Public Document Pack

MEETING: HEALTH AND WELLBEING BOARD

DATE: 8th December 2021

TIME: 2.00 pm

VENUE: Town Hall, Bootle

Member

Cllr. Ian Moncur (Chair)
Cllr. Paul Cummins
Cllr. Mhairi Doyle, M.B.E.
Lisa Lyons
Deborah Butcher
Margaret Jones
Dr. Rob Caudwell
Fiona Taylor
Peter Chamberlain
Gary Oakford
Superintendent Graeme Robson
Lorraine Webb
Andrew Booth
Angela White
Louise Shepherd
Bill Bruce
Sir David Dalton

COMMITTEE OFFICER: Amy Dyson Democratic Services Officer
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If you have any special needs that may require arrangements to facilitate your attendance at this meeting, please contact the Committee Officer named above, who will endeavour to assist.

We endeavour to provide a reasonable number of full agendas, including reports at the meeting. If you wish to ensure that you have a copy to refer to at the meeting, please can you print off your own copy of the agenda pack prior to the meeting.

A G E N D A

1. Apologies for Absence

2. Minutes of Previous Meeting (Pages 5 - 10)

Minutes of the Meeting held on 14 October 2021

3. Declarations of Interest

Members are requested at a meeting where a disclosable pecuniary interest or personal interest arises, which is not already included in their Register of Members' Interests, to declare any interests that relate to an item on the agenda.

Where a Member discloses a Disclosable Pecuniary Interest, he/she must withdraw from the meeting room, including from the public gallery, during the whole consideration of any item of business in which he/she has an interest, except where he/she is permitted to remain as a result of a grant of a dispensation.

Where a Member discloses a personal interest he/she must seek advice from the Monitoring Officer or staff member representing the Monitoring Officer to determine whether the Member should withdraw from the meeting room, including from the public gallery, during the whole consideration of any item of business in which he/she has an interest or whether the Member can remain in the meeting or remain in the meeting and vote on the relevant decision.

4. Sub Group Updates (Pages 11 - 32)

Report of the Director of Public Health

5. Health and Wellbeing Board Development (Pages 33 - 38)

Report of the Executive Director of Adult Social Care and Health

6. Shaping Care Together

Presentation by Accountable Officer, NHS South Sefton and NHS Southport and Fomrby CCGs

7. Place Based Partnership Communications and Engagement Update (Pages 39 - 40)

Report of the Head of Communications and Engagement, NHS South Sefton CCG and NHS Southport and Formby CCG

8. Obesity and Healthy Weight in Sefton Progress Update; (Pages 41 -

Challenges, Barriers and Action Plan 62)

Report of the Director of Public Health

9. **VCF Sector Transformation Brochure Sefton Voluntary, Community and Faith Sector at the Front-line of Transformation** (Pages 63 - 104)

Report of the Chief Executive of Sefton CVS

10. **Dementia Profile** (Pages 105 - 132)

Presentation by the Cabinet Member for Adult Social Care

11. **Early Years Foundation Stage** (Pages 133 - 140)

Report of the Executive Director of Children's Social Care and Education

12. **Report on the Council's Not in Education, Employment or Training Reduction and Early Intervention Service commissioned through Economic Growth and Housing (Employment & Learning)** (Pages 141 - 154)

Report of the Head of Economic Growth and Housing.

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THIS SET OF MINUTES IS NOT SUBJECT TO “CALL-IN”

HEALTH AND WELLBEING BOARD

MEETING HELD AT THE COMMITTEE ROOM - BOOTLE TOWN HALL, TRINITY ROAD, BOOTLE, L20 7AE ON THURSDAY 14TH OCTOBER, 2021

PRESENT: Councillor Moncur (in the Chair) (Sefton Council) Councillor Doyle (Sefton Council), Lisa Lyons (Sefton Council), Deborah Butcher (Sefton Council), Margaret Jones (Sefton Council), Dr. Rob Caudwell (Southport and Formby Clinical Commissioning Groups), Peter Chamberlain (South Sefton Clinical Commissioning Group)

Also in attendance, Dwayne Johnson - Chief Executive of Sefton Council.

10. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Cummins (Sefton Council), Bill Bruce (Healthwatch Sefton), Sir David Dalton (Liverpool University Hospitals NHS Foundation Trust), Superintendent Graeme Robson (Merseyside Police), Louise Shepherd (Alder Hey Children’s NHS Foundation Trust), Fiona Taylor (NHS Sefton Clinical Commissioning Groups), Lorraine Webb (Venus Charity) and Angela White (Sefton Council for Voluntary Service).

11. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the minutes of the meeting held on 9 June, 2021 be confirmed as a correct record.

12. DECLARATIONS OF INTEREST

No declarations of any disclosable pecuniary interests or personal interests were received.

13. INTEGRATED CARE PARTNERSHIP GOVERNANCE

The Board considered the presentation of the Executive Director of Adult Social Care and Health. The presentation outlined Governance Architecture – Sefton’s Place Based Partnership and informed the Board on the relevant next steps and timescales.

RESOLVED: That

(1) the presentation be noted; and
(2) a further report on obesity and the relevant task group be presented to the board in future.

14. SEFTON INTEGRATED CARE PARTNERSHIP PRIORITIES

The Board considered the presentation of a Public Health Consultant and an Acting Public Health Consultant. The presentation informed the board on population health, health inequalities, the impact of the pandemic and obesity in the borough as well as detailing an action plan.

RESOLVED:

That the presentation be noted.

15. HEALTH AND WELLBEING BOARD DEVELOPMENT

The Board considered the report of the Executive Director of Adult Social Care and Health. The report summarised key developments around the Health and Wellbeing Board and the establishment of a Sefton Integrated Care Partnership. The report included reflections of a development session held on the 2nd of August and future session proposals.

RESOLVED: That

(1) the Board be clearly accountable for the oversight, review and delivery of the Joint Strategic Needs Assessment and the Place Plan within the Sefton Integrated Care Partnership;
(2) the nature and sequence of a programme of further informal development sessions for the Board be considered;
(3) the proposed future Agenda item around terms of references and governance structure be agreed; and
(4) best thanks of the Board be extended to the Local Government Association and Steve Bedser of FD Associates for their valuable support in running the session and commitment to future events.

16. SUB GROUP UPDATES

The Board considered the report of the Director of Public Health that provided an update and summary of activity from the five identified sub-groups:

(1) Special Educational Needs and Disabilities Continuous Improvement Board (SEND CIB) which had met twice since the last report, on 25th May 2021 and 29th June 2021
(2) Children and Young People Partnership Board (CYPPB) which had met thrice since the last report on 26th May 2021, 23rd June 2021 and

4th August 2021, from June 2021 the meetings moved to bi-monthly

(3) The Adult's Forum terms of reference and membership was under review as part of the design of the Sefton Integrated Care Partnership
(4) The Health and Wellbeing Executive which had met twice since the last report on 17th June 2021 and 26th August 2021
(5) The Health Protection Forum's work that had been superseded during this time by the outbreak board. It was anticipated the Forum would reconvene in 2021.

RESOLVED:

That the report be noted.

17. CARE HOME STRATEGY

The Board considered the report of the Executive Director of Adult Social Care and Health. As part of the integration agenda, the Local Authority and the two Sefton Commissioning Groups (CCGs) had developed a draft Care Home Strategy for the period 2020/23, which outlined a strategic direction for the sector and future work plans. The Key Themes included in the Strategy included: Service Users, Care Homes and their workforce, Quality, Consultation and Engagement and Commissioning/Finance/Analysis. The strategy also informed the Board on recommendations and next steps.

RESOLVED: That

(1) the draft strategy be noted;
(2) the report be submitted to governance structures such as Cabinet and the CCGs Leadership Team for approval;
(3) approval be given for detailed plans relating to workstreams identified within the strategy which will be developed and implemented, with oversight by the Integrated Commission Group and progress on these plans be regularly reported to the Health and Wellbeing Board; and
(4) It be noted that engagement with key stakeholders (such as Care Home Providers) will take place on the strategy and its implementation.

18. INTEGRATED INTERMEDIATE CARE STRATEGY

The Board considered the report of the Executive Director of Adult Social Care and Health. The report presented the Sefton Joint Intermediate Care Strategy 2021-24 for approval. Immediate Care was defined as a range of integrated services that: promoted faster recovery from illness, prevented unnecessary acute hospital admissions and premature admissions to long-term acre, supportedtimely discharge from hospital and maximised independent living.

RESOLVED: That

(1) the Sefton Joint Intermediate Care Strategy 2021-24 be noted; and
(2) further reports be submitted to the Board throughout the life of the strategy in order to provide updates on delivery of the strategy.

19. SEFTON TECHNOLOGY ENABLED CARE SOLUTIONS STRATEGY 2021 – 2024

The Board considered the report and presentation of the Executive Director of Adult Social Care and Health. The report outlined the Sefton Technology Enabled Care Solutions (TECS) Strategy which had been written in response to the development of Sefton's Digital Strategy 2021-23, to ensure that Technology Enabled Care Solutions (TECS) could contribute to meeting the needs of individuals to ensure independent living at home and within the wider community.

RESOLVED: That

(1) the final version of the Sefton Technology Enabled Care Solutions Strategy 2021-24 be approved; and
(2) the proposed reporting pathway be approved.

20. SOUTHPORT AND ORMSKIRK CARE QUALITY COMMISSION INSPECTION

The Board considered the report of the Southport and Ormskirk NHS Executive Director of Nursing, Midwifery and Therapies. The report detailed the latest Care Quality Commission Improvement Plan Report received by the Southport and Ormskirk Hospital NHS Trust Quality and Safety Committee (QSC) in June 2021.

RESOLVED: That

(1) the report be noted; and
(2) a follow up report be presented to the Board at a future meeting.

21. MENTAL HEALTH REVIEW

The Board considered the presentation of the Clinical Commissioning Groups' Director of Strategic Partnerships. The Presentation detailed the Phase One Overview of the Sefton Integrated Care Partnership Mental Health Review. The main points covered were the background and context to the presentation, approach and insights and the implications and next steps.

RESOLVED:

That the presentation be noted.

22. CHILDREN'S SOCIAL CARE WORKFORCE REVIEW

The Board considered the report of the Executive Director of Children's Social Care and Education. The report was presented to the Board for information and detailed further injection into the workforce and further improvements in practice for children, as well as addressing costs within the structure of Children's Social Care.

RESOLVED:

That the report be noted.

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Report to:	Health and Wellbeing Board	Date of Meeting:	Wednesday 8 December 2021
Subject:	Sub Group Updates		
Report of:	Director of Public Health	Wards Affected:	(All Wards);
Portfolio:	Health and Wellbeing		
Is this a Key Decision:	N	Included in Forward Plan:	No
Exempt / Confidential Report:	N		

Summary:

This report is to present to the Health and Wellbeing Board a summary of activity from the five identified sub groups. This is activity since the last report received by the board on the 14th October 2021

Recommendation(s):

(1) The updates are received and noted by the Board

Reasons for the Recommendation(s):

The Board is asked to routinely receive and note updates to ensure compliance with required governance standards.

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

Not applicable

What will it cost and how will it be financed?

(A) Revenue Costs

There are no additional revenue costs identified within this report

(B) Capital Costs

There are no additional capital costs identified within this report

Implications of the Proposals:

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

Legal Implications:
Equality Implications: There are no equality implications.
Climate Emergency Implications: The recommendations within this report will

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

The report details updates of the subcommittee activity which in themselves have no specific impact negatively or positively on Climate Change

Contribution to the Council's Core Purpose:

Protect the most vulnerable: Ensure the Health Wellbeing Board has oversight of Subgroup activity and its impact
Facilitate confident and resilient communities: Ensure the Health Wellbeing Board has oversight of Subgroup activity and its impact
Commission, broker and provide core services: Ensure the Health Wellbeing Board has oversight of Subgroup activity and its impact
Place – leadership and influencer: Ensure the Health Wellbeing Board has oversight of Subgroup activity and its impact
Drivers of change and reform: Ensure the Health Wellbeing Board has oversight of Subgroup activity and its impact
Facilitate sustainable economic prosperity: Not Applicable
Greater income for social investment: Not Applicable
Cleaner Greener: Not Applicable

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD.6626/21) and the Chief Legal and Democratic Officer (LD.4827/21.) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

Not applicable

Implementation Date for the Decision

Immediately following the Board meeting.

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Appendices:

The following appendices are attached to this report:

1. The 2021/22 Better Care Fund Plan.

Background Papers:

There are no background papers available for inspection.

1. Introduction

1.1 As agreed at the December 2019 meeting of the Health and Wellbeing board the Board has agreed to receive a standard agenda item of summarised activity of its formal sub groups.

1.2 The subgroups are identified as: the SEND Continuous Improvement Board, the Children & Young People Partnership Board, the Adults Forum, the Health and Wellbeing Board Executive and the Health Protection Forum

2. Updates

2.1 SEND Continuous Improvement Board

As the Board are aware the SEND Improvement Notice has now been lifted and the SEND Continuous Improvement Board has agreed to continue to meet, albeit moving to every other month. Due to the fact there is no longer an improvement notice in place it is proposed that updates move to bi annual, with the next update to the Board expected in January.

2.2 Children & Young People Partnership Board

Meetings of the CYPPB are now bi-monthly and the last meeting was held on 6th October. The next meeting is scheduled to take place in December 2021.

At the meeting the following items were discussed: Children and Young People Plan (CYPP) Themes, Early Help Annual Report, and Fostering Annual Report. In addition, there was a presentation around the theme of Employment Education and Training for Care Leavers with further reports on Education, Employment and Training deferred to the following meeting. At every meeting the Risk Register is reviewed.

The reports on the themes from the CYPP were received from Alder Hey, 0-19 Service, Merseyside Police, Public Health, Early Help and Sefton CVS. Each report provided an update on previous reports on what the organisations are doing to deliver against each of these themes.

Alder Hey's report noted for the theme on achieving that they have a key role in supporting children and young people to be ready for school and transition into adulthood. The main acute hospital site undertakes a range of activities to support children and young people accessing either outpatient or inpatient services. The report noted the work of the School @ Alder Hey, the NHS Cadets Programme, The Princes Trust Getting into NHS Programme and Supported Internships. For the theme on Happy the report provided details on the Arts Programme, DadaFest (which promotes deaf and disability arts), Creative Writing Programme< Young Makers Craft Residency, Read for Good, Play Service at Alder Hey and an annual programme called National Play in Hospital Week. In terms of Healthy, the report outlined the work around the Trust Board Lead for Health Inequalities, how they address health inequalities through system collaboration, the Partnership with the LFC Foundation around addressing health inequalities in Respiratory and Obesity, Youth Violence Workers, and The Princes Trust and Immunisation for children and young people. Alder Hey also provided a report on the theme of Heard which noted the range of opportunities for children and young people to be heard and contribute to services. This work involves the Youth Forum, Camhelions (young people who represent the CAMHS Service), and gave examples of work undertaken. In addition, it was noted that young people support recruitment to key posts. Work is also ongoing with the NSPCC, The Jockey Club (a programme to boost young people's confidence at Aintree Racecourse) and Health Champions who were responsible for co-designing Covid 19 and winter messages. Young people also got involved in other projects throughout the Trust.

MerseyCare provided a report covering the same key themes and was based around the actions they had undertaken and what progress had been made. For Heard this noted the work on a pilot to complete health assessments for children engaged with YOT to support a reduction in offending, develop a 16-19 pathway to ensure the health needs of this population group are not missed, this has been embedded into practice. Other work that has taken place is around the theme of Happy which includes introduction of virtual contact for Yr 11 children with the school nurse to discuss any concerns, aligning Strength and Difficulties Questionnaire (SDQ) with statutory assessments to ensure all children with emotional difficulties are supported and referred without delay. In terms of the theme around Healthy there has been training to evaluate SDQ pathway started and was delivered to 5-19 workforce, and work to support earlier intervention for none engagement with health for looked after children. The report also outlined the work taking place against the theme of achieving including reviews for children

who attend childcare settings, alternative opportunities for assessing the needs of school aged children whilst covid restrictions were in place and act on feedback from audits.

Merseyside Police provided information on referrals that take place every time a child comes into custody or attends for interview under caution, scrutiny of performance against a number of measures and Youth Engagement and Diversion. In addition, the report outlined Safer School Officers, Vulnerable Children and Violence against Women and Girls. Information was also provided on all children who face the traumatic experience of policy custody being assessed by a health professional and having an appropriate adult to support them during and after the custody event. The report concluded by providing information on the PAYES scheme which is a Youth Encouragement Scheme to install self-development and confident into young people and prevent them falling victim to socio-economic issues such as those who have a family history of crime related activity or domestic abuse as well as work they undertake with the Princes Trust.

The report from Public health outlined the work of the 0-19 Programme delivered by Merseycare, development of a Children's Living Well Sefton Concept, Dental Health, Breastfeeding and Emotional Health and Wellbeing. In addition, the report outlined the work of Active Sefton, work around obesity looking at a whole systems approach and planning work for future commissioning activity.

A lot of the report on Early Help and the CYPP themes was incorporated into the Early Help Annual Report but highlights included video stories, emotional health and wellbeing and reducing parental conflict. Work on the ACEs programme is being piloted in schools.

The Annual Report of Early Help was provided to the Board to outline the work that had taken place across the Early Help Partnership. The report reflected and showcased the work that takes place through the partnership, it was noted that this was during the pandemic 2020-21. This work is part of the Team around the Family and the Troubled Families Programme is now known as Supporting Families Programme. It was noted that 81% of early help cases are held by the Council. Other partners include Schools, community partners, SWACA, Parenting 2000 and Venus. Regular meetings are held around "stuck" cases in the South of the Borough and agreement reached as to which partner would be better suited to work with a family. This is yet to be rolled out in the North and Central areas. There is a step up (to Children's Social Care) and step down (from Children's Social Care) and it may be that safeguarding is taken into account when a decision is made. Case studies were included and providing information on what works well or what we can learn from what has not gone so well.

The Fostering Annual Report was provided to CYPPB and gave an overview of the work undertaken by the Fostering Service between April 2020 – March 2021, specifically foster carer recruitment, retention and service delivery. Information on the number of Fostering Households in Sefton was provided and Children Looked After Data. Placement sufficiency was also covered as well as Foster Carer Recruitment including enquiries, Covid response, information sessions and outreach.

Care leavers and employment, education and training was the theme of a presentation on the role of the Virtual Headteacher on why young people in care are a priority and the barriers they face in training, education and its importance to them and the new role of the Virtual School to promote outcomes for all children with a social worker. Employment opportunities were covered as was the involvement of Headteachers in developing a strategy and plan, the Virtual School has a Governing Body and headteachers recently received a request for them to be involved in social worker training. Training has also taken place with Foster Carers.

It was agreed that further information on Employment, Education and Training would be brought to the next Board.

The Board also receives notes from the following groups for information if they had met:
SEND CIB
Early Help
Emotional health and Wellbeing Group
Community Safety Partnership

2.3 The Adults Forum

Since the last report the Forum has met twice on the 29th September and the 10th November. In September the Forum refreshed its Terms of reference and widened its membership to reflect a stronger Health representation. The Forum reviewed an oversight of the Ageing Well programme form a NHS England perspective and the local emerging place priorities. It also received an overview and update of Sefton's Membership of the UK Network of Age Friendly Communities and Membership of the World Health Organisation network of Age Friendly Cities and Communities. In November the Forum received an overview and update of the Integrated Care System Development in Sefton and a current Day Opportunities consultation.

2.4 Health and Wellbeing Executive

The Executive has met once since the last report on the 14th October 2021. The Group received performance and financial performance reports and discussed the emerging governance of the Sefton place Based Partnership Arrangements. The group reviewed the Better Care Fund plan for 2021/22 and agreed inclusion of the Ageing Well funding, shared posts advocacy and agreed to further explore the inclusion of planned spend to increase the capacity of reablement. The final plan was submitted to the national Better Care team on the 16th November and appended is the final plan documentation that was submitted with approval of the Chair on behalf of the board.

2.5 Health Protection Forum

The Stakeholder Outbreak Management Board on Friday 12th November 2021 agreed that the wider partnership Outbreak Board can be incorporated into the Health Protection Forum. The first meeting of the revised Health Protection Form is planned for January 2022.

2.6 Other updates

Pharmacy updates

In 2021 the Health and Wellbeing has received 19 notifications from NHS England of changes to Pharmacy provision in Sefton. These are received and noted by the Chair ion behalf of the Board and any objection sin line with Sefton Pharmacy Needs Assessment are raised by correspondence. The following table summarise the notifications received:

Rowlands 35 Upper Aughton Road Birkdale	Consolidation of Rowlands Birkdale with closing 13 Union Street Southport Store
Higgins Pharmacy	Consolidation and change of ownership of the site at Higgins Pharmacy, 77 Crosby Road North, Waterloo, Liverpool, L22 4QD (continuing site) from Higgins Services Limited to Sharief Healthcare Limited and Sharief Healthcare Limited currently at Crosby Road Pharmacy, 59 Crosby Road North, Waterloo, Liverpool, L22 4QD (closing site).
Lloyds Pharmacies	Notification to change supplementary opening hours at six Lloyds branches across C&M
Fishlocks	Change of ownership
Care+ Medicines	Relocation from Unit 1 27A Banastre Rd PR8 5AW to 34 Shakespeare St PR8 5AF
Rowlands 35 Upper Aughton Road Birkdale	Consolidation of Rowlands Birkdale with closing 13 Union Street Southport Store
Higgins / Sharief	Consolidation Waterloo
Fishlock/AshaEve	Change of ownership
Rightdose Healthcare	Change of ownership
Rowlands 35 Upper Aughton Road Birkdale	Consolidation of Rowlands Southport
RB Healthcare Ltd	Change of ownership application for Smartts Chemist at 42 Fernhill Road, Bootle, L20 9HH
RB Healthcare Ltd	Change of ownership application for Ashaeve Ltd 159 College Road
R. B. Healthcare Ltd	Change of ownership application for Hirshmans Ainsdale
R. B. Healthcare Ltd	Change of ownership application for SK Chemist Bootle
R. B. Healthcare Ltd - COO - PR8 3HN - CAS-85484-S8D7N1	Change of ownership application for Station Road Ainsdale

Boots	Boots Consolidation Westway & Central Sq Maghull
Hirshman 2U	Ainsdale Closure
Care +	Relocation to Shakespeare St Southport
RB Healthcare	Change of ownership application approval from Gordon Short Chemist

Emotional Health and Wellbeing Tool Kit

The boards attention is drawn to publication of a refreshed Emotional Health and Wellbeing Tool Kit, primarily designed to support schools to meet the needs of their pupils. The Tool Kit can be accessed here: Sefton In Mind: Young People's Emotional Wellbeing Toolkit

3. Conclusion

The Board is asked to receive and note the contents of the report and to await further updates as part of the standard agenda going forward

BCF narrative plan template

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s)

Sefton

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

The plan has been developed by the CCG and Local Authority in line with delivery of the Health and Wellbeing Strategy and local NHS 5 year plan Sefton2gether. The Better Care Fund supports the delivery of key integrated strategies such as the Care Home Strategy and Intermediate Care Strategy, which have been developed with a wide range of stakeholders. In the current transition to a Place Based partnership arrangement under the Health and Care Bill, the plan has also been developed and discussed the Finance Forum and Programme Delivery Group of our local system Place Based Partnership Governance infrastructure. The full plan and metrics was presented to our Programme Delivery Group which is part of our Place Based Partnership Arrangements, this included representatives from Liverpool University Hospital Foundation Trust and Southport and Ormskirk Hospitals NHS Trust, and Alder Hey Children's Hospital NHS Trust. This formed part of a discussion on flow challenges and practical changes as a system e can make to affect the current picture.

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

In 2021 – 22 we continue to deliver our core BCF with new developments being brought on line. In 2020/21 there was a pause on requirements for Better Care Funding and planning this has offered the opportunity to reflect on the program in more detail. The current total budget equates to £48 Million and is well above the minimum requirement for pooled funding. There is a recognised ambition in Sefton to grow this fund and in national policy it is recognised as part of the infrastructure that will further the development of the Integrated Care System at a borough level.

We already have a well-established Integrated Commissioning work programme an outcome of much of this will be growth of the pooled budget. The following points reflect those work areas where the integrated commissioning workstream activity is likely to result in growth:

Drug and Alcohol

Advocacy

Carers

Community Equipment

Telecare

Intermediate Care

Joint funded LD Packages

CAMHS

Care Homes

Increase in Integrated posts

Winter Planning.

Sefton is currently working with the LGA to support the reprofiling of the Better Care Fund with a longer term plan to execute the identified profile of historical services that require the removal or recommissioning now they aren't strategically relevant to integration and to grow service areas that reflect the ambitions Sefton collectively holds through the emerging place plan/strategy for the borough.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The Better Care Fund is currently overseen from a performance and financial planning perspective by the Health and Wellbeing Executive. This is a sub group of the Health and Wellbeing Board that is constituted by a Section 75 agreement to allow members of the CCGs and Local Authority to make joint decisions on pooled funded enabled by their individual schemes of delegation. The Health and Wellbeing Board receive regular updates as part of a standard Agenda item at the start of each meeting. There is a task and finish group made up of key commissioners and finance colleagues from across Social Care and Health that drive the day to day workings of the fund led by a jointly appointed post of Integrated Social Care and Health Manager. During the planning and transition to ICS/ICP structures Sefton holds a Strategic Task and Finish Group giving overall oversight to developments, which then has a System Resource group underneath this. during this period Sefton have agreed the System Resource infrastructure will also be utilised to agree and shape the Better Care Fund Plan. In the future the Better Care Fund will be a significant corner stone to Integrated Health and Care in Sefton, and its governance will be brought into the proposed structure which includes a dedicated finance forum. The plan has also been shared with the programme delivery group which represents NHS providers.

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

In 2021- 22 Sefton has worked hard to prepare for the implementation of the Health and Care Act in April 2022. During this time 3 main priorities for Sefton following a review of the Health and Wellbeing Strategic priorities and those included in the local NHS 5 year Plan Sefton2gether alongside emerging understanding of the impact of COVID 19 on our already challenging Health and Wellbeing needs in Sefton to define the following:

Resilient Communities

Mental Health

Obesity.

Sefton has a well established Integrated Commissioning Group, this group acts as a formal sub group of the Health and Wellbeing Executive and has operated since the establishment of the BCF. This group meets on a monthly basis and drives an Integrated work programme addressing 4 overarching work programmes of Children's Integrated Commissioning, Early Help and Prevention, Vulnerable adults and Older Adults. As the emerging Place Startegy develops it is proposed we take forward work through a life course thematic approach of Start Well, Live Well, Good End of Life and Age Well. Sefton currently have four joint funded Commissioning posts, 3 Integrated Commissioners and a Integrated Social Care and Health Manager, these posts of been key to driving forward integration in Sefton and provide the blue print for further posts being developed within this financial year.

Our overarching approach to supporting people to remain independent at home wherever possible is clear. We want people who live in Sefton to live healthy and fulfilling lives for as long as possible.

If and when they need it, we want people to have access to a choice of good quality care and support that has a positive impact on their lives.

We want to offer Care and Support that empowers people to live an independent life, exercise choice and control, and be fully informed. We will ensure that services are targeted at protecting the most vulnerable and enabling everyone to be as independent as possible for as long as possible. Our offer will be focused on prevention, support, advice and build support plans based on an individuals assets and built around gaining the right outcomes for that individual from a range of minimally invasive offers. We will support individuals to live as independently as possible and work to prevent needs escalating to a point of reliance on more formal complex care delivery. We will focus our efforts on ensuring a diverse range of high quality care and support offers to meet the full spectrum of need. We will learn the lessons from responding to Covid 19 and continue to deliver quality effective service to people who live in Sefton that meets needs what ever the challenge may be.

The Better Care Fund supports integration through its focus on services that support discharge and help individuals to remain in their own home. It is also used to fund one of our integrated posts this will be built on to include all current and several proposed posts. The fund will also be used in 2021- 22 to grow the reablement offer in Sefton during the response to the pandemic and as a key area of winter planning it has become clear that Sefton is not benefiting from the value of ensuring reablement is used as a strategic tool to support outcomes and the utilisation of the care market. The Sefton Joint Intermediate Care Strategy 2019/22 outlines that provision of Intermediate Care is defined as a range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living. The Sefton Intermediate Care Group has been tasked with the delivery of the Sefton Intermediate Care Strategy and within this strategy it is highlighted that the expansion of Reablement is a key mechanism to deliver the strategy, principally with respect to supporting more people in their own homes to remain as independent for as long as possible. Reablement funding is in continued discussion and a greater investment in this is excepted in year as discussion continue.

This years plan includes the inclusion of 3 integrated posts and a BI and Programme Support resource this will support and help drive our programme of integration. It also includes the joint commissioning of a new advocacy contract that helps prepare the system for the introduction of new legislation around deprivation of liberty and mental capacity. When the winter planning funding picture becomes clearer it is also proposed this will be included.

Work continues within the wider integration agenda to explore the following key areas of funding that we expect to be included in the BCF in 2022/23; CHC funding, Care Home spend, Technology enabled Care spending, Voluntary Sector funding, Jointly funded LD and MH packages of Care

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

Agenda Item 4

How is BCF funded activity supporting safe, timely and effective discharge?

One of the major risk's factors facing the Council is the outstanding number of POC's. There is continued work with the acute and CCG on challenging risk averse practices (i.e. over prescribing POC and utilising other independence at home services funded by the BCF as an alternative, for example Community Equipment.

We continue to explore the expansion of reablement in line with the evidence based provided by Professor John Bolton (MBE) work in the North of the borough to ensure that the national target for pathway 1 discharges as outlined in the hospital Operating Model (2021) of 75% is achieved. This will be flow through the Better Care fund.

We provide a Rapid Response Service provided by New Directions and expansion across the borough, to provide a two-hour response to avoid hospital admission and ED turnaround.

In 2021/22 we have funded an expanded ICB unit and seeking to develop a further reablement unit this is funded the BCF.

While we are taking steps to alleviate the pressures immediately in the Dom Care markets such as block booking additional 400 hrs Dom Care Capacity for 6-month period. We are also adopting a strategic approach to the long-term management of this market with a newly established strategic partnership and implementation of the ADASS 'Fair Cost of Care'.

Workforce challenges in both Dom Care and Care Homes is currently impact in Sefton and we are mitigating this through weekly meetings with providers, supporting them to consider higher acuity. Market management activity is supported through the joint funded posts contained in the BCF The national discharge service operating model for all NHS trusts has now been operational in Sefton since March 2020 with the intention to support more people to be discharged to their own homes and Sefton's integrated intermediate care model reflects the elements of the policy within our 4 delivery models which are Crisis response, reablement, homefirst and bed based intermediate care.

The services which deliver integrated discharge planning and community based rehabilitation services are funded via the BCF. This involves attendance at daily bed boards and review every person and make decisions, informed by the no criteria to reside. Daily ready for discharge reviews take place a discharge to recover model in place. The recovery and support provided post-discharge is provided by health and social care to include rehabilitation and reablement either in the patient's own home or for a limited time within a community bed setting.

Very few decisions are made in the acute hospital trust to place people with more complex needs in Long term placements. Individuals requiring social care needs assessments or NHS continuining health care needs are offered a period of recovery and these assessments take place within a community setting. Sefton would like to build on this in the future and deliver a full discharge to assess model, as we feel that we could achieve even greater gains in reducing variation and performance with length of stay for people in hospital.

As part of our intermediate care offer we have a crisis response element and the CCG have commissioned this from Sefton community provider for hospital avoidance and carer breakdown via the single point of access. Referrals are received via primary care, NHS 111, secondary care and other health professionals, this is funded via the BCF and as integrated health and social care commissioning function further develops we will be extending and expanding this offer to include other referral routes such as NHS 999, care homes, pharmacies etc. The Better Care Fund this year also includes a joint approach to commissioning intermediate care beds as the beginning of the delivery of our wider Integrated Intermediate Care Strategy.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Sefton has an clear Independence at Home Service offers as part of its Integrated Commissioning Work programme this includes ambitions to being together and develop service offers from Community Equipment Services, Telecare and the Home Improvement Service. Sefton has recently published an integrated Digital and Technology Enable Care Startegy and is working to improve these sets of services under the Adaptations without Delay framework form the Royal College of Occupations Therapists.

Improvements to DFG delivery include:

Increasing capacity in the Home Improvement Team and OT team to enable an increased volume of applications for DFGs and ensure the full budget is utilised.

A project is underway to consider the removal of some means testing to increase the effectiveness and efficient of the wider programme

Improved contract tendering process and more aligned working between the service and finance are also a key focuses to improve effective working and see a greater number of people befit from the DFG offer.

Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

The Better Care Fund supports the commissioning and delivery of services that maximise choice and control for the people of Sefton. This flexibility allows for Care to be delivered to people in a way that suits their lives not the way we think it should be. The population health management approach that we are currently develops allows us to have a far greater understanding of need and barriers to accessing health care as we continue to work with the Marmot agenda. The emerging place Strategy for Sefton will contain drivers for improve health inequalities in our borough and the implementation of the Health and Care Bill is a significant opportunity. COVID has highlighted the need to support all older people to have greater control over where they receive Care and Support, since the pandemic we have seen a reduction in Care Home placements and an increase in domiciliary Care Packages, this has helped shape our wider approach to increase focus and drive to ensure there a range of options to support independence at home, including Technology Enabled Care, use of DFGs and major and minor adaptations and Community Equipment. The Better Care Fund allows us strategically to commission across boundaries based on outcomes ensuring a move away from rigid block contracts that can unintendedly not accommodate the Equality and Diversity of the people who need them. The inclusion of services such as advocacy, carers and discharge planning will support the aim of ensuring that people are supported to voice their views and exercise choice and control in what services they receive and they are supported to make informed decisions. The BCF contains different types of services which reflect elements such as the various discharge pathway options / routes. COVID has informed the BCF plan as it has highlighted the need to ensure that the plan reflects the need to have in place various service / pathway options. The BCF includes schemes which will be delivered with underpinning wider requirements, such as the Care Act, in terms of delivering services in a fair and equitable manner an also delivering personalised care at home. The schemes also reflect the aim of reducing inequalities such as those relating to access to services for people in care homes, which has been highlighted during the pandemic

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Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Sefton

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	2,875.0	3,417.0	After a drop in Apr-20 due to the pandemic levels have stabilised to a lower average than pre-pandemic levels. Forecast position based on M1-6 suggests year end levels of 3417 ACSC admissions. System work remains in place focusing on a number of areas linked to ACSC to support reduced levels of

Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	12.7%	12.3%	Steady reduction in 14+ LoS from and average of 12.9% towards the England average of 11% but with acknowledgement performance consistently above this and will take longer to reach England levels beyond Q3/Q4 2021/22. The reduction equates to approx. 25-45 patients per month having a reduced length of stay. Again Sefton is higher than both North West and National levels with demographic factors an influence with older patients accounting for longer lengths of stay. Both plans
	Proportion of inpatients resident for 21 days or more	7.0%	6.8%	

Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.3 Discharge to normal place of residence

	21-22 Plan	Comments
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.4%	Latest levels at 91.6% and average between Apr19-Aug21 91.7%. Plan to improve and move in line with England average of 92.4%. (approx. increase of 20-35 additional discharges to usual place of residence per month)Current forecast indicates Sefton will average 90.9% for 21/22 and has dropped each year since 19/20 (Current actuals

Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	756	860	553	594	The Covid-19 pandemic had a significant impact on overall care home admissions over 20/21 and continues to do so in 21/22. Having seen unusually low admissions for 20/21 and a 'recovery' in some aspects of admissions since we do not consider it realistic to expect a continued fall in admissions between 20/21 and 21/22. As a result
	Numerator	490	560	362	398	
	Denominator	64,779	65,126	65,463	66,974	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	90.3%	80.3%	90.2%	Despite an increase in the denominator between 19/20 and 20/21 we saw an increase in the proportion of clients supported to remain at home. We would expect this improvement to continue and have set a 5% improvement target for this year.
	Numerator	213	192	230	
	Denominator	236	239	255	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Agenda Item 5

Report to:	Health and Wellbeing Board	Date of Meeting:	Wednesday 8 December 2021
Subject:	Health and Wellbeing Board Development		
Report of:	Executive Director of Adult Social Care and Health	Wards Affected:	(All Wards);
Portfolio:	Health and Wellbeing		
Is this a Key Decision:	N	Included in Forward Plan:	No
Exempt / Confidential Report:	N		

Summary:

The report follows the report of the 14th October which summarised key developments around the Health and Wellbeing Board as we move towards the establishment of a Sefton Integrated Care Partnership and included reflections of its development session on the 2nd August. This report presents the outcomes of the second session held on the 1st November 2021 and proposes the next steps.

Recommendation(s):

(1) The Board notes the contents of the report

(2) The board endorses the identified next steps

Reasons for the Recommendation(s):

The criticality of the Board to affecting the delivery of a Sefton Place Based Partnership and affecting the Health and Wellbeing of people who live in Sefton must be recognised and acted upon by all partners.

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

Remaining as is would limit the impact and ability of the board to play a full role in the implementation of the Health and Care Bill in Sefton

What will it cost and how will it be financed?

(A) Revenue Costs

None identified by the contents of the report

(B) Capital Costs

None identified by the contents of the report

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets):
Legal Implications:
Equality Implications: There are no equality implications.
Climate Emergency Implications: The recommendations within this report will

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

Although the contents of the report have no direct impact on Climate Change the future operation would hope to have a positive impact.

Contribution to the Council's Core Purpose:

Protect the most vulnerable: Proposals allow a Sefton Health and Care system focus on health inequalities and wider determinants of health
Facilitate confident and resilient communities: Proposals allow greater localised control and focus on the needs of the borough of Sefton in the design, delivery and review of Health and Care Services
Commission, broker and provide core services: Proposals will allow a greater focus on wider determinants of Health Outcomes
Place – leadership and influencer: leadership and influencer: proposals set out the road map for greater local control driven by the Health and Wellbeing Board
Drivers of change and reform: Proposals allow a Sefton Health and Care system focus on health inequalities and wider determinants of health
Facilitate sustainable economic prosperity: Proposals allow for a broader financial focus on the borough of Sefton for Health and Care services

Greater income for social investment: Proposals allow for a broader financial focus on the borough of Sefton for Health and Care services
Cleaner Greener: Proposals will allow a greater focus on wider determinants of Health

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD.6633/21) and the Chief Legal and Democratic Officer (LD 4834/21.)have been consulted and any comments have been incorporated into the report.

(B) External Consultations

Not applicable.

Implementation Date for the Decision

Immediately following the Board meeting.

Contact Officer:	Eleanor Moulton
Telephone Number:	07779162882
Email Address:	eleanor.moulton@sefton.gov.uk

Appendices:

There are no appendices to this report

Background Papers:

There are no background papers available for inspection.

1. Introduction

1.1 In Octobers meeting a report was received detailing the importance of the Board in the emerging Health and Social Care landscape and detailing the themes that emerged from the development session in August. These can be summarised as;

- Collaboration between local government and other system players
- Decisions taken as close to the community as possible
- Building on local strategies and evidence to agree and work to shared
- activity and action plans
- Strong co-production and commitment to engage with local people
- Focus on preventative population health
- Striving for best value
- Trust, openness to innovation, learning and challenge

- An ability to deliver measurable change
- Membership that flexes as the Board's role evolves

1.2 The board agreed the following key themes as pivotal as;

- The disparity of life expectancy and inequalities in the borough, and the desire to reduce this will drive the boards focus
- A focus on prevention particularly in Mental health was identified.
- The success in the COVID response must be built on.
- A simple set of focused areas of priorities are need to support full engagement of all
- The Health and Wellbeing Board has a strategic Oversight role and careful consideration is need as where it sits in the Cheshire & Merseyside Structure.
- Transparent, Ethical and Respectful discussion even when conversations are difficult must remain focus on achieving a positive and meaningful change for the people of Sefton

2. Further development session

2.1 The Board agreed to hold a further development Session on the 1st of November to explore further the compete of 'Be More Sefton' and how this is taken forward as part of the development of Place Based arrangements in Sefton

2.2 At the event on the 1st of November the following critical points were identified:

- The group were keen to explore the prominence and meaningfulness of the boards unique position in the system through a tighter process and cohesive work programme. The group want to see the board fulfil its potential as a promoter, overseer and enable of changes to improve health and wellbeing for all building on its role within Sefton as part of a Marmot region.

- There is a need for the board focus on and increase its understanding of the financial regime it operates in.

- The board must be driven by a population health framework that focus on system outcomes not individual organisations performance. This should build on the CIPHA work locally.

- The board has a pivotal role in supporting a furthering the workforce challenge that the Health and Social Care system in Sefton faces.

- There is a need for a review of structures and process to ensure its streamlined and able to deliver in the 'place' landscape. To do this it must be adequately resourced.

- There is a need for a membership review to ensure wider determinants are adequately represent and able to influence.

- There is a clear role for the board in furthering the digital agenda and delivery of care closer to home.

- A communication and engagement strategy is needed that helps raise the profile of the Health and Wellbeing Board in Sefton and its priorities.

3. Next steps

A further event is planned for February 2022 which will allow the board to develop a clear implementation plan
The key points raised in the first two sessions must be embedded and enacted through the Place Based Partnership arrangements. Including its governance and collaboration agreement or Memorandum of Understanding at a Sefton level.

Review of membership and Terms of Reference for the Board.

Exploration of ensuring adequate resource and capacity are available to support the board, its sub groups, and ensure stakeholder and wider involvement in determining priorities and evidencing impact.

A clear forward plan and programme of work must be developed and delivered along side a ‘place’ plan for Sefton.

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Sefton Health Communications, Engagement and Information Group

Quarterly update to HWBB

Introduction

Sefton Health Communications, Engagement and Information Group was established in response to the COVID-19 pandemic. It intended to formalise a Sefton-wide network for the co-creation and cascade of health and care communications, whilst addressing inequalities in health communication

Prior to the pandemic, Sefton Health and Wellbeing Board members mandated the establishment of a communications group to support joint work and longer-term, support the Sefton Health and Wellbeing (HWB) Board to deliver joint priorities from the HWB strategy and Sefton2gether plan.

The group's terms of reference were updated and agreed at the Sefton Partnership Task and Finish Group in June and its roles now include supporting the development and delivery of a communications and engagement strategy for the partnership.

The group is co-chaired between Public Health at Sefton Council and communications and engagement at NHS South Sefton and NHS Southport and Formby CCGs. Members comprise communications and engagement representatives from local NHS services and the council, members of the council's Public Health team and representatives from Sefton CVS and Healthwatch Sefton.

The group meets fortnightly and will provide Sefton Health and Wellbeing Board with quarterly updates on its activities for the preceding quarter.

Updates

Pandemic response

- The group supported the communications and engagement for Sefton's outbreak management plan and health protection response, cascading information across partner networks.
- The group supported the vaccine delivery programme in Sefton by gathering and sharing data and insights on vaccine hesitancy and rates of infection, to shape the communications and engagement outputs and target messages to those in need.
- The group has produced regular information packs and toolkits for cascade across a broad network of community gatekeepers including VCF partners

Place partnership communications and engagement

- Group members from across health, care and VCF sectors in Sefton took part in environment scanning workshops to map and prioritise stakeholders and conduct a

PESTLE analysis to help inform the Sefton partnership communications and engagement strategy.

- Members have audited communications and engagement channels and structures to support a system approach and help commissioners and operational staff with their engagement.
- Utilising the combined footprint of group partners, updates about ongoing work to establish the Sefton partnership have been cascaded to potentially around 37,300 people working in organisations that provide support to residents of the borough.
- A task and finish group to support how the partnership engages with people and communities has been established between the CCG, Sefton Council and Healthwatch Sefton.

Health related communications and engagement

- The group has supported partners in developing and communicating health information for cascade across partner stakeholders to maximise reach and provide targeted in-reach into marginalised groups, on topics including:
    - Stay well in winter
    - Flu
    - Self care
    - Stroke services
    - Adult social care referrals
    - Mental health (via Sefton in Mind)
    - Safeguarding

- A task and finish group has been established to lead on developing and delivering a winter communications strategy to support the health and wellbeing of residents.

Further information

Updated terms of reference for the group and the Sefton place communications and engagement organisational chart outlining how the group links to wider communications and engagement cells are included in the appendices.

Appendices

Appendix 1: Sefton Health Communications, Engagement and Information Group Terms of Reference

Sefton Health Communications En

Appendix 2: Sefton Place Communications & Engagement Organisational Chart

C&E Org CHart V2.docx

Report to:	Health and Wellbeing Board	Date of Meeting:	Wednesday 8 December 2021
Subject:	Obesity and Healthy Weight in Sefton Progress Update; Challenges, Barriers and Action Plan		
Report of:	Director of Public Health	Wards Affected:	(All Wards);
Portfolio:	Health and Wellbeing		
Is this a Key Decision:	N	Included in Forward Plan:	No
Exempt / Confidential Report:	N		

Summary:

This report provides an up to date summary of the work currently underway in Sefton, exploring the current local context in relation to overweight and obesity and identifies opportunities to help local people maintain a healthy weight through a whole system approach.

The report outlines our progress to date, priority areas and current work programme, including opportunities and challenges for the short, medium and long term.

It is important to recognise that a long-term approach needs to be adopted to tackle this serious and significant issue and as the National Food Plan 2021 highlights, the complexities of obesity are far ranging. Today's dietary patterns have formed over a period of at least 70 years, and we will need long-term political commitments to reverse them. Sefton however, is committed to working together to halt the rise in obesity and overweight and a multi-agency task force has been created to adopt a whole system approach to tackling this growing trend. Priorities for this work are outlined within this report.

Recommendation(s):

(1) The HWBB recognises that whole system approaches also requires a long-term commitment, with actions across the short, medium and long-term. The HWBB endorses the requirement for agencies to work together, identifying specific areas where they can take tangible actions to halt the continuing rise in obesity

(2) The HWBB recognises that we must create a culture and opportunity to build knowledge and awareness across the partnerships from senior leadership through to practical delivery of healthy weight ensuring that organisations understand the impact the broader wider determinants have on obesity

(3) The HWBB will use the obesity action plan to monitor progress in tackling obesity and hold all Sefton partners, who have 'signed up' to lead change, to account for taking agreed action within the time frames proposed

Reasons for the Recommendation(s):

It is challenging times for all partners however, if we are serious about change we will need to drive a new way of working across the borough that requires commitment, energy, drive and importantly local political and senior level buy-in across a variety of stakeholders and organisations. Complex issues, like obesity, require sustained and systemic action and buy-in from systems leaders. This is essential to support implementation and enable local authorities to work differently and test new approaches.

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

What will it cost and how will it be financed?

(A) Revenue Costs
Time limited funding has been aligned to the initial development of the Children's Living Well Sefton (CLWS) programme with an expectation that sustainability of the CLWS will be supported by the wider partners from existing budgets.

(B) Capital Costs

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets):
None

Legal Implications:
None

Equality Implications:
There are no equality implications.

Climate Emergency Implications:

The proposal will have a positive impact on climate emergency, however the proposal will focus improving the health and wellbeing of children and their families, which will have overlaps to the environmental agenda; e.g. active travel, healthy planning, increased use of green spaces.

The recommendations within this report will

Have a positive impact	Y
Have a neutral impact	N
Have a negative impact	N
The Author has undertaken the Climate Emergency training for	N

report authors	(We have liaised with Project Officer for Climate) Change

Contribution to the Council's Core Purpose:

Protect the most vulnerable: Yes
Facilitate confident and resilient communities: Yes
Commission, broker and provide core services: Yes
Place – leadership and influencer: Yes
Drivers of change and reform: Yes
Facilitate sustainable economic prosperity: No
Greater income for social investment: No
Cleaner Greener Yes – longer term

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director Corporate Resources and Customer Services has been consulted and has no comments on the report (FD 6625/21)
The Chief Legal and Democrat Officer has been consulted and comments have been incorporated into the report (LD 4826/21)

(B) External Consultations

Extensive consultation has taken place across team meetings, forums and specific multi agency focus groups of up to 200 stakeholders. Additional external local research has been commissioned to corroborate initial findings.

Implementation Date for the Decision

Immediately following the Board meeting.

Contact Officer:	Anna Nygaard
Telephone Number:	
Email Address:	Anna.Nygaard@Sefton.gov.uk

Appendices:

The following appendices are attached to this report:

A. Pillars of Population Health

B. Summary of Recent Initiatives

Background Papers:

There are no background papers available for inspection.

1. Introduction/Background

1.1 Obesity is one of the most serious health challenges of the 21st century. The causes of obesity exist where we live, work and socialise, where the environment often makes it difficult to make healthier lifestyle choices. This is applicable to Sefton and gives us the opportunity to work with communities and partners to help tackle and prevent the causes of obesity, complementing work at a national level. We know there is no one single solution. This is not about assuming individuals simply need to be more physically active, we can only tackle obesity if it becomes everybody's business and is prioritised and embedded in everything we do. In doing so we are addressing changes in the way that we live our lives that have evolved over decades. There are no quick wins, and the evidence suggests that goals for changes in this area need to be considered in the longer term but are achievable.

1.2 Maintaining a healthy weight has many health benefits, including improved quality of life and a reduced risk of health conditions including heart disease, stroke and some cancers. Yet, the majority of adults are above a healthy weight – it has become the social norm and there is no evidence to suggest the situation is improving. Of significant concern is that nationally 1 in 5 children start school above a healthy weight; the proportion rising to 1 in 3 of primary school leavers. We are seeing similar trends locally in Sefton via our National Child Measurement Programme. There are marked and growing inequalities, with the national prevalence of obesity in children in the most deprived parts of the country more than twice that in the least deprived. This has implications not just for health but for employers and social care needs: each year, obesity and its related ill health costs the UK NHS £6.1bn; it also costs local government in England £0.35bn in social care costs and the wider UK economy £27bn

1.3 It is important to consider the context in the way in which providers and commissioners across the health economy work together and how that is changing. As of April 2022, Cheshire and Merseyside will have an operational Integrated Care System (ICS). ICSs are partnerships that bring together providers and commissioners of NHS services across a geographical area with local

authorities and other local partners to collectively plan health and care services to meet the needs of their population. The central aim of the ICS is to integrate care across different organisations and settings, joining up hospital and community-based services, physical and mental health, and health and social care. Each of the nine areas comprising Cheshire and Merseyside will form Integrated Care Partnerships (ICPs) as part of this transition.

1.4 The Sefton ICP has decided to begin to focus on three issues where data is available before the pandemic and assumptions can be made that issues will have been exacerbated as a result of the pandemic. These are mental health, community resilience and obesity. These three priority areas have considerable overlap and linkages, with the pattern of disease and wellbeing matching existing health inequalities seen across Sefton. Because of this, none of the priorities will be viewed in silo, but rather grouped by the stages across the life course. This will build upon the whole systems approach already being implemented examining obesity, with considerations of the linkages between mental wellbeing and weight management as well as how resilience in communities can help maintain sustainable changes.

2. What do we mean when we talk about overweight and obesity?

Overweight and obesity are terms which refer to an excess accumulation of body fat, to the extent that health may be impaired. Overweight and obesity in adults is most commonly measured using BMI, which is defined as the body mass in kilograms divided by the height in meters squared (World Health Organization (WHO 2004). The calculation produces a figure that can be compared to various thresholds that define the weight status of an individual (see Table 1).

Table 1
WHO (2004) classification of 'healthy' and 'unhealthy' weight in adults
Source: WHO (2004)

Classification	BMI (KGs m2)
Underweight	<18.5
Healthy Weight	18.5 - 24.99
Overweight	25.0 - 29.99
Obese 1	30.0 - 34.99
Obese 2	35.0 - 35.99
Obese 3 (Morbidly Obese)	40.0 or more

3. What is the picture of overweight and obesity locally?

The local picture for Sefton indicates that a significant number of the population is overweight or obese and suggests therefore, that focusing on individual choices alone will not reduce levels of obesity – we need the whole system working together to make a

difference. The data and its relationship to current programmes and interventions is highlighted below.

3.1 National Child Measurement Programme – NCMP

3.1.1 Background

The National Child Measurement Programme (NCMP) is a national mandated Public Health programme which measures the height and weight of children in Reception class (aged 4 to 5) and year 6 (aged 10 to 11), to assess overweight and obesity levels in children within primary schools. The data is used nationally to support public health initiatives, and locally to inform the planning and delivery of services for children.

The programme was set up in line with the government's strategy to tackle obesity, and to:

- inform local planning and delivery of services for children
- gather population-level data to allow analysis of trends in growth patterns and obesity
- increase public and professional understanding of weight issues in children and
- be a vehicle for engaging with children and families about healthy lifestyles and weight issues.

Heights and weights are measured and used to calculate a Body Mass Index (BMI) centile. The measurement process is overseen by trained healthcare professionals in schools.

3.1.2 NCMP Data 2020/2021

NCMP was halted during 2020 due to COVID-19 and data for reception aged children is incomplete. The programme was due to recommence in January 2021 however, this was hindered because of further lockdown measures. Trend highlights that overweight and obesity levels in reception remain steady, however by the time children reach YR6, almost 37% are overweight or obese and boys fair worse than girls at the same age. It is anticipated that there will be further negative impact on overweight and obesity levels due to the pandemic. There continues to be a strong correlation between socio economic disadvantage and obesity and with inequalities widening as a result of COVID-19, we expect that poor nutrition and lack of opportunities to be physically active, will impact on people living in poverty the most.

3.1.3 Excess Weight Prevalence by Ward (2017/18 to 2019/20)

Excess weight (rate of overweight and obese children) in both Reception and Year 6 pupils tends to follow a social gradient, with higher prevalence in Sefton’s most deprived wards and lower prevalence in the more affluent wards.

Reception (Age 4 to 5 years)

Excess Weight in Reception pupils is highest in Netherton & Orrell Ward (31.4%), followed by Derby Ward (30.6%)

Netherton and Orrell's rate is statistically significantly higher than the Sefton average (25.7%)

Bludellsands has the lowest excess weight prevalence (20%)

No wards have an excess weight prevalence that is statistically significantly lower than the Sefton average

Year 6 (Age 10 to 11 years)

Year 6 excess weight is highest in Derby Ward (44.3%), the only ward with a rate significantly higher than the Sefton average (36.7%)

Harington Ward (27.4%) has the lowest Y6 excess weight prevalence.

Harington, along with Meols (27.9%) Blundellsands (28.6%), and Park (30.6%) has a Y6 excess weight prevalence that is significantly lower than the Sefton average

Heathy Weight Interventions

Locally, NCMP data has been used to influence the design of a children's healthy weight programme, which has been implemented and further developed over the last few years. By identifying hot spot areas and schools with highest rates, resource has been appropriately targeted. All schools have access to a univesal 0-19/Active Sefton offer which includes prevention and early intervention programmes, focusing on nutrition and physical acitivity. During COVID-19, core programmes – Active Schools and MOVE IT continued to be delivered online and support for schools has been made available. As schools return, 0-19 and Active Sefton are working with settings to provide phased and flexible ongoing interventions.

1. **Food Banks**

The relationship between poverty and overweight and obesity is evident in Sefton and the impact of COVID-19 has further impacted in this inequality. Increasing numbers of families in Sefton, are struggling to access to nutritious food, relying on food banks and free school meals to get by. The Trussell Trust, who co-ordinate Foodbanks across Sefton have provided the following summary of support that has been provided to families experiencing food poverty over the last year.

1st April 2020 – 1st Feb 2021	South Sefton	Southport
Total Vouchers received	5262	1604
Adults Fed	6639	2189
Children Fed	4463	1640
Total Fed	11,102	3829
Crisis Type	Low income – 3362 vouchers presented 7234 people fed	Low income – 875 vouchers presented 2215

		people fed
Family Type	Single 2842 vouchers presented 54.01%	Single 767 vouchers presented 47.82%
Age group	25-64: 5776	25 – 64: 1836

Referral pathways are far reaching and include, children services, schools, dentists. The Emergency Limited Assistance Scheme (ELAS) accounts for nearly 60% of referrals to South Sefton and 45% of referrals in Southport. (ELAS subsidises the Foodbanks financially to support these referrals)

Research has shown that if the focus is on simply educating individuals about healthy eating, this can widen the previously described gap in obesity rates between the most and least deprived people who live locally. However, at a local level, there is the opportunity to go beyond educating people about healthy eating to tackling key local environmental drivers of obesity and supporting people who are already overweight. A whole systems approach to obesity provides local authorities with the process to do this.

2. What we are aiming to achieve?

We want Sefton to be a place where residents are supported to make changes to enable them to get to or maintain a healthy weight, as well as prevent our younger generations from becoming overweight in line with the national trend. We want to work with the whole community around improving health and keeping healthy and well. We will do this by working across the whole system of agencies and partners, taking action across the stages of life from childhood into adulthood and will have a focus on individuals, whole families and communities. Public Health England have developed a guide on how to utilise this approach which has been adapted for Sefton. The whole systems approach is best suited to achieve meaningful change across the plethora of variables impacting on our residents every day of their lives, such as access to healthy food choices and opportunities to engage in physical activity.

3. What is a Whole Systems Approach?

There are many ways to interpret a whole systems approach to working. The definition developed by Public Health England is aligned with our vision for Sefton which is:

> *"A local whole systems approach responds to complexity through an ongoing, dynamic and flexible way of working. It enables local stakeholders, including communities, to come together, share an understanding of the reality of the challenge, consider how the local system is operating and where there are the greatest opportunities for change. Stakeholders agree actions and decide as a network how to work together in an integrated way to bring about sustainable, long-term systems change".*

This approach draws on the strengths of organisations, businesses, communities and local assets to achieve better, more focused collective and sustained results. Having the visible and active support of elected members, the chief executive and senior leaders,

sends a clear signal that tackling obesity is a priority for the whole local authority, not just public health and its wider partners.

Local authorities are in a uniquely influential position to lead their communities and local partners to tackle obesity, including working with local NHS organisations and integrated care systems. At national level, there has been increased government commitment since 2016, to preventing and tackling obesity through the Childhood Obesity Plan[1]. At a local level, there is opportunity to build on this momentum, to tackle key local environmental drivers of obesity, and support people living with obesity, aligning with actions at a national level.

An increasing number of local areas across the UK are testing and embedding new ways of working and there is a growing recognition that a whole systems approach is more likely to be effective in tackling the root causes of obesity, rather than focusing on a small number of public health interventions. [2],[3]

There is also evidence emerging from municipality and community work in the Netherlands[4] and Australia[5] which supports the benefits of whole systems working which may also support a more sustainable approach to tackling obesity, rather than reliance on the more traditional interventionist approaches.

This frames our approach as being a truly collaborative one; one which is not "owned" by public health in the local authority, but rather is a collective effort across the whole system serving the local population in Sefton to see real impacts on their health. We also want to reach out and engage with all our local communities so that they feel part of what is happening, we will do this by integrating prevention initiatives with activity taken by primary care and other community partners and via the development of community engagement processes.

With the correct plan in place, the issues surrounding obesity in Sefton are all preventable. Through our collective efforts, Sefton will become a healthier place to live, where the healthiest choice is the easiest choice.

4. Reflecting on work already done and where we need to go within Sefton

When we reflect on the good work which has already been carried out across Sefton, it is clear that the foundation for a whole systems approach to obesity has already been set and there are some obvious examples of progress such as Active Sefton's decision to remove high fat items from vending machines in Council leisure centres as well as Sefton signing up to the healthy weight declarations developed by Food Active. Sefton is committed to the principles of the Healthy Weight Declaration and is already implementing actions defined within its action plan whilst developing a comprehensive short, medium and long-term approach to delivering on the broader issues.

Several interventions and services are already in place in Sefton and have delivered some results to varying degrees. These initiatives range from the development of this

[1] HM Government. Childhood Obesity, A Plan for Action, Chapter 2 2018
[2] Government Office for Science 2007 Butland B et al Project Report 2nd ed London
[3] Lancet 2017 Rutter et al Need for a complex systems model of evidence for public health 390;2602-4
[4] BMJ 2018 361;k2534 Sheldon T Whole city working against childhood obesity
[5] Allendar S et al Whole of Systems trial of prevention of obesity: WHO stops childhood obesity.

Healthy Weight Declaration and implementation of guidance for food takeaways, to mapping of pathways and delivery of obesity training. A summary is contained under (Appendix B Table 1) in this report and highlights the work to date that is already in place to tackle the issue, such as investment in the Active Schools programme offering targeted support for schools tackling obesity, as well as the implementation of supplementary planning guidance for hot food takeaways. We recognise that much of the work that has been carried out to date has been delivered at a local level, however, it is also recognised that there is a need to improve the strategic co-ordination of our healthy weight approach across a wide range of partners.

Recent Developments 2021

A Strategic Obesity and Healthy Weight Group was developed in Spring 2021 to take forward the coordination of this work and to oversee the development of the programme for Sefton. The group is a multi-agency group with a focus on the social wider determinants of health and considers all stages of the life course[6] with particular attention to those most vulnerable.

The wide range of at-risk population groups will therefore form the priority for the targeting of healthy weight interventions in Sefton, either through specific services working with the priority groups or the targeting of service delivery to those population groups more at risk, that they serve. To do this effectively, a number of cross-cutting themes will be identified, including the built environment and planning, housing, health services, communities including the voluntary and faith sector, education, mental health, commercial, training, including behaviour change and Making Every Contact Count (MECC), communication and evaluation.
The group draws insight from the intentions of the Health and Wellbeing Strategy 2019, which sets out a vision for 'improving the health and wellbeing of residents and reducing inequalities at every stage of people's lives by 2025'. The focus will support these forward-thinking local policies by addressing one of the key health challenges the residents of Sefton face. These policies support the drive to tackle excess weight amongst residents in our borough. The group will take a whole systems approach, focusing on prevention. This approach is particularly important as there are shared values and aspirations across the partnership to work together for the benefit of the residents.

Additional research has also been commissioned which will provide qualitative insight through a place-based approach which will help us understand how the impact of the COVID-19 pandemic has had a particularly detrimental affect on widening then inequalities gap in relation to healthy food and behavioural patterns. This will provide

[6] The life course age groups identified either relate to critical periods of metabolic change, are linked to spontaneous changes in behaviour, or periods of significant shifts in attitudes. This strategy will incorporate key priorities identified for each age group and are divided in to the life course groups of Start Well, Live Well and Age Well

critical insight into limitation of choice for people living in our most deprived communities and support our research at a local level with the wider childhood poverty agenda. Delivery and expected outcomes of this research are included in the action plan aligned to this report.

5. Our Sefton Vision, Aims and Objectives

The vision in the Health and Wellbeing Strategy 'Living Well in Sefton 2019-2025' makes clear, our focus is on the places where we live, to make it easy to be healthy and happy with opportunities for better health and wellbeing on our doorstop. This gives us a clear context to ensure the vision for healthy weight endorses our direction of travel.

The priorities for our obesity programme are;

- mitigating the impact of an obesogenic environment to support adults and children in Sefton to achieve a healthy weight.
- addressing the health inequalities gap for children living in households with the lowest incomes. Focusing on poverty will be central to our approach to improving outcomes by 2026 and will include halting the trend in increasing children's obesity.
- applying a targeted approach across the whole life course, gender, geography environment and culture and delivered across the whole system to ensure collective responsibility from all partners.

The aims of the programme are;

- halt the rising trend of obesity in Sefton through a multi-agency approach to encourage and enable all those living and working in Sefton to live a healthy and active lifestyle within a healthy environment, supported by appropriate services where necessary.
- prioritise poverty whilst maintaining a universal offer.
- embed a whole system approach and a collective responsibility across the partnerships.
- respond to the impact of the pandemic in the context of opportunities for change, challenges and barriers to making healthy lifestyle behaviours. This will consider the impact the pandemic has had on; diet/snacking/sleep/exercise/alcohol consumption- frequency and amount
- Increasing the proportion of residents who are a healthy weight
- Creating a culture and environment that creates opportunity access to make positive and healthy life changes easier

Current best practice suggests there are several issues that could be explored via this approach that could lead to local action and include:

- adoption of the Local Government Declaration on Healthy Weight. This has been successfully employed in fifteen North West Councils and is designed to support Councils to exercise their responsibility in developing, implementing and enforcing policies which promote healthy weight
- maximising opportunities with health and care providers to address overweight and obesity
- addressing the availability of assets in communities to support healthy weight for example; access to affordable fruit and vegetables, concentration of ‘unhealthy’ food and approaches to food and fuel poverty locally
- the role of physical regeneration in promoting safe spaces for cycling and walking
- Corporate Social Responsibility and peer to peer challenge to ensure an environment of affordable healthy options is accessible to all.
- the potential levers of the Council’s statutory responsibilities e.g. planning and licensing in relation to healthy weight
- the role of business in developing innovative solutions to create a healthy workforce and healthy communities.
- enhancing our community assets by engaging residents in the development of solutions
- the development of transport plans including the provision, access and affordability of public transport, safe environments and infrastructure for walking, cycling and recreation
- the opportunities for nurseries, schools and colleges to facilitate healthy eating and increase physical activity
- accessing the support available from Public Health England to work with the Council to develop a whole systems approach to promoting healthy weight
- collaboration and co- design with providers

6. Challenges and barriers

The causes of obesity exist in the places where we live, work and play, where the food and built environment often makes it difficult to make healthier lifestyle choices. Individuals and families live in local communities and this gives local government the opportunity to work with communities and partners to help tackle and prevent the causes of obesity, complementing work at a national level. We know there is no one single solution. We can only tackle obesity if it becomes everybody’s business and is prioritised and embedded in everything we do.

As a borough we have identified obesity as one of 3 key priority areas for our place-based partnership. There will be considerable overlap between these 3 priority areas of obesity, mental health and community resilience when trying to improve population health and wellbeing. The challenge will be for all stakeholders to understand and own the strategic context in terms of their responsibility to support change and be able to provide the required operational levers to make that change happen at a local level. In addition, this change is happening as part of an iterative agenda so stakeholders will

have to be adaptable and flexible in their approach, particularly as emerging intelligence gives us a broader understanding of the true impact of the pandemic.

It is clear, if we are serious about change that we will need to drive a new way of working across the borough that requires commitment, energy, drive and importantly local political and senior level buy-in across a variety of stakeholders and organisations. Complex issues, like obesity, require sustained and systemic action and buy-in from systems leaders. This is essential to support implementation and enable local authorities to work differently and test new approaches.

Whole systems working also requires a long-term commitment, with actions across the short-, medium- and long-term. Challenging obesity will require a complete multi-agency approach. There is no one solution to tackle such an ingrained problem and local action to promote healthy weight across the life course requires a coordinated collaborative approach to support change. The disproportionate impact on individuals and families living in more deprived areas means that the status quo on obesity is no longer acceptable. It is a priority and requires alignment across agendas and organisational boundaries to make it everybody's business.

The obesity task and finish group have focused on 3 key areas which are aligned to the life course which will be the main drivers within the obesity action plan. These are indicated below, and current progress is contained within the highlighted areas in the action plan.

- Development of the Children's Living Well Service aligned to **Start Well**
- Achieving the competencies outlined in the Healthy Weight Declaration aligned to **Live Well**
- Obesity pathway development, from low level prevention through to treatment programmes which include falls and frailty service development aligned to **Age Well.**

The obesity task group are working to ensure relevant stakeholders understand and actively 'sign up' to their part in creating systemic change. The immediate priority will be to align stakeholders as owners to the tasks in the action plan below which has been developed in line with our collaborative approach. The plan will highlight relevant and lead partners who will lead on making change in line with our objectives and outcomes. We will seek to put those most affected by the issues we are tackling at the centre of the process. Although the action plan identifies *proposed,* albeit relevant stakeholders, the next step will be to gain focused and tangible commitment from those stakeholders who will **actively commit, 'sign up', take ownership and work collectively to drive the agenda forward**. This task will be completed in January / February 2022 and the action plan will be shared with the HWBB once stakeholders have been aligned, timeframes agreed and gaps within the whole system identified.

Obesity Action Plan

Whole System Approach						
Objective	**Related Action**	**Lead responsibility and system partners**	**Planned Outcomes**	**Timeline**	**Progress To date (November 2021)**	**Link to Dashboard**

Healthy Weight Declaration (Live Well)

A local authority declaration on healthy weight has been designed and developed by the Health Equalities Group – Food Active. The Healthy Weight Declaration (HWD) describes why tackling obesity is important and sets out several pledges which local authorities can make to address obesity. Sefton Council is fully signed up to the declaration and much of the work undertaken locally is framed under its pledges. Progress will be continually under review.

Objective	Related Action	Lead responsibility and system partners	Planned Outcomes	Timeline	Progress To date (November 2021)	Link to Dashboard
Identify and gain commitment from all relevant stakeholders to deliver the 14 competencies of the HWD	Engage with Food Active and aligned stakeholders to gain ownership to deliver the 14 objectives	Public Health and NHS. An accountable officer for each pledge area e.g. catering will be identified within the Obesity T&F group	To develop a revised and updated HWD action plan To create accountability from all partners and ensure actions are delivered in line with the pledges.	24 months	Task and finish group established Review and evaluate progress of the HWD underway. Stakeholders for each competency area to be identified by Jan 2022	We will embed a whole system approach and a collective responsibility across the partnerships.

Childhood Obesity

- To reduce obesity prevalence in children and young people
- Increase the engagement with obesity services
- To coordinate a holistic well-connected pathway for healthy weight management

across Sefton

Children's Living Well Sefton Service (Start Well)

Objective	Related Action	Lead responsibility and system partners	Planned Outcomes	Timeline	Progress To date (November 2021)	Link to Dashboard
Develop a Children's LWS model providing a holistic health and well-being offer for children, young people and families Deliver a suitable weight management programme for children and YP, with holistic, well connected pathway.	To build a hub and spoke model of Public health commissioned services. Coordinated follow up with children and young people identified through NCMP and PCN's Review and re-design existing current offer	PH 0-19 PH commissioned services, e.g. Mental health services Sexual health services Active Sefton, 0-19 VCF Early Help Education	Timely single point of access to relevant support for Families and young people More children achieving and sustaining a healthy weight and behaviours	12- 24months	Funding established Partners identified and project manager identified. Obesity T&FG to identify stakeholders for each element of Hub Jan 2022	Applying a targeted approach across the whole life course, gender, geography environment and culture and delivered across the whole system to ensure collective responsibility from all partners.

Adult Weight Management (Age Well)

Creation of an obesity pathway	To have a clear pathway of interventions from low level support to therapy and treatment services	PH commissioned services CCG acute sector	To have a clear referral pathway distributed amongstal partners	Within next 12 months	Initial meetings and identification of stakeholders and updated the ICG of plans	Redesign weight management pathway for those who are already overweight
Review existing adult weight management tier 2 offer delivered with external funding grant	To develop an improved tier 2 weight management offer	PH Active Sefton LJMU LWS VCF	Timely single point of access to relevant support for adults More adults achieving and sustaining a healthy weight and behaviours	12 months	Review has taken place, offer is being shaped and commissioning in process	Redesign weight management pathway for those who are already overweight

Appendix A – Pillars of Popultation Health

4 Towards our vision for population health: the four pillars of our framework

Population health needs to be rooted in what drives our health, and what can improve and maintain it over time. Given this, and given the evidence discussed in the previous sections, it should be no surprise that the four 'pillars' we see as crucial to this are the wider determinants of health, our health behaviours and lifestyles, an integrated health and care system, and the places and communities we live in and with (Figure 7). A comprehensive approach to population health must be able to work across all four pillars.

Figure 7 The four pillars of a population health system

A Vision for Population Health; Towards A Healthier Future' The Kings Fund, Buck D et al 2018

Appendix B

Table 1 Summary of Recent Initiatives

Update with information when we meet with the current workforce task group

Date	Initiative	Summary
	National Child Measurement Programme (NCMP)	Data to inform targeted programmes and activity to support children and families with greatest levels of overweight and obesity. This includes the Council's 'Active Schools' offer that is available to all schools. It places equal emphasis on combining all elements known to be vital in treating and preventing overweight or obesity, healthy eating advice, increasing physical activity and behavioural change.
	Healthy Weight Declaration	A Local Authority Declaration on healthy weight has been designed and developed by the Health Equalities Group – Food Active. The declarations set out why tackling obesity is important and several pledges which local authorities can make to address obesity. Sefton Council is fully signed dup to the declaration and much of the work undertaken locally is framed under its pledges. An update on progress went to Health and Wellbeing portfolio on 6th August 2018.
	Implementation of Supplementary Planning Guidance for hot food takeaways	This policy has only been in place for just over a year. It has been used to successfully restrict opening times of a takeaway at The Crescent in Thornton (no earlier than 5pm) as this is close to Holy Family School. It was also used to help refuse a takeaway at Endbutt Lane, Crosby as this was close to Sacred Heart, St Marys and Merchant Taylors schools.
	LCR Obesity Notice of Motion	Sefton Public Health led the development of the Liverpool City Region Notice of Motion on obesity. This focused on national action to address obesity including restrictions on advertising, broadening sugar tax to food items and tackling food poverty. This was presented to Sefton Council on the 19 April 2018. It was passed by Knowsley Council 21 March, Wirral Council 9 July and is due to go to Liverpool Council and Halton Council.
	Obesity Training	As part of the development of care pathways for adult and child weight management and concerns raised by multiagency staff about their role in tackling obesity, Public Health has commissioned Food Active to help ensure that a range of education, health and social care professionals are confident and competent to engage, inform and support children and families about healthy weight and wellbeing.

		To inform the development and implementation of an obesity training programme, Food Active facilitated several focus groups in July 2018, with front facing practitioners. Attendees included health visitors, nursery nurses and school nurses, community adolescent service staff, children and family support staff, young carers support staff and other VCF staff. The findings have been reported back to Public Health and available on request. Key themes include staff not feeling confident to raise the issue of weight, they lack the knowledge to provide information and the skills to promote change or refer to other help and support. The recommendations within the report are informing the development of training that will available to a range of staff and will ensure consistency of messaging across the health and care workforce. The focus will be on knowledge and skill development to equip staff to act. Commitment from senior management and senior leaders concerning healthy weight, the raising of the issue routinely and the promotion of behaviour change is essential.
	Mapping of pathways and production of a Healthy Weight Guide and Pathway Toolkit	Intervention and referral pathways from universal to specialist for children and young people and adults have been produced alongside a toolkit 'Sefton guide to talking about weight with adults, children and families' to help support health and community staff to provide early intervention and know where and how to refer or signpost for further support. This toolkit will be rolled out as part of the Food Active healthy weight staff training (see above).
	Delivery of Making Every Contact Count Training	To date over 1200 frontline staff have been trained. In addition, North West Borough staff have accessed PHE physical activity training to improve physical activity advice and support.
	Review of Active Sefton Public Health Programmes	A review has been completed of the LA Active Sefton Programme which includes the provision of health and wellbeing interventions for children and families. The review has resulted in recommendations to re-model the service to have a greater population prevention focus and include: A primary school health promotion offer which brings together policy, activities & services led by evidence-based practice & intel data e.g. NCMP A children's & young people's weight management programme to provide support to children who are

		overweight which is aligned to 0 to 19 services by April 2018. A healthy weight influence support programme which includes co-design and implementation of Sefton Council healthy eating / catering guidelines, support to workplaces / organisations to be health promoting, food retailers and delivery of adult weight management support, adopting best practice from diets don't work aligned to Living Well Sefton by April 2018. A young person's physical activity promotion & targeted support programme which builds on practice with Positive Futures by April 2018.
	Sefton council to work towards Workplace Wellbeing Charter (inc standards to promote & enable healthy weight)	A task group has identified specific areas that need to be addressed including having a healthy workplace statement outlines the offer to staff.
	Develop healthy food and drink guidelines - include events / meetings / vending / procurement	A task and finish group has drafted a set of guidelines based on the NHS standards for catering. This is part of healthy workplace statement for Sefton Council
	Development and delivery of plan to increase breast feeding.	The 0 to 19 service have key performance indicators and a plan to increase breastfeeding. This includes delivery of promotion of breastfeeding and staff training. The Feelgood Factory have recruited Sefton breastfeeding mentors who actively support mums to breastfeed and encourage venues across Sefton to be breastfeeding friendly.
	Encourage partners to adopt a Health Weight Declaration and commit to pledges to tackle obesity.	Sefton is part of the North Mersey Prevention Group which is working to encourage NHS partners to adopt their own Healthy Weight Deceleration and or commit to their lead Local Authority Declaration. A template HWD and pledges has been circulated to all NHS partners in NW. To date Sefton CCG, Aintree Hospital and Southport and Ormskirk Hospital have all developed draft plans.

Agenda Item 8

SEFTON

Voluntary, Community and Faith Sector at the Frontline of

TRANSFORMATION

October 2021

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Research and report undertaken by:

Voluntary Sector North West

Foreword

In Sefton, we have long understood the value of our VCF sector. Throughout the life of our local clinical commissioning groups (CCGs), we have sought to engage, involve and support our VCF sector colleagues whenever possible and as a result the sector has led some remarkable work, resulting in positive changes for the lives of some of our most vulnerable residents. I'd particularly commend the sector for its achievements during the COVID-19 pandemic. You can read examples of the difference the VCF sector is making to Sefton residents later in the report.

Forthcoming changes to the health and social care system expected in 2022 present a real opportunity to further build on these successes. It is a chance for all partners in Sefton to find new and stronger ways of working together to transform and better integrate health and care. In advance of this we have already come together to start shaping an Place Based Partnership, and VCF sector colleagues are very much part of this.

Sefton's CCGs will cease to exist in April 2022 and they leave a strong legacy of partnership with our VCF Sector. In light of these forthcoming system changes I welcome the recommendations set out in this brochure. As we look to the future, we must ensure the good outcomes the local NHS and the VCF Sector have achieved together in recent years will provide the foundation for deeper successes in the future.

Fiona Taylor
Chief Officer
South Sefton CCG
Southport and Formby CCG

"Sefton Voluntary, Community and Faith Sector (VCF) at the frontline of Transformation" is the title of this brochure describing our vital role in delivering quality health and social care services for Sefton residents. The importance of which has become more evident and increasingly amplified as thousands of interventions have been undertaken in supporting our local residents during the world wide pandemic.

Sefton's VCF sector is vibrant, agile and diverse in terms of delivery; reflective of the neighbourhoods and locality and predominantly grown from the local community, providing a critical asset alongside our key partner agencies in health and the local authority. As our health services undertake a significant change with the development and implementation of a local Place Based Partnership (PBP) by 2022, this brochure describes why the VCF sector is integral to strong and successful partnership working illustrated by case studies, with recommendations to build upon this collaboration and the opportunity for place based social innovation being at the heart of community wellbeing services.

Angela White, OBE FRSA
Chief Executive - Sefton CVS

Executive Summary

2020 was a year of unprecedented change, challenge and uncertainty, however it was also a year where cross sector relationships with the VCF sector in Sefton were significantly strengthened and the role of the sector as critical public sector partners has been more important and recognised than ever before.

As we navigate through 2021 and beyond, the health and care challenges associated with COVID-19 will persist, with the pandemic having a disproportionate impact on our already vulnerable and disadvantaged communities as well as individuals and families whose circumstances have forcibly changed. This impact will undoubtedly be felt in the long-term, with recovery likely to take many years as people's lives, ways of working and society respond to such fundamental change..

While the VCF sector adjusts to the aftermath of the pandemic, we also must pave our way and cement our place within the transformation of the health and care landscape nationally, regionally, and locally. The changes in the health and care systems from local Clinical Commissioning Groups (CCGs) to Place Based Partnerships (PBPs) and Integrated Care Systems (ICSs) present both opportunities and challenges for the VCF sector in Sefton. The pandemic has fortified understandings of just how essential the sector is at designing and delivering innovative and effective services, engaging with communities and improving health outcomes across the borough, particularly at a local placed-based level.

There is an appetite and energy across all sectors in Sefton to collaborate and partner, and there are many great examples of how this is already happening with long-established networks of organisations working together to develop solutions to improve outcomes for places. In order to develop truly impactful integrated care systems across Sefton, the VCF sector must be recognised as equitable and sustainable system partners, with the protection of place and accountability to local communities.

Following consultation across networks in Sefton, including the VCF sector, NHS and local authority colleagues, we have arrived at a series of recommendations contained on the following pages. They provide the building blocks for developing a mature working relationship between the VCF sector and Sefton PBP. These recommendations for achieving change will be shared with Sefton's emerging PBP partnership for consideration to support PBP planning and delivery and build collaborative working arrangements. The VCF sector networks and leaders look forward to working in partnership with the PBP to put these recommendations into practice.

Recommendations for Achieving Change:

Recommendation 1:

Increased public sector understanding of the VCF Sector Ecosystem

a

Increase the diversity, range and local VCF sector representation of those involved in governance, partnerships and decision making. Ensure that all stages of PBP planning and delivery are directly informed by their knowledge and that of existing social infrastructure through engagement with established VCF sector networks and forums.

c

Deepen the understanding of system leaders, commissioners, PBP staff and frontline practitioners of the VCF sector structure, organisations and services. Provide training and inductions for public sector staff to better understand and how to work with the VCF sector.

b

As an PBP principle, build on the unique strengths, diversity and reach into communities of Sefton's VCF sector ecosystem and strong networks.

Recommendation 2:

Continued assurance of the maturity of PBP and VCF sector working relationships as the new health and care system is implemented

a

Sefton PBP to adopt the VCF sector checklist to ensure the sector is embedded within PBP processes and policies.

Recommendation 3:

Increase the reach of the New Realities agreement and principles to widen its influence

a

Sefton PBP to embrace the New Realities principles and system leaders to champion these measures, include them within PBP planning and delivery and ensuring new staff and teams understand the principles.

b

Embed New Realities outcomes and measures of success within the PBP Dashboard.

c

Develop and deliver an engagement plan to increase the number of partners adopting the New Realities way of working.

Recommendation 4:

Explore opportunities for PBP investment in the VCF sector and provide opportunities for building community capacity and resilience

a

Scope out the feasibility of a 1% Community Levy on large PBP tenders, with proceeds invested into the VCF sector to promote sector collaborations to ensure capacity and resilience.

b

Explore opportunities for developing a small grants programme to invest in local grassroots organisations to deliver innovative projects for improving health and wellbeing outcomes at the most local levels.

c

Scope the potential for large-scale, longer-term 3-5 year VCF sector investment. This investment should be significant and drive shifts in public service demand driven by a significant portion of the local VCF sector

d

Support a consistent approach to social value as part of all PBP commissioning, planning and delivery with support for commissioners to put this into practice.

e

Explore opportunities for a joint workforce development initiative for VCF sector leadership to support the stimulation and growth of tomorrow’s leaders, encouraging diversity of leadership to support continuity and sustainability.

Recommendation 5:

Further develop integrated relationships with NHS and wider partners with better incorporation into community structures

a

Enable the VCF sector to lead on agreed workstreams and priorities where it has particular expertise and knowledge including areas such as social prescribing and hospital discharge.

b

Invest in co-design and co-production processes as part of local PBP work programmes and commissioning arrangements.

c

Utilise the cross-sector estate and acknowledge the accessibility and location of buildings rather than centralising services into single buildings to avoid destabilising VCF sector assets and diminishing reach into localities. Strengthen front line practitioner knowledge and awareness of key VCF sector services and locations.

d

Ensure VCF sector practitioners are involved in the Integrated Care Team approach of multi-disciplinary team working that has been enhanced in South Sefton, soon to be borough wide, with more people involved in the Sefton 100 workforce model to bring in more VCF sector organisations, locality and place-based working into that collective workforce and Team Sefton approach.

Recommendation 6:

Develop a local, universal social impact tool for the VCF sector in Sefton

a

Develop a VCF sector social impact tool that is localised for Sefton and scalable to all types and sizes of organisations to provide a collective evidence base for the social impact of the VCF sector, aligning to PBP Dashboard priorities.

b

Design a programme of engagement with the VCF sector to encourage sign up to using the tool including training, ongoing support and how to effectively use this information.

c

Ensure that VCF sector social impact data is captured within the PBP Dashboard and is embedded within the delivery of the PBP work programme.

Introduction

OUR VCF SECTOR IN SEFTON ARE TRUE EXPERTS IN OUR PLACES & NEIGHBOURHOODS

The VCF sector in Sefton are true experts in our places and neighbourhoods and we have a deep understanding of the needs and desires of our communities due to the scale of the footprints we work within, from very local, grassroots groups to organisations working across borough lines. Early intervention, prevention and social prescribing activities are our bread and butter, providing population health improvement services in a variety of delivery models and as key providers of health, care and wellbeing NHS and Local Authority services in Sefton. It is therefore essential that the Sefton VCF sector is firmly embedded as a key partner in the health and care transformation in the Borough and enabled to continue to innovate and transform its offer in collaboration to improve health outcomes for our communities.

The purpose of this report is to develop a transformation narrative for the VCF sector in Sefton, through the lens of both wider health and care transformation and in the aftermath of COVID-19. We also want to support our public sector partners to understand how the sector works in Sefton, how it continues to adapt and innovate, and how embracing our community assets can really help shape the delivery and improvement of health and social care outcomes for our Sefton communities at a place-based level.

Following extensive research and engagement with the VCF sector, we have produced several recommendations for Sefton's Place Based Partnership (PBP) that emphasise the sectors crucial role as a key partner within population health management, and how the PBP can support the sector to become more sustainable and resilient for the benefit of Sefton communities.

National and Regional Health and Care Context

The NHS Long Term Plan (2019) and the NHS Five Year Forward View (2014) both point to evidence as to why our health systems should be working smarter with their local VCF sector as a way of engaging with communities and local people and importantly as an equal partner in delivery of services to improve health and wellbeing outcomes.

The Department of Health & Social Care's recent White Paper (February 2021) provided proposals for how Integrated Care Systems (ICS) should function, with Place Based Partnerships (PBPs) as key building blocks for the ICSs. It emphasises the need to work with the sector to improve the health of local areas with a joined-up approach to strategic decision making and specifically makes it clear that the term "health and care partners" includes the VCF sector as standard. More recently, the proposed Health and Care Bill (July 2021) introduces Integrated Care Boards (ICB) which will take on the commissioning functions of clinical commissioning groups and focus on integration between NHS bodies. ICBs will form part of the ICS alongside PBPs which will focus on integration between a wider range of providers, including the VCF sector, to address the health and social care needs of the local population.

Regionally, the VCF sector in Sefton is a key contributor to health structures with its role well recognised and understood across various policy areas within Cheshire and Merseyside, and at a sub-regional level within Liverpool City Region (LCR).

Through Sefton CVS, the VCF sector has a strong presence within the Cheshire and Merseyside VCF Sector Health & Care Leaders group, which links directly into the Cheshire and Merseyside Health & Care Partnership Board to influence health strategy, service delivery and PBP transformation.

Sefton CVS is also a member of the VS6 Partnership of infrastructure organisations in Liverpool City Region (LCR), representing the VCF sector across Merseyside and working closely with the LCR Combined Authority. As a member of the VS6 Partnership, Sefton CVS represents the VCF sector on a number of boards and programmes throughout the City Region, including the Local Enterprise Partnership (LEP), and has been key to mobilising the LCR VCF sector emergency and recovery response to COVID-19.

Sefton Council's Joint Strategic Needs Assessment (JSNA) for 2018/19 highlights core areas of concern across the borough with Sefton 'significantly worse' than the England average in areas including male and female life expectancy, mental health including suicide rates, cancer, and alcohol use. Sefton also has an ageing population growing faster than the national average, which will put increasing future demand on health and social care services with rising rates of severe frailty, dementia and social isolation in this population.

These areas of concern, amongst others, are mirrored within the Sefton2gether Strategy which highlights these areas as priorities for the Sefton health and care system, including the VCF sector, to deliver against as well as addressing the wider determinants of health.

About Sefton

Cheshire and Merseyside
Health and Care Partnership

As with many areas of the country and the Liverpool City Region, Sefton faces significant health and wellbeing challenges both now and in the long-term. This graphic, from Cheshire and Merseyside Health and Care Partnership, shows what the population of Sefton would look like as a village of just 100 people.

If Sefton was a village of just 100 people...

34 Children are overweight or obese by year 6

20 Adults suffer from depression

9 5-16 year olds have a MH disorder

29 Will die from cancer

68 Adults are overweight or obese

3 Adults under 40 have Type 2 diabetes

60

people are living with a long term condition

10 Will die from heart disease

16 Are smokers

82 Is the average age that women will live to

32 People take less than 30 mins exercise a week

78 Is the average age that men will live to

10 People are over 75

Statistics from PHE are for the Sefton Local Authority area, pop: 177,000

Size and Scope of the VCF Sector in Sefton

Sefton is fortunate to be home to a rich and varied VCF sector that is dedicated to supporting communities and those in need through an assortment of diverse services and organisations.

The sector is made up of organisations and services of all shapes and sizes, from our small voluntary place-based grassroots groups working at hyper-local levels to larger indigenous organisations working across Sefton.

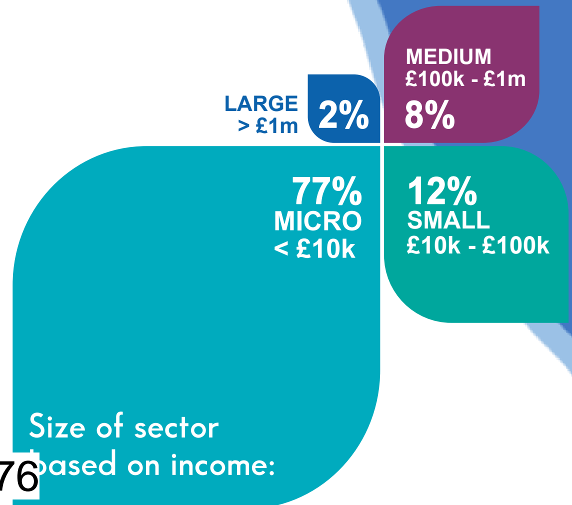
Many of our VCF sector organisations provide services commissioned by our NHS or Local Authority partners, evidencing the sectors' ability to apply and be successful in securing public sector procurements and contracts.

However, there are significantly more organisations in Sefton that are funded through other sources such as local, regional and national charitable trusts, funding bodies and grant makers (e.g. National Lottery Community Fund). Our micro and grass-roots, organisations, which make up the majority of the VCF sector, rely on small grants, fundraising and donations to provide their services, often utilising their funding in the most innovative, cost-effective and placed-based ways.

The funding brought into the borough through our VCF sector organisations contributes significantly to the local and regional economies, and ultimately supports communities to improve health outcomes through services such as social prescribing, prevention and early intervention.

Number of VCF sector services in the three Sefton localities:

CENTRAL



1,158
VCF SECTOR SERVICES

NORTH

There are approximately 1,000 VCF sector organisations delivering 3,500 voluntary, community and faith services available to Sefton across the three localities: North, Central and South Sefton *(1) This locality approach mirrors that of local authority locality areas and allows the gathering of more targeted intelligence.

Sefton is home to approximately

280

community businesses, including Community Interest Companies and social enterprises.

2,343 services are delivered by organisations physically located in Sefton, with approximately

1,000

services available to Sefton residents which are delivered by organisations based outside of Sefton.

The sector is a significant contributor to the local and regional economy, providing

£149 million

GVA to the Sefton economy every year.

509
VCF SECTOR SERVICES

SOUTH

Employs over **3,900** FTE employees in the VCF sector.
There are over **33,000** volunteers in the borough providing over **99,000** hours of volunteering per week, or the equivalent of **2,645** full time jobs. *(2)

Sefton Voluntary Sector Estate

A particular characteristic of Sefton's VCF sector is that it has largely developed locally or "bottom up", in response to needs identified within neighbourhoods and communities. Our townships and centre places throughout Sefton such as Waterloo, Bootle, Crosby, Southport and Formby have strong local identities, and VCF sector formation reflects this with many organisations physically based within their localities in close proximity to communities.

Most organisations are locally managed and governed with strong connections to communities and residents, alongside borough-wide organisations with local and outreach services. These strong connections make Sefton's voluntary sector estate ideal for place-based delivery of health and wellbeing services and outcomes, as trusted community assets.

Our Voluntary Sector Estate includes:

The faith sector including worship centres and ancillary buildings used by VCF sector organisations for social activities.

Social Care and End of Life services such as hospices, care homes and day centres.

Decommissioned or redundant public sector buildings such as libraries and community centres passed to community organisations to be revitalised.

Sports and leisure organisations and associated green spaces.

Purpose built flagship projects such as Netherton Feelgood Factory and May Logan Centre.

Delivery of community outreach services in partner premises.

Use of commercial premises such as community centres, charity headquarters, shop fronts.

The development of a social highway of organisations located within the Strand Shopping Centre in Bootle made up of organisations including Reach Men's Health, The Big Onion, South Sefton Foodbank, Bootle Tool Shed, Kingsley Children's Book Shop, In Another Place and "Strand By Me" (Sefton CVS).

System Partnerships

The VCF sector in Sefton is identified in all local strategic documents, both produced by Sefton Council and our NHS strategic partners, as a key delivery partner within early intervention, prevention and population health management. The role of the sector in addressing the wider determinants of health at a place-based level is not underestimated by our public sector colleagues, however we continue to push for a more equitable role to maximise the value of the sector's activity.

The New Realities agreement between Sefton Council and the VCF sector is a great example of collaborative working and re-imagining of local, more productive relationships with the public sector. The agreement aims to improve outcomes for Sefton communities by strengthening working relationships to make the most of available resources, tap into unused community assets and establish a new culture of working together through finding common solutions and reducing bureaucracy. It represents good practice for commissioning and procurement, focusing on stimulating micro-level activity for the common good of Sefton communities with Sefton Council acting as the enabling authority for encouraging cultural shift within local authority workforces. The agreement has been recognised as best practice and has won awards including the National Compact Awards Community Impact Award and the NHS Health Education England Adult Learners Week Award.

New Realities has been refreshed for 2021 with learnings from the collaboration and support in Sefton in response to COVID-19, reflecting on what worked well and how to keep the shared enthusiasm and positive changes post-pandemic with case studies, measures of success, and key priorities for Sefton until 2025. The document is currently out for consultation.

New Realities Steering Group

Front Left to Right:
Councillor Hardy Cabinet Member for Communities and Housing and Angela White
Back Left to Right:
Nick Thompson, Lorraine Webb, Andrea Watts, Mandy Elliot

VCF Sector Response to COVID-19

Without a doubt we know that the COVID-19 pandemic has had a profound and significant impact on the health and wellbeing on people nationally, however we also know that it has and will continue to intensify the health and wellbeing challenges facing Sefton communities.

The impact on the VCF sector itself has been considerable, with significantly increased demand in the face of limited resources yet continuing to step up and support our most vulnerable despite these challenges. A survey undertaken by the VS6 Partnership of VCF sector organisations across the LCR during the first wave of the pandemic found that, in Sefton:

Despite the struggles and challenges presented throughout the pandemic, the VCF sector in Sefton has evidenced just how truly adaptable and innovative it can be. The mobilisation of the sector to support those most impacted on the crisis has been immense, with some organisations adapting their service delivery to be as safe as possible whilst others have changed their focus all together to ensure those in need get the most appropriate support.

83% of organisations stated that their beneficiaries were becoming more vulnerable as a direct result of the impact of COVID-19.

73% organisations reported an increased need for mental health support and **53%** for health and wellbeing support for service users.

Almost three quarters of organisations surveyed **(70%)** stated that they had been able to adapt their delivery to meet these increased needs.

Almost half **(49%)** were working in collaboration with other organisations to respond effectively to the crisis.

Collectively, the VCF sector organisations highlighted below achieved the following during 2020/21:

Provided **268,229** Supportive interventions to **55,449** people

Contributed **65,114** hours of volunteer support. If these hours of support were offered by one person, they would have to volunteer 24 hours a day, everyday, for over seven years. This equates to an economic and social value contribution to Sefton of **£892,061**

Supported people in Sefton to claim financial assistance totalling **£8,222,895**

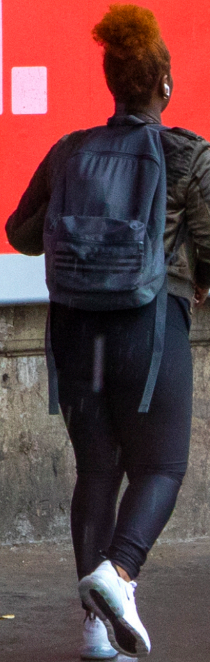
> "If you weren't here to help I couldn't have done it, I would have just sat and cried."

Delivered **21,341** Meals and food parcels

> "Many thanks, you do all really make a wonderful difference to people's lives."

> "You have been BRILLIANT no other word for it."

> "Thanks for your help, we felt lost and didn't know where To begin! You swooped in and helped us sort everything out."


COMMUNITY
IS
STRENGTH.
BE STRONG. LET'S LOOK OUT FOR ONE ANOTHER.

Sefton VCF Infrastructure

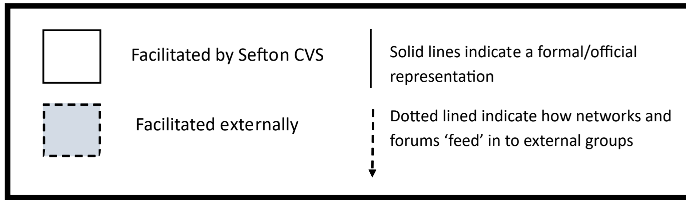
The value of strong VCF sector infrastructure cannot be underestimated for developing a strong, robust and sustainable VCF sector. The government's Civil Society Strategy "Building a future that works for everyone" (2018) emphasises the importance of strong leadership and local infrastructure support systems to enable the VCF sector to flourish and to support the development of thriving local VCF sector ecosystems.

Sefton has an active VCF sector infrastructure representation through the Sefton Council for Voluntary Service (CVS). Active since 1974, Sefton CVS is one of the the largest CVSs in the country and provides support and assistance to the VCF sector within Sefton through key activities including:

- **Providing support services to the VCF sector.**
- **Promote partnerships with the sector, and between the VCF sector and other sectors.**
- **Provide a channel through which the VCF sector is represented.**
- **Develop new ideas, strategies and organisations.**
- **Support and developing volunteering opportunities.**
- **Promote equality of opportunity and access, and the value of diversity.**

As well as Sefton CVS, the borough is home to key VCF sector networks, collaborations and user voice groups spearheading the sector and our communities on multiple agendas, providing a thorough social infrastructure for Sefton. The diagram on the next page shows the recognised strategic representative eco-system for Sefton's VCF sector to local authority and NHS structures, and evidences just how far the influence of the sector reaches into these structures.

This architecture has been in place for a considerable amount of time and over the years has been strengthened. It provides an ideal framework though which PBP interaction can occur with the sector with well-established networks, connections and areas of expertise to build upon.



Recognised strategic rep
for Sefton's VCFSE sector to the lo

NETWORKS &

Children, Young People & Families

Every Child Matters (ECM) Forum

Children With Additional Needs Network (CWAN)

SEND Continuous Improvement Board

SEND Co-production and Engagement Sub-group

The Thrive Network (CYP EHWB)

Emotional Health and Well-Being Partnership

Local Safeguarding Children's Board (LSCB)
Early Help Partnership/Model of Practice Group
Children's Partnership – Health and Well-Being
Corporate Parenting Board

Combined intelligence from ECM, H&SC & wider CVS networks & forums

Sefton Community Safety Partnership

Youth Offending

Sub-groups previously under Sefton Provider Alliance

Early Years

Integrated Care Teams (ICT)

Falls

Complex Lives

Social Prescribing Sub-Group

Health &

Health & Soci

Adult Forum

Health and Wellbeing Board

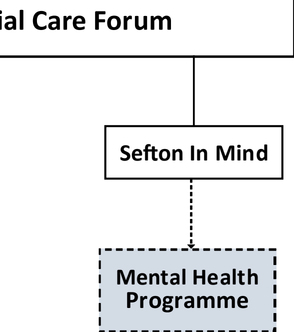
on CVS
Local Communities

presentative eco-system
ocal authority and NHS structures

CROSS-CUTTING

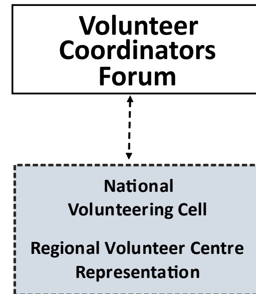
& FORUMS

Wellbeing

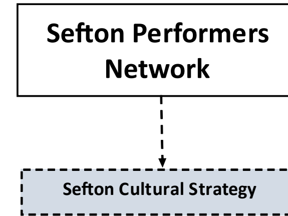


Sefton CVS representation on behalf of the wider VCF sector

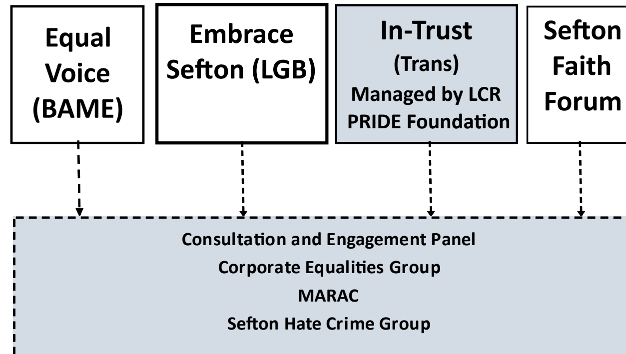
Volunteering



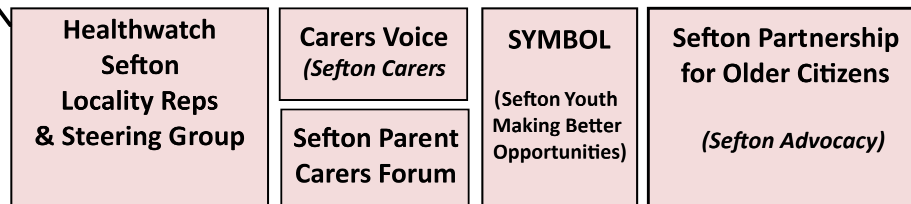
Art & Culture



Equalities



User Voice Forums



CUTTING

Consortium
digital inclusion consortium

New Futures Sub -Contractors

Kickstart Partner Orgs

REGIONAL & NATIONAL

Recognised strategic conduit to the Liverpool City Region Combined Authority , Metro Mayor, LEP, C&M Partnership (via VSNW)

National membership body for local infrastructure organisations

Our VISION for the Sefton VCF Sector

Our vision is for the VCF sector to be at the heart of Sefton's health and social care system to support the Borough's ambitions for integration and improved health and wellbeing outcomes. The local VCF sector in Sefton are essential transformation, innovation and integration partners and the sector's diversity means it is well placed to be both at the heart of population health and prevention services, as well as supporting and leading on specialist and hospital-based services.

We need the VCF sector to play its part in Sefton because the sector helps by:

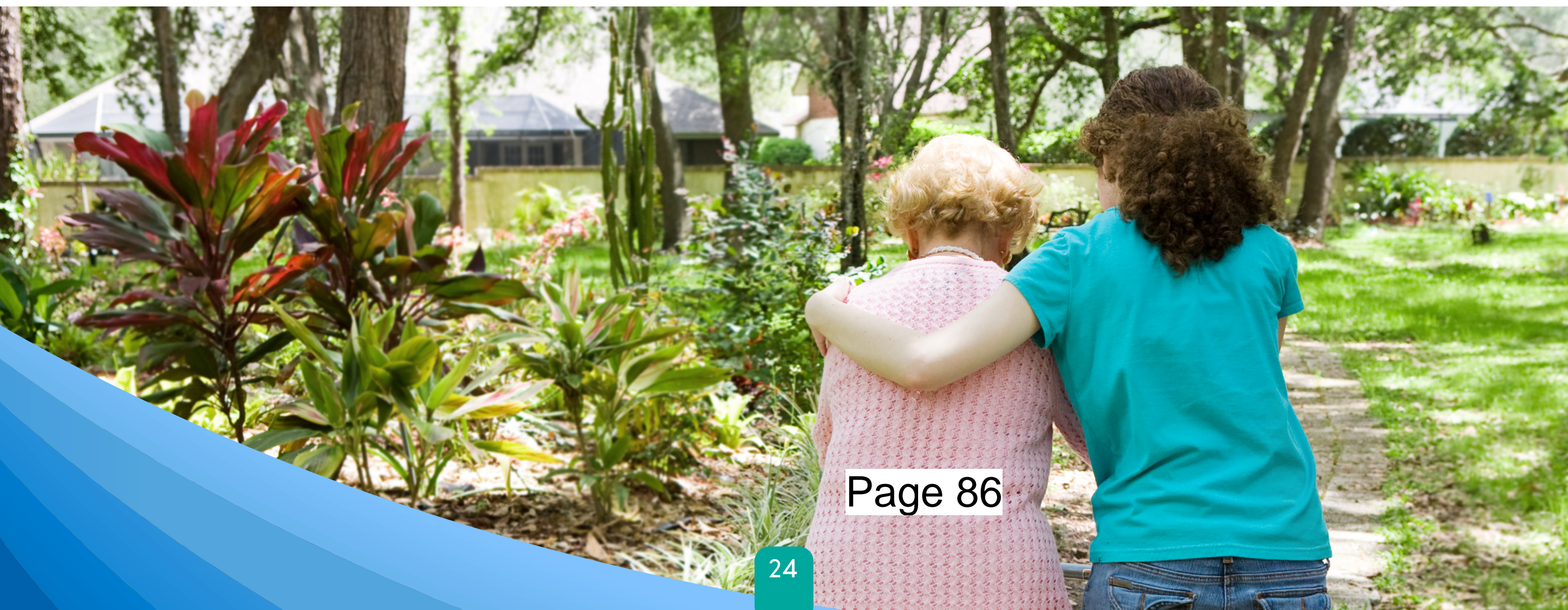
Bringing vital community insight and local intelligence to inform service planning and service redesign and integration of services.

Providing reach into and hold the trust of different communities and groups, working across systems, including communities of geography, ethnicity, people with similar health conditions.

Addressing inequalities and promote engagement - particularly for groups with the poorest health and those who are most marginalised.

Bringing assets into partnerships, including volunteers, non-statutory funding, insights into inequalities and prevention as well as community assets such as the people who live there and their unique skills and knowledge and premises.

Delivering services and activities that are value based, holistic and person centred. VCF sector staff and volunteers make up a significant proportion of the health and care workforce.



The OFFER of the VCF Sector

There are many award winning examples of the work of the VCF sector in Sefton. We have set out many of the reasons why the sector in Sefton is important to local people, partners and communities throughout this document, with a summary of the collective offer of the sector below.

The VCF sector in Sefton provides a network of groups and organisations which are:

Accessible: Support individuals to access the services they need. Provide a bridge to 'hard to reach' communities and pick up people who 'fall through the net' .

Trusted: Get to the heart of local communities who may be disengaged to understand their needs and build confidence in public services, particularly those furthest away .

Values based: delivering more than what is written in the contract.

Close to communities: Understand the needs of communities, both geographic and of interest.

Socially innovative and flexible: Find innovative solutions to Sefton's needs through co-production and trialling new approaches.

Working with residents and communities: Enabling people to look after themselves and prevent ill health, eg. through local support networks, health promoting activities, co-production.

Needs and outcomes focused, not money and targets: Prevent people needing to go to hospital, or more costly interventions, by providing support at an earlier stage.

The next few pages showcase a series of case studies that demonstrate the flexibility, diversity and the importance of the sector to achieving local health and wellbeing outcomes in a variety of ways, featuring some of our innovative VCF sector organisations and projects from across Sefton.

Sefton High Intensity User Project (HIU)

AIM

A new pilot service funded by Sefton CCG's. HIU aims to reduce inappropriate A&E attendances and admissions from individuals identified as frequent attenders through a strengths-based, person centred and solution focused approach, working closely with individuals to help address the underlying reasons for attending A&E.

OUTCOMES

From September 2020 to March 2021, the team supported 36 patients in total. The service has been successful in supporting many patients with complex social issues, with many not attending A&E at all during and post-intervention, achieving an approximate 40% reduction in attendances across the cohort*(3).

Given that this service has been operating since September 2020 these figures are likely to increase in the future as normal service starts to resume following the COVID-19 pandemic.

Extrapolating patient outcomes over 12 months, the service will achieve:

An average reduction of **36** hospital admissions reducing costs to the NHS by **£193,000**

An average reduction of **132** In A&E attendances reducing costs to the NHS by **£25,000**

This reflects in-year savings of **£54,001** *(4) to the NHS

Sefton CVS
Supporting Local Communities

Living Well Sefton

Living Well Sefton is a voluntary sector collaborative led by Sefton CVS comprising May Logan Centre, Netherton Feelgood Factory, Brighter Living Partnership, Citizens Advice Sefton, Sefton Carers' Centre and Community Connectors. It liaises closely with Smoke Free Sefton, Active Sefton, and Sefton Council and in addition to 20+ Living Well Sefton Neighbourhood Partners from the VCF sector.

CASE STUDY

AIM

To reduce health inequalities experienced by vulnerable groups and those living in Sefton's most deprived communities. The programme delivers a cohesive and seamless integrated wellness service, continually evolving to meet the needs of Sefton communities and improve access to health and wellbeing services. LWS also manages the Social Prescribing Link Worker Service working closely with Sefton GP's, reducing demand and utilising community-based approaches to improving wellbeing.

This collaborative approach has been procured for an initial 3 years through Public Health Sefton Council. It builds on the integrated wellness service with the same group of providers which had operated through a directly commissioned model. The new hub and spoke model procured CVS as the lead agent with the named VCF sector partners. CVS manage and commission the investment and programme delivery, training and development, communications and facilitate neighbourhood and themed micro grants.

PARTNERSHIP

The LWS collaborative working approach is fundamental to the success of the programme, building upon the strengths and specialisms of the delivery partners to provide a seamless and effective service to communities that reach across the borough. The service adopts a 'no wrong door' approach, with clients able to attend any partner for support whilst receiving a consistent service across all agencies using the specially designed Integrated Wellness System database which is shared by all Delivery Partners. The staff across the providers participate in joint workforce training to ensure consistency and knowledge across all providers.

The established collaboration of local organisations also meant that LWS could respond quickly and innovatively to meet the needs of communities throughout COVID-19 working closely with other CVS services, neighbourhood partners and the direct referral process from Sefton Council's Call Centre into LWS and CVS. LWS is also closely linked to the National Academy for Social Prescribing and the North West Social Prescribing Network.

OUTCOMES

In 2020/21 alone **3,167** clients interacted with LWS with **86%** completing a Universal Consultation

Based on the calculated value of a 3-year social prescribing model providing savings to the NHS of **£269** Per client *(5)

this equates to LWS providing potential cost savings to the NHS system of **£851,923**

The Power of Small Grants and Grassroots Activity

Grassroots activity and organisations are the cornerstone of homegrown VCF sector activity across Sefton. They have a vital role in achieving better health and wellbeing outcomes for Sefton residents through their hyper-local place-based services, meeting local needs in innovative ways with small investment yet big impact.

Sefton Council and both of Sefton's CCG's have a track record of recognising the importance of our micro VCF sector organisations and the importance of the transformative impact of grants to stimulate grassroots activity and build capacity and resilience in Sefton's communities. Small grants for the VCF sector have the power to provide much needed community services that reach deep into communities due to the ideal placement of organisations within neighbourhoods and places. The maturity of the VCF sector ecosystem within Sefton, with the well-established networks and connections, means that the sector is ideally placed to support the administration and delivery of grants.

Successful grant programmes established within Sefton include:

- Winter Pressures Grants
- Sefton Council Transition Fund
- Community Resilience and Neighbourhood Action Grant Programme
- Community Champions Fund
- Violence Reduction Partnership Grants
- CCG VCF Fund
- Covid-19 Grant Funding

Community Resilience Grants Programme

Living Well Sefton

AIM

The Community Resilience Grants Programme has been running since 2016, providing funding and support for a range of community programmes to generate innovative solutions to tackle long-term problems in Sefton communities, enable personal and community resilience, and improve health and wellbeing outcomes

HOW

Small grants of up to £2,500 per organisation are awarded to Sefton community groups, voluntary organisations, faith groups and social enterprises. Further grants of up to £500 are also available for individuals with ideas to improve health and wellbeing at a very local level. The application process is designed to be very simple to attract groups that may not normally apply for larger grant funds. Each round has a different theme reflecting community needs, with the latest theme focused on COVID-19 recovery and resilience.

Over **£220k** has been awarded through **132** small grants

Since the beginning of the programme, with awardees demonstrating tremendous value in developing high-impact, low-cost responses.

The Community Resilience Grants Programme is a great model for supporting communities and funding grassroots organisations, as well as providing cost-savings for the NHS, that we would like to see continue, supported, and replicated.

The next two case studies are examples Community Resilience Grants programme awardees, and showcase the power of small grants and grassroots activity.

Small Grants Spotlight 1

Get Outdoors Southport Strollers Project

Southport Strollers in North Sefton

Grant amount
£1,730

Southport Strollers, a walking and running group, aimed to encourage more people to take part in the club and benefit from physical exercise whilst building social connections. Organised running evenings and training sessions were unable to continue through the COVID-19 pandemic however the club supported members to run on their own and held monthly challenges to encourage members. The grant helped the club formalise and, despite the pandemic, their membership grew from 35 to 74.

Outcomes: The value of confidence training per person is estimated at **£1,195***(6), therefore attracting **39** new members generated a potential total value of **£46,605** in improved confidence.

Small Grants Spotlight 2

A Wellbeing Space for Young People

Merseyside Youth Association (MYA)
in South Sefton

Grant amount
£2,000

MYA originally aimed to deliver their 'A Wellbeing Space' project to address physical and emotional wellbeing from their base in Bootle. With the pandemic, the project moved online with a total of 100 young people taking part in the 'Space to Talk' sessions which provided one-to-one opportunities where the young person could discuss their feelings and anxieties with a Volunteer Peer Support Mentor. The Mentors have worked so well that MYA has secured extra funding for sessional hours and recruited two of the peer mentors into paid roles.

Outcomes: The value of a meaningful increase in the self-confidence in young people is estimated as **£499.38** Therefore with 100 participants,

A Wellbeing Space has potentially generated a total of **£49,938***(7) in value for young people in Sefton.

Making Every Contact Count (MECC) A whole system approach to Having healthy conversations

AIM

Making Every Contact Count (MECC) is a National Programme aimed at reducing health inequalities by training non-health professionals to have 'healthy chats' with the people they see every day. MECC supports the Early Intervention and Prevention Agenda as well as building community resilience and positive behaviour change.

MECC has been delivered to more than 1,400 beneficiaries over the period of the project to date including the VCF sector, Primary Care, Council and DWP staff. Additionally, the training was recently adapted to be online focusing on supporting people with health behaviour changes linked to COVID-19, with an additional 64 participants in these sessions from a variety of organisations.

MECC training is still ongoing, following the success of the project and is a great example of a VCF sector led integrated training programme and increasing community resilience.

OUTCOMES

It has been calculated that a MECC project training 1,000 staff each with 100 MECC encounters across all topics could result in a lifetime saving to the NHS of approximately

£500k *(8)

With over 1,460 people trained in MECC in Sefton, this provides potential long-term cost savings to the NHS of approximately

£730k

Sefton's Voluntary Sector Estate

and the strength of place-based working

The VCF sector in Sefton is home to several important community hubs and assets across the different geographies of the borough, providing the foundations of the voluntary sector estate. These dynamic hubs are particularly important as they are place-based within localities and provide irreplaceable support for their local communities.

Sefton's community hubs focus on levelling up the communities they serve to improve health and wellbeing through enabling and building upon assets that already exist within communities, developing resilience and empowering residents to manage their health and wellbeing. Utilising Sefton's community hubs and all of the voluntary sector estate aligns with the PBPs emphasis on place-based working, with the VCF sector in Sefton well attuned to local population configuration through local community organisations.

A sample of our community centres and key locality assets across Sefton include:

1. Netherton Park Neighbourhood Centre
2. Woodvale & Ainsdale Community Association
3. Southport Community Centre & Brighter Living Partnership
4. Linacre Bridge Community Hub
5. Strand By Me
6. The Orrell Trust
7. Compassion Acts
8. Citizens Advice Sefton (Southport)
9. Citizens Advice Sefton (Bootle)
10. Sefton Carers Centre
11. Swan Women's Centre
12. Linacre Methodist Mission
13. Brunswick Youth and Community Centre
14. Litherland Youth and Community Centre
15. Waterloo Community Centre
16. L30 Community Centre
17. The Salvation Army
18. Southport Salvation Army
19. Bowersdale Resource Centre
20. SING Plus Centre
21. Sefton Council for Voluntary Service (CVS)
22. Venus
23. Ykids
24. Alchemy Crosby (Parenting 2000)
25. Alchemy, Southport (Parenting 2000)
26. Light for Life
27. St Leonards / South Sefton Foodbank
28. Sefton Women's & Children's Aid (SWACA)
29. Formby Hub (at Formby Methodist Church)
30. The Independence Initiative
31. Regenerus
32. Seans Place
33. The Reach Mens Centre
34. Ainsdale Lunch & Leisure

L30 Community Centre

AIM

Based in the Netherton estate of Sefton, L30 Community Centre has been operating for over 30 years providing a diverse range of activities and support for all members of the local community. L30 specialises in supporting communities to mobilise with community-based solutions – focusing on what talents, skills and opportunities already exist and enabling them to make a difference for all.

CASE STUDY

Throughout the COVID-19 pandemic, L30 have been busier than ever. Some great examples of innovative ways of bolstering community assets including working with a local fitness instructor to organise street exercise sessions, providing pedometers for those social isolating to improve physical exercise and maintain mobility around the house, and supporting the community to set up a Community Pantry, attended by a Community Connector, for families struggling financially.

This activity has supported people to develop support networks, friendships amongst neighbours, improve physical activity, reduce social isolation, and provide food to the most vulnerable.

OUTCOMES

L30 has seen membership grow from 300 to over **1,000** Since the start of the pandemic.

An increase of over 700 members over the past 12 months could mean that, if all the members were active, L30 could be generating **£662,018** In value to the community every year. *(9)

It is a great example of just how important Community Hubs and our Voluntary Sector Estate is in reducing health inequalities in some of Sefton's most deprived communities effectively

Independence Initiative

AIM

Independence Initiative have been operating throughout Sefton since 1998, supporting people with complex and interdependent forms of exclusion to reduce substance dependency, improve physical and mental health, reduce the risk of homelessness and offending whilst promoting social inclusion and resilience.

CASE STUDY

Independence Initiative have supported over 9,000 people over the years, working in partnership with local agencies and the wider community to facilitate long-term rehabilitation from substance and alcohol misuse through person-centred and community-based approaches. In addition to providing one-to-one support, Independence Initiative provide a supported housing service for people in recovery for a transitional period of 9-12 months, giving much needed security and on-going support for clients.

On average, 150 individuals are housed at with Independence Initiative every year, providing people with the best possible chances to maintain recovery and improve health and wellbeing.

This model of recovery also reduces demand on NHS and Local Authority services by working closely with clients in a community based setting and developing support networks within the community.

OUTCOMES

Local authorities spend on average

£6,874

On temporary accommodation per person per year *(10).

With an average of **150** Individuals housed every year, Independence Initiative is able to save local government over

£1million

A year, without even taking in to account the potential cost savings of reduced health service use and criminal justice spending.

A Framework For Collaboration With The VCF Sector

From our conversations with the VCF sector and local health and care partners we recognise that there are already well established relationships in Sefton and a strong track record of working together. To achieve our desired step-change in the role for the sector into the future we will need to build on this with:

A flourishing and diverse local VCF sector working as an equal partner in the Integrated Care System for Sefton.

An agreement with local health care partners that the role of the sector is key and valuable and that the case has been made for the VCF sector to be at the heart of integration.

Investment into the structures and networks that will help to make this happen, recognising the current good practice that exists in Sefton.

A more sustainable approach to funding the VCF sector and its work that enables the vision to happen and recognises how key the sector is to Sefton's ambitions.

This checklist, designed by VSNW, VS6 and the Cheshire and Warrington Infrastructure Partnership in collaboration with the Cheshire & Merseyside Health & Care Partnership, provides a framework for PBPs to work with the sector. It also supports the sector to hold PBPs accountable for ensuring the sector is in a strong position to work with PBPs to shape local services that support health and wellbeing for local people, building upon place-based partnerships and developing the maturity of PBP collaboration.

A Framework For Collaboration With The VCF Sector

A defined equitable role

1. There is a plan which shows how a clear and equitable role for the VCF sector will be developed and implemented within the PBP.
2. There is a clear position and role for the sector at different levels in the PBP.
3. There is a chance to make time for relationships, trust and understanding to be developed with VCF sector leaders, providers and other PBP members.
4. There is a lead role within the PBP for working with VCF sector representatives linked into the local VCF sector networks that already

Building on existing infrastructure

1. Existing representative bodies through Sefton CVS and the local networks are connected into the PBP and have an agreed role in enabling the PBP to involve, embed and invest in the sector.
2. There is a clear plan which is resourced to enable the PBP to build capacity within the VCF sector to meet any identified gap and/or respond to specific needs, and to lead on key areas of expertise.

Co-designing outcomes

1. There is an inclusive approach: including VCF sector partners in decision-making at the initial stages of strategic planning and the development of new service delivery models.
2. Services are co-designed with VCF sector partners ensuring the PBP makes use of their expertise and knowledge.
3. There are systems in place which make it easy as possible for VCF sector organisations and communities to be involved in system-wide workstreams and service redesign.
4. The value of VCF sector partners in decision-making and service design is recognised and evidenced.

Commitment to longer term investment

1. Specific commissioning arrangements in place to ensure that VCF sector activities are accessible, sustainable and flexible including strategic grants and reducing barriers by proportionate tendering and monitoring.
2. VCF sector leaders are supported to drive forward large-scale workforce and organisational development work.
3. The PBP support calls for further national government financial support for the sector and actively engages and partners in funding bids with VCF sector organisations.
4. The PBP is using the principles of the social value charter to create investment opportunities for the sector e.g., requiring suppliers to contribute to a grant fund or build VCF sector into their supply chain.

Embedded in service delivery and redesign

1. A consistent approach to measuring and understanding the impact and value that VCF sector providers and the wider sector brings.
2. Alliances and partnerships for VCF sector providers with clinical services are actively created to support joined up delivery.
3. VCF sector activities are consistently and proportionately including in data collection and operational returns with resource to support this work.
4. The PBP uses the VCF sector to gather intelligence and insight, collate wider community feedback, escalate priority issues and take action on these issues.

FINDINGS

These findings summarise the research carried out to inform this document and the feedback obtained following consultation held with VCF sector networks, NHS and local authority colleagues to understand how the role of the VCF sector within local health and care transformation can be strengthened. They emphasise the importance of integrated, collaborative working between the VCF sector and Sefton's emerging PBP, forming the basis for the recommendations for achieving change in planning and delivery to develop healthier, happier communities in Sefton.

Finding 1:

The VCF sector within Sefton is recognised and respected by public sector partners as being a vital link into communities, providing innovative and diverse service delivery models to improve health and wellbeing at the most local levels often in ways that are unique to the sector. However, even more than being closely connected to communities, the sector is made up of organisations, networks, collaborative groups, leadership, and user voice forums that form the architecture of the vast VCF sector ecosystem. A greater understanding of these structures within the public sector will provide valuable opportunities to improve strategy and service design, as well as forming a framework for PBP interaction to happen with the VCF sector.

Finding 2:

In addition to greater public sector understanding of the VCF sector ecosystem, there needs to be greater representation and participation of the VCF sector within PBP working to truly shape services that are place-based to support the health and wellbeing of local people. A framework, such as the PBP Checklist provides an opportunity for the sector to hold PBPs accountable for ensuring the sector is in a strong position to work with PBPs. The checklist covers areas including the sector having a defined and equitable role, building on existing infrastructure, co-designing outcomes, longer term investment and embedding the sector in service delivery and redesign.

Finding 3:

The New Realities agreement is a highly commended piece of work promoting collaborative and equitable partnerships with the VCF sector, ensuring services and policies consider place-based community needs. We need to see more partners adopting this way of working, promoting a better culture of working with the sector and its values, and signing up to its principles and build upon it.

Finding 4:

The VCF sector within Sefton is made up of a large number of diverse organisations operating at different levels and sizes throughout the borough. They play a key role within communities, particularly smaller grassroots organisations, in supporting the people of Sefton by providing local informal and formal support to improve health and wellbeing outcomes and quality of life.

We have seen in the case studies throughout this document just how much value the sector can generate and cost savings to the health system from these small projects delivering health and wellbeing outcomes based on needs. To enable the sector to continue to develop innovative ideas and models for population health management, prevention, and early intervention the sector must be resourced properly and sustainably with opportunities for leadership development.

Finding 5:

The VCF sector provides innovative and impactful population health management services across Sefton, with expertise in early intervention and prevention of poor health and wellbeing within communities. The voluntary sector estate is a vast trusted asset and enabler for delivering these place-based local services right in the centre of communities. It provides significant opportunities for NHS partners to build upon the assets already available within the VCF sector ecosystem to make services accessible, rather than adding the sector on to NHS systems that are further away from communities.

Finding 6:

The Sefton2gether strategy emphasises the need to embed social value and social impact across the commissioning process to contribute to healthier, happier communities and create a wealthier and more prosperous borough for everyone. The VCF sector in Sefton generates substantial social impact by its very nature being focused on people, places and communities and the sector should be supported to measure and demonstrate this impact to funders, commissioners, and public sector partners. This has been an area identified by the sector as being of value to understanding both individual organisation and collective VCF sector impact. Demonstrating social impact will also allow VCF sector organisations of all types and sizes in Seton to understand and contribute to place priorities, linking in with the PBP.

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2. Measuring the size and scope of the voluntary and community sector in Liverpool (2015), Liverpool John Moores University

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3. Data from internal evaluation of HIU by Sefton CVS
4. Total projected savings over 12 months (£218,000) minus cost of service for 12 months (£163,999)

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5. Rotherham Social Prescribing Service Evaluation (2015) pg.30

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6. Evaluation of Salford's Third Sector Fund Grants Programme (2016) Pg. 47
7. University of Bristol "Off Centre" Social Return on Investment Analysis (2012) Pg. 11

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8. Making Every Contact Count: Values for Money (2016) Pg. 4

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9. Evaluation of the Salford Third Sector Fund Grant Programme (2019) Pg.91

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10. Evaluation of the Salford Third Sector Fund Grant Programme (2019) Pg.56

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Sefton CVS
Supporting Local Communities

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Agenda Item 9

30/11/2021

Dear Health and Wellbeing Board Member,

Re: Alzheimer's Society - Local Dementia Profile Sefton, July 2021.

Please see enclosed a copy of the Alzheimer's Society, Local Dementia Profile for Sefton, produced in July 2021. This profile will give recommendations for local authorities to help improve the lives of people living with dementia in Sefton, and will inform our work going forward.

Kind Regards,

Eleanor Moulton.

Integrated Social Care and Health Manager.

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Local Dementia Profile

Sefton

July 2021

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Introduction

What is dementia?

Dementia is a progressive neurological condition. It occurs when the brain is damaged by diseases (such as Alzheimer's disease) or by a series of strokes. The symptoms of dementia can include memory loss and difficulties with thinking, problem-solving, language and physical function.

The specific symptoms that someone experiences will depend on the parts of their brain that are damaged and the underlying cause of their dementia. The rate of progression will also vary from person to person.

This profile will give recommendations for local authorities to help improve the lives of people living with dementia in Sefton.

What is a dementia pathway?

A dementia pathway will begin at the point that someone becomes aware of changes to their memory, or other symptoms associated with dementia, and will progress through diagnosis, post-diagnosis support, living well with dementia, and eventually end of life care.

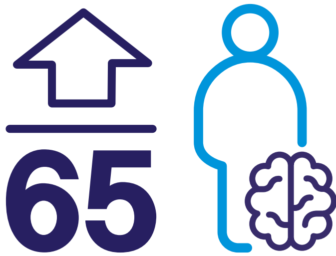
Why are dementia pathways important?

There are currently 850,000 people living with dementia in the UK. This is set to rise to 1.6 million by 2040[1]. The scale and the need to prevent, diagnose, support, live and die well with dementia will only become greater.

Dementia causes complex cognitive and behavioural symptoms and is unpredictable. This means that the provision of appropriate care and support, across the entire dementia pathway, is also complex. This has led to significant variation in practice, with more focus on the early stages of the pathway, and less focus on the later stages, where people find it harder to access appropriate care and support.

This document will give more information about people living with dementia in the **Sefton** area, and will provide good practice recommendations and case studies for each stage of a dementia pathway. These recommendations are only a few of the recommendations for each area, and form part of a larger body of work by the Alzheimer's Society.

Dementia and your local area

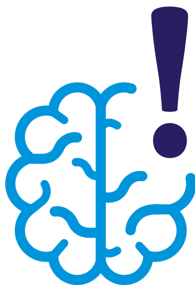


There are an estimated **4,193 people over 65 living with dementia** in Sefton[2]

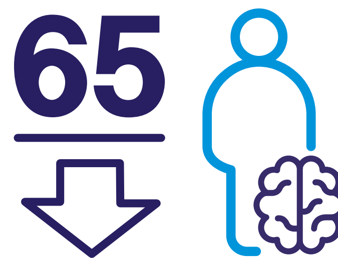
6,438 people will be living with dementia in Sefton by 2030[3]

It is predicted that the cost of dementia care in Sefton by 2030 **will be £293m**[6]

Currently, the annual cost of dementia care in Sefton **is £193m**[5]



By 2030, it is estimated that there will be **4,171 of people living with severe dementia** in Sefton[4]



Currently there are **15,006 people under the age of 65 living with dementia** in England[7]

What should be happening in your area?

Key recommendations to consider:

Each Clinical Commissioning Group (CCG) should have a dedicated dementia lead.

A CCG dementia lead should be responsible for ensuring the delivery of training to GPs on referral criteria, diagnosis and personalised care and support planning, as well as any other dementia priorities identified by the CCG. Having a dementia lead within a CCG area will help to remove variation in dementia services based on postcode.

Leads must have adequate, dedicated time to fulfil this role. Support from senior leadership at the CCG will be vital to making sure that the role of the dementia lead is understood at the GP level.

Involving people affected by dementia in the production and monitoring of local dementia strategies, and the planning of dementia services.

Where they don't currently exist, councils should work together with local Clinical Commissioning Groups (CCGs) to develop a local dementia strategy that maps current and future needs along the NHS England's well pathway.

People affected by dementia should be consulted during any refresh or development of a dementia strategy. To develop this even further the goal should be co-production. Co-production is a way to involve people who have dementia when producing or evaluating services or products for people with dementia.

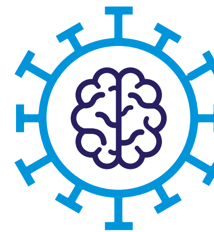
Every health and social care professional directly involved in providing dementia care should be trained to at least Tier 2 of the NHS-backed Dementia Training Standards Framework.

To ensure that people living with dementia receive the standard of care they need from health and care services, it is vital that all health and care staff who are directly providing care are adequately trained in providing specialist dementia care services. This must be accompanied by protected training time, targets for numbers of staff trained and training standards being a part of inspections by regulators. All staff indirectly working in health and social care should be trained to a Tier 1 standard.

Covid-19 and dementia at a glance[8]

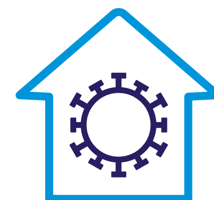
We know that people affected by dementia have been disproportionately impacted by the Covid-19 pandemic.

45.8% of all care home resident deaths involving Covid-19 were people with dementia in England and Wales between March 2020 and 2 April 2021



Dementia and Alzheimer's disease was the most common pre-existing condition among COVID-19 deaths for care home residents. Between the two waves, there were **19,426 people with dementia who died of Covid-19 in care homes**

There were 42,341 care home resident deaths in care homes during the pandemic, including 21,677 deaths in the second wave. **This represents 24.3% of all deaths of care home residents**



1,181 of people have died from Covid-19 in care homes in Sefton between 20 March 2020 and 2 April 2021[9]

For people who survived the crisis, the effects of social isolation were severe. **46% of people with dementia reported that the pandemic had a negative impact on their mental health**

During the pandemic, 92 million extra hours have been spent by family and friends caring for loved ones living with dementia. **95% of carers reported that [it] had had a negative impact on their mental or physical health**

What could the local authority be doing?

Key recommendations to consider:

Local authorities should have a recovery plan in place to help people living with dementia, and their carers, to recover from the adverse effects of Covid-19.

Local authorities, and local NHS partners, should have plans in place to help people affected by dementia, and their carers, rehabilitate and make sure their new needs are being addressed. This could be addressing physical or cognitive deterioration that someone living with dementia or their carers may have experienced due to the pandemic, or helping people living with dementia to re-start living the life they want once restrictions on movements and activities have been eased.

The needs of people living with dementia and their carers may well have changed, so support interventions should happen to ascertain whether any changed or additional support is needed to help the person to continue to live well and manage their condition.

Local authorities must guarantee that where care was stopped due to coronavirus precautions (particularly domiciliary care), it will be reinstated when deemed safe, without the need for unnecessary further formal assessment.

The care needs of people living with dementia did not stop during the Covid-19 pandemic, and in some cases, people's care needs will have intensified during a time when regular care may have stopped. It is therefore vital that care packages are re-instated as soon as possible, to at least the level being received before the pandemic, without having to wait for a formal assessment before care is resumed. We recognise that national government will have a part to play in this in supporting local authorities financially and with guidance.

Diagnosing well:
Data, recommendations and good practice

What is it?

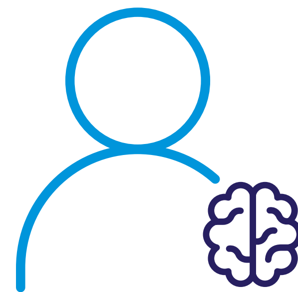
Everyone with dementia should be delivered a diagnosis in a timely and compassionate way. The time between symptoms developing and receiving a formal diagnosis should be as short as possible.

Why is it important?

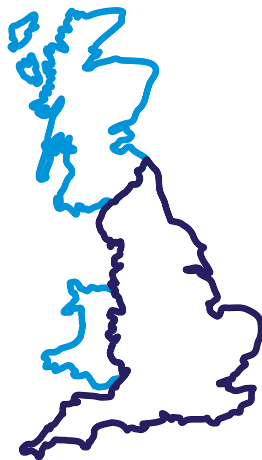
Receiving a dementia diagnosis can be life-changing, and often leads to feelings of grief, loss, anger or helplessness. But a diagnosis is essential in supporting people to live well, even in the absence of a cure or drugs to slow the progression. It opens the door to emotional, practical, legal and financial advice and support.

Diagnosing well in your local area

The dementia diagnosis rate for Sefton is 62.9%, the average for England is 61.7%[10]



2,638 people have received a dementia diagnosis in Sefton[11]



The national target for **diagnosis rates in England is 66%**[12]

35 days

is the average wait time between a referral and an initial appointment at a memory clinic in England[13]

3 ⇨ 34 weeks

is the range of time **between referral and diagnosis of dementia** in England, meaning that many people wait over six months to receive a diagnosis[14]

58.5% of people are diagnosed in the mild/early stages of their condition in England[15]

Recommendations for diagnosing well

Key recommendations to consider:

Health and Wellbeing Boards should monitor the time it takes for a dementia diagnosis to be made.

As we recover from the impact of the Covid-19 pandemic, the initial aim should be a return to pre-pandemic timescales. Once achieved, the aim should be a maximum of six weeks between a referral being made and a diagnosis being received.

Memory services should consider accepting referrals from sources other than primary care, including social services and patients and carers themselves. This would support access to timely specialist input, especially in urgent or crisis situations.

Enabling direct access to specialist services from sources other than primary care, particularly in urgent or crisis situations, reduces the number of potential gatekeepers, therefore providing more timely access to a diagnosis. Speeding up the diagnostic process will allow people to better plan for their condition, as well as facilitate access to other support services sooner.

Memory services should have clear referral pathways to enable access to psychiatrists, psychologists, occupational therapists, social workers and dementia advisers, as well as linguists and interpreters, during the diagnostic process.

Navigating the health and social care sector can be complex and confusing for people with dementia. Yet identification of health and social care needs at point of diagnosis, with clear pathways to allied health professionals, clinicians, and support services, can enable people to access the right services, at the right time, for the right level of need.

Good practice for diagnosing well

Primary Care

As part of the Integrated Care Communities model in North Cumbria, a pilot is taking place in which a nurse-grade Memory Link worker is based in a GP surgery one day a week. The worker screens and reviews patients identified at the practice with existing or suspected dementia.

They can make fast-track referrals to the Memory and Later Life Service (MLLS), with the GP offering triage of more complex cases. This pilot is a partnership between MLLS and primary care, resulting from consultation with people living with dementia and their families. It aims to improve access to MLLS and free up GP time.

Supporting well:
Data, recommendations and good practice

What is it?

Everyone who has received a dementia diagnosis is entitled to immediate short-term support to help come to terms with their diagnosis, and plan for the future. A dementia diagnosis does not just affect the person with a diagnosis. Informal carers will also need support post diagnosis.

Why is it important?

Initial post-diagnostic support is vital to ensure that people can come to terms with their diagnosis and that they're better able to manage their condition. Given the variety of symptoms that people can experience; post-diagnostic support is essential to facilitate access to services.

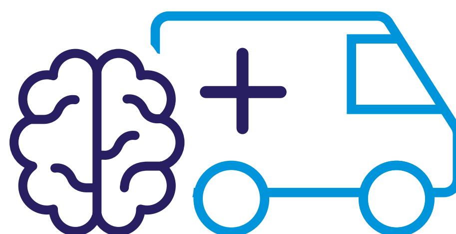
Supporting well in your local area

The value of dementia support contributed by unpaid carers in **Sefton is £118.9m**[16]

In Sefton, 34.4% of carers spend 100 hours or more per week providing care[17]

43% of all carers reported caring for someone living with dementia in Sefton[18]

Nationally, ADASS reported **4.2m more people became carers** in the first 3 months of the pandemic



The standardised figure for emergency admissions related to dementia is **3,517 nationally and 4,176 in** [illegible] 100,000[19]

Recommendations for supporting well

Key recommendations to consider:

Everyone with a dementia diagnosis should have a named care coordinator. For example, this could be allocated during the initial post-diagnostic support meeting with the memory service but could be reviewed within primary care.

Under NICE guidance, everyone diagnosed with dementia should have access to a named health or social care professional. This person is responsible for coordinating their care from the point of diagnosis to the end of life. During the early stages of the condition, this may involve signposting to services. In later stages it may involve coordinating all aspects of the person's health and social care.

Memory services should all include dementia adviser services, with people automatically referred to the service unless they opt out. There must also be integration of dementia adviser services within primary care.

Receiving a diagnosis can be an overwhelming experience, often with too much or too little information given at the point of diagnosis. Diagnostic services are often only commissioned to provide diagnosis only, and will discharge once the diagnosis is given, allowing few opportunities for patients to follow up.

Therefore, ongoing dementia advice is a crucial part of supporting well, with people able to get advice as their dementia changes. This will help people to better plan for their care and be able to ask questions about their dementia progression.

Evidence-based, post-diagnostic support interventions should be provided for people with dementia and their carers. These must be appropriate and tailored, considering age, ethnicity, religion, gender and sexual orientation.

Post-diagnostic support interventions, when appropriate for that individual and tailored to their preferences, can be beneficial for cognitive function as well as general wellbeing, and provides a sense of personalised care.

Good practice for supporting well

In Bristol, the GP provides care coordination, but the Dementia Wellbeing Service ensures each GP and person living with dementia also benefits from the support of a named Dementia Navigator and named Dementia Practitioner – these are linked to each GP practice across the city.

The Dementia Navigator and Dementia Practitioner provide additional support to GPs to identify and support people with memory problems and possible dementia, as well as supporting the person with dementia. Every person with dementia has a named Dementia Navigator and knows how to contact them for consistent and proactive follow-up care and support.

Living well:
Data, recommendations and good practice

What is it?

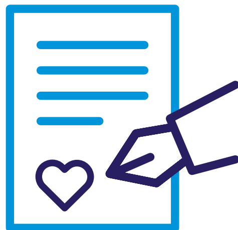
We want to make sure that people affected by dementia live as well as possible for as long as possible.

Why is it important?

People can live well with dementia, given the right opportunities and support. This is helped by consistency of follow-up interventions, care coordination and care plan reviews. It can be achieved through support for carers, and further assessments of need as someone's dementia progresses.

Agenda Item 10

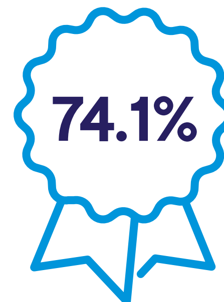
Living well in your local area



In Sefton, 73.0% of people reported having had a **dementia care plan re-assessment within the last 12 months**[20]

In Sefton, **20.9% of carers reported feeling socially isolated**[21]

66.6% is the proportion of care home beds in Sefton rated as 'good' or 'outstanding' by CQC[23]



is proportion of care home beds in England rated as 'good' or 'outstanding'.

In Sefton, **63.7% of carers reported feeling stress or anxiety**[22]

40% of direct care staff report **having dementia-specific training** in the North West[24]

* This figure represents the proportion of care homes rates as eithe[illegible]nding' by the Care Quality Commission. The remaining homes may be yet to receive a rating, or have been rates as 'requires improvement' or 'inadequate.

Recommendations for living well

Key recommendations to consider:

There should be ongoing opportunities for people with dementia and carers to access support interventions following diagnosis.

Dementia is a progressive disease, with symptoms worsening over time. This can lead to changes in care needs of the person living with dementia, and support needs for carers. Therefore, people affected by dementia should be able to easily access support interventions as soon as their needs or symptoms change. This can help people to live in the way that is important to them for longer.

Councils' carers' strategies should include a specific focus on carers of people with dementia, detailing the support to them, including access to psychological support and practical training for unpaid carers.

Carers of people with dementia are vital contributors to our health and social care system. Unpaid carers', or families and friends providing care to their loved ones, are providing care to a value of £13.9billion a year. Yet many of them are struggling in silence, often dealing with myriad challenges including practical, financial and emotional difficulties including stress, loneliness and depression.

Councils should work to ensure that their local authority area is dementia friendly and safe for those living with dementia.

Dementia-friendly communities are vital in helping people live well with dementia and remain a part of their community.

Too many people affected by dementia feel society fails to understand the condition they live with, its impact or how to interact with them. That's why people with dementia sometimes feel they need to withdraw from their community as the condition progresses.

Good practice in living well

Clinical input and quick access to advice and support from a multidisciplinary team working within care homes, to ensure people with dementia can access the right services at the right time and benefit from fast-track referrals.

For example, Care Homes Assessment Teams in Enfield is an integrated, multidisciplinary mental and physical health team. It includes community matrons, geriatricians, a consultant psychiatrist and mental health nurses, occupational therapy, a phlebotomist and pharmacists. It also works closely with primary care, frailty networks and a tissue viability service.

Dying well:
Data, recommendations and good practice

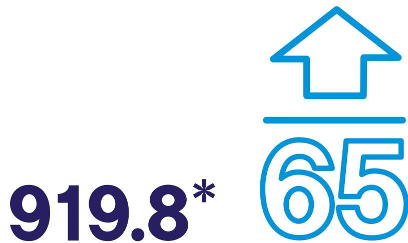
What is it?

Everyone deserves the chance to have the right support and setting at the end of life, and to be as comfortable as possible.

Why is it important?

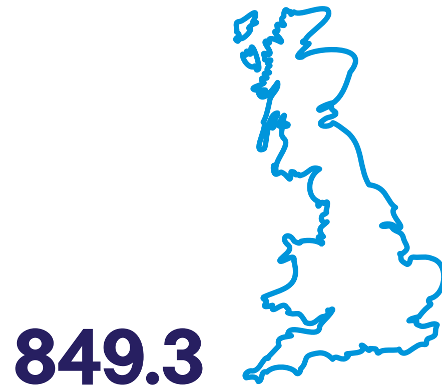
Everyone diagnosed with dementia will have the condition at the end of their life. Dementia is a life-limiting condition and can be the primary cause of, or a significant factor contributing to, a person's death.

Dying well in your local area



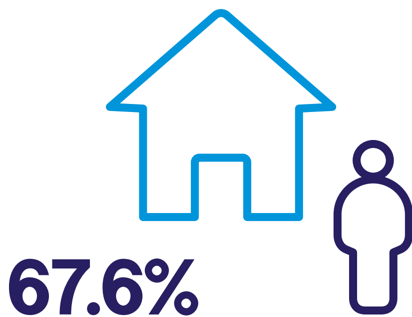
919.8*

is the standardised rate of mortality for people living with dementia over the age of 65 in Sefton[25]



849.3

is the standardised national rate of mortality for people living with dementia over the age of 65



67.6%

was the percentage of people dying at their place of usual residence in Sefton[26]

70%

was the national average of people dying at their place of usual residence

* per 100,000

Recommendations for dying well

Key recommendations to consider:

Health and social care professionals should ensure that all people living with dementia have the opportunity to discuss advance care plans at each stage of a person's pathway.

When a person with dementia is approaching the end of their life, it can be a very difficult time for them and the people around them. Planning for the end of life is important for anyone who has a life-limiting condition. For a person with dementia, it is important to try and have these conversations as early and as often as possible, while they can make decisions for themselves. Discussions at each stage of the pathway will allow for revisions to be made to a care plan, should the person change their mind.

Health and social care staff should ensure that individuals' care plans are always up-to-date and include end-of-life plans.

CCGs and councils should ensure that where accreditation is available all directly delivered or commissioned services meet the National Gold Standards Framework end-of-life care.

The Gold Standards Framework (GSF) aims to optimise care for all people nearing the end of life by helping to improve the quality of care provided and how care is coordinated across boundaries, to enable more people to live well and die well at home.

The GSF provides quality improvement via training, quality assurance via the standards of care that it sets and quality recognition via its recognition scheme. This enables councils to track the standards of end-of-life care delivered by services in their area.

Clearly identify dementia as a terminal condition and conduct an area review of capacity and access to palliative care in care home settings. This must include an audit of training for care home staff, as well as access to out-of-hours support.

We know that people living with dementia often struggle to access palliative care services towards the end of life. This may be in part due to the fact that dementia is often not recognised as a terminal condition or incorrectly categorised as a mental health condition. Some health and social care professionals therefore do not see dementia as a condition that would require palliative care, and do not include end-of-life care in care plans.

Local authorities should conduct a review of their area to determine whether there is sufficient availability of palliative care serv[illegible]are homes, and that staff are suitably trained to deliver end-of-life care.

Good practice in dying well

Developing partnerships between care homes and hospices, where there's extensive experience in palliative and end of life care. For example, Wigan & Leigh Hospice provide a service called 'Hospice In Your Care Home', which sees the hospice work with care homes in the borough. The service provides: support to care home staff to understand the principles of palliative and end of life care, a formal education programme and bespoke training, additional support at short notice if needed, support for the development of advance care plans, and additional support for those important to the person who is dying.

Further information and resources

- **Detailed look at the 'Well Dementia' Pathway**
- **Covid-19 and the impact on people affected by dementia**
- **'The Fog of Support': in-depth look at caring and dementia**
- **A future for personalised care**
- **Your Regional Public Affairs and Campaigns Team**
- **local@alzheimers.org.uk**

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2. **https://digital.nhs.uk/data-and-information/publications/statistical/recorded-dementia-diagnoses**
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21. Ibid.
22. **https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia/data#page/0**

    This figure represents the total of care homes rated as either 'good' or 'outstanding' by the Care Quality Commission. This does not mean that remaining care homes are 'requires improvement' or 'inadequate' as some care homes will not yet have received a rating.
23. **https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/publications/national-information/The-state-of-the-adult-social-care-sector-and-workforce-in-England.aspx**
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25. Ibid.

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Report to:	Health and Wellbeing Board	Date of Meeting:	Wednesday 8 December 2021
Subject:	Early Years Foundation Stage		
Report of:	Executive Director of Children's Social Care and Education	Wards Affected:	(All Wards);
Portfolio:	Education		
Is this a Key Decision:	N	Included in Forward Plan:	No
Exempt / Confidential Report:	N		

Summary:

To brief members on current activity taking place within the LA focused on increasing the proportion of children in Sefton who start school ready to learn.

Recommendation(s):

(1) Members of the board are asked to note the content of the report.

(2) Members of the board are asked to endorse the proposed next steps.

Reasons for the Recommendation(s):

This is a critical area of activity in achieving the outcomes of the Health and Wellbeing Strategy and Children and Young Peoples Plan for Sefton.

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

Not applicable

What will it cost and how will it be financed?

(A) Revenue Costs

No identified Revenue costs from the contents of this report

(B) Capital Costs

No identified Capitals costs from the contents of this report

Implications of the Proposals:

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

Equality Implications: There are no equality implications.
Climate Emergency Implications: The recommendations within this report will

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

The contents of this report reflect a neutral impact on climate change.

Contribution to the Council's Core Purpose:

Protect the most vulnerable: The paper details activity to support all our children to achieve school readiness
Facilitate confident and resilient communities: The paper details activity to support all our children to achieve school readiness
Commission, broker and provide core services: Not applicable
Place – leadership and influencer: The paper details activity to support all our children to achieve school readiness
Drivers of change and reform: The paper details activity to support all our children to achieve school readiness
Facilitate sustainable economic prosperity: The paper details activity to support all our children to achieve school readiness and contributors to sustainable economic prosperity in the future
Greater income for social investment: Not applicable
Cleaner Greener: Not applicable

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD.6627/21.) and the Chief Legal and Democratic Officer (LD.4828/21) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

Not applicable

Implementation Date for the Decision

Immediately following the Board meeting.

Contact Officer:	Suzanne Payne
Telephone Number:	
Email Address:	Suzanne@suzannepayne.co.uk

Appendices:

The following appendices are attached to this report:

Appendix One – Overview of Sefton Early Years in Sefton

Background Papers:

There are no background papers available for inspection.

1. Introduction

1.1 From the start of the current academic year Schools and other early years providers are required to implement a revised version of the Early Years Foundation Stage Statutory Guidance. This provides a refreshed focus on the skills children need in order to be; ready for school at the age of 5; capable of making expected or better progress throughout their school career and therefore well placed to be a resilient and self-reliant Sefton resident.
Within the revised framework, it states that a child's Early Years (pre-conception to age 5) is the optimum time to bring learning and progress back on track. This is confirmed by evidence-based research conducted by the Education Endowment Foundation which states that if a child leaves the Early Years Foundation Stage with their learning and development below the age-related expectation, they are unlikely to regain this lost ground at all during the remainder of their school career.

The focus on school-readiness at the age of 5 is necessarily part of the delivery model and outcomes framework of the LA and partner agencies as we aspire to the following:

- all parents having access to the support they need
- high quality early years services across education, health, Early Help and private and voluntary service providers
- excellent places to play, develop and learn
- strong leadership and systems

The information below details;

I. The systems and collaboration in place in Sefton to facilitate these improved outcomes
II. Considerations for future development in order to maximise the impact of this window of opportunity in the life of every Sefton resident and potentially decrease demand on public services.

2. Body of report

The Sefton Early Years Landscape

I. 0-5 Education provision in Sefton is delivered by; maintained Nursery Schools, schools with Nursery Classes, PVI providers (day nurseries and voluntary pre-schools) and in some cases child-minders.
II. All Local Authorities have a statutory duty to secure sufficient childcare of an appropriate quality (ie judged good or outstanding by OFSTED).
III. To support the maintenance of quality, challenge and support is currently provided to schools through the School Improvement Service (Education Excellence) and to PVI settings and Childminders through a team of 3 'Quality Improvement Officers' (Early Help). Plans are underway to deliver this support and challenge via a single Early Years Team within the Education Excellence Function.
IV. LA Officers in both teams maintain an overview of the quality of provision in each school / setting, through scrutiny of intelligence, including OFSTED Reports and targeted support and challenge visits delivered by LA officers, professional partners and the QIOs. This is complemented by a repertoire of professional development opportunities.
V. Longstanding partnership with Children's Health Services has facilitated a strategic approach to quality improvement activity focused on thematic areas for development such as Communication and language. This activity is currently funded by underspend from the Early Years Block of the DSG which makes long term delivery uncertain. Discussions between senior council and health officers about a place-based approach to the resourcing of projects such as this would be of assistance in securing long term delivery.
VI. Recently Early Years Leads from across the LCR commissioned the LGA to undertake a Peer Review of Early Years Services across the region. The outcomes of this review not surprisingly identify the need for a co-ordinated strategy to improve outcomes in children's communication and language. Work to develop this is currently underway. In addition, the Merseyside Violence Reduction Unit has been successful in recurring resources from the NSPCC in the form of the LCR 'Look Say Sing Play' initiative. This has been designed to support parents to develop better attachments and to become more 'in tune' with the needs of their babies and young children. Each Local Authority within the LCR will be provided with £50,000 of resources to disseminate the project across the local area. The dissemination of resources will be accompanied by a media campaign to raise the profile of this approach.

Outcomes for Children

I. Currently the proportion of children achieving a Good Level of Development (GLD) varies considerably between Sefton localities. Achievement of the GLD in Sefton is inverse proportion to deprivation.
II. Cabinet members may have read or seen in recent news items detailing further delays in children's development occurring as a direct result of the COVID-19 pandemic. These reports relate specifically to children's communication skills, which; schools, early years providers and health professionals were already concerned about prior to the pandemic.
III. Clearly these delays in children's development and attainment not only risk impairing their capacity to become resilient and self-reliant citizens, they also risk creating a significant cost to public services.
IV. Early Years Services in Sefton are therefore focused on intervening at the earliest opportunity to address; environmental, social or developmental issues that may create barriers to a child achieving the expected outcomes at the age of 5.
V. The supporting document that accompanies this report details the range of providers (public, private and voluntary services) directly involved in service delivery focused on support, assessment and, where appropriate, intervention to ensure that babies and young children meet expected milestones at key points in their development from pre birth to age 5.

VI. Members will be aware that the work of these providers is complimented by a broader range of services, including the police, housing and benefits departments and other voluntary services e.g. SWACA.

VII. The range of services involved in supporting all Sefton residents is substantial, and co-ordination and a shared purpose is necessary to ensure that residents can access support in a timely and appropriate manner and without duplication.

VIII. Given that Early Years (pre-birth to age 5) is the optimum time to set Sefton residents on the path to achieving expected outcomes and becoming self-reliant citizens, co-ordination of Early Years services is essential.

IX. To address the disparate nature of Early Years Services an 'Early Years Development Group' was established in September 2019. The group is comprised of representatives from;

- LA Services; Education, SEND, Early Help and Finance
- Health Services; Health Visiting and Children's Therapy Services
- Schools; Primary and Nursery School Headteachers
- Private and Voluntary Early Years Providers
- Other providers that complement the work of those detailed above are invited as necessary in order to progress or inform a particular action.

The group was created from the Early Years Sub-group of Schools forum and agreed terms of reference for the group include;

- the development of; a shared Early Years Strategy and implementation plan for Sefton
- proposing to Schools Forum the allocation of the permitted percentage of the Early Years Block of the Dedicated Schools Grant in order to fund the activity detailed in the implementation plan.
- The expectation that all members of the group will contribute to the delivery of the implementation plan and provide the group with reports detailing progress towards the collectively agreed objectives.
- Accountability for all members of the group to feedback to and influence the direction on travel of their respective organisations in relation to Early Years' service delivery.

Reports detailing the work of the Early Years Development Group are shared at; School's Forum and the Early Help Partnership Board.

Achievements of the group and the Early Years Services represented are:

- Establishment and implementation of a COVID Recovery Plan for Early Years providers.
- The proactive involvement of all services represented in the co-ordination and delivery of Early Years services with a view to improving the number of children who meet expected milestones from pre-birth to age 5.
- Identification and allocation of funding to support providers that remained open during the first lockdown (in advance of the government and LA grants open to Private providers)
- Delivery of and Early Years Education Improvement Training programme in partnership between the LA, Sefton Teaching Schools and a Maintained Nursery School.
- Delivery of training and briefing events to ensure that teaching staff and leaders, including headteachers in schools and other early years settings are best place to implement the new Early Years Framework.
- Delivery of an accredited award for early years Special Educational Needs Co-ordinators

- Collaboration across the Liverpool City Region to deliver a shared approach to support for children's communication and language through the implementation of the 'Sefton Language Pathway'. This had previously run for a number of years in Sefton as a partnership between the LA and the Speech and Language Therapy Service. Capacity to deliver this had reduced as a result of re-organisation within LA services. Temporary funding has been secured from the Early Years Block to continue this approach during 2020-21 and again during 2021-22, however there is a risk that this funding may not be available in future years.

3. Next Steps

At a strategic level:

I. Continue and strengthen the work of the Early Years Development Group
II. Review reporting and communication structures to ensure that the co-ordination of Early Years Work is reported at the highest level within the LA and partner organisations e.g. the Children and Young peoples partnership Board, The Early Years Provider Alliance and the Clinical Commissioning Group.
III. Establish a 'Sefton Early Years Service' within the Educational Excellence Function and collaborate with partners to; develop an Early Years Strategy for Sefton and co-ordinate service delivery in line with partners' aims and objectives.

At an operational level

IV. Review progress towards objectives set out in the Early Years Development Group implementation plan for 2021-22.
V. Undertake a review of the process of carrying out the integrated review for 2 year old children. This is a review of children's health and educational development that is a requirement of the both the Health Visiting 'Healthy Child Programme' and the Early Years Foundation Stage.
VI. Create closer collaboration between Early Help and Social Care to identify children not benefiting from access to the free educational entitlement at age 2,3 and 4.
VII. Implement the agreed revised processes to support the inclusion of children in schools and early years settings with Special Educational needs and Disability (this has been undertaken as part of the review of the Las SEND services)

4. Resource Implications

Sustain the cost of delivering the Liverpool City Region Communication Pathway
Review the co-ordination of Early Years Strategy and Services

Sefton Early Years in Sefton

The table below illustrates the partners and stakeholders collaborating to deliver Early Years Function across Sefton. Delivery of the functions detailed is intended to facilitate early identification of need leading to intervention to impact significantly on children's:

- school readiness at 5
- overall education attainment
- future economic potential, resilience and independence.

This aim is underpinned by the principles of Public Service Reform and concepts of early assessment and identification of need, intervening assertively and using interventions that have a proven evidence base of success. The functions detailed support the wider aims of the LA in making tangible progress in supporting residents to be independent and self-reliant, and to reduce expensive demands on public services

Service and status	**1. National Healthy Child Programme - HCP(Universal) Statutory - Commissioned by Health**	**Healthy Child Programme HCP (Targeted)**	**2. Sefton Speech and Language Pathway Universal / Targeted and Specialist Services**	**3. National EYFS Universal Statutory for all registered providers – Commissioned by the LA**	**EYFS Targeted**	**4. Sefton Educational Excellence Service, incorporating EYFS Quality Improvement Interventions. Statutory Interventions related to School Based provision Non-statutory Quality Improvement Interventions – commissioned by LA / Schools**	**5. National Early Help - targeted**
Explanation	The HCP aims to: 1. Help parents develop and sustain a strong bond with children 2. Support parents in keeping children healthy and safe and reaching their full potential 3. Protect children from serious disease, through screening and immunisation 4. Reduce childhood obesity by promoting healthy eating and physical activity 5. Identify health and wellbeing issues early, so support and early interventions can be provided in a timely manner 6. Focus on the health needs of children and young people ensuring they are school ready (SEND Code of Practice 0 – 25 years, 2017) 7. Make sure children are prepared for and supported in all child-care, early years and education settings and especially are supported to be 'ready for to learn at two and ready for school by five'		Locally developed Pathway delivered in partnership between Children's Therapy Services, Local Authority Early Years Team and Early Education Providers in schools and PVI settings. The aims of the pathway are: 1. To support parents, through universal provision, to promote their children's SLC Development. 2. To use universal assessment points to identify whether children may be at risk of delay in their SLC Development. 3. To reduce the number of children referred to specialist services by upskilling Early Education Providers to identify and address children's emerging low-level SLC needs in setting-based provision. 4. To deliver professional development and access to the advice of a S&L Therapist (drop-ins service) – in order to achieve 3 above. 5. To provide access to accredited training for Language Champions to promote deep knowledge and understanding of early language development and strategies that support early identification and intervention. 6. To develop assessment children's early Language development using WellComm at 2 and for entry into Reception.	**The Early Years Foundation Stage (EYFS) sets standards for the learning, development and care of children from birth to 5 years old. All schools and Ofsted-registered early years providers must follow the EYFS, including childminders, preschools, nurseries and school reception classes.** The EYFS framework supports an integrated approach to early learning and care. It gives all professionals a set of common principles and commitments to deliver quality early education and childcare experiences to all children. As well as being the core document for all professionals working in the foundation years, the EYFS framework gives mums and dads confidence that regardless of where they choose for their child's early education, they can be assured that the same statutory commitments and principles will underpin their child's learning and development experience.		Bespoke support for EYFS settings and schools, provided in inverse proportion to success and where appropriate, in the context of Sefton School Causing Concern Strategy Projects / interventions co-ordinated by LA Officers / System Leaders to support EYFS Education Providers, including schools to deliver high quality provision that is effective in accelerating progress where necessary and securing expected attainment.	Early help is support given to a family when a problem first emerges in order to minimise escalation of problems and statutory involvement of services... The main focus of Early Help Services is to improve outcomes for children and increase protective factors in a child's life (Early Intervention Foundation (EIF), 2018). Family Wellbeing Centres offer a range of Early Help Services to: children, young people and their families; education providers; as well as partnership delivery for targeted priorities. **Various Parenting Programmes**; • Playing to Learn • Relax Kids • Incredible Years • VIG (Video Interactive Guidance) • Think Differently, Cope Differently • Triple P • ACEs • Therapeutic Services via IAPT (Improved Access to Psychological Therapies) Early Help workforce offer support for families to access the 2YOO and increase take up of the offer.

Explanation	As set out in the HCP: ready for school is assessed as every child will have reached a level of emotional development, which enables them to: • communicate their needs and have good vocabulary • become independent in eating, getting dressed and going to the toilet • take turns, sit still and listen and play • socialise with peers and form friendships and separate from parent(s) • have physical good health, including dental health • be well nourished and within the healthy weight for height range • have protection against vaccine-preventable infectious diseases, having received all childhood immunisations	See explanations detailed in columns 1 and 3.	As set out in the EYFS Statutory Guidance: The statutory framework for the **Early Years Foundation Stage** (**EYFS** 2017), describes **school readiness** as 'giving children the broad range of knowledge and skills that provide the right foundation for good future progress through **school** and life'. School Readiness therefore, is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally. The good level of development (GLD) is used to assess school readiness. Children are defined as having reached a GLD at the end of the Early Years Foundation Stage if they achieved at least the expected level in the early learning goals in the prime areas of learning (personal, social and emotional development, physical development and communication and language) and in the specific areas of mathematics and literacy	Quality provision in EYFS is secured through a workforce which is confident in: • Working together • Engaging with families • Understanding the importance of pedagogy and chid development • Ensuring high expectations for children to realise the best outcomes • Delivering high quality practice and teaching that make a difference on a daily basis to children's outcomes. Quality improvement is the means by which schools, settings and professionals consider how best to create, maintain and improve provision in order to offer the high-quality learning experiences. Children who experience high quality provision are well placed to achieve higher outcomes and develop better social, emotional and cognitive abilities necessary for life-long learning.	Protective factors include the development of strong social and emotional skills combined with access to a strong social support network for the family – including: • support for good parental mental health • income support, benefits and advice • good community services and facilities
Success Measure	Assessments and contact delivered Assessments points evidence an increase in the proportion of children at expected levels of development. Increase in proportion of children attaining GLD.	See success measures detailed in columns 1 and 3 plus, number of providers accessing drop in S&L service and impact on referral rates.	Number of providers judged good or better by OFSTED Increase in proportion of children attaining GLD. 2YO Integrated Review evidences increase in proportion of children with development at expected level WellComm assessments evidence increase in proportion of children with communication development at expected level	Increase in proportion of children attaining GLD.	Increase in proportion of children attaining GLD.
	The following specialist services compliment the range of universal and targeted services accessibly by children and families: I. Children's Therapy Services II. Specialist Speech and Language Therapy Involvement as set out in Sefton Speech and Language Pathway III. Local Authority SEND Services				

ntributors and Barriers to Success

ntributors	Possible Next Steps
1. The opportunities to the system afforded by the whole-family, pathways detailed in columns 1 and 3 above (from pre-birth to the last term before the child's fifth birthday). 2. A track record of securing funding and implementing evidence-based interventions – in order to improve school readiness. 3. Quality Improvement systems – resulting in no provider of Early Years Education being judged less that good by OFSTED. 4. Quality Workforce 5. System Leadership - The facility to draw on the education system to support a consistent coherent approach to the maintenance of quality practice	1. Appraise elected members, senior LA officers and public bodies such as the CYPPB , HWBB, and Provider Alliance of the breadth of Early Years delivery 2. Undertake a review of the position and connectivity of 'Early Years' in its widest sense, in Sefton – currently there is no strategic lead and functions are split across council departments. 3. Explore the role of Day Care and Early Education providers delivering the free entitlement in helping drive parent engagement in education, employment, training and volunteering. 4. Develop a data dashboard showing ward level GLD data mapped against levels of deprivation to help identify areas of good practice, support shared learning and intervene to address emerging need. 5. Consider the development of a shared outcomes framework of population indicators and individual child measures. 6. Consider how long-term impact will be evaluated in order to ensure families' needs continue to be addressed

Report to:	Overview and Scrutiny Committee (Children's Services and Safeguarding) Health and Wellbeing Board	Date of Meeting:	16 November 2021 8 December 2021
Subject:	Report on the Council's NEET Reduction and Early Intervention Service commissioned through Economic Growth and Housing (Employment & Learning)		
Report of:	Head of Economic Growth and Housing	Wards Affected:	All Wards
Portfolio:	Regeneration and Skills		
Is this a Key Decision:	No	Included in Forward Plan:	No
Exempt / Confidential Report:	No		

Summary:

To update Members on work relating to this Key Decision and advise on the progress of the Sefton Economic Strategy Action Plan (Dec 2019), the associated Covid-19 Recovery plan and plans to refresh and update the Sefton Economic Strategy Action Plan from April 2022.

Recommendation(s):

That Members note:

(1) The report and the progress made by the NEET Reduction and Early Intervention Service.

Reasons for the Recommendation(s):

To provide information to Members on the performance of this key contract delivered by Career Connect on behalf of Sefton Council.

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

None

What will it cost and how will it be financed?

(A) Revenue Costs

There are no direct revenue costs associated with the recommendations in this report.

Costs for the operation of this service fall within existing budgets within the Economic Growth and Housing (Employment & Learning) department.

(B) Capital Costs

There are no direct capital costs associated with the recommendations in this report.

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets):
All resources required for the operation of this service including adequate staffing levels of professionally qualified staff are operated by the Council's commissioned provider, Career Connect.

Legal Implications:
None arising from this report

Equality Implications:
There are no equality implications.
The equality implications of this Service are positive. The service improves the lives of young people from across Sefton through effective and personalised progression planning which take individual needs and aspirations into account. Specific focus on vulnerable groups enhances the ability of disadvantaged young people to reach their full potential and make a successful transition to adulthood.

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

Contribution to the Council's Core Purpose:

Protect the most vulnerable:
This service brings added value to the Council through its sustained focus on their wellbeing and attainment of various vulnerable groups including young people known to the justice system, looked after children and care leavers, young people with SEND, teenage parents and others.

Facilitate confident and resilient communities:
Employment is a key indicator in improving resilience within our communities, as young people will be more able to make a positive and confident contribution if they can plan and achieve their goals.

Commission, broker and provide core services:

This commission delivers the statutory duties related to the tracking and destinations of all young people aged 16 and 17 in the borough of Sefton and supplies regular reports to the government on rates of NEET required by all Local Authorities. The service also supplies the key requirements for the Council related to the Raised Participation age.
Place – leadership and influencer: This commission plays a key role in the wider local offer for young people in Sefton and works in synergy with education and the Post-16 training and employment system to provide pathways for their progression
Drivers of change and reform: The Council has chosen to extend and add value to its statutory duties for young people aged 16 and 17 by extending tracking through this service for 18-year olds and introducing innovative early intervention approaches to identify younger people from year 9 upwards most at risk of becoming NEET at age 16.
Facilitate sustainable economic prosperity: This service operates within the portfolio of employment and skills support programmes offered by the Council through the Employment & Learning team in Economic Growth and Housing, alongside regeneration, planning and business support. These links amplify connectivity with employers offering apprenticeships, traineeships, jobs and vocational training and contribute to the economic prosperity of Sefton.
Greater income for social investment: All routes for employment, work experience and vocational progression are promoted to young people and wherever possible the options to undertake these activities with organisations and employers with a social investment agenda are maximised.
Cleaner Greener The service provider, Career Connect, has provided an environmental sustainability plan as part of the procurement process and refreshes this regularly. This includes promotion of public transport, awareness of the Council's policies on carbon emissions, single use plastics etc.

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD 6606/21) and the Chief Legal and Democratic Officer (LD.4807/21) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

N/A

Implementation Date for the Decision

Immediately following the Committee/Board meeting.

Contact Officer:	Claire Maguire
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Appendices:

There are no appendices to this report

Background Papers:

There are no background papers available for inspection.

1. Introduction/Background

The Education and Skills Act 2008 legislated to raise the age of compulsory participation in education or training to 18 by 2015 and until the end of the year in which young people turn 17 in 2013 – this is known as Raising the Participation Age (RPA). Local Authorities are responsible for ensuring that young people in their area participate in learning and to ensure there is support for young people to overcome personal barriers to engagement. Local Authority RPA plans are inspected by OFSTED, as part of reviewing arrangements for their support of school improvements.

The Act placed the following two duties on local authorities with regard to 16 -18-year olds, known as the **September Guarantee** and **Tracking duties** which are described as follows:

- To promote the effective participation in education and training of 16-17-year olds in their areas with a view to ensuring that these young people fulfil the duty to participate in education or training

- Make arrangements to identify 16-17-year olds who are not participating in education or training ensuring that robust tracking arrangements are in place to identify young people who are not engaged in education or training or who have left provision enables local authorities to offer support as soon as possible.

The September Guarantee is a guarantee of an offer, made by the end of September, of an appropriate place in post 16 education or training for every young person completing compulsory education. Ensuring that every young person has an offer of a place to progress onto is particularly important as it helps young people make a seamless transition into post 16 learning or employment with training.

The Council, like all local authorities must consider how best to meet its duties for young people Not in Education, Employment and Training (NEET) within a dynamic legislative framework whilst also considering ongoing budgetary constraints.

The transition from school into work is a vital stage in the lives of our young people. A successful transition through a high quality, valued pathway can be the start to a promising career. Becoming trapped in poor quality, low paying alternatives can trigger many downstream costs and contribute to a loss of personal, social and economic capital, (which can be measured through increase in the number of those who are NEET).

We know that young people who do not make successful transitions at 16, 17 or 18 years of age may well require the support of a range of partners and agencies in later life to help them get back on track or to a positive outcome. Furthermore, young people who spend periods NEET at this key time in their lives are less likely to feel empowered to have ambitious goals and aspirations for their future, leading to a loss to themselves in terms of their individual potential unfulfilled but also a loss to their communities and the wider economy benefitting from their talents.

2. The NEET Reduction and Early Intervention Service

The NEET Reduction and Early Intervention Service (NR&EIS) was commissioned by Economic Growth & Housing in December 2018 under the leadership of the Cabinet Member for Regeneration and Skills and aims to achieve the following objectives:

- Reduce the levels of young people NEET year on year over a 3 – 4-year period and cover all the relevant statutory duties for the Council as listed above
- Track the destinations of all young people so as to reduce the number of Not Known young people
- Introduce an Early intervention model for those young people most at risk of becoming NEET and monitor the impact of this model on NEET levels
- Continue the destination tracking of academic age 18 young people no longer covered by the statutory duty to Local authorities from 2018
- Provide a focused support service for a designated range of vulnerable groups who have high levels of NEET with a primary focus on disengaged young people below the age of 19 and relevant adults up 25 who have an Education, Health and Care Plan (ECHP) and care leavers who are NEET.
- Augment the provision of high-quality careers guidance provided by schools in line with the Gatsby standards for those young people who are NEET
- Work in partnership with Sefton@work and other local agencies such as the FE Colleges and training providers and schools to design interventions to reduce NEET and promote sustainable employment

Following a procurement exercise Career Connect were appointed to deliver the Service and operations commenced in June 2018 for a period of three years, with an option for the Council to extend for a further year on the basis of effective performance.

The key elements of the contract include:

- Supporting the Local Authority Statutory Duty to ensure young people who are NEET aged 16-19 years old (and those up to 25 with an ECHP in place and Care Leavers who are NEET) receive relevant information, advice and guidance in

order to be supported to a successful transition into post 16 education, employment and/or training. This includes young people who attend out-of-borough Alternative Provision settings or young people who have been excluded from mainstream school and are vulnerable to becoming NEET.

- Identify young people in the Spring term of Year 11 and Year 12 who have no intended destination or whose intended destination is doubtful and deploying skilled advisors to support them into an offer of an appropriate place, to meet the Councils responsibilities under the Raising Participation Agenda and DfE reporting.

- A targeted IAG service to promote EET to vulnerable groups through intensive working in partnership with specialist services to support identified vulnerable groups. This includes an engagement service to target those in the NEET cohort and those whose situation is currently Not Known (NK), in order to achieve full participation in education, employment or training (EET) through to age 18 and ensure individuals are supported to remain EET thereafter.

- An early intervention response for young people in years 9,10 and 11 who are deemed most at risk of becoming NEET and disengaging from provision by the age of 16 and 17.

The innovative model of Early Intervention and Prevention within the commission is primarily targeted at young people from vulnerable groups and those from disadvantaged backgrounds who require additional support to access learning and employment opportunities with a particular focus on promoting retention and preventing disengagement in years 9, 10 and 11. Close liaison and communication with schools is key and the underlying relationships of trust with Career Connect have proven essential. This new element was introduced as the Council recognised that there are a variety of potentially complex reasons for why these young people find the transition from school to be challenging. For example, they may have a lack of awareness or understanding of the potential opportunities available to them, the absence of a role model or low self-esteem. However, with early intervention we can work with these young people to provide support and identify ways of addressing any challenges or barriers they have, which will support the Council to continue to reduce the number of young people becoming NEET.

The service carries out an Annual Destinations Survey where the destination of all young people aged 16-18 is confirmed. The purpose of the Destinations Survey is primarily linked to the September Guarantee in terms of ensuring Year 11/12's continue on in education, training, or other positive destinations. Those young people that are identified as not moving into a positive destination are offered appropriate support and alternative opportunities. Those who have not made a successful transition after the survey will form part of the NEET group and therefore are targeted by Career Connect specialist advisers and coaches. The LA must also report monthly on young people's destinations.

Whilst NEET terminology commonly conjures up images of the long-term unemployed known as the "Core NEET groups", it also covers to those who drift in and out employment and/or education and/or training (NEET 'churn'), and to those who take 'time

out' after completing compulsory education (transition/gap NEET). There are also several significant equality issues to be considered related to disability, gender, orientation and other characteristics which mean that a personalised approach to meet the needs of all young people is required.

The continued tracking of 18 year olds as an additional local measure has given the Council a much better understanding of where these young people are in relation to positive destinations and identify those who need additional support to enable earlier engagement, working towards an onward pathway of support into the adult world of work through referrals into our in-house job brokerage service, Sefton@Work.

We believe that by strengthening a more preventative approach at an earlier age will reduce the number of young people being disengaged from aged 16 onwards and this commission expects to demonstrate the effects of this shift over time with increased preventative actions feeding through into reductions in the overall NEET population over the course of this commission and beyond.

The Key Outcomes we expect to achieve through this commission are:

- An overall reduction in the NEET rate for Sefton, improving throughout the contract period
- A reduction in the Number of Young People whose destination is Not Known
- A reduction in the Number of days Young People spend NEET
- An increase in the Number of Young People who are EET
- A reduction in the levels of NEET within the following vulnerable groups:
    - SEND young people up to the age of 25 who have an EHCP in place
    - Looked after Children and Care Leavers
    - Young people known to YOS Services
    - Young people who are part of Sefton's Turnaround Families
    - Young Carers

Achieving these targeted outcomes will help Sefton Council to improve its performance in relation to the reduction of NEET in comparison with the LCR, statistical neighbours and at a national level. This commission sets out to improve this ranking year on year, through the lifetime of the project wherever possible.

As part of this service and additional to supporting NEET and Vulnerable Young People the following activities take place on an annual basis. The timeline for the operational year July 2021/2022 is as follows:

Date	Activity
July/August	• September Guarantee Contact with schools/providers and colleges continuing to update offer of learning • Support those young people with no offer or at risk of NEET • Work with identified Year 11 RONI and Vulnerable Groups
End August	• All Education and Learning Destinations Expire and require follow up for all and review for all 16/17/18 years (SEND up to 25yrs)
Sept/Oct	• Confirm destinations of full cohort approx. 8500 young people • Activity Survey all Year 11's educated in Sefton report on 31st October.

	• Starters lists received, input starts and update September Guarantee status • Liaising with schools regarding Statutory Duty and performance of post 16 • Request UCAS lists for Year 14 • End of September – report on September Guarantee Offers Met. • Review of SEND eligibility – plan reviews for the academic year • Review Looked After Cohort and transition to Leaving Care Cohort • All year groups move • October is a known leaving points for early 'dropouts' target support for early intervention.
November	• RONI Focus: Cohort Check and for Year 11 risk of NEET identification • Review of all vulnerable group cohorts
Mid-January	• **Mid Jan** - Start Year 11 and 12 Cohort Checks • **End Jan** -School re-confirm cohort and registration status of each student, including details of any students now not on roll and where they have moved onto (new school, out of area into another LA). • Update any characteristically and risk of NEET information. • Report on Activity Survey and individual school data produced
February Half Term	• Transition support for Year 11/Vulnerable groups on going but targeted resource reviewed to maximise impact.
March	• **Focus: September Guarantee** send previous cohort check (Jan) returned to school and request offer information for each Year 11.
April	• Send supporting reminder requests for final checks from any outstanding schools • End of April - Send previous cohort checks (from Jan) returned to school and request a final 'sign off' of the cohort
Early May	• Final Cohort Check
June	• Identification of vulnerable groups • Start of September Guarantee Process

3. How are we Doing? A snapshot of Current Performance on NEET

As part of the NR&EIS, a suite of agreements has been put in place to enable us to bring forward the completion of the September Guarantee destinations. This gives us increased assurance that the data we have on destinations for those leaving school is extremely robust. On 30th September 2021, our data confirms that we have now achieved our best ever performance for the September Guarantee for year 11 at **98.7%** and for year 12 at 95%. This is due to the excellent relationships we have with Sefton Schools, FE Colleges, 6th Form Providers and Training Providers where they share information regarding learning offers made to young people for September Through these links, we can work with the relevant institutions to ensure early identification of young people who fail to start their offered place to identify alternative provision as soon as possible.

Through the delivery of our NR&EIS, we have adapted our delivery methods to meet the needs of young people we are working with and have remained focused on key contract performance indicators. Through robust planning we have identified a range of solutions

to address barriers and advocate for young people which has been key to this. During this past year, the Council has benefitted from insight on trends in terms of young people's motivation during college/school closures

The provision of independent Information Advice and Guidance (IAG) is an integral part of the broader education, skills, and employment system. Timely, relevant, and good quality IAG reduces the possibility of mismatches between supply and demand, generates feedback on performance of the system and maximises young people's potential. We aim to ensure that all young people have access to good quality careers guidance, through their school and through our targeted service where this is necessary.

3.1 NEET and Not Known (NK) across our wider 16-18 group

- Our latest data confirms that Sefton has achieved its best ever performance for October 2021, at **3.36%** for NEET/NK for all 16-17-year olds. In October 2020 Sefton ranked 4th out of the 151 Local Authority Areas this year's national comparisons will be published end of November.
- Compared to 2020 Sefton had improved NEET/NK 16-17-year olds by 15 young people and 0.31%
- NEET has decreased for all ages 16-18-year olds, the biggest improvement is with 18year old with a NEET reduction of 52 young people – evidence the service offer is seeing year on year improvements.
- Although participation is slightly down by 0.03% on last year, the cohort is actually an additional 58 young people.
- We have seen an improvement on those young people in (EET) and an increase compared to October 2020 with an additional 73 more young people entering EET destinations
- Career Connect have tracked over 8000 young people in September and October working alongside schools, colleges, and training providers.
- Year on year performance improvement with an annual reduction since 2016/17 from 8% to 4.2% a reduction of 3.8% with NEET/NK and consistently better than North West and England averages
- The current rate and frequency of engagement with clients for tracking Not Known (NK), vulnerable groups and case loaded young people is excellent in Sefton at 0.5% it is the 2nd lowest in LCR, lower than both the Regional and National averages and also the lowest in comparison to our Statistical Neighbours.
- Sefton has the lowest % for NEET and Combined across all our Local Authority areas,
- Sefton is performing better that the North West NEET & Not Known combined measure
- Sefton is performing better that the England NEET & Not Known combined measure

- Sefton is ranked on average month on month second out of its statistical neighbours

3.2 NEET & EET Data for our Vulnerable Groups

The following table gives an outline of the current performance for young people within the vulnerable groups targeted by this service.

	Special Education Need or Disability	Care Leavers	Young Carer	Alternative Provision	Young Parents	Pregnancy /Teen Mums	Known to Youth Offending Service	Elective Home Education - statutory school
Oct-21	**SEND**	**CL**	**YC**	**AP**	**YP**	**P**	**YOS**	**EHE**
Academic Age	16-24	16-18	16-17	16-17	16-18	16-18	16-17	16-17
Cohort size	**650**	**34**	**58**	**70**	**31**	**41**	**26**	47
EET	522	23	52	50	9	13	19	37
NEET	64	11	6	17	21	26	7	7
Other not RPA (eg jobs without training)	2	0	0	0	0	0	0	0
Not Known	62	0	0	3	1	2	0	3
NEET & Not Known %	**19.4%**	**32.4%**	**10.3%**	**28.6%**	**71.0%**	**68.3%**	**26.9%**	**21.3%**
NEET %	9.8%	32.4%	10.3%	24.3%	67.7%	63.4%	26.9%	14.9%
Not Known %	9.5%	0.0%	0.0%	4.3%	3.2%	4.9%	0.0%	6.4%

3. NEET Reduction & Early Intervention Service Supporting Council Departments

Career Connect, our service provider, are committed to working in partnership with the Council responding to local needs and developing opportunities for EET that meet the requirements of young people. We recognise that young people do not fall into convenient categories where complex needs and barriers to progress can be met by a single off the shelf offer. We have therefore ensured that the service does not stand alone, it is an integrated collaborative approach working with a range of other Council departments to support their own statutory duties and a range of Careers Advisors and Coachers are allocated to Council teams which has yielded the excellent results we are not seeing in relation to our current NEET figures.

Priority Group	Area of Support
Leaving Care and LAC Cohorts	• Link with Virtual School for pre-16s young people educated or living in Sefton • Support the Personal Education Plans and Career Action Plans • Post transition support for clients on Sefton MBC Employability Pathways and other destinations, focused on threats to retention • Co-ordinate EET progression support for out-of-borough clients

	including face to face interventions, case conferencing and advocacy • EET participation data shared with Virtual School to target support • Quarterly Report will be produced and presented at Corporate Parenting Report. • Monthly collaborative production of accurate IYSS report on accommodation (populated by Social Care), education, employment, and training status of Looked After form 16/18 up to 25 • working closely with looked after children and those leaving care 16-18 year olds and up to the age of 25 with EHC plan living in Sefton to improve their resilience in finding education, employment, and training. This is underpinned by strong partnership working with local social work teams, housing options, employers, Sefton@work, Sefton's Adult and Community Learning, DWP and employers to ensure young people have the support needed to progress • Member of the new Next Steps – Panel • Membership of NEET/EET Group and Employability Group to look at specific needs and opportunities
YOT	• Pre 16 support for at risk of NEET • Clients supported into provision/employment meeting the requirements of their Order. The adviser will contribute to pre-sentence, panel reports and final reviews ensuring that movement into EET is given high profile. • IAG and career planning to manage the transition from custody to post custody licence, including support to clients and their parents/carers whilst on police bail • Effective engagement with young people who have multiple barriers to access services • EET destinations shared with YOT team • YOT Board Member and Operational Group
SEND 14-25 Years (With EHCP or High Needs agreed with SENSIS Team)	• Bespoke support provided from yr9 (or 3 years from transition) with specialist advisers linking into schools and SEN LA team. Provision dovetails with existing school CEIAG arrangements and wider partner support for client (e.g. YOS, Social Care Team). It will be informed by information/views of partners, parents, and the client – with aspirations, supported, challenged, and developed to ensure individual potential is realised • Support to clients at their annual SEN review including career planning to inform the EHCP 'preparation for adult life' • Clients encouraged/supported to access the SEN Local Offer/specialist provision to ensure progress to stated outcome(s) • Support tailored to individual needs e.g. adapted resources for dyslexia • Brokerage and linked advocacy to opportunities and appropriate referrals (e.g. Job Centre Plus) • supporting SEND young people with an EHCP and or High Need Funding: • (From Year 9 to Year 14) – there is a team of SEND advisers working closely with schools/colleges and the L.A. statutory

	assessment team to support work the council undertake in relation to young people with an EHCP or HNF and their transitions. • (From Year 14 to age 25) – there is a specialist advisor, undertaking a complex role that requires strong partnership working with SEN, Adult Social Services and Mental health services. • Service Lead is Deputy Chair of Preparation for Adulthood Group and also a member of the SEN Forum
Alternative Education	• Impact – coach support looking at Year 10 and 11 • Pinefield – IAG support focusing on Year 10 and 11 – looking at resilience and support with mental health. Liaise with EHE.
Elected Home Educated	• Engage with year 9, 10 and 11 to ensure a positive transition at year 11. • To be an active member of Monitoring and Placement Group coordinated by Schools Regulatory Service, working in collaboration to ensure that robust systems and procedures are in place across agencies to identify, support, track, and monitor those children not receiving education, ensuring and supporting a speedy re-entry to the education system and taking a lead agency role as appropriate. • Liaise with Pinefield to do home visits to those pupils who receive complimentary education. These pupils are often educated in the home and do not attend the Pinefield centre. • Assessment and IAG with all young people who engage. • Education and Learning referrals to providers and other agencies. • Intensive Transition support
Teenage Mothers/ Pregnancy 14-19	• Support delivered jointly with Health and Well Being Centres, Parenting2000 and a network of Health professionals, including joint home visits and IAG sessions • Active promotion of Care to Learn, support with health issues, finance, and housing to support integration into learning • Brokerage with providers/family etc to ensure childcare arrangements in place for EET destinations
Young Carers	• Identification of pre/post 16 and core offer provided • Link with Young Carers Project to increase EET outcomes, engagement, and sustainment.
Early Help and Supporting Families	• Develop successful transitions for pre and post 16 young people who are at risk of becoming, and remaining NEET. Young people will be identified through referrals to and from the Supporting Families Programme. • Referral form identification for Early Help • Complete evidence of all inventions using agreed documentation for each EET outcome • Track all identified young people and report progressions into education, employment and training contributing to the outcome-based funding claims. • Ensure young people identified through Sefton Supporting Families have agreed Transition/Action Plans in place post 16 • Active member of Early Help Board
Year 11 'Risk of	• Work with school and other agencies to determine those 'at Risk of NEET' and establish at RONI register for each school leaving cohort.

NEET Indicator' RONI	• The Year 11 identification with schools will start earlier in November. Those identified will be case loaded to a coach and support will be provided in partnership with schools and other agencies to ensure that those identified progress to EET. • lead on and support the September guarantee for the current leaver group. We will deliver the guarantee processes, focussing on the tracking of and engagement with the cohort to ensure the identification of young people leaving compulsory education who would benefit from engaging with this service.

In addition, the data collected through our NR&EIS also supports and informs the Council, using "best in class" tracking system provides reliable and up to date evidence on destinations for our most vulnerable groups to connected teams and structures across the Council including the SEND team, the Virtual School, the YOT Management Board, Corporate Parenting Board, High Needs Panel, Placing and the Children's and Young People's Partnership Board.

4. Post 16 Pathways Partnership

In 2020, the Council established a strategic Post 16 Pathways Partnership which brings together agencies and services to support the reduction of young people who are NEET by developing clear pathways for all pupils post 16. By strengthening our partnership arrangements, the aim is to improve transition, retention, and achievement of our young people. Actions completed to date through the Partnership include a survey of secondary schools' barriers and strengths in offering employment and industry placements for compliance with the Gatsby Careers guidance standards and setting up a new Caseload Conferencing model to support specific groups of NEET young people who are ready for work or learning but cannot access appropriate opportunities. The work of the Post 16 Pathways Partnership brings together a range of these agencies to support young people to improve EET outcomes and will help the council to deliver even further reductions in NEET number.

We have extensive and up to date local knowledge of learning/training provision and the local labour market as part of the annual activity survey for the September Guarantee there is a commitment from FE colleges, 6th Forms, schools, and providers in Sefton to share information with us regarding the learning offers made to young people for September. The partnership ensures early identification of young people who fail to start their offered place to identify alternative provision as soon as possible. Additionally, young people already identified as at risk of becoming NEET and the vulnerable group cohorts receive enhanced transition support.

5. Managing the impact of COVID

We believe that a preventative approach in terms of NEET and NK rates has mitigated the impact of Covid 19 and a series of lockdowns during the past 18 months and therefore reduced the negative impact we may otherwise have felt. This is borne out through comparisons with other areas and statistical neighbours throughout this period. We recognise there remain some very real challenges ahead to improving outcomes particularly for our most vulnerable client groups in the borough, and we will continue to utilise our strong working relationships with education institutions and training providers

in Sefton and the wider City region and beyond to track and record destinations and activities of our young people.

In Sefton Career Connect have adapted their delivery to meet the needs of those young people they are working with and have remained focused on key contract performance indicators.

Through robust planning they have identified a range of solutions to address any barriers and advocating for young people has been key to this. During the first 12 months of Covid-19, they have reported trends in terms of young people's motivation during college/school closures and believe that this has resulted in more young people more likely to disengage from their education, learning or training and that those who were already facing disadvantage have been hit the hardest.

To address this, they have targeted young people categorised in vulnerable groups such as Looked After Children, those young people involved in Youth Justice System, young people with Education Health Care (EHC) plans, Young Carers, Teen Mums, Elected Home Educated and those young people involved with Early Help. Supporting effective early intervention for young people at risk of poorer outcomes, ensuring retention and reducing risk of NEET. For those young people in NEET we are building trusting relationships and working in collaboration to reduce length of time NEET.

As part of the Sefton's response to COVID-19 and the impact it was having on our young people, Career Connect also actively followed up young people early in EET destinations especially those in Apprenticeships to provide earlier interventions including high quality IAG and access to our service at the most appropriate time. In total, 953 young people were tracked between April – June 2020 and Jan – March 21. They assessed support needs and those at risk of unemployment and targeted particular sectors to review and support – for example those likely to be furloughed – hospitality sector, retail, beauty/hairdressing. They advocated on behalf of our young people with employers and training providers to look at ways to deliver a more blended offer. They offered additional support to those young people who dropped out of their apprenticeships during the pandemic (89) offering additional IAG support to move them back into EET.