by NHS England https://www.england.nhs.uk/long-read/optimising-personalised-care-for-adults-prescribed-medicines-associated-with-dependence-or-withdrawal-symptoms/
 	
Advance poly-pharmacy structured medication reviews for patients living in their own home and care homes.
	• Develop a Medicines Management Care Home Policy, proactive safe and secure handling of medicines audits, and monthly medicines management training to:
	  ○ improve the quality and safety in care homes in relation to medicines.
	  ○ reduce admissions to secondary care due to medicines related incidents.
	• Reduce prescribing of dependence associated medications.
	• Reduce medicines related incidents/admissions.
		March 2024

Enablers – Medicines Optimisation

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Innovation Continue to work as an integrated team which includes the employment of all Sefton Primary Care Network (PCN) funded pharmacists and technicians managing ICB and PCN priorities.	• Supports development of PCNs. • Delivery of QIPP/IIF/Medicines Hub. • Supports delivery of ARRS roles and PCN priorities.	**March 2024**
Productivity Optimise prescribing to release cost savings across Sefton.	• Contributes to Place and System QIPP target. • Schemes deliver savings, and also improve quality.	**March 2024**
Prevention Continue to undertake quality improvement work, including clinical audits, to consolidate the improvements made in recent years and minimise selection pressure for Anti-Microbial Resistance (AMR)	• Reduce prescribing. • Improve clinical pathways. • Support quality improvement.	**March 2024**

Enablers – Organisational Development (OD)

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Clarity on devolved decision-making and budgetary responsibilities for the Partnership to support local OD.	• Clarity of purpose, reduction in duplication, positive relationships and collaborative working at all levels.	**October 2023**
A delivery plan of OD activities that support the development of an effective place- based partnership in keeping with Sefton Partnership's values, culture and behaviours.	• Effective Partnership Board (and sub-structure) which has clarity of purpose, adheres to agreed ways of working and oversees the delivery of priorities for the benefit of local residents. • Increased trust and openness between partners to enable a collaborative approach with parity of esteem to more effectively spend the "Sefton pound."	**January 2024**
Availability of a range of OD & individual training and development opportunities that support delivery through system leadership skills and behaviours	• Clear evidence that the programme has tangibly enabled the development of skills and capability (including strong co-design and co-production) though improved delivery of priorities.	**January 2024**

Enablers – Population Health Management (PHM)

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Mobilisation of a partner-wide PHM working group with new membership and a clear terms of reference that supports evidence-based decision making in support of all Partnership activities. This will be supported by stronger links between business intelligence, commissioning and delivery.	• Enable a strong focus on prevention, inequalities and strategic intelligence, and ensure a single uniformed approach across all programmes. • Identification of clear priorities, backed by evidence and outcomes, that support transparent working, allowing resources to be re-directed to prevention, the unnecessary use of services and consideration of the disproportionate impact of the disease burden across Sefton.	**September 2023**

Enablers – Population Health Management (PHM)

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Full integration and consideration of all partner data with the ambition to achieve equal parity between quantitative and qualitative data, in such a way that maximises both staff and community insights.	• Ensure approaches are informed by using data and intelligence sourced from across the public, VCF sector and Healthwatch. • Ensure approaches support effective strategic planning across all partners. • Optimise all available information to inform a life-course, patient-centred approach, maximising outcomes and resources. • Ensure patient experience and community insights are common themes.	**March 2024**
Oversight and connectivity with system programmes, including CIPHA and System P, to ensure key insights are taken forward within and across Sefton.	• Use data and evidence to ensure that best practice is followed. • Support creative use of data to engage with Core20PLUS5 cohorts, enabling bespoke work to trial new ways of engaging, ensuring outcomes are measured to support a continuous improvement approach.	**March 2024**

Enablers – Workforce

Objective What are we trying to achieve?	Impact What difference will it make?	Timeframe Our target date?
Establish a Sefton Partnership Health & Care Career Academy as part of an integrated workforce strategy.	• Support all partners to have the appropriate workforce with the right skills, values and culture. • A plan to address workforce risks..	**Local approach agreed by October 2023**
Implement the NHS Universal Family (Care Leaver Covenant) Programme and advertise the 'offer' to care experienced young people.	• Care experienced young people will have opportunities to be supported into roles in the NHS with their talents helping to deliver services within Sefton.	**An advertised 'offer' by October 2023**
Develop a shared understanding of the workforce plans and risks in order to develop collaborative solutions.	• Sefton is seen as a great place to work, with opportunities for development across the Partnership. • Minimise the shifting of workforce risk across partners.	**March 2024**
Support effective delivery of the NHS People Plan promises for all staff working in Sefton.	• Improve retention and wellbeing of staff.	**March 2025**

Delivering our objectives

- **Monitoring & reporting**
- **2023/24 financial plan**
- **Quality improvement**
- **Quality & safety leadership**
- **Delivering personalised care**

Monitoring & reporting

Monitoring & reporting

- Our approach has been one of identifying key priorities, to ensure that our plan is both ambitious but realistic. Given this, we are implementing a three-phase approach to delivery, in line with the indicated timescales.
- Formal reporting of progress, including impact and risks, will be to the Sefton Partnership Board on a quarterly basis and the Cheshire and Merseyside Integrated Care Board through quarterly place review meetings.
- Although in development, a balance scorecard of headline metrics and a more detailed place performance scorecard will provide the evidence base to enable both Boards to assess progress.
- Our approach to delivery resides with all partners, on the basis of our ***"whole population, whole partnership approach"***. We will therefore be working with all of our partners, and through our governance structure, to progress delivery in line with a programme management approach.

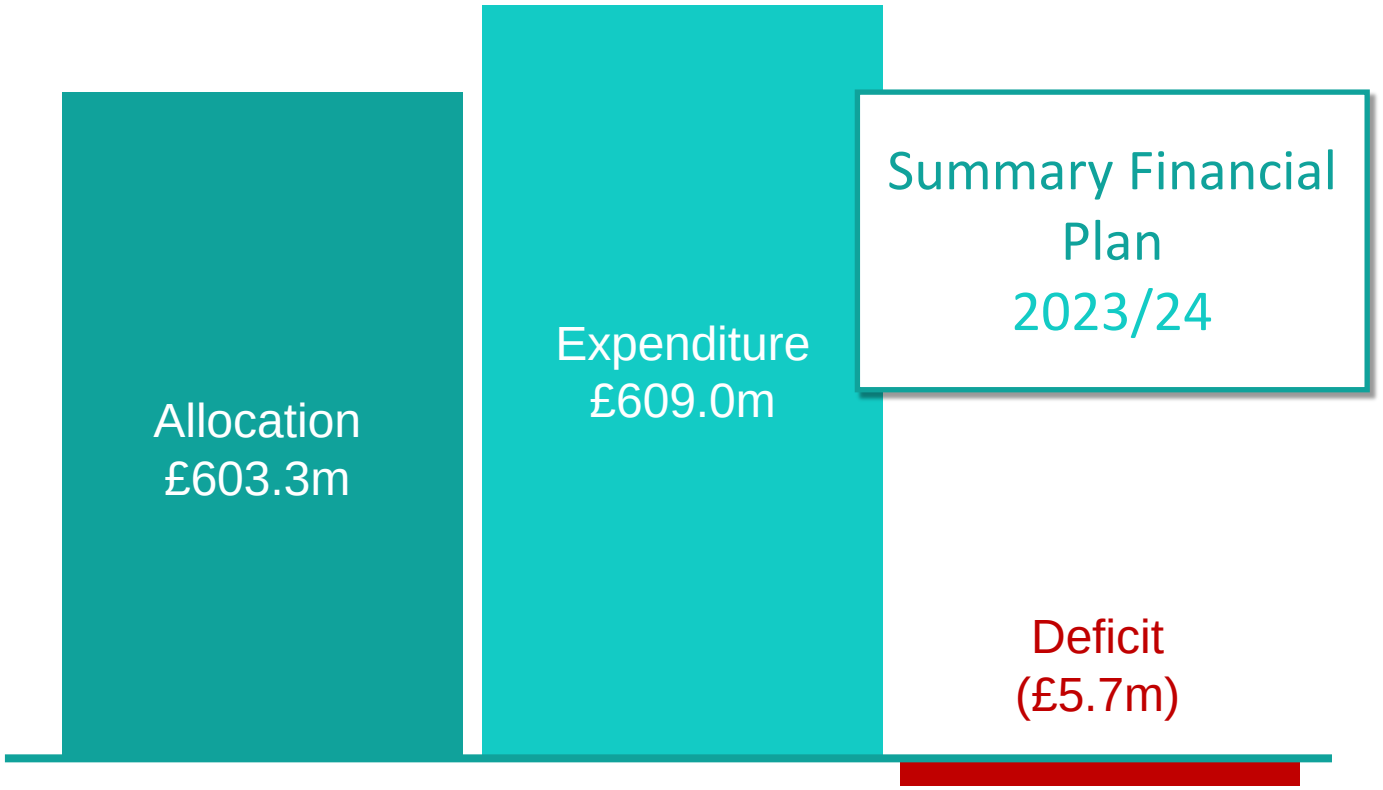
2023 / 24 Financial Plan

2023 / 24 Financial Plan – Summary

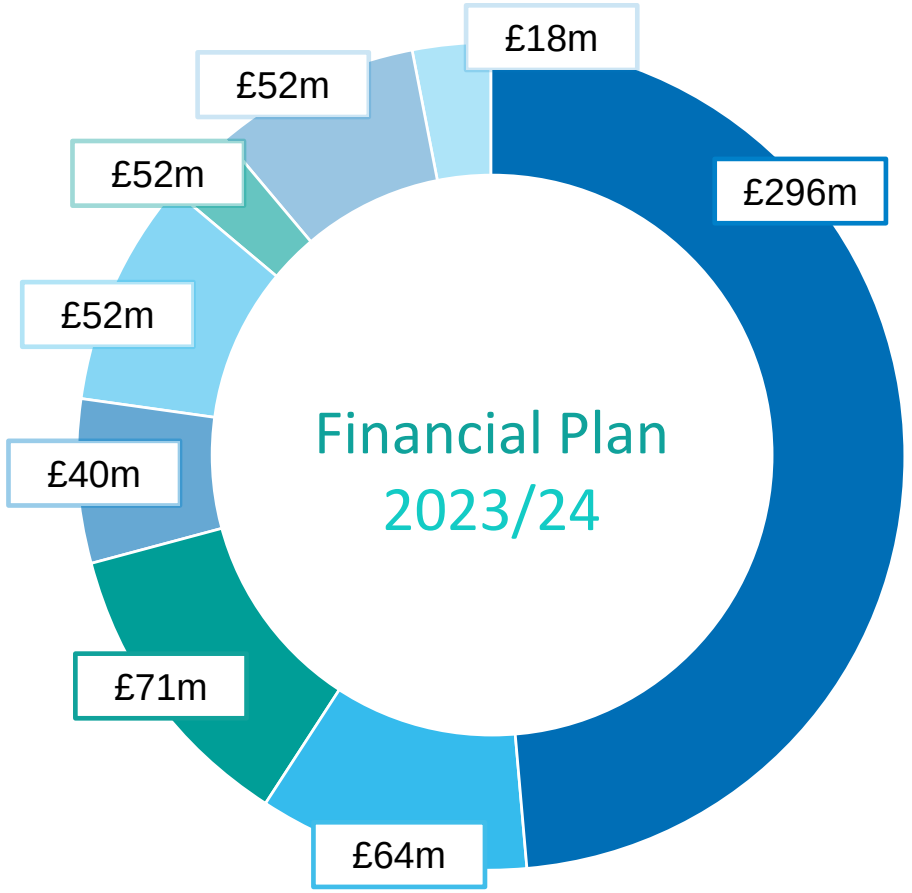
Sefton's financial allocation is **£603.3m**

The expenditure commitment is **£609.0m**

resulting in a (£5.7m) planned deficit



2023 / 24 Financial Plan – Spend allocation

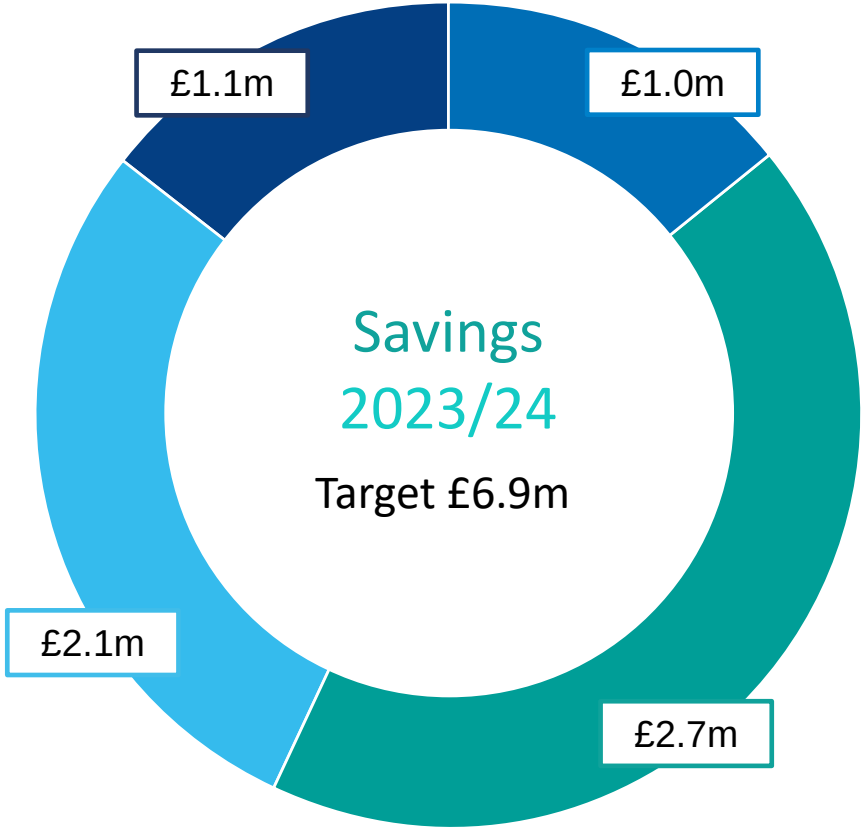


£609m	Expenditure commitment
£296m	Acute Services
£64m	Mental Health Services
£71m	Community Health Services
£40m	Continuing Care Services
£53m	Prescribing
£18m	Primary Care Services (Other)
£48m	Primary Care Co-Commissioning
£18m	Other Programme Services

Almost half of all spend is on acute services.
The figures include new investment for hospital discharge, mental health and CYP services

2023 / 24 Financial Plan - Savings

The 2023/24 plan includes a **£6.9m cost improvement plan (CIP)**



£6.9m	CIP
£1.0m	Primary Care
£2.1m	Continuing Care
£2.7m	Prescribing
£1.1m	Other Programmes

Quality Improvement

Quality Improvement

Key principles for quality and safety

Supporting safe, effective, positive experience, responsive, personalised, caring, well-led, sustainable and equitable care.

Management of risk and quality operating frameworks

Provider quality governance, place quality governance, ICB system quality governance, regional and national quality governance.

Quality Management

Supporting safe, effective, positive experience, responsive, personalised, caring, well-led, sustainable and equitable care.

Developing a single shared view of quality

Quality assurance for NHS Cheshire and Merseyside

Partnership approach to address/escalate quality issues: e.g. Urgent Care Board, People and Communities Group, Cancer Collaborative, Serious Incidents Panels, ICB Quality and Performance Committee, GNBSI, SEND CIB, Contract Meetings, Safeguarding Boards, LPS Steering Groups.

Quality Improvement in Care Homes: Working with Council and wider stakeholders to drive improvements.

Quality Improvement

Quality assurance and monitoring: mechanisms for oversight, monitoring and triangulation of intelligence	
Quality and performance monitoring meetings	• Contractual oversight aligned to the ICB's operating model through formal quality governance, including the ICB Quality and Performance Committee and System Oversight Board and Sefton Partnership's Quality and Performance Group. • Monthly meetings with NHS providers which are supported by quality schedules including key performance indicators, commissioning for quality improvement initiatives (CQUIN) and service development improvement plans (SDIPs) to facilitate effective monitoring of: i. Quality risks, safety and patient experience of services, alongside performance. ii. The impact on the population together with plans to improve services. iii. Areas for development, innovation and/or improvement for clinical services.
System quality groups and events	Processes and mechanisms for continual system learning which is undertaken utilising: • Focused workshop events including (as examples) safeguarding, infection and prevention control, transforming care, cancer pathways. • Assurance and embedding learning from post learning events including; serious incident reporting and safeguarding incidents such as domestic homicide reviews and care home evacuation/closures. • Supporting and facilitating co-production across the Partnership with careers and families for key areas including transforming care and special educational needs and disabilities (SEND)

Quality Improvement

Quality assurance and monitoring: mechanisms for oversight, monitoring and triangulation of intelligence	
Using a partnership approach to address issues that impact on the quality and delivery of services to eliminate unwarranted variation, using quality governance forums across the ICB to escalate risks	• Supporting people to have the right care in the right place and valuing patient time by supporting urgent care and patient flow. • Ensuring individual needs are met and supported via legislative frameworks e.g. Continuing Healthcare (CHC), CYP Continuing Care and joint funding arrangements. • Improving the pathway and outcomes for people with suspected and/or a confirmed cancer diagnosis, • Ensuring the voice of the person is heard to support service change and improvement, improving patient / family experience as part of their journey. • Ensuring that learning from serious incidents is understood, embedded and shared to prevent harm occurring to others. • Supporting the implementation of legislative frameworks e.g Liberty Safety Protection (LPS). • Contributing to agendas as active partners for Sefton Partnership including safeguarding for both children and adults. • Implementing the infection and prevention control national agenda, reducing health care acquired infections, ensuring learning from post infection reviews and appropriate prescribing of antimicrobial therapy. • Improving the access, pathways, outcomes and experience for individuals and families with Special Education Needs and Disabilities (SEND). • Supporting Sefton Council with the quality oversight and improvement for care homes.

Quality Improvement

Learning, innovation and improvement methodology	
Learning from incidents	• Supporting the implementation of the National Patient Safety Incident Response Framework. which is a systems based approach to learning that will replace the national serious incident framework. • Working in collaboration with NHS providers and across the ICB's nine places to ensure there are robust processes in operation and supporting the transition.
Learning from complaints	• Ensuring Sefton has robust processes in place for the oversight of PALS, complaints, MP enquiries and Parliamentary Health Service Ombudsman (PHSO) complaints, ensuring quality of responses and that learning is embedded.
Learning from deaths	• Ensuring the learning from reviews including LeDeR (lives and deaths of people with a learning disability and autistic people), safeguarding adult and children and domestic homicide reviews are understood and embedded, including system-wide learning across the Partnership.

Quality Improvement

Learning, innovation and improvement methodology	
Research as a statutory duty for commissioning organisations	• Contributing and supporting research projects as a member of the National Institute for Health and Research Applied Research Collaborations Northwest Coast (NIHR ARC NWC). • Researching activity in collaboration with local Higher Education Institutions (HEIs) when opportunities for research projects are available. • Contributing to the national research project for 'hydration' across a number of care settings using assistive technology. • 'Aquarate Cup' is being co-ordinated by Sefton on behalf of the ICB with the Associate Director of Quality & Safety Improvement as the project lead.

Quality & Safety Leadership

Quality & safety leadership

Service area	Area of focus	
Infection and Prevention Control (IPC) Healthcare Associated Infections (HCAIs)	• The Associate Director of Quality Safety Improvement is the senior responsible officer (lead) for IPC/HCAIs across Cheshire and Merseyside Integrated Care Board on behalf of other Place areas. • Quality Team monitor rates, learning and improvement plans of HCAI's which includes: gram-negative blood stream infections, clostridium difficile, methicillin-resistant staphylococcus aureus (MRSA), COVID. • Oversight of the quality schedule as part of NHS contracts which includes IPC and HCAI's with assurance at the trust monthly contract quality review meetings which includes the trust Board Assurance Framework for IPC to support compliance and improvement plans.	• Monitoring and management of HCAI outbreaks within a NHS hospital and or independent care setting (care home, supported living) including reporting to the NHSE Northwest IPC team. • Contributing to the Liverpool and Sefton Place ICB antimicrobial reduction (AMR) board with a focus on reduction on avoidable antibiotic prescribing, championing pilot activity, having oversight of programmes, seeking assurance on AMR plans and sharing learning across Sefton Place and the ICB • Sefton Place is lead on the NHSE hydration pilot across the ICB with the Associate Director of Quality Safety Improvement as the lead, reporting to the ICB and the national team.

Quality & safety leadership

Service area	Area of focus	
Safeguarding and patient safety	• Safeguarding is a statutory function with the Partnership needing to provide assurance that statutory functions are being discharged across Sefton by NHS Cheshire and Merseyside • The Associate Director of Quality & Safety Improvement is one of the three safeguarding statutory leads for children across Sefton and is a core member of the Safeguarding Partnership Boards. • Designated and Named Professionals are in place for safeguarding adults and children to ensure the functions are delivered and the health system is working in partnership.	• Ensuring there is partnership working to support good outcomes for those at risk of abuse and neglect to protect the most vulnerable across Sefton including children and adults at risk, children in care, those who are subject to domestic abuse and domestic violence and those who require safeguards under the mental capacity act/deprivation of liberty safeguards. • Supporting and ensuring the development, contribution and application of legal frameworks, policy and procedures across NHS commissioned services as part of contract quality monitoring.

Quality & safety leadership

Service area	Area of focus	
Safeguarding and patient safety	• Co-ordinating the health oversight, contribution and monitoring of all review processes from health commissioned services, in line with legal frameworks, policy and procedures and related processes. • Ensuring robustness of investigation/review, identification of learning, recommendations and action plans associated with NHS commissioned services.	• Ensuring dissemination of learning including learning events, communications, seven minute briefings, noting of trends and themes and escalation t o support system learning, oversight of contractual compliance and assurance.

Quality & safety leadership

Service area	Area of focus	
Individual Patient Activity (IPA) All Age Continuing Care.	• Oversight of all IPA programmes and partnership arrangements to ensure individuals are receiving the right care in the right environment to meet their clinical needs in line with legislative frameworks as part of funding pathways; continuing healthcare, mental health act (MHA), children continuing care, joint funding arrangements for learning disability and physical disability, complex care arrangements (acquired brain injury/rehabilitation) and discharge to assess pathways.	• Oversight and monitoring of children and young people (CYP) to support appropriate care when experiencing a mental health or emotional crisis, either as part of the hospital attendance/ admission or discharge arrangements. Chairing partnership meetings when applicable to support a partnership approach and wrap around care and services.

Quality & safety leadership

Service area	Area of focus	
Special Education Needs and Disabilities	• Supporting Sefton's partnership commitment to the system wide continuous improvement of services, outcomes and experiences of CYP and their families with Special Education Needs and Disabilities (SEND). Ensuring oversight and monitoring of the delivery of health services for CYP with SEND, including commissioning arrangements, pathways, improvement plans and the quality of Education Health Care Plans. Sefton Place has a specific SEND Health Performance Improvement Group as part of the overarching SEND governance arrangements.	• Sefton Place has a Designated Clinical Officer (DCO) in post which is a statutory role to ensure Sefton Place are discharging the statutory duties in relation to SEND, working in partnership and co-production with statutory partners and wider stakeholders (VCF sector).

Quality & safety leadership

Service area	Area of focus	
Care Home Quality and Safety	• Working in Partnership with Sefton Council as the lead commissioner and wider stakeholders on clinical quality/safety concerns affecting residents living in care homes in Sefton as part of CQC regulated placements. • Supporting the application of safeguarding policy and procedures by co-ordinating the health response under section 42 of the Care Act adult safeguarding arrangements either for individuals, organisational or in response to care home failures. Ensuring the appropriate communication with the wider NHS system where required as part of responsible commissioner arrangements.	• Working in partnership with Sefton Council to support the learning from significant care home safeguarding/closures and revise local arrangements in response. • Working in partnership to support the development of quality contracting assurance processes for CQC regulated placements. • Provide advice on requirements as part of contract/procurement for health community bed base within in nursing homes.

Delivering personalised care

Patient Choice

Patient experience, learning from incidents/safeguarding, complaints, Court of Protection, mental capacity act, personal health budgets (PHBs).

Social Prescribing & Community Based Support

Working in partnership with the VCF sector, and as part of the Integrated Care Team model to embed the community first approach.

Personalised Care & Support

Patient experience, learning from incidents/safeguarding, complaints, Court of Protection, MCA, Quality schedules.

Patient Activation & Supported Self Management

QIAs, patient experience, learning from incidents/safeguarding, complaints.

Shared Decision Making

Patient experience (Caring 01), learning from incidents (safe13), complaints (Well Led 01), safeguarding, Court of Protection, MCA.

Personal Health Budgets

Quarterly reporting, PHBs for CHC, personal wheelchair budgets, Children's Continuing Care, Personal budgets to support discharge planning.

NHS Cheshire and Merseyside

NHS Southport and Ormskirk Hospital NHS Trust

NHS Liverpool University Hospitals NHS Foundation Trust

NHS Alder Hey Children's NHS Foundation Trust

Southport & Formby Primary Care Network

NHS Mersey Care NHS Foundation Trust

OneVision Housing

South Sefton Primary Care Network

Sefton CVS Supporting Local Communities

Sefton Council

healthwatch Sefton

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Report to:	Health and Wellbeing Board	**Date of Meeting:**	7th June 2023
Subject:	Special Educational Needs and Disabilities Joint Commissioning Plan 2023 – 2026		
Report of:	Executive Director of Children's Social Care and Education and Executive Director for Adult Social Care and Health/NHS Place Director	**Wards Affected:**	(All Wards);
Portfolio:	Cabinet Member for Children's Social Care Cabinet Member for Education		
Is this a Key Decision:	No	**Included in Forward Plan:**	No
Exempt / Confidential Report:	No		

Summary:

A report to present the Special Educational Needs and Disabilities (SEND) Joint Commissioning Plan for 2023 – 2026. Detailing the process of development and highlight the key points.

Recommendation(s):

(1) Members are asked to review and endorse the adoption of the Strategy

Reasons for the Recommendation(s):

It is a statutory requirement under the Children- and Families Act 2014 to have a defined Joint Commissioning Strategy.

Alternative Options Considered and Rejected: (including any Risk Implications)

N/A

What will it cost and how will it be financed?

(A) Revenue Costs

The contents of the report do not constitute additional revenue costs

(B) Capital Costs

The contents of the report do not constitute additional revenue costs

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets):

Legal Implications:

Children and Families Act 2014

Equality Implications:

There are no equality implications.

Impact on Children and Young People: Yes

The report details the strategic approach to the Joint Commissioning of services for Children and Young People with Special Educational Needs and Disabilities.

Climate Emergency Implications:

The recommendations within this report will

Have a positive impact	No
Have a neutral impact	Yes
Have a negative impact	No
The Author has undertaken the Climate Emergency training for report authors	Yes

The contents of the report represent a neutral impact on the climate emergency

Contribution to the Council's Core Purpose:

Protect the most vulnerable: The Strategy will deliver improved services for Children and Young People with Special Educational Needs and Disabilities
Facilitate confident and resilient communities: The Strategy seeks to deliver comprehensive offer of support which is accessible in our local community.
Commission, broker and provide core services: The Strategy directly details how we will commission services in this area
Place – leadership and influencer: Sets out ambition to drive improvement in this area
Drivers of change and reform: The Strategy is a key piece of work for the SEND Continuous Improvement Board.

Facilitate sustainable economic prosperity: N/A
Greater income for social investment: N/A
Cleaner Greener N/A

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD.7251/23) and the Chief Legal and Democratic Officer (LD.5451/23) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

The Strategy has been developed with input from the SEND Continuous Improvement Board and Health and Wellbeing Board, and Sefton Parent Carer Forum.

Implementation Date for the Decision

Immediately following the Cabinet meeting.

Contact Officer:	Eleanor Moulton
Telephone Number:	Tel: 0151 934 2068
Email Address:	Eleanor.moulton@sefton.gov.uk

Appendices:

The following appendices are attached to this report:

The SEND Joint Commissioning Strategy 2023 – 2026
Plan on the Page

Background Papers:

There are no background papers available for inspection.

1. Introduction

1.1 The Children and Families Act places a legal duty on Local Authorities and NHS Place teams to secure services to meet the provision set out in individual EHC Plans.

1.2 This means that NHS Place Team and the Local Authority will work together to ensure the full integration of special educational needs and disabilities (SEND) provision across education, health and care and strengthen the principles of joint

planning and commissioning of services as set out in the Children and Families Act 2014, including those that will:

- improve the identification of needs
- support and develop further joint commissioning arrangements between the Cheshire and Merseyside Integrated Care Board, Sefton Pace, the Local Authority and Public Health
- build on work already undertaken in the joint health and wellbeing strategy
- support the creation of a draft joint commissioning strategy

1.3 The Children and Families Act requires the Local Authority and its partner NHS Place Team to act consistently with the joint commissioning arrangements, to keep arrangements under review and to update them.

1.4 Joint commissioning strategies will consider the whole system challenges of personalisation, personal budgets and resource allocation. In addition to this, strategic, costed and evidence-based decisions about early intervention will be identified to ensure shared outcomes. To this end the Local Authority and NHs Place Teams are working together to review current provision within children's services. Current provision will be compared to the needs identified in the Joint Strategic Needs Assessment (JSNA) and we will then explore opportunities to commission services jointly.

1.5 Ultimately, the joint commissioning arrangements and strategy will ensure that the Local Authority and the NHS Place Team are able to secure education, health and care provision for all children and young people who have special educational needs and disabilities, including those who have an Education, Health and Care Plan

2. Process of development

The report presents to Cabinet/health and Wellbeing Board a SEND Joint Commissioning Strategy for 2023 – 2026 the following steps have been taken in creating this document.

- Consideration of other key strategies including Education Excellence, the Children and Young Peoples plan and the Emotional Health and Wellbeing Strategy.
- A detailed review of the last 4 years of Parent Carer Surveys
- A comprehensive audit of the previous Startegy which ran from 2020 -2023. This identified the completed actions and brought forward anything that needed further work
- Consideration of national best practice and local need recorded through the Joint Strategic Needs Assessment

3. Key points

The Startegy ultimately seeks to ensure that Sefton's Special Educational Needs and Disabilities (SEND) offer enhances the experience and outcomes for children and young people, our focus is on co-production and collaboration to provide good

quality services, to achieve good outcomes for the children, young people, and families we serve.

It highlights 4 priorities.

1. High aspirations for all our children and young people
2. A comprehensive offer of support which is accessible in our local community.
3. The opportunity to provide support at the earliest opportunity.
4. To work with families and young people to maximise choice and control

These will be delivered through a delivery plan summarized as follows:

Outcomes & Actions	Priority 1	Priority 2	Priority 3	Priority 4
Delivery of the Delivering Better Value (DBV) Programme including Diagnostic Case Reviews and development of a DBV Action Plan for June 2023	X		X	X
Consider the social care needs of families when developing SEND services and pathways by recruiting a Designated Social Care Officer (DSCO)	X		X	X
Increase choice and control for those with complex health needs via Personalisation or Personal Health Budgets, utilising a partnership approach in the delivery of services. Actions will include developing a 18-25 diagnostic pathway and a graduated neurodevelopmental approach, reviewing OT sensory services and the development and implementation of shared care pathways.	X	X	X	X
Improved access to Early language and communication support tools including Speech and Language Therapy support, advice and assessment if specialist support required.	X	X	X	
Improved awareness of SEND amongst workforce including the continued promotion of the Local Offer and enhanced staff training.	X		X	
Increase accessibility of information for SEND through the creation of an information helpline hosted on Integrated Front Doors.	X		X	X
Improved access to timely and efficient mental health support through investing to support access and improve waiting times.	X	X	X	X
Embedding Technology Enabled Care (TEC) to secure the best outcomes for those with SEND through rollout of training to all staff; evaluation of the Brain in Hand pilot, workshop planning for the Sefton Youth Conference and raising awareness internally of TEC.	X	X	X	X
Partnership approach to service delivery including implementing the NW Framework SEND Purchasing systems.	X		X	
Enhancing provision of SEND services and groups first by mapping existing resources and	X		X	

Outcomes & Actions	Priority 1	Priority 2	Priority 3	Priority 4
reviewing best practice and producing a snap shot tool				
Committing to continually improving the SENDIASS offer by improving our delivery models to ensure sufficient capacity and impartiality by supporting continuous improvement through monitoring.	X		X	
Working across Health and Adult Social Care to review and ensure contract compliance and quality assurance across SEND contracts.	X		X	
Develop a joint outcomes framework and shared approach to needs assessment in the interest of continuous improvement and transparency.	X		X	
Adapting our strategic approach to understand educational sufficiency and its current pressures per the Delivering Better Value Programme, going on to deliver Sefton's Education Strategy via a delivery plan.	X	X	X	

4. Next Steps

4.1 The Strategy reinforces our committee to co-production and we will go on to develop a joint outcomes framework and shared approach to needs assessment in the interest of continuous improvement and transparency. Working with the Sefton Parent Carer forum to ensure we prioritise what matters most to them and those Children and Young People with special educational needs and disabilities in Sefton.

4.2 We commit to producing an easy read version to support accessibility to the Strategy.

4.3 We will re convene a Joint Commissioning group as a subgroup of the SEND Continuous Improvement board to action the delivery. This group will be made up of key stakeholders across Education, Social Care and Health and ensure representation for the Parent Carer forum and children and young people themselves. This will include ensuring an appropriate and sustainable resource is allocated.

5. Conclusion

This comprehensive Strategy has been developed with the intention to make a real and lasting difference to our Children and Young People. We ask members to consider its content, provider any comment and consider their endorsement to adopt the Strategy.

SEND Joint Commissioning Strategy

2023-2026

Sefton Partnership

NHS Mersey Care NHS Foundation Trust Community and Mental Health Services

Contents

Foreword

We are delighted to present the Joint Commissioning Strategy for the Sefton SEND Partnership, we are committed to ensuring that Sefton's Special Educational Needs and Disabilities (SEND) offer enhances the experience and outcomes for children and young people, our focus is on co-production and collaboration to provide good quality services, to achieve good outcomes for the children, young people, and families we serve. The Strategy seeks to reflect on what we have achieved across the life of the previous Startegy, a period of significant improvement for Sefton's SEND services, whilst also recognising we need to do more to achieve our ambitions for the Children, young People and their Parent Carers in Sefton. We have defined key priorities of holding High aspirations for all our children and young people, ensuring we have a comprehensive offer of support which is accessible in our local community and giving all the opportunity to provide support at the earliest opportunity and working with families and young people to maximise choice and control. The Strategy builds on a strong evidence base, national and local strategic drivers and responding to what our Parent Carers tell us. We envisage at the end of the Strategy we will have seen a tangible impact on key performance areas and that our Children and Young People enjoy more positive outcomes and receive support in a timely and effective way focused on early intervention and prevention and a holistic pathway built on local assets.

ıncillor Diane Roscoe

ɔinet Member, Education Excellence

Councillor Paul Cummins

Cabinet Member, Adult Social Care

Councillor Mhairi Doyle

Cabinet Member, Childrens Social Care

Introduction

This strategy represents the next phase of our work to grow together as a Local Area. Despite the significant improvements to our SEND offer in recent years the system remains committed to building upon the successes and learning from our last Strategy, especially in light of the disproportionate impact Covid has had upon SEND Children and Young People.
A full breakdown of our Progress features later in the Strategy but the key headlines are:

- 0-19 Healthy child programme has been extended to young people up to the age of 25.
- Co-production of a Mental health Digital Information and Referral Platform
- All Special Schools have access to Mental Health Support Teams
- Preparation for adulthood guide developed as part of a clear post-16 transition pathway for young people with SEND.
- Initiatives and innovations following national best practice, such as the Children and Young People Mental Health Digital Information and Referral Platform
- Interventions to introduce hearing impairment into the curriculum.
- Intervention of identifying maths as a key area for development for our children and young people.
- Improvement of the ASD and ADHD diagnostic and post-diagnostic pathways
- Development of a co-produced Occupational Therapy sensory graduated model.
- Development of a multi-disciplinary and assessment review for Speech and Language, Physiotherapy and Occupational Therapy (SPOT)
- Training and development of workforce for children and young people with SEND.
- Development and expansion of the use of digital and assistive technology to promote and support independent living.

To ensure that Sefton's Special Educational Needs and Disabilities (SEND) offer enhances the experience and outcomes for children and young people, **our focus is on co-production and collaboration to provide good quality services, to achieve good outcomes for the children, young people, and families we serve**. Sefton is committed to working collaboratively and we have developed a shared vision and set of principles that underpin this strategy.
In Sefton we want to continue to prioritise:

1. High aspirations for all our children and young people

2. A comprehensive offer of support which is accessible in our local community.

3. The opportunity to provide support at the earliest opportunity.

4. To work with families and young people to maximise choice and control.

All children and young people deserve the support they need to be confident, resilient individuals with their own ambitions and aspirations as they develop into adulthood irrespective of their learning needs or abilities. We know how important it is for support to be provided at the right time particularly for children and young people with SEND so that they can develop the skills they need to thrive and to be ready to transition to the next phase of their lives. We believe in celebrating difference and learning from each other, whilst making everyone feel included. We want Sefton's Local Offer to reflect this. This will mean that every child and young person can grow in their local, inclusive and supportive community. Finally, whilst this strategy covers Sefton, we are committed to continue working with neighbouring Local Authorities and our colleagues in the NHS Cheshire and Merseyside Integrated Care Board to share best practice, data and information and to explore opportunities to improve services.

The SEND Joint Commissioning Strategy 2023-2026 will build upon the aims and objectives of fellow Sefton strategies such as the **Children Cared for Sufficiency Strategy**, **Sefton's Health and Wellbeing Strategy, Sefton's Children and Young People's Plan 2020-2025, Education Excellence Strategy and the National Delivering Best Value Programme** (all of which can be found and accessed via the Sefton Council website).

e purpose of this strategy is to:

- Deliver improved outcomes for children and young people with SEND across the local area.
- Provide a framework for effective joint planning, understanding and review of SEND services in Sefton.
- Identify a set of key commitments and priorities that will underpin all joint planning and commissioning decisions, informed by the SEND Joint Needs Assessment and in line with the requirements of the SEND Code of Practice: 0 to 25 years and feedback from our communities inclusive of children, young people, parents and carers.
- Provide a framework for effective joint planning, understanding and review of SEND services in the borough, which should inform all elements of working practices (including Emotional Health and Wellbeing Services, Speech and Language Therapy, Physiotherapy and Equipment Provision)
- Ensure that we jointly commission services with a clear assessment of local needs, delivering personalised integrated support that delivers outcomes and brings support together across the system.
- The Strategy will inform the development of robust priorities and effective joint working. This will then inform commissioning intensions and meet local needs more effectively.

About Sefton

Our SEND partnership includes the Council, schools, health commissioners and providers working with our voluntary, community and faith sector, business sectors, and most importantly children, young people and their families.

Sefton has a resident population of 279,239 people, with 57,904 (21%) children and young people in Sefton (age 0-19) and 74,281 children and young people in Sefton (age 0-25). In January 2022, the local authority maintains an EHC Plan for 2,243 children and young people, which to represent approximately 3% of the population of children and young people aged 0 – 25 years resident in the borough, compared to the national percentage of 4.0%.

- In 2020/21 there were 9,501 children (aged 0 to 19) living in relative low-income families in Sefton, equating to 16% of the Borough's children, but this varies across Sefton, rising to 28% in places.
- Throughout the Covid-19 pandemic 81% of low-income families reported lower income and 54% of the lowest income families had borrowed money to cover everyday living costs. The current Cost-of Living-Crisis is impacting further on the those who are living in poverty and experiencing financial pressure before cost increases hit.
- There are 107 school settings in Sefton with 42,576 attending those settings. 40,245 children and young people are educated in 102 Sefton state-funded, maintained nursery, primary, secondary, special schools and pupil referral units (PRUs). 2,331 children and young people attend 5 non-maintained and independent settings.
- The percentage of children and young people with Special Educational Needs and/or Disabilities requiring support from the Council has increased each year since 2010.
- In January 2022, the number of school pupils with SEN but no EHC plan (SEN support) has increased to 5,403, 12.7%, compared to the national percentage of 12.6%.

SEND Need in Sefton – Key Information

The SEND and Alternative Provision Green Paper, published in March 2022 alongside the Schools White Paper, set out bold proposals to deliver a generational change for a more inclusive SEND system, followed by the Government's Special Educational Needs and Disabilities (SEND) and Alternative Provision (AP) Improvement Plan (Right Support, Right Place, Right Time) release in March which sets out the government's proposals to improve outcomes for children and young people; improve experiences for families, reducing the current adversity and frustration they face; and deliver financial sustainability. The transition to a new national SEND and alternative provision system and national standards will result in significant change across the local system between 2022 and 2026. A refresh of the Joint Strategic Needs Assessment (JSNA) has been conducted to consider the needs of Sefton's population. The 2023 JSNA has enabled the partnership to analyse the needs of Sefton children and young people and identify priorities in response to a rise in demand for services and changing landscape of support required following the covid pandemic. The full Joint Strategic Needs Assessment is available on the Sefton website but some of the key findings were that:

- In January 2022, the number of children and young people with EHC plans and receiving SEN support in Sefton increased to 16.5%, compared to a national average of 16.5% and a northwest average of 16.9%. This equates to 2,243 children and young people (0-25 years).
- Of the 2,243, 37% were children aged 11-15yrs. 4% are aged under 5 years and 11% are young people/adults aged 20-25yrs.
- Of the 2,243, 1,604 are aged 2 ½yrs – 19yrs and are educated in Sefton schools or post 16 provisions (including maintained and non-maintained settings). 1,550 of these attend a Sefton maintained school setting.
- In January 2022, Sefton reported that in 2021 602 requests were made for EHC plans, with 321 being issued, of the 325 assessed in the 2021 calendar year.
- In January 2022, the percentage of pupils with an EHC plan in mainstream state-funded primary and secondary schools in Sefton is 46.7%, (national comparator 51.4%), whilst the percentage of pupils with an EHC plan attending state-funded special schools in Sefton is 45.5%, (national comparator 39.4%).
- Whilst the needs vary across primary, secondary and special schools, the primary needs of pupils with a Sefton EHC plan or receiving SEN support include, Speech and Language, Social Emotional & Mental Health and Autism.
- In January 2023, the number of Sefton maintained EHC plans has increased further to 2,565, which represents a growth of more than 77% since 2019.
- In January 2023 Sefton completes 18% of EHC plans in a 20-week timescale (down from 50.3% in previous years). There are signs of recovery, and the average performance is now 30%, but there is still further improvement required to return to a level consistent with national and northwest comparators.
- 44.4% of children and young people with an EHC Plan received an annual review in the 2022/23 academic school year and 100% of children transitioning into Reception or Secondary school received a review in order to allocate school placements by the statutory deadline of 15th February.
- In recent years' consultation with parents, carers, children and young people to gather their views, opinions and experiences of

local SEND system suggests the 'SEND System' is improving, though there remain areas for improvement and parts of the SEND system that could work better together.

- The average attainment 8 and progress 8 scores at Key stage 4 for pupils with SEN (EHC Plan and SEN Support) is below the national and North West comparators.
- The percentage of SEN pupils who receive 'SEN support' in secondary school going to or remaining in education & employment or training overall is consistent with the national comparator, but above both northwest and statistical neighbour averages.
- The SEND cohort that Career Connect work with has increased significantly by 27.9% over the last 3 years. The number of 16–17-year-olds with SEND in learning is 91.3% (December 2022).
- % 16-17 children with SEND not in employment, education, or ning (NEET) and 12.8% for 16–24-year-olds with SEND needs.
- The demand for Home to School Travel Support has grown to approximately 40% for children and young people with SEND aged 0 – 25; for 150 post-16 students and 964 aged 0-16. Sefton provides SEND Personal Travel Budgets for 214 0–25-year-olds.
- The number of statutory school age students transported to out of borough settings increased 147% and the number of out of borough settings that the Council transports children and young people to has increased by more than 47% and demand for a Personal Travel budget has increased by 77%.
- 258 children and young people have participated in the Aiming High short breaks programme for 5–19-year-olds. The short breaks service has delivered 29,862 hours of respite to local families in Sefton. In addition, the service has organised and delivered family activities, providing 2,120 hours of supported events that include parents, carers, and siblings.
- 35 children and young people currently make use of the Springbrook residential unit and on average a total of 871 nights stay is offered each year.
- In April 2022 under 38% of those waiting for Speech and Language Therapy services had been waiting less than 18 weeks, by January 2023 performance has continued to improve and now 65% of patients are waiting under 18 weeks.
- The Paediatric Dietetics Service has seen a growth over the last 3 years in both referrals and contacts. Performance has consistently been above the commissioned target of 92% (those on waiting list waiting less than 18 weeks), though there has been a drop to 70% recently.
- Occupational Therapy referrals and contacts has achieved the 92% target (those on waiting list waiting less than 18 weeks) throughout 2022/23.
- In 2021/22 referrals for ASD & ADHD Assessment and Diagnosis increased significantly: a 75.3% increase in ASD and a 265% increase in ADHD, and referral rates for 2022/23 are projected to be higher again.
- As of January 2023, just over 40% of children and young people were waiting under 6 weeks for a "choice" appointment and 60% under 18 weeks for a "partnership" appointment for Child and Adolescent Mental health Services.

Other key strategies and programmes

Delivering Better Value Programme

Sefton Council, along with 54 other Councils, is engaged in the national **Delivering Better Value (DBV) in SEND Programme**, which is overseen by the Department for Education. The Programme Objective is to identify and implement local and national opportunities to improve the outcomes for children and young people with SEND and the programme is designed with 2 key approaches in mind:

- Short Term Help – To identify sustainable changes in each Local Authority that can drive high quality outcomes for children and young people with SEND, and informing:
- Long Term Reform – To build an objective evidence base across a third of the Local Authority sector, which will be used to:
    - Inform future policy and reform.
    - Build a national playbook and share best practice.
    - Inform future national programmes of similar scale and intent.

The driver of improving outcomes for children and young people with SEND is a key theme across the SEND Joint Commissioning Strategy and the outcomes from the DBV Programme will feed into an Implementation Plan that will run alongside the SEND Joint Commissioning Strategy.

The Programme will identify sustainable changes in the Local Authority that can drive high quality outcomes for children and young people with SEND and inform long-term national reform, building an objective evidence base which will be used to inform future policy and reform, build a national playbook and share best practice, and inform future national programmes of similar scale and intent.

Sefton Children and Young People's Plan 2020/ 2025: My Sefton, Happy, Healthy, Achieving, Heard

The **Sefton Children and Young People's Plan** sets out how we intend to maximize the health and wellbeing of all our children and young people living in Sefton. Sefton Council, NHS Cheshire and Merseyside Integrated Care Board and the Sefton Partnership, have agreed a series of priorities for future services and support. These priorities are based on what children, young people and their families have told us of their experiences and what we know about their current care.

We used Sefton's Joint Strategic Needs Assessment to inform the plan to seek to ensure that children and young people's needs are understood and met. It is based around the four themes of:

- Happy
- Healthy
- Achieving
- Heard.

Education Excellence Strategy

The **Education Excellence Strategy** is based around these four themes. The Education Excellence Strategy's key theme for 2022-2027 is that Education and training will enable every young person to unlock the door to more choices and opportunities. For Children and Young People with SEND and their families this means:

- Ensure a system wide approach to whole school development in relation to school staff's SEND knowledge and training received.
- Support inclusive and innovative practice that promotes the wellbeing and emotional health of our children and young people.
- Develop local processes in line with the proposed national standards for SEN in relation to transition to ensure consistent, timely, high -quality transition preparation for children and young people with SEND.
- Continue to develop the supported internships and traineeships programmes to provide more young people with SEND with the skills they need to secure and sustain paid employment.
- Implement the National Standards for SEND that the government reforms will introduce to ensure consistency of how needs are identified and met at every stage of a child's journey across education, health and care.
- For pupils with EHC Plans, in line with planned SEND Green Paper reforms, where a pupil requires placement in specialist provision, the local Inclusion Plan will set out the provision available within the local area, to provide families with a tailored list of schools that are appropriate to meet their needs.
- Engage with the planned new national and local SEND data dashboards to ensure that the right information is collected in the right way at the right time to enable timely responses to local needs.
- Implement planned changes to the SEND national funding system to ensure the most effective use of high needs funding to support schools.


4
PRIORITIES
PRIORITY 1
Excellent teachers supported by excellent staff
PRIORITY 2
Raise achievement and ensure young people have the life skills to prepare for adulthood
PRIORITY 3
All Children and young people achieve their full potential
PRIORITY 4
School Systems to Support Children and their Families

What our Children and Young People and their Parent Carers have told us

To help inform the plan we have analysed the results of the 2023 Parent Carer consultation exercise. In summary:

- There is some positive feedback and examples that touch the different areas of the SEND partnership. Parents and carers have provided testimonies of individuals, team and services where they have felt supported and received communication, contact and support.

- There are some parents and carers who report that their needs are met by the different areas, however, it is Education where the needs are met the most, although some parents and carers feel that the school isn't making the reasonable adjustments needed, that there needs to be an increase in funding and the staff would benefit from an increase in understanding and training in Autism Spectrum Disorder (ASD), Foetal alcohol spectrum disorder (FASD) and neurodiversity.

- Parents and carers report that there needs to be improved contact and communication generally by all areas of the SEND partnership; including about the Education, Health, and Care Plan (EHCP) process, after diagnosis, Foetal alcohol spectrum disorder (FASD) and post 18.

- In health, Occupational Therapy is generally well received by parents and carers, as highlighted by their feedback.

- Waiting times for assessments and appointments was something parent and carers expressed concerns about across the SEND partnership. This included for EHCP assessments and plans, ASD assessment and pathways and health and Child and Adolescent Mental Health Service (CAMHS) appointments.

- Some parents and carers also reported dis-satisfaction with the EHCP's in that it didn't meet need, the views of the parents and carers are not listened to and reviews not taking place or all professionals not attending the review.

- From an analysis of the equality monitoring questions against the comments received, it appears that there are themes connected to support and early help/intervention services for 0 – 4 years olds and services and support post 18 years and reasonable adjustments in schools to help meet needs.

- The Sefton Parent Carer Forum is valued by parents and carers; they have trust and confidence in the Forum and welcome the sharing of information and opportunity to hear from guest speakers and services at their events.

Sefton Partnership pledge to use the joint commissioning plan as a platform to address all of the feedback received from children and their families to ensure the local offer meets the needs and addresses those areas where communication and improvements in services are required over the next 2 years.

Our Approach to Joint Commissioning

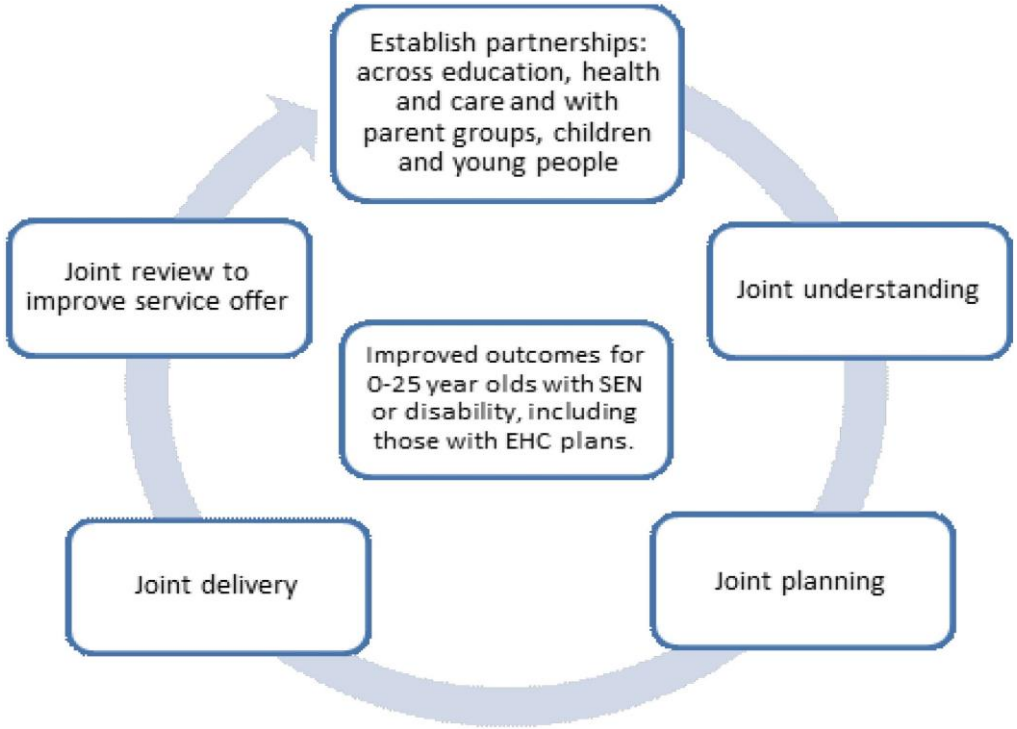
Commissioning is the process of identifying the needs of a community and planning services and activities to meet those needs within the resources that are available. Joint Commissioning is where the assessment of need and planning of services and activities is undertaken by two or more partners working together, striving for continuous improvement. The SEND Code of practice requires us to have a Joint Commissioning Strategy across education, health and Social Care and ensure services arecommissioned in response to identified need.

We have a proven track record in partnership working but we recognise that we need to further improve our partnership working and co-production activity in respect of SEND. Our approach to joint commissioning for SEND is designed to ensure the best possible response to a child's or young person's needs, aligning and integrating needsassessment, planning and delivery of services/activities to achieve the best possible outcomes within the resources available. This includes jointly identifying current and future needs, any gaps in provision and maximising resources and sharing intelligence across all services to both improve outcomes for children as well as help inform commissioning and planning decisions across all aspects of SEND support.

will ensure we work with the local Safeguarding board and its annual reports as part of our evidence base Commissioning.

We will continue to provide universal services that are accessible to everyone in the borough, through our localities and emerging Primary CareNetworks.

We will adopt the Commissioning Cycle identified in the SEND Code of Practice as outlined in the diagram opposite and ensure we use the newly established Sefton partnership to drive this.



Our Commitment

Agencies in Sefton are committed to providing the best quality education, care and support for all children and young people with special educational needs and disabilities (SEND) through our partnership. As Commissioners we will act on the following principles that are central to the Sefton partnership Collaborative agreement.

- Work together to deliver a single vision through a focused set of priorities to reduce the unacceptable gap in health and wellbeing inequalities.
- Work to achieve financial sustainability by working to create the conditions to guarantee the most efficient, effective and value for money-based use of public resources in Sefton.
- Deliver person centred services informed by the voice of experts by experience through commitment to codesign, coproduction and listening at all levels to our owners – the people that need Care and Support.
- Commit to acting ethically at all times with the ultimate interest of the citizen [here children and young people with SEND needs] held at the heart of what we do. This is to be achieved through openness, honesty, transparency, and constructive challenge.
- To build on what we learnt during COVID – the power of acting as one, being risk enabled, outcome focused, and solution driven to solve our 'wicked problems'.
- Invest in innovative and creative services that bring best practice to Sefton and offer digital solution that bring maximum impact and solutions to our citizens.
- Ensure that all that we do is informed by a population health framework that enables shared, collective data to ensure that residents are getting the best possible care and support – in the right place at the right time.

We will do this is through identification of needs of our population and focus on matching all our resources to deliver better outcomes across the borough. Then being clear on full resource to deliver this including (Finance, Capital, Workforce, Markets, Citizens, Communities and Assets).

There is a clear relationship between population needs, what is commissioned for children and young people with SEND, and individual EHCPs. We will consider the needs of our population as identified in our JSNA 2023 and the thorough review into the needs of population of children and young people aged 0 to 25 years who have SEND. In line with the Local Area's drive for early intervention andprevention we will take a preventative approach to manage rising demand from the earliest point in a child's life, encouraging independence where appropriate and building on the strengths of families and their inclusive networks.

Our Approach to Joint Commissioning

Our joint commissioning in Sefton will be outcome based, designed around the needs of the people that live here, joined up, inclusive and measured to ensure the impact is the right one and continually reviewed and improved to ensure we are delivering the best possible outcomes. We will continually measure quality to ensure provision is targeted to local needs and inequalities. We will routinely review national best practice and expertise to understand we can improve our services and the Local Offer.

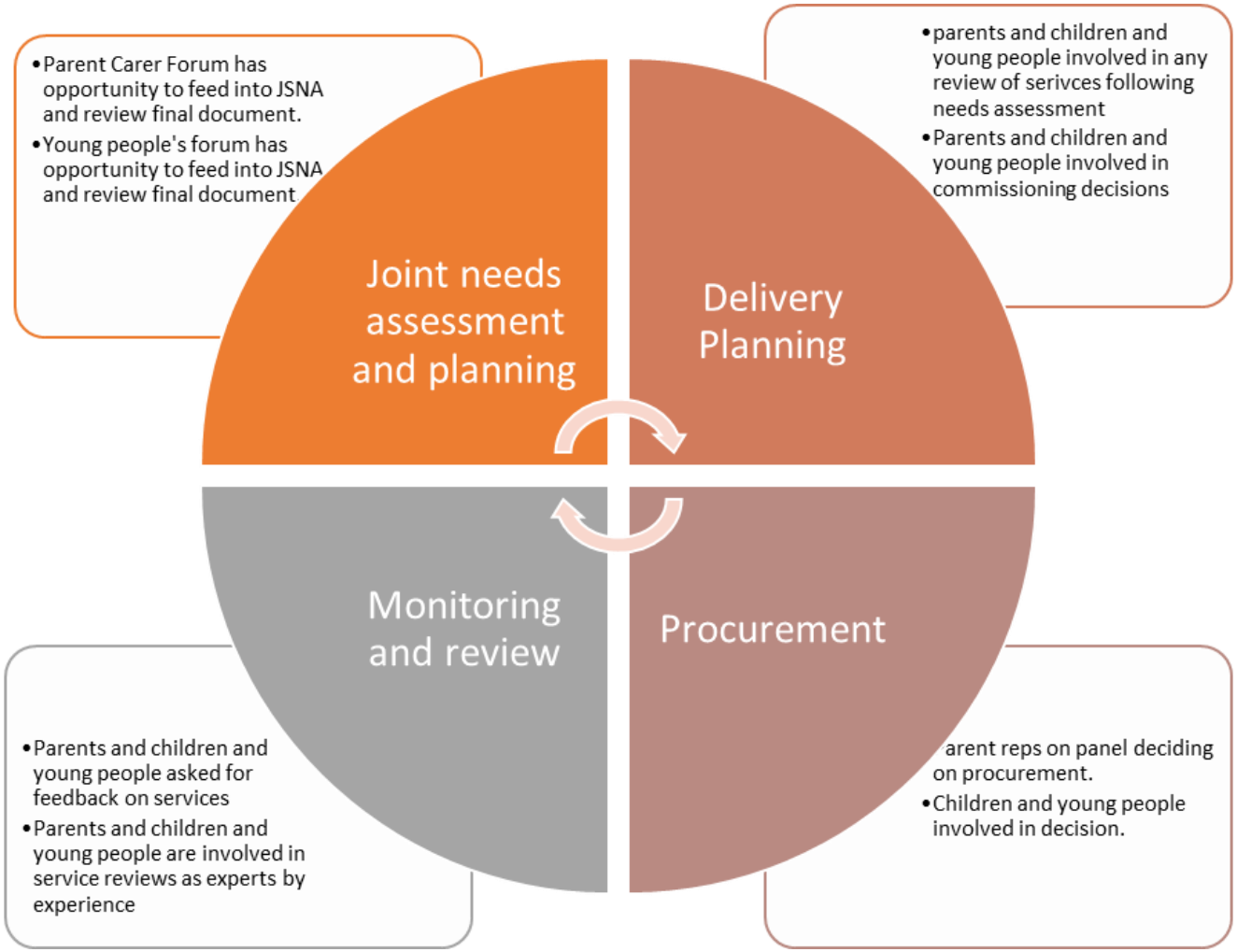
Our approach to this will be about.

- Co-production, consultation, engagement, and participation
- Outcome reviews
- Developing a Framework to help us decide how best to deploy resource, utilising the best possible procurement routes to market and contract models to ensure the highest possible quality and value for money within our financial envelope.
- Seek to learn from good practice in other areas and make use of available research.

In developing our plans, we will take account of the Local Government Association paper "Developing and Sustaining an effective SEND System" which states the key ingredients to developing an effective approach to joint commissioning which includes:

- Aligning key sources of data and intelligence in the form of a joint dataset on children and young people with SEND, so that partners can take decisions about joint commissioning based on a broad and shared understanding of current and future needs.
- Having an agreed set of outcomes that partners are seeking to achieve together through the services that they commission.
- Being clear on the resources required to meet current needs and achieve agreed outcomes, and what each agency will contribute.
- Bringing together frontline practice as much as possible, integrating services where possible but also doing simple things like organising joint training for staff across different agencies and ensuring that there is a common language and a consistent approach to support young people with SEND and their families across all agencies; and
- Collating all available stakeholder data to inform the joint strategy in co-production.

Coproduction, Consultation, Engagement & Participation



The SEND Code of practice recommends that Local areas should be involving parents and children and young people at each stage of the commissioning cycle. We are committed to improving co-production, to ensure that the views of parents and carers, children and young people, providers and workforce are reflected in the planning process and delivery of this strategy. We will continue to use these forums and approaches to continue to offer real opportunities for co-production and codesign as we deliver the priorities in our action plan.

Engagement Forums

Delivery of this Strategy and achieving the aims and ambitions in it will driven by our partnership with Parent Carers and Children and Young People themselves, we will make best use of the strong infrastructure we have in Sefton including but not limited to the following:

- The Co-production, engagement and communication group meet bimonthly as a multistakeholder group, including representation from the parent carer forum, health, education, social care, and the voluntary sector. The key purpose is to work collaboratively in respect of the improvement plan, by advising, challenging, and providing assurance to the governance system.
- Schools Get Talking, for young people attending the Special Schools meet fortnightly via Zoom. This provides the opportunity to share issues that are relevant to them. Guest speakers are invited to attend, from a range of agencies across health, education, and social care.
- Get Talking is a weekly online group that was originally established to support the refresh of the Local Offer.
- A Primary Youth Conference is arranged each year, following the themes Happy, Healthy, Heard and Achieving.
- A Secondary Youth conference is also arranged each year, with the theme Preparation for Adulthood, based around the 4 principles of Education/Employment, Living Healthy, Independent Living and Community Engagement.
- A Strategic Youth Voice group has also been established to support the engagement of young people with SEND across Sefton.

Transitions

The National Preparing for Adulthood Program sets out 4 main areas that young people with SEND say are important to them: Employment Education and Training, Independent Living, Community Inclusion and Health. An EHCP review at Year 9 aims to detail personalised support in the following areas:

- Identifying post-16 pathways that lead to employment options or higher education.
- Training options, supported internships, apprenticeships, and traineeships.
- Support to find and do a job (e.g., work experience opportunities or job coaches)
- Support to help young people develop a lifestyle that is based on their hobbies, leisure activities, access to community facilities, meeting friends and having fun.
- Help in understanding any welfare benefits available in work.
- Preparation for independent living, including where young people want to live in the future, who they want to live with and what support they may need.

- Information about personal budgets and direct payments
- Local housing options, including housing benefits and social care support.
- Support to help young people participate in society, including activities, having friends, maintaining relationships and being a part of, and contributing to,the local community and voluntary opportunities.
- Information about lifestyle choices based on young people's interests and personal requests.
- Advice to enable young people to travel independently.
- Advice about continuing health care services so young people understand which professionals may be supporting them in adulthood. This should include the production of a Health Action Plan and prompts for annual health checks for young people with learning disabilities.

As part of our Joint Commissioning Strategy, we will review our transition pathways to ensure that they are meeting the needs of our young people. Young people have identified several ways in which they were supported at times of transition, and they would like further support in:

ravel training
elp with life skills and
onger taster sessions in college.

Young people have identified several barriers for them gaining employment including:

- academic achievement
- health needs and
- the ability to travel independently.

This information has informed our priorities.

Sefton's Commitment to Inclusion

Sefton works hard to foster the ethos of inclusion in all our services and every school has an allocated Inclusion Consultant (IC) who meets with the SENCO on a termly basis.

The Inclusion Service supports schools in the identification of teaching approaches that enable pupils with additional needs make progress and take an active part in their settings. It is staffed by teachers who have expertise and experience of working with young people with

special needs and understand national and local expectations for schools in their delivery of inclusive practice.

Universal Services

There are a range of services that are available to everybody, without the need for any assessment or referral. These are often called 'universal' services and they include a range of support from social activities in the community, Family Wellbeing Centres, Libraries and Leisure Centres and universal Public Health Services such as GPs, Dentists, Pharmacists, Opticians and Walk-in centres. Emergency and urgent care is available to everyone through a local A&E or calling 999, as necessary. Universal services can befound on the Sefton Directory, the Sefton Partnership and Provider websites, the Local Offer and CVS Directory.

Commissioned/Targeted provision.

Council and NHS Cheshire and Merseyside Integrated Care Board and Sefton Partnership team deliver many activities and services support and can be accessed by children and young people with SEND and their families. Appendix 2 provides a snapshot of local vision that is available and a range of services depending on need.

Our Strategic Priorities

Our analysis of this information on need, demand, and experience, coupled with legislative obligations and the need to deliver within a defined budget envelope have led us to identify the following priorities for our system:

- High aspirations for all our children and young people
- A comprehensive offer of support which is accessible in our local community.
- The opportunity to provide support at the earliest opportunity.
- To work with families and young people to maximise choice and control.

have developed an action plan under these priorities. The action plan will be reviewed on a yearly basis. The SEND Continuous Improvement Board and Health and Wellbeing Board will hold us to account on progress and performance of the strategy.

Progress Since the Last Strategy and the Current Picture

For the 2020-2023 Joint Commissioning Strategy, an action plan was developed to address the needs and priorities identified. It was a partnership plan that was reviewed on an annual basis. The delivery of the Joint Commissioning Strategy for SEND and progress against delivery of this Action Plan has been measured to understand if actions were fully completed, partially completed or remain outstanding. This allows us to then consider what should be brought forward into the next plan and reflect on what has been working, and what needs to be revised. A Task and Finish group was pulled together with leads from across Education, Health and Social Care to perform this Audit, including the DCO.

A summary of progress highlights the following:

1. *Review of Local Offer using SEND Needs Assessment, feedback from engagement activities and feedback from reviews.*
   We have put in place a Needs Assessment, reviewed Aiming High and held a Local Offer Live Event on 1st March 2023.
   We will continue to review, improve and promote the Local Offer, through audit and feedback from all stakeholders.

2. *Encourage universal services to be more inclusive of children and young people with SEND.*
   0-19 Health Child Programme has been extended to support SEND children up to the age of 25.
   We will work with Parent and Carer representative on the healthy weight for Sefton programme; and focus on universal offers for SEND.

3. *Children and Young People Mental Health Digital information and Referral Platform.*
   Platform co-produced with young people, families and professionals and enables access to Emotional Health and Wellbeing information to make direct referrals to commissioned services.

4. *Mental Health Support Teams (MHST).*
   All Special Schools have support and access to Mental Health Support Teams.
   Secondary Schools to access MHST. Alder Hey will utilise MHST to train and support schools with their ASD and ADHD referral process.

5. *Sensory friendly environment.*
   Pilot conducted to improve hospital and clinical environments for children and young people with sensory needs.
   We will share our learning from the pilot with partners and other services.

6. *Develop an effective Post 16 pathway for young people with SEND.*
   Development of Preparing for adulthood guide shared with Sefton education system and partners in health VCFSE, the Parent Carer Forum and Local Offer. We hold annual Young Person's Next Steps Transition Event. Main post- 16 college providers sit on the Secondary Headteacher Association meetings.
   We have an ongoing supported internships workstream; Educational Psychologist service will work closely with colleges to enhance transition processes.

7. *Review national best practice.*
   Educational Psychologists training and professional development has improved planning process for children and young people. Graduated Response booklet produced for SENCOs, as well as information and materials. Every Leader a Leader SEND programme delivered; SEND in a Nutshell Tool adopted by schools.
   The Delivering Better Value Programme will analyse service delivery and sharing of best practice approaches.

8. *Identify barriers to a more diverse post-16 offer and support to remove those barriers.*
   1. Maths identified as a key area for development for 2020-2021.
   2. Personal Understanding of Deafness curriculum developed starting at Key Stage 1.

9. *To implement neurodevelopmental diagnostic pathway across Sefton which includes NICE compliant diagnostic pathway for ASD.*
   Health investment to develop ASD/ ADHD assessment and diagnostic pathway. NICE compliant pathway implemented from April 2020 with monthly performance monitoring. ASD waiting list cleared between April 2020-June 2021. Improvements to patient information and referral systems have been possible through consultation and engagement with clinical team, Alder Hey's Youth Forum and Sefton Parent Carer Forum. Further innovations made with online ASD/ ADHD referral platform. Establishment of a Sefton Partnership Neurodevelopmental Pathway Task & Finish group.
   Further system wide development of the graduated offer.

10. *18-25 ASD Diagnostic Pathway Developments.*
    Development of Sefton Neurodevelopmental Pathway Task & Finish group. Success in Transforming Care joint bids for post diagnostic service pilot. Sefton have received funding from the Cheshire and Merseyside Transforming Care Programme.
    C&M Beyond Programme funding secured to continue pre-diagnostic open access community service. Development of 18-25 diagnostic ASD/ADHD pathways, Neurodevelopmental graduated approach and shared care pathways.

11. *Performance Management Frameworks.*
    Strengthening of SEND performance and quality monitoring. Key performance indicators have been aligned with Sefton Place contract measures.
    Services that continue to be challenged will be reported by exception to the SEND Continuous Improvement Board. The SEND performance dashboard will be developed to reflect and align the revised SEND Improvement Plan (2023/24)

12. *OT Sensory Service.*
    Service review developed a co-produced OT sensory graduated model. Service commenced in January 2022.
    Joint commissioning of the graduated model will be reviewed as part of 12-month review of phase 1 implementation.

13. *Specialist SALT Services.*
    Identified need for graduated support model to strengthen early intervention and prevention. Development of Speech and Language, Physiotherapy and Occupational Therapy service.
    Ongoing work to address arising challenges. Development of new roles in speech and language to support children and families to reduce waiting times.

14. *Explore opportunities for early help/ brief interventions from universal practitioners and voluntary, community and faith sector to reduce the need/ pressure on specialist services.*
    Health visitors trained in SLT brief interventions. OT sensory service training supporting families to support low level OT sensory needs. Training has also been made available for schools to support inclusion. Kooth online mental health service extended for 18–25-year-olds and the contract extended for another 4 years.
    Autism friendly training pilot commenced. Inclusion team working to provide support and training to schools.

15. *Neurodevelopmental community network.*
    Open access family support provided by Advanced Solutions- service does not require formal ASD/ADHD diagnosis. Funding secured for 2023/2024.

16. *VCF Commissioned Mental Health Services and Support.*
    Low level mental interventions and group work delivered at community venues.

17. *OT Sensory Workshops.*
Community based education and advice workshops delivered by Alder Hey to families and professionals.

18. *Train and develop the early years workforce for children with SEND.*
Training and development provided; SDIP completed with Trusts. Training will continue as business as usual.
Educational Psychology Service to deliver training to upskill Early Years Practitioners.

19. *To develop a campaign to promote the use of PHBs as part of delivery of EHCPs.*
Training delivered to staff. PHB awareness campaign commenced.
Ongoing awareness raising events with the Sefton Carers Centre to promote uptake of PHBs.

20. *Develop and implement an All-Age Assistive Technology Strategy.*
Sefton TEC Strategy published and underwent first annual review.
All Age Assistive Technology Strategy is in development.

21. *Expand use and resource of assistive technology to support and promote greater independent living.*
Local Offer published to refer Children and Young People to the Visual Needs Team. Visual Interaction Guidance available to families to support developing communication skills. TEC e-learning available to Sefton prescribing staff teams. Brain in Hand pilot launched for 16–35-year-olds. TEC Roadshows conducted with young people, adults and social care professionals. Ask SARA service commissioned for self-assessment for minor aids and equipment. TEC guidance and information available for prescribing teams.
Evaluation of TEC e-learning prior to rollout as mandatory training; Brain in Hand pilot to be evaluated. Ongoing TEC presentations to staff teams to raise awareness of TECs.

22. *Implement a review of the current offer involving young people and their parents/ carers in redesigning the offer.*
Communities have supported the SEND inspection review for children with disabilities. We began the short breaks service review, unfortunately this was suspended due to Covid. We have adapted our provision to offer tailored outreach support for socially isolated overnight support and use of day care venues to for safe activities. “Dave” brand produced with young people to produce a podcast and maintain an Instagram presence for young people with neurological conditions.

Our Priorities 2023-2026

A more detailed snapshot of the Action Plan can be found appended to this strategy, but a brief summary of the actions to meet our priority objectives features below. As stated earlier in the strategy, we will continue to focus on the following priorities for 2023-2026:

1. High aspirations for all our children and young people
2. A comprehensive offer of support which is accessible in our local community.
3. The opportunity to provide support at the earliest opportunity.
4. To work with families and young people to maximise choice and control.

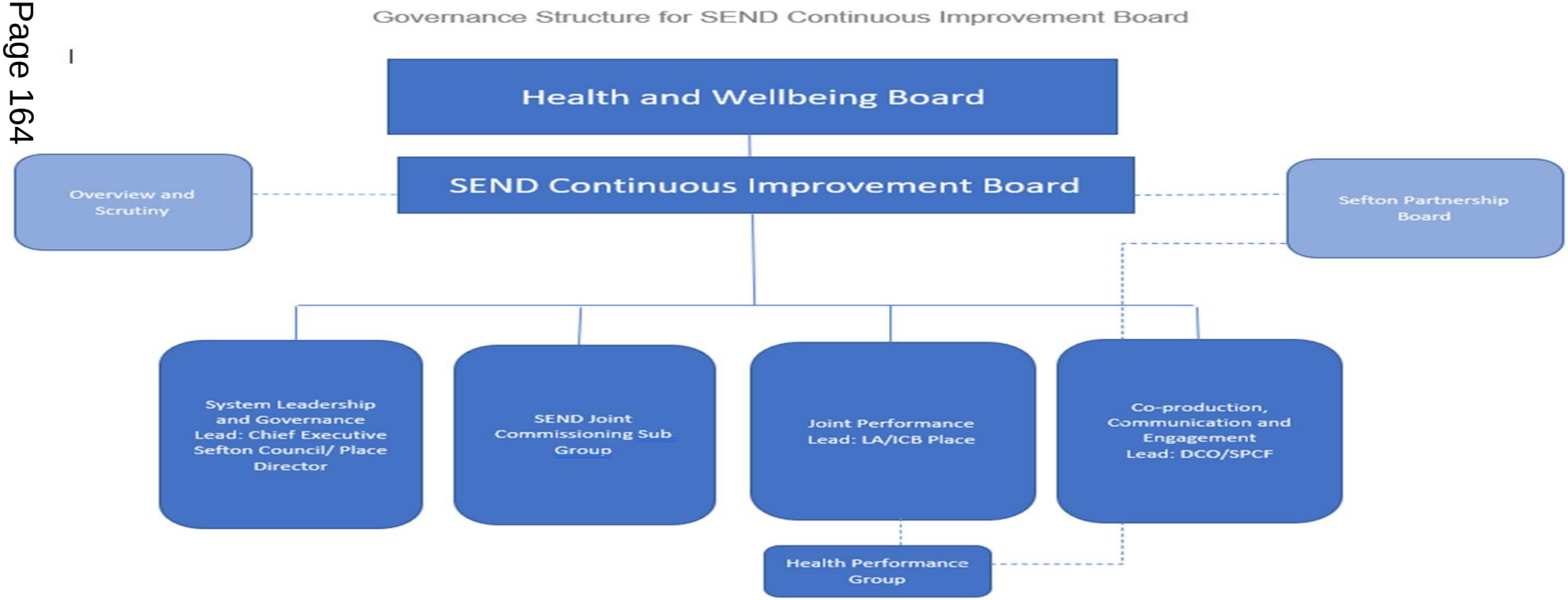
Outcomes & Actions	Priority 1	Priority 2	Priority 3	Priority 4
Delivery of the Delivering Better Value (DBV) Programme including Diagnostic Case Reviews and development of a DBV Action Plan for June 2023	X		X	X
Consider the social care needs of families when developing SEND services and pathways by recruiting a Designated Social Care Officer (DSCO)	X		X	X
:rease choice and control for those with complex health needs via Personalisation or Personal :alth Budgets, utilising a partnership approach in the delivery of services. Actions will include veloping a 18-25 diagnostic pathway and a graduated neurodevelopmental approach, reviewing OT nsory services and the development and implementation of shared care pathways.	X	X	X	X
proved access to Early language and communication support tools including Speech and Language herapy support, advice and assessment if specialist support required.	X	X	X	
Improved awareness of SEND amongst workforce including the continued promotion of the Local Offer and enhanced staff training.	X		X	
Increase accessibility of information for SEND through the creation of an information helpline hosted on Integrated Front Doors.	X		X	X
Improved access to timely and efficient mental health support through investing to support access and improve waiting times.	X	X	X	X
Embedding Technology Enabled Care (TEC) to secure the best outcomes for those with SEND through rollout of training to all staff; evaluation of the Brain in Hand pilot, workshop planning for the Sefton Youth Conference and raising awareness internally of TEC.	X	X	X	X
Partnership approach to service delivery including implementing the NW Framework SEND Purchasing systems.	X		X	
Enhancing provision of SEND services and groups first by mapping existing resources and reviewing best practice and producing a snap shot tool	X		X	
Committing to continually improving the SENDIASS offer by improving our delivery models to ensure sufficient capacity and impartiality by supporting continuous improvement through monitoring.	X		X	
Working across Health and Adult Social Care to review and ensure contract compliance and quality assurance across SEND contracts.	X		X	

Outcomes & Actions	Priority 1	Priority 2	Priority 3	Priority 4
Develop a joint outcomes framework and shared approach to needs assessment in the interest of continuous improvement and transparency.	X		X	
Adapting our strategic approach to understand educational sufficiency and its current pressures per the Delivering Better Value Programme, going on to deliver Sefton's Education Strategy via a delivery plan.	X	X	X	

Our Governance Arrangements

Sefton's Cabinet Member for Adult Social Care chairs the joint SEND Continuous Improvement Board (SENDCIB). The SENDCIB is a multi-agency partnership arrangement that includes senior representatives from the Sefton Parent Carer Forum, local authority, Sefton Place ICB, NHS Providers, along with other key stakeholders such as the Designated Clinical Officer. It is designed to monitor the actions in the focused Improvement plan and ensure the delivery of the required improvements to maximise opportunities and positive outcomes for children and young people with SEND and their families. SEND CIB meetings are monthly, overseeing the progress and delivery of the plan and reporting to the Health and Wellbeing Board. SENDCIB operates as a sub-group of the Health and Wellbeing Board and has specific task and finish groups established to drive the changes we need. SEND Joint Commissioning is a sub-group as part of this structure as demonstrated below, the group has worked with others to develop the strategy.

Quantifiable targets are yet to be set for our priority actions for 2023-2026, but will instead by determined by our working groups who will deliver the strategy; groups such as the Health Performance group will work to monitor and scrutinise progress against the strategy.



Our Approach to Early Resolution of disagreements

Disagreement resolution arrangements cover all children and young people with SEN, not just those who are being assessed for or have an EHC plan. They are available to parents and young people to resolve disagreements about any aspect of SEN provision, and health and social care disagreements during the processes related to EHC needs assessment and EHC Plans. Used early in the process of EHC needs assessment and EHCP development they can prevent the need for mediation once decisions have been taken in that process and appeals to the Tribunal. We will work to jointly commission a service that best meets the needs of service users and achieves the best possible quality and value for money including the exploration of Liverpool City Region opportunities.

The Disagreement Resolution Service is independent of the local authority, NHS, l education providers. The arrangements cover all children and young people n SEN, not just those who are being assessed for or have an EHCP and a ge of disagreements. They are available to parents and young people to resolve agreements about any aspect of SEN provision, and health and social care disagreements during the processes related to EHC needs assessments and EHCPs. They can provide a quick and non-adversarial way of resolving disagreements. Use of the disagreement resolution services is voluntary and has to be with the agreement of both parties.

The disagreement resolution service is to help resolve four types of disagreement or to prevent them from escalating further:

The first is between parents or young people and local authorities, the governing bodies of maintained schools and maintained nursery schools, early years providers, further education institutions or the proprietors of academies about how these authorities, bodies or proprietors are carrying out their education, health and care duties for children and young people with SEN whether they have Education, Health, and Care plans or not. These duties include duties on the local authority to keep their education and care provision under review, the duties to assess and draw up Education, Health and Care plans and the duty on governing bodies and proprietors to use their best endeavours to meet children and young people's SEN.

The second is disagreements between parents or young people and early years providers, schools or post-16 institutions about the special educational provision made fora child or young person, whether they have EHC plans or not.

The third is disagreements between parents or young people and NHS Integrated Care Boards (ICBs) or local authorities about health or social care provision during EHC needs assessments, while EHC plans are being drawn up, reviewed or when children or young people are being reassessed. Disagreement resolution services can also be used to resolve disagreements over special educational provision throughout assessments, the drawing up of EHC plans, while waiting for Tribunal appeals and at review or during reassessments.

The fourth is disagreements between local authorities and health commissioning bodies during EHC needs assessments or reassessments, the drawing up of EHC plans orreviews of those plans for children and young people with SEN. In relation to EHC plans, this includes the description of the child or young person's education, health and care needs and any education, health and care provision set out in the plan. These disagreements do not involve parents and young people.

Disagreement resolution meetings are confidential and without prejudice to the Tribunal process and the Tribunal will disregard any ers or comments made during them. Partial agreement achieved by use of disagreement resolution services can help to focus any sequent appeals to the Tribunal on the remaining areas of disagreement.

agreement Resolution in Sefton is provided by Global Mediation.

Our Approach to Appeals

Effective dispute resolution is key to the success of the new procedures. The Local Authority and Cheshire and Merseyside ICB Sefton Partnership are fully committed to pursuing practical solutions with parents and young people at every stage and to ensure continuous review and reflection to further improve outcomes.

Our Designated Clinical Officer

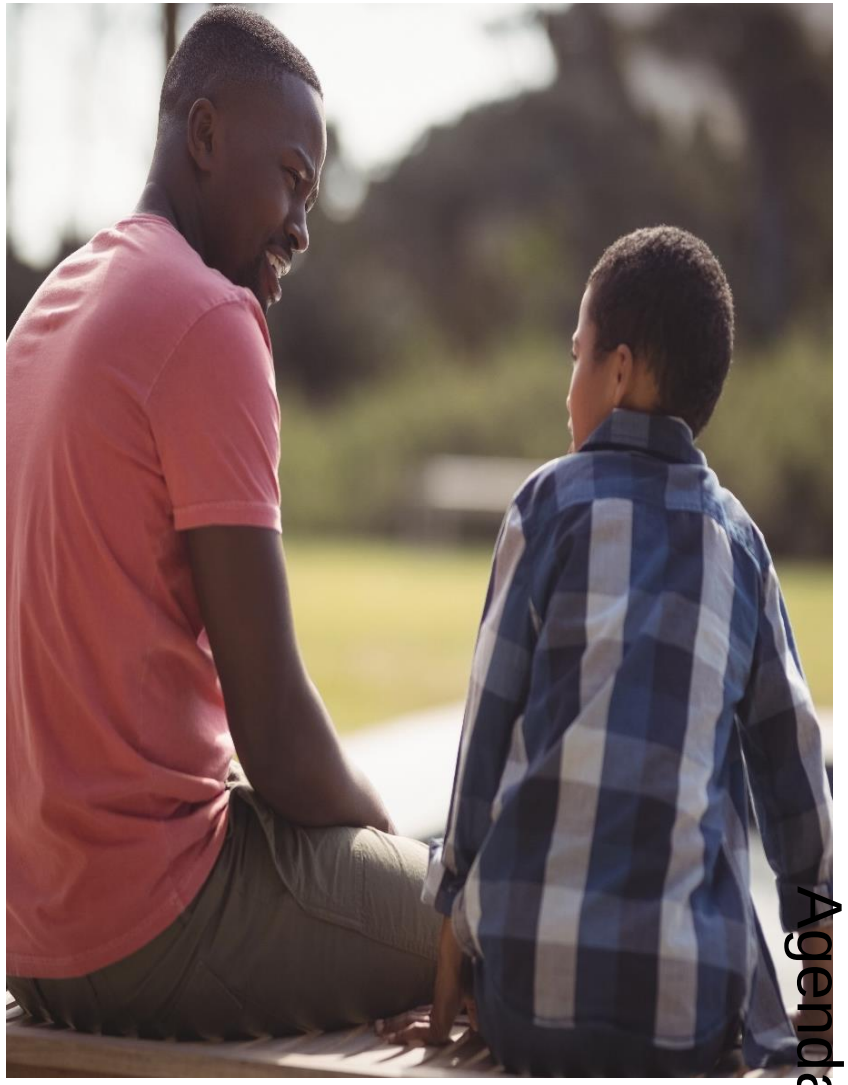
The Designated Clinical Officer (DCO) role is a key element in supporting health services in the implementation of the Children and Families Act 2014 and the scope of the role is very broad. The key responsibilities of the DCO are as follows:

- Oversight – across all health professionals delivering healthcare to individual disabled children, young people and those with special educational needs.

- Coordination – supporting providers in relation to responsibilities and accountability relating to SEND, such as health information shared on the Local Offer, processes regarding the health element of Education, Health and Care plans (EHCP), complex case management, Early Notification of children with SEN/possible SEN to the LA, and many other groups such as Children & Young People's Continuing Care and the transition of young people with SEND to adulthood.

- in relation to the Local Offer, process for mediation arrangements regarding the health elements of the EHC plan and EHC assessments with other key assessments suchas Children & Young People's Continuing Care assessments and Looked After Children Health assessments.

- Strategic – SEND strategies, working in collaboration with all stakeholders and supporting the health system to meet its statutory duties.



Our Designated Clinical Officer is a key partner in supporting the development and implementation of our Action Plan.

Data Sharing and IT infrastructure.

The Local Authority and ICB are part of wider data sharing agreement, Mersey Links. Sefton are also part if the wider Liverpool City region workstream looking to progress shared records initially between authorities and then between Health and Social Care as the second phase.

Appendix 1 Glossary of Terms

Joint understanding:
needs of children and young people with SEN are identified, reviewing services that meet these needs and identify the resources available.

Joint Planning:
identify gaps in services, develop a commissioning strategy which explains the services required and the outcomes we want to achieve with the resources we have.

Joint delivery:
services are procured and contracts put in place to deliver the services.

Joint review:
services are reviewed to see if they have met the outcomes of the specification. This includes feedback from service users and their families to help improve current servicedelivery and feed into future needs assessment.

ND
ecial Education Needs and Disability

MHS
Children and Adolescent Mental Health Services

SALT
Speech and Language Therapy

PRU
Pupil referral unit

PSS
person Shaped Support, a charity designed to find the right solution to support individuals to make their life better.

VENUS
A charity whose vision is to empower, promote and support women, young women and their children in developing their potential, recognising their choices, achieving their goals, and challenging injustice.

Appendix 2 A Sample of Provision

A sample of commissioned and universal are listed below:

Services & Activities	Services in place- Description
Local health services- commissioned by Sefton Place and NHSEngland.	There are services that support and treat people with certain conditions and normally you will have to be referred to the services by certain professionals or agencies e.g., GPs, schools, etc. These are called 'targeted' services. Children, young people with a disability, medical condition and/or a special educational need will probably be supported by one or more of these services through their life. These are listed below: (With very complex medical or health needs it may be necessary for individuals to get some very specialised treatment, medicationor therapy which is provided locally. These would be called 'specialist' services and access to these will be via the clinical consultant that is managing the care and treatment of that individual. It is not possible to list all these specialised services, but information should be provided directly to the patient and their family when the treatment etc. is being discussed /arranged).
ɔeech and Language ıerapy	Speech and language therapists are the lead professionals in the diagnosis and management of communication and swallowing disorders. The Speech and Language Therapy service work to support all communication difficulties including specific speech and language disorders, stammering, cleft lip and palate, voice difficulties, hearing impairment, Autism, Learning Disabilities and eating, drinking and swallowing difficulties. Speech and language therapists work with children who may need help with: • Listening and following instructions. • Playing and talking with other children. • Understanding what people say to them. • Saying sounds and talking clearly. • Using words in sentences. • Eating and drinking. Children learn from parents, teachers, friends and family. Some children learn communication skills quickly and some children maytake longer. Speech and Language Therapists recognise the importance of working collaboratively with everyone in the child's life to get the best outcomes. More information about the service and information on how to help in developing speech and language skills can be found at the **Alder Hey Hospital Speech and Language Therapy webpage.**

Services & Activities	Services in place- Description
Occupational Therapy	The Occupational Therapy service offers specialist assessment and intervention to enable and maximise the potential for children to engage in their daily living activities. The paediatric occupational therapists will work with the child, family and other key professionals in the child's life, to identify areas where a child's function, participation and independence at school, home and the community can be improved. They alsoprovide advice and support to children requiring equipment to maintain their daily function. Close liaison with Sefton EquipmentStores enables the request and provision of equipment in the community. Occupational therapy services are delivered at Clinics, Workshops, Home and School settings, and at equipment assessment clinics. Educational workshops are held for parents and carers of children with sensory processing problems. Referrals are only acceptedirectly from parents.
Podiatry	The service aims to prevent, diagnose, treat and rehabilitate conditions affecting the feet and lower limbs. Qualified podiatrists supported by podiatry assistants offer a service to children at community venues and can conduct home visits. The service has podiatrists who provide specialised in diabetes, wound care, rheumatoid arthritis, or muscular-skeletal and biomechanical conditions. The podiatry service treats and manages foot complications related to diabetes and other disorders that may affect the feet; arthritic conditions and those that affect circulation, nervous and Musculo-skeletal systems.
Continence	The children's continence service in Sefton is led by a specialist nurse & provides advice & support to those with constipation & soiling, daytime & night time wetting, toileting issues & children with additional & complex needs who may require a continence product. Children & young people from 4-19 years can be referred into the service by their GP, consultant, health visitor, other health professionals, education & voluntary sector. Assessments can be conducted in the home & clinic setting with ongoing support.

Services & Activities	Services in place- Description
ASD & ADHD Nursing	The service is for families requiring advice, support and intervention for children and young people from 0-19 years who have a diagnosis of ADHD/ASD. Specialist Nurses provide initial assessment/reassessment to assist families in understanding the need of their child following diagnosis. Further intervention is delivered from Associate Practitioners to support the child/young person and familieswith personalised behaviour strategies to improve emotional wellbeing.
Complex Children's Community Nurse	The Children's nursing team works with children and young people who have disabilities and complex health needs to provideexpert nursing care, support and advice. The Children's Community Nursing (CCN) Service compromises of five teams of experienced children's nurses. The team see children and young people aged 0-19 years who have a nursing need across Sefton. The teams provide nursing care for children and young people, with acute and complex health requirements in their home orwithin a community setting. The Children's Community Nursing Teams work with children by: • Providing a service that enables children and young people to be nursed at home with their family or guardian. • Reduce hospital admissions and to shorten the time spend in hospital. • Work closely with other multi-agency professionals. • The team also Provide training to nursery staff, school staff, carers and other health professionals to support and maintain children's care close to home.
Community Dietetics	The service provides up-to-date information and guidance about childhood nutritional matters to: • Children who have a nutritional need and their carers. • Professionals in contact with children so that advice given by them to carers/children is based on best practice and isconsistent. Some examples of nutritional issues that the service can support include: • food allergies particularly cow's milk protein allergy/intolerance, • selective eating, • overweight, • underweight

Services & Activities	Services in place- Description
	• Constipation. The service support children and their carers who require a special diet to ensure nutritional needs are met considering growth and disease progression. They work closely with other members of the multidisciplinary team to deliver a holistic approach. The service also provides the home delivery service for enteral feeding equipment for all children in Sefton who have complex and additional needs.
Child and Adolescent Mental Health Services (CAMHS)	CAMHS is a partnership comprised of Sefton CAMHS, with Alder Hey offering specialist services to support children and young people in Sefton, up to the age of 18, who are experiencing mental health difficulties. They also provide support to their families or carers. Some of the issues that CAMHS can help with include: • Anxiety •Attachment Difficulties •Conduct/Behaviour Problems • Depression • Psychosis •Obsessions and Compulsions • Self- harm •Post-Traumatic Stress Disorder (PTSD) • More complex psychological difficulties • Emotional & Behavioural difficulties in children with Learning Disabilities CAMHS provide consultation, advice and training to other agencies and accept referrals from a wide range of professionals. The team is multi-disciplinary, which means our clinicians come from a range of clinical and professional backgrounds. The service works with the young people, parents, carers and partner agencies to make sure that the right care is provided to eachindividual, depending on their needs and circumstances.
Physiotherapy	The service provides assessment, diagnosis, treatment, equipment, practical advice and support to children and young people with a wide range of conditions to promote maximum recovery and independence. The service also provides advice and support tochildren and young people's carers and families. Community physiotherapists predominantly see children who have difficulties with their physical abilities due to either an underlying neurological cause or associated with a global developmental delay. We specialise in treating children with neurological conditions, including: • Cerebral Palsy. •Developmental Delay. •Developmental Co-ordination Disorder. • Spina Bifida, Genetic Syndromes. •Acquired Brain Injuries By ensuring appropriate and timely information, advice, assessment, intervention, review and equipment

Services & Activities	Services in place- Description
	provision they can reducethe risk of long-term problems for children.
Audiology	The audiology service provides a comprehensive range of services for children with all types of hearing and balance problems. The service is delivered by a team of Audiologists, Consultant Audio vestibular Physicians and a Specialist Nurse Practitioner. The service includes: • Diagnostic follow-up for New Born Hearing Screening Programme. • School entry hearing screen follow-up. • Assessment and management of temporary hearing loss such as 'glue ear' in children. • Investigation into the cause of hearing loss and assessment and management of permanent hearing loss in children with speech and language delay with suspected hearing loss. • Hearing assessment of children with social and communication difficulties or learning disabilities and other complex needs. **For further information please visit Alder Hey Hospital website via this link**
eurodevelopmental ommunity Paediatrics	The Neurodevelopmental Community Paediatric Service deliver services for children and young people who may be experiencing. • Children with developmental delay. • Children with social and communication difficulties. • Children with complex medical needs. • ADHD assessment, treatment and monitoring. • Child protection service covering physical, sexual and emotional abuse. • Behaviour problems for the under 5s. • Liaison with other professionals caring for the child. Community Neurodevelopmental Paediatricians also support the ASD and ADHD assessment and diagnostic pathways. For more information you can also visit the Alder Hey **website**
Community equipment	The Community Equipment Service provides health and social care equipment to meet the needs of Sefton children, enabling safe discharge from hospitals and promoting independence and mobility in the home environment. They work closely with the occupational therapy team to ensure children requiring equipment; receive it to maintain their daily functions.
Community diabetes team	Sefton have a Community Diabetes Team and the nurses can be accessed by referral from a GP or consultant. They deliver 'Drop in' clinics, with no appointment needed. The 'drop in' clinics are mainly for problems with

Services & Activities	Services in place- Description
	meters, insulin pens and for general advice. If a person needs further investigation / advice / changes in medication an appointment will be arranged for them to see a Diabetes Specialist Nurse for a full assessment.
Asperger's team	Sefton Asperger service provides diagnosis and support for people living with Asperger Syndrome from its base at the Hesketh Centre in Southport. Their aim is to provide specialist support for those people who may have previously fallen through the gaps bynot being regarded as having a mental health problem or a learning disability. The team utilise creative interventions which help with the social and communication difficulties faced by people with Asperger syndrome, their families and care teams. The team works with other services such as social services and local colleges to help support service users. Anyone aged 18 years and over may self-refer or be referred by another person for example a family member; GP or other mentalhealth professional.
Educational psychology service	This is an educational service that is commissioned through schools and other organisations. All mainstream schools are allocated core time that enables the local authority to carry out its statutory duties, in relation to educational psychology services. The Educational Psychology service support the learning and wellbeing of children and young people.
ıming High	
ɹummer scheme -	Some schools and other locations offer a range of activities during the summer break period
Aiming High - Specialist After-School Club	Some schools and other locations offer sessions that cater for children aged 6 – 11 years with complex needs in a closely supervised, safe environment. Here children can build on skills such as independence, social skills, physical and emotional skills.Different activities are planned on a weekly basis for the young people. They can choose to participate in these activities or just have some free play. All young people must be referred to the Aiming High Team in order to access this session, as correct staffing ratios must be inplace as we are governed by Ofsted regulations.
Aiming High - Phoenix Youth Club	This session provides opportunities for disabled young people/young adults aged 11 – 19 to socialise, increase independence andto influence the services available to them whilst in a safe and encouraging environment. All young people must be referred through the Aiming High Team in order to access this session, as correct staffing ratios must bein place as we are governed by Ofsted regulations.

Services & Activities	Services in place- Description
Aiming High	
Aiming High - Phoenix SocialGroup	This session provides opportunities for disabled young people/young adults with Autistic Spectrum Conditions aged 11 - 19 to socialise, increase independence and to influence the services available to them whilst in a safe and encouraging environment. All young people must be referred to the Aiming High Team in order to access this session.
Aiming High - Alchemy	This session provides opportunities for disabled young people/young adults with Autistic Spectrum Conditions aged 11 – 25 to socialise, increase independence and to influence the services available to them whilst in a safe and encouraging environment. All young people must be referred to the Aiming High Team in order to access this session, as correct staffing ratios must be in place as we are governed by Ofsted regulations.
Aiming High - Aiming for eStars	Aiming for the stars is a musical theatre session aimed at disabled children aged 6-19. The sessions aim is to help to improve confidence, self-esteem and skill set in singing, dancing and acting. We hope to improve development by integrating our young people into Shine's annual showcase, this will involve them planning, producing their own ideas and will also include costume design. The young people will get to attend numerous rehearsals with the other performers from Shine to help develop their social skills and also give them an insight into the professional world of performing arts. The young people will get to perform for their families and also showcase their work on a regular basis at our Aiming High Family Fun Days. All are welcome, provided they have been referred into the Aiming High Team and meet criteria. Aiming for the Stars also runs on a Monday, after school at Dunes Leisure Centre, The Promenade, Southport, PR8 1RX.
Aiming High - Nature Group	This session provides an opportunity for young people, aged between 6 and 10 and 11 years plus to gain independence while learning about the Sefton's coastline, forestland. The programme is in conjunction with the Coast and Countryside Team which brings their skills and knowledge to the sessions. Young people have the opportunity to be outdoors, be a part of nature and develop new friendships in a safe, engaging environment. All young people must be referred into the **Aiming High Team** in order toaccess these sessions.
Aiming High - Specialist SaturdayClub Primary	This session caters for children aged 6–11 years with complex needs in a closely supervised, safe environment. Here children can build on skills such as independence, social skills, physical and emotional skills. Different activities are planned on a weekly basis for the young people. They can choose to participate in these activities or just have some free play.

Services & Activities	Services in place- Description
	All young people must be referred to the Aiming High Team in order to access this session, as correct staffing ratios must be in place as we are governed by Ofsted regulations.
Aiming High - Football - Ability Counts	These sessions offer coaching and skills training by fully qualified FA coaches. The young people gain confidence and self-esteem by achieving and gaining success in the multi skill coaching drills, and then finish the session off with a competitive game which helps create team spirit as well as strengthening and widening friendship groups. The team also play regularly in Liverpool County FA Ability Counts Football League. All young people must be referred to the Aiming High Team in order to access this session.
Aiming High - St Joseph's Youth Club (Junior)	This session provides opportunities for disabled young people/young adults with Autistic Spectrum Conditions aged 10 - 12 to socialise, increase independence and to influence the services available to them whilst in a safe and encouraging environment. All young people must be referred to the Aiming High Team in order to access this session.
Aiming High - The NAC outh Club	This session provides opportunities for disabled young people/young adults aged 11– 19 to socialise, increase independence and toinfluence the services available to them whilst in a safe and encouraging environment. All young people must be referred to the Aiming High Team in order to access this session, as correct staffing ratios must be inplace as we are governed by Ofsted regulations.
ming High - Specialist aturday Teen Club Secondary	This session caters for children aged 11-19 years with complex needs in a closely supervised, safe environment. Here children canbuild on skills such as independence, social skills, physical and emotional skills. Different activities are planned on a weekly basis for the young people. They can choose to participate in these activities or just have some free play. All young people must be referred to the Aiming High Team in order to access this session, as correct staffing ratios must be inplace as we are governed by Ofsted regulations.
Aiming High - Active & Able	These sessions are for children and young people of all abilities and disabilities to take part in and try various sports including football, basketball, boccia and athletics, followed by a swim. With specialist events often held at the leisure centres across the borough this is a great club to perfect favourite sports and meet new friends. All young people must be referred to the Aiming High Team in order to access this session, as correct staffing ratios must be inplace. Active & Able sessions run at: Crosby Leisure Centre (6+years) Bootle Leisure

Services & Activities	Services in place- Description
	Centre (6+ years) Dunes Leisure Centre (6+ years)
Aiming High - Southport Junior PHAB Club (Phabkids)	Phab's aim is to promote and encourage people of all abilities to come together on equal terms, to achieve complete inclusion within the wider community through leisure time activities. The age group is for children aged 6+.
Aiming High - Aintree Junior Youth Club	Aintree Junior Youths is one of Aiming High's youth sessions for disabled young people aged 10 - 12 years. It runs every Tuesday during school term at Aintree Village Youth and Community Centre. Whilst there, young people can socialise with their friends in a safe, engaging environment. The club offers a large social area, arts and craft room, an ICT suite and a secure outside area with flower/vegetable beds and plenty of space for outdoor games and sport. It is the perfect space to develop friendships, experience new opportunities to build self-esteem, confidence and to be more independent. The sessions follow the same format as Aiming High's other Youth Sessions. 'Junior Youths' are encouraged to share their 'voices' and identify what they wish to do, helping staff to plan and deliver a range of activities for them. These include sessions that look at youth issues in the world today, equipping disabled young people with the knowledge and skills to help them confidently make the right choices and assist them in later life.
0-19 provision	Offers an integrated universal Public Health Service that delivers Health Visiting, Breastfeeding Support, School Nursing and school aged immunisations. The service is delivered by North West Boroughs Healthcare NHS Foundation Trust and aims to give every child in Sefton the best start in life and help support young people to make healthier choices. Health Visitors are registered nurses or midwives who have a specialised qualification in the care and development of pre-school children. The health visiting team works in accordance with the Healthy Child Programme, which is a national programme aimed at promoting health and wellbeing for all children by: • Keeping children healthy and safe • Encouraging healthy eating and physical activity • Preventing disease through immunisation • Promoting breastfeeding • Improving readiness for school • Checking development pre-school and school age • Addressing risky behaviour Every school in Sefton has a School Nurse who works as part of the integrated 0-19 service to deliver the Healthy Child Programme to children aged 4-19 years within the borough of Sefton. The School Nursing

Services & Activities	Services in place- Description
	service plays an active role in safeguarding vulnerable children and young people and offers: • Advice, information and support on all aspects of health and wellbeing encompassing both physical and emotional health. • A health needs assessment which is completed by parents of reception aged children and pupils in years 6, 9 and 11. • Health screening for all reception aged children which includes height, weight, vision and hearing and height and weight measurement offered to all pupils in Year 6. • Annual health assessments for looked after children. Support for young carers.
Family Wellbeing Centres	Family Wellbeing Centres offer support with: • Parenting - parents to be, new parents, behaviour, speech and language. • Health - midwifery, health visitors, mental health, healthy eating, sexual health • Employment - including training and apprenticeships. • Education - early learning, attendance, further education, achievements • Leisure - social opportunities, events, clubs, activities • Relationships - counselling, loneliness, bereavement • Welfare - benefits, debt advice, housing To access an activity or intervention from one of the family wellbeing centres please complete the Family Wellbeing Referral Form (Sefton Family Wellbeing Centres | The Sefton Directory)and send it to the Early Help Front Door (**early.help@sefton.gcsx.gov.uk**) or local centre.
Libraries	There are 6 libraries in Sefton. What is on offer, how to find your local library, and opening times is available on the Council website. This includes a Home Visit Library Service for Sefton residents who experience difficulties getting to a local branch library bythemselves. You can also borrow e-books and e-audiobooks through the Sefton Library Service app. It is free to download and gives readers the flexibility to borrow and reserve multiple titles anywhere in the borough.
Home to school transport	The LA has a statutory duty, and in appropriate circumstances discretionary powers to help with home to schooltravel, based on a pupil's individual needs and circumstances. Where appropriate the service seeks to empower young people and their families to become more confident and connected through independent travel. The service will support them in developing sustainable

Services & Activities	Services in place- Description
	travel skills. This could be through travel passes, Independent Travel Training (ITT) or Personal Travel Budget (PTB). The Council will offer commissioned transport where there is no viable alternative available to the student.
Springbrook	Springbrook's primary role is to provide short residential breaks to disabled young people usually between the ages of 8-17 yearswho have been identified as needing such a service by a Social Worker assessment. Springbrook can accommodate up to 5 young people at any one time. This, however, is dependent on the assessed care needs ofindividual people. Springbrook is committed to offering individualised programme of stays for service users in a homely, friendly, fun environment.
Leisure Centres	Leisure Centres offer a whole host of activities to help people achieve a healthier lifestyle. They offer a range of options for children and young people and help young people across Sefton find a sport or activity that they love and want to become a partof for a long time. Whether it is swimming or team sports, short sessions, or holiday camps you are looking for, they are sure to offer something for all. Plus, Crosby Lakeside Adventure Centre offers a host of fun-filled water-based adventures for all ages.
e Active	Every school holiday, fully qualified, experienced and enthusiastic Be Active coaches deliver a great range of activities to children aged 3-16 across Sefton. A fantastic way for children to keep active, have fun and make friends in a safe environment, our activitiesinclude one to five-day camps, shorter sessions and reduced cost swim and splash sessions.
Natural Alternatives Programme	This is a biodiversity and access programme providing work and training opportunities for local people to manage the coast and countryside areas of Sefton. It provides a safe, secure and challenging work environment for participants providing training, education and work experience for • local disengaged young people • vulnerable adults • adults and young people with learning disabilities • volunteers It is an environment where they can add to their knowledge, improve their work skills, confidence, and self-esteem, and become anintegral member of the team.

Services & Activities	Services in place- Description
	Based at the Ainsdale Discovery Centre Complex people can either work in a specialist woodworking unit or on various other projects including nature trails, access, woodland and nature reserve management and rights of way maintenance. The woodwork unit manufactures countryside timber products for use on coast and countryside in Sefton.
The Targeted Youth Prevention (TYP)	The Targeted Youth Prevention (TYP) Team works with young people to promote young peoples', personal and social development, enable them to be safer, have less opportunity for negative behaviour and enable them to have a role, influence and place in their communities and society. The team seeks to safeguard young people, particularly those who are vulnerable, offering safe places to explore their identity, experience decision making, increase confidence, develop inter-personal skills, and think through the consequences of their actions which leads to better informed choices, changes in behaviour, improved outcomes and better life chances.
Community Learning	The Sefton Community Learning Service is committed to inclusion and equal opportunity of learning for all adults regardless of their sexuality, race or ability. The prospectus is updated on a regular basis.
Sefton@Work	Sefton@Work offers a range of free and confidential job-related services to residents aged 16 years and above throughout Sefton.
Voluntary Services	
Sefton CVS	Sefton CVS co-ordinate several Children' and Young Peoples Services that are inclusive to some Children and Young People with SEND. Many would not recognise themselves as doing so or as specialised services.

Services & Activities	Services in place- Description
Buddy up scheme	Buddy Up is commissioned by Aiming High Short Breaks services and a part of Sefton's short breaks offer. Buddy Up is a mentoring and befriending project for young people aged between 13 and 18 who have additional needs and are at risk of social isolation. The project support's these young people to engage in fun, age-appropriate activities in their local community with the support of peer mentors. This helps to reduce social isolation, increase confidence and self-esteem, improve independence skills, and prepare the young person for adulthood. The project works with mainstream schools, colleges, universities and youth groups to identify and recruit peer mentors agedbetween 13 and 25 who are keen to volunteer within their community and have the relevant skills to fulfil a peer mentor role.
Sefton Carers Centre	Sefton Carers Centre provides free advice and guidance, emotional and practical support, training and a range of holistic therapiesfor unpaid carers living in Sefton.
efton Young Carers efton Carers Centre	The Sefton Young Carers Service provides support to children and young people between 5 and 17 years of age who look after someone in their family who could not manage without this help. Sefton Young Carers Service work alongside families, schools and professionals to ensure that the role of young carers is supported and recognised - including by young carers themselves. All young carers are entitled to an assessment of their needsand to receive appropriate personalised support.
Together Trust	The Together Trust is a voluntary organisation providing a wide range of care, special education and community services forchildren and adults with autism, learning difficulties and/or complex needs.
Home Start – Southport and Formby	A voluntary organisation committed to promoting the welfare of families with at least one child under 5 years of age. Volunteers offer regular support, friendship and practical help to families under stress in their own homes to prevent family crisisand breakdown. SEND support is incorporated into their role in supporting families
Autism Initiatives	Autism Initiatives offers specialist day services, residential, supported living services, and short breaks services to adults with Autistic Spectrum Conditions. They also run Peterhouse School in Southport, support autistic children who are in mainstream education, and facilitate parentsupport groups.
Sefton Emotional AchievementService (SEAS)	Undertakes specific Emotional and Wellbeing work with Children with Additional Needs – members are VENUS, PSS, Space (MYA), Parenting 2000 and Sefton CVS. Please see the Sefton Local Offer for further information on these organisations.

Services & Activities	Services in place- Description
Information and Advice	
Sefton's Information, Advice andSupport Service (SENDIASS)	The jointly commissioned SENDIASS service. This is a statutory service that provides confidential and impartial information, advice and support to disabled children and young people, and those with SEN, and their parents (who have children/young people 0-25 years). The services are impartial, accessible and free, and all staff are independently legally trained.
SENIS – The Special Educational Needs and Inclusion Service	The SENIS Early Years Team provide advice and guidance on including children aged 0-5 years who have, or may have, special educational needs. They work closely with families and early years settings in helping to understand young children's strengths and needs and finding ways to promote all aspects of their learning and development. Their work includes: • contributing to the assessment of children's needs e.g., through observations, direct work and discussions with those who know the child best. • helping to plan and review interventions and monitor progress. • working with other agencies including speech and language therapists and community paediatricians • supporting children's transitions • signposting families and settings to other services • developing and training

Appendix 3- 2023-2026 Action Plan

Our Priorities

1. High aspirations for all our children and young people
2. A comprehensive offer of support which is accessible in our local community.
3. The opportunity to provide support at the earliest opportunity.
4. To work with families and young people to maximise choice and control.

The Outcomes we are aiming for	The Actions we are taking	Why we are doing it	Impact we will have	Responsible lead	Date to be achieved by
Ensure that Children and Young People with SEND receive the right support at the right time to achieve the best possible outcomes.	Delivery of the Delivering Better Value Programme, key milestones include: Diagnostics Case Reviews Development of Action Plan for June 2023. Implementation of the NW Framework SEND Purchasing systems	To identify sustainable changes that drive high quality outcomes for children and young people with SEND.	To improve the outcomes for children and young people with SEND while ensuring effective, efficient delivery of services to support this.	Assistant Director Education Excellence	Action Plan developed June 2023 Implementation 2025
To ensure that the social care needs of families are considered in the development of pathways and	Recruitment of a Designated Social Care Officer	In recognition of the range of need in families where children and young people have complex needs, and the need	Unblocking services for children with SEND and their families	Exec Director of Children's Services	Q2 23/24

The Outcomes we are aiming for	The Actions we are taking	Why we are doing it	Impact we will have	Responsible lead	Date to be achieved by
services across SEND		to align social care support with other services.			
Increase choice and control for Children and Young People with complex health needs through Personalisation or PHB and ensuring a partnership approach to delivery of key services.	Further work needed to promote PHBs and increase uptake.	So, children and young people can have their needs identified and understood as early as possible and have access to support to meet those needs. Because children, young people and their families benefit from when they are in control of the care and support, they receive.	More CYP and families will feel they are having their needs identified and met. More CYP and the families will have more control over the care they receive leading to improved experience and satisfaction.	Assistant Chief Nurse (Sefton Place)	Q1 2024/25
Improved system wide availability and access to neuro developmental and sensory support, based on need and not diagnosis	Development of a graduated model of support, knowledge, understanding and awareness of how services work and how they may be accessed; including SLT support, advice and assessment if specialist support required Review of OT sensory service and requirement for joint commissioning of	Early identification and support for children and young people with neurodevelopmental needs. ND/sensory pathways and support respond to need and not diagnosis. aligned priorities of Start Well Programme and All-Age Autism.	Development of approach to better support our children and young people and their families in identifying and supporting their neurodevelopmental and sensory needs.	CYP Commissioning Lead (Sefton Place) Sefton Partnership Local authority SEND Lead	Q3 2023/24

The Outcomes we are aiming for	The Actions we are taking	Why we are doing it	Impact we will have	Responsible lead	Date to be achieved by
	further levels of support. Develop/implement shared care pathways, to support management of ADHD in primary care.				
Improved access to Early language and communication support tools	Create an information helpline accessed through the Integrated Front Door for families and professionals wanting advice about social care support. Work with our communities and voluntary sector to ensure best use of local assets including volunteers	CYP are waiting longer than the agreed time for assessment. Opportunities to support and identify CYP sooner with speech and language needs.	CYP will not wait longer than the agreed time for accessing NHS assessment and treatment (18 weeks for 92% of referrals). Recovery date to be confirmed in revised improvement plan, due June 2023. Schools will feel better equipped and confident to support and identify CYP with speech and language needs.	Exec Director of Children's Services	Q3 23/24
Increase transparency and accessibility of information about social care services for children, young people, and their families.	Investment to support access to meet national access targets. Improvement in waiting times. Ongoing work to plot the Early Help offer across all partners	Because children, young people and their families have told us about the need for clearer, more readily available information.	Children, young people, and their families will know how to access the help and support they need.	CYP Commissioning Lead (Sefton Place)	Q4 2023/24

The Outcomes we are aiming for	The Actions we are taking	Why we are doing it	Impact we will have	Responsible lead	Date to be achieved by
	linked to THRIVE. Ongoing actions related to our JTAI are being picked up in other workstreams but will be monitored via IPR and SEND Dashboard groups in a partnership approach focusing on how we jointly commission. Continue to build on the Mental Health in Schools Support teams and how we maximise coverage				
Improved access to timely and efficient mental health support through Thrive model and graduated approach.	TECS Evaluation of TEC E-learning and feedback will precede the training being tolled out to all social care staff as mandatory training. Evaluation and assessment of Brain in Hand pilot around June 2023. Workshop planning for Sefton Youth	So, children and young people can have their mental health needs identified and understood as early as possible and have access to support to meet those needs.	More CYP and families will feel they are having their mental health needs identified and met. CAMHS recovery to waiting time targets for assessment and treatment (to be confirmed in revised improvement plan, due June 2023). Improvement in knowledge and understanding of local universal and targeted	Assistant Director for Integrated Life Course Commissioning	Q4 2023/24

The Outcomes we are aiming for	The Actions we are taking	Why we are doing it	Impact we will have	Responsible lead	Date to be achieved by
	Conference March 2023. TEC presentations to staff ongoing and all guidance and information has been shared with Managers and Team Leaders to disseminate		services for children, young people and their families.		
Technology Enabled Care is a key part of meeting the needs of and enabling our C dren and Young P ple with SEND	Mapping of existing resources and gap analysis and production of a SEND snap shot tool	To ensure Children and Young People with SEND benefit from innovation and get the right support they need. To ensure we have a robust, accessible and engaging digital offer to help and support children, young people and their families with SEND.	Maximised the number of outcomes able to be met. We will work to utilise technology, new innovations and ideas in a partnership approach and with the involvement of young people to secure the best possible outcomes for Sefton's people.	Assistant Director Integrated whole life Commissioning	Q1 2024/25
Sefton children and families understand the services available to them through a range of communications and can access them through the local offer.	Review of national best practice Expand upon our methods of communication for children and young parents with SEND	To understand prioritise and help inform the picture of resource allocation.	To enable us to deliver a comprehensive model of delivery that is resourced appropriately.	Executive Director for Children's Services	2025

The Outcomes we are aiming for	The Actions we are taking	Why we are doing it	Impact we will have	Responsible lead	Date to be achieved by
	needs and their parents and carers. Utilisation of social prescribing to best meet the practical, social and emotional needs of children and young people with SEND.				
	A service review has been undertaken. Implement an improved model of delivery that ensures sufficient capacity and impartiality. Improvement of monitoring arrangements to support continuous improvement of the service.	Because our Children and Young people and their parent carers have told us of the difficulties finding a comprehensive picture of wants available to them	Children, Young People, their parent carers and educational settings can easily access a wide range of support and information through a single route. In turn supporting greater inclusion and allowing children and young people to meet their full potential.	Assistant Director of People (Communities) / Assistant Director of Educational Excellence.	Q1 2024
Continuous improvement of the SENDIASS offer to ensure a fully functioning model to ensure families feel supported and that is compliant with Statutory Requirements.	Review and understand the best model to meet need	To deliver a service that has appropriate capacity to support as many Children, Young People and their Parent Carers as possible to achieved desired outcomes.	A greater number of Children, Young People and their Parent Carers can access advice and support in timely manner and reporting a high level of satisfaction with that support.	Assistant Director of Educational Excellence	Q1 2025

The Outcomes we are aiming for	The Actions we are taking	Why we are doing it	Impact we will have	Responsible lead	Date to be achieved by
Performance and Impact of SEND services are transparent and drive continuous improvement	Co-produced development of a Joint Outcomes Framework and Shared Approach to Needs Assessment	To be able to reflect real impact and allow this to drive management of day-to-day business, improvement work and longer-term strategic delivery.	Improved overall performance and increased satisfaction. from those that need our services.	CYP Commissioning Lead (Sefton Place)	Q4 2023/24
Improved access to timely and effective ASD& ADHD assessment, diagnosis and support.(0 – 19)	Review of investment to support access to timely ASD & ADHD assessment and diagnosis. Development of 18 - 25 diagnostic ASD/ADHD pathways and KPIs	Timely identification of children and young people's needs so that children and young people and their families can be connected to the support they need. Children, young people and their families benefit from and have control of the care and support, they receive..	Reduction in waiting times for diagnosis, improved performance in the pathway. Robust pathway for assessment, diagnosis and support. Waiting times for 0 – 18 assessment/diagnostic pathway to reduce in line with NHS national covid recovery targets for elective care, as outlined in the service improvement plan.	CYP Commissioning Lead (Sefton Place) Commissioning Lead- Adult Mental Health (Sefton Place)	Q4 2023/24
We understand educational sufficiency on a strategic level	Work of Delivering Better Value Programme Gaining a fuller understanding of pressures in current sector Rolling out an implementation plan	To ensure sufficiency that maximises outcomes from Children and Young People while delivering best value.	More children having their outcomes met locally by a high-quality provider.	Assistant Director of Education Excellence	March 2027 (in line with the Education Excellence Strategy)

The Outcomes we are aiming for	The Actions we are taking	Why we are doing it	Impact we will have	Responsible lead	Date to be achieved by
	to deliver Sefton's Education Strategy.				

Useful Links:

Council website People and Place Information
sefton.gov.uk/your-council/plans-policies/business-intelligence,-insight,-performance/borough-ward-profiles.aspx

Council website Children & Young People's Plan
sefton.gov.uk/media/1633080/children-and-young-peoples-plan-2020-2025.pdf

Council website Sefton Integrated Early Help Strategy for Children, Young People and Families sefton.gov.uk/media/1630716/Sefton-Early-Help-Strategy-2019-2025-Final-.pdf

CAMHS
Home (seftonliverpoolcamhs.com)

eech and Language Services
os://www.alderhey.nhs.uk/

hool Transport -
ton.gov.uk/schools-learning/home-to-school-transport.aspx

Local Offer
seftondirectory.com/kb5/sefton/directory/localoffer.page?localofferchannel=0

SENIS Early Years
seftondirectory.com/kb5/sefton/directory/advice.page?id=VlDvJK2cDjg

SEND Code of Practice
gov.uk/government/publications/send-code-of-practice-0-to-25

SENDIASS
seftondirectory.com/kb5/sefton/directory/service.page?id=wBXaryM_SUo

Sefton Parent Carer Forum
seftonparentcarerforum.co.uk/about/

Agenda Item 7

SEND Joint Commissioning Plan 2023 -2026

Our Ambition

To ensure that Sefton's Special Educational Needs and Disabilities (SEND) offer enhances the experience and outcomes for children and young people, our focus is on co-production and collaboration to provide good quality services, to achieve good outcomes for the children, young people, and families we serve.

Our Priorities

High aspirations for all our children and young people	The opportunity to provide support at the earliest opportunity.	A comprehensive offer of support which is accessible in our local community.	To work with families and young people to maximise choice and control.

Delivery of the Delivering Better Value (DBV) Programme including Diagnostic Case Reviews and development of a DBV Action Plan for June 2023	Partnership approach to service delivery including implementing the NW Framework SEND Purchasing systems.
Consider the social care needs of families when developing SEND services and pathways by recruiting a Designated Social Care Officer (DSCO)	Enhancing provision of SEND services and groups first by mapping existing resources and reviewing best practice.
Increase choice and control for those with complex health needs via Personalisation or Personal Health Budgets, utilising a partnership approach in the delivery of services. Actions will include developing a 18-25 diagnostic pathway and a graduated neurodevelopmental approach, reviewing OT sensory services and the development and implementation of shared care pathways.	Embedding Technology Enabled Care (TEC) to secure the best outcomes for those with SEND through rollout of training to all staff; evaluation of the Brain in Hand pilot, workshop planning for the Sefton Youth Conference and raising awareness internally of TEC.
Improved access to Early language and communication support tools including Speech and Language Therapy support, advice and assessment if specialist support required.	Committing to continually improving the SENDIASS offer by improving our delivery models to ensure sufficient capacity and impartiality by supporting continuous improvement through monitoring.
Improved awareness of SEND amongst workforce including the continued promotion of the Local Offer and enhanced staff training.	Working across Health and Adult Social Care to review and ensure contract compliance and quality assurance across SEND contracts.
Increase accessibility of information for SEND through the creation of an information helpline hosted on Integrated Front Doors.	Develop a joint outcomes framework and shared approach to needs assessment in the interest of continuous improvement and transparency.
Improved access to timely and efficient mental health support through investing to support access and improve waiting times	Adapting our strategic approach to understand educational sufficiency and its current pressures per the Delivering Better Value Programme, going on to deliver Sefton's Education Strategy via a delivery plan inclusive of schools workforce .

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