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Sefton Council

MEETING: HEALTH AND WELLBEING BOARD

DATE: 14th October 2021

TIME: 12.00 pm

VENUE: Town Hall, Bootle

Member

Councillor
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
Steve Warburton
Lorraine Webb
Andrew Booth
Angela White
Louise Shepherd
Bill Bruce

COMMITTEE OFFICER: Amy DysonDemocratic 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.

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A G E N D A

1. Apologies for Absence

2. Minutes of Previous Meeting (Pages 5 - 8)

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. Integrated Care Partnership Governance

Presentation of the Executive Director of Adult Social Care and Health.

5. Sefton Integrated Care Partnership Priorities

Presentation by Acting Public Health Consultant and Public Health Registrar.

6. Health and Wellbeing Board Development (Pages 9 - 16)

Report of the Executive Director of Adult Social Care and Health.

7. Sub Group Updates (Pages 17 - 26)

Report of the Director of Public Health.

8. Care Home Strategy (Pages 27 - 84)

Report of the Executive Director of Adult Social Care and Health.

9. Integrated Intermediate Care Strategy (Pages 85 - 110)

Report of the Chief Officer of NHS Southport and Formby Clinical Commissioning Group and NHS South Sefton Clinical Commissioning Group and the Executive Director of Adult Social Care and Health.

10. Sefton Technology Enabled Care Solutions Strategy 2021 – 2024 (Pages 111 - 188)

Report of the Executive Director of Adult Social Care and Health.

11. Southport and Ormskirk Care Quality Commission Inspection (Pages 189 - 196)

Report of the Southport and Ormskirk Hospital NHS Executive Director of Nursing, Midwifery and Therapies.

12. Mental Health Review

Presentation by the Clinical Commissioning Groups' Director of Strategic Partnerships.

13. Children's Social Care Workforce Review (Pages 197 - 204)

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

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THIS SET OF MINUTES IS NOT SUBJECT TO "CALL-IN"

HEALTH AND WELLBEING BOARD

MEETING HELD AT THE BALLROOM - BOOTLE TOWN HALL, TRINITY ROAD, BOOTLE, L20 7AE ON WEDNESDAY 9TH JUNE, 2021

PRESENT: Councillor Moncur (in the Chair) (Sefton Council) Councillor Cummins (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 Group), Fiona Taylor (NHS Sefton Clinical Commissioning Groups), Dr Peter Chamberlain (South Sefton Clinical Commissioning Group), Andrew Booth (SPAC Advocacy) and Bill Bruce (Healthwatch Sefton)

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

1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Superintendent Graeme Robson (Merseyside Police), Gary Oakford (Merseyside Fire and Rescue Service), Jan McMahon (Sefton Council), Louise Shepherd (Alderhey Children's NHS Foundation Trust), (Steve Warburton (NHS Acute Provider Sector Representative) and Angela White (Sefton CVS).

2. MINUTES OF PREVIOUS MEETING

RESOLVED:

That the Minutes of the meeting held on 10 March, 2021 be confirmed as a correct record.

3. DECLARATIONS OF INTEREST

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

4. SUB GROUP UPDATES

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

(1) Special Educational Needs and Disabilities Continuous Improvement Board (SEND CIB) which had met thrice since the last report, on 16th March 2021, 27th April 2021 and the 25th May 2021.
(2) Children and Young People Partnership Board (CYPP) which had met twice since the last report, on the 17th March 2021 and the 26th May 2021.
(3) The Adults Forum which had not met since the last report received by the Board.
(4) The Health and Wellbeing Executive which had met once since the last report, on the 22nd April 2021.
(5) The Health Protection Forum's work that had been supersede during this time by the outbreak board. It is anticipated the Forum will reconvene in 2021.

RESOLVED:

That the report be noted.

5. CCG PRIORITIES IN THE NEXT 3 MONTHS

The Board considered a verbal update from Fiona Taylor – Chief Officer of NHS South Sefton Commissioning Group – who outlined the Clinical Commissioning Group's priorities in the next three months. The presentation covered the CCGs 5 strategic objectives:

- Implement Sefton2gether/HWBB strategy
- Drive quality improvement & seek assurance
- Deliver a robust financial plan & cost improvement
- Support PCNs to enable robust and resilient general practice
- Progress changes to Borough based ICP model & contribute to the ICS development

And went onto describe system working and transition, Primary Care Network development, lessons learned and improvements and a summary of financial performance.

Fiona particularly raised the issue of transition to PCNs and the work which Dr Rob Caudwell commented on. It was agreed to devote an informal HWBB session to general practice and invite key practitioners to this session.

Dr Peter Chamberlain – Chair of South Sefton Clinical Commissioning Group – updated the Board on the Borough's COVID vaccination programme and more specifically vaccination uptake. Citing the highest number of Care Home Vaccinations in Cheshire and Merseyside.

RESOLVED:

That the verbal update be noted.

6. OFSTED FOCUSSED VISIT ITEM

The Board considered the report of the Head of Children's Social Care which provided an overview of the Ofsted focused visit conducted in March 2021. The focused visit looked at key decision-making points in the child's journey, in the context of the COVID-19 pandemic. The report included identified areas of Priority Action and areas of Improvement. A draft plan had been submitted to OFSTED, a report would be presented to the Health Overview and Scrutiny Committee and the DfE had issued a notice to improve for the two priority actions.

RESOLVED:

That the report be noted.

7. EARLY HELP ANNUAL REPORT

The Board considered the report of the Interim Head of Communities which provided a summary of the work carried out across some of Sefton's Early Help partnership. Such services support children, young people and their families. The report outlined previous and current activity as well as next steps to be taken.

RESOLVED:

That the report be noted.

8. MENTAL HEALTH IN SEFTON SCHOOLS

The Board considered the report of the Director of Public Health which outlined the progress regarding activity to improve mental health in Sefton Schools/Colleges. The report covered new services (Mental Health Support Teams), widened services (Kooth and QWell) and new partnership work (Wellbeing for Education Return and the new Children and Young People's Emotional Wellbeing Strategy 2021-26).

RESOLVED:

That the report be noted.

9. SEFTON INTEGRATED CARE PARTNERSHIP DEVELOPMENT

The Board considered the report of the Executive Director of Adult Social Care and Health which presented the latest position with regard to steps to develop a Sefton Integrated Care Partnership following Cabinet approval

to do so in April 2021 and is a follow up to the report the Health and Wellbeing Board received at its March 2021 meeting.

The Cabinet Member for Adult Social Care, Councillor Cummins suggested that the Board (with Membership additions) adopt the function of the Integrated Care Partnership and in addition, become a statutory body.

RESOLVED: That

(1) the report be noted; and
(2) members' oversight be given to the direction of travel and decisions as they develop.

Report to:	Health and Wellbeing Board	**Date of Meeting:**	Wednesday 8 September 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:

This report is to summarise key developments around the Health and Wellbeing board as we move towards the establishment of a Sefton Integrated Care Partnership. The report includes reflections of its development session on the 2nd August, and future session proposals.

Recommendation(s):

(1) Recognise that a priority for action is for the Board to 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) Consider the nature and sequence of a programme of further informal development sessions for the Board

(3) To agree the proposed future Agenda item around terms of references and governance structure

(4) Extends the best thanks of the Board to the Local Government Association and Steve Bedser of FD Associates for their valuable support in running the session and commitment to future events.

Reasons for the Recommendation(s):

We are a critical stage of the roll out of this significant legislative shift brought by the Health and Care Bill, and the ability to release the fill opportunity this can offer to the people of Sefton

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

None

What will it cost and how will it be financed?

(A) Revenue Costs

None identified within this paper, however it should be noted that the ICP is likely to involve Pooled Budgets. Work will be undertaken to determine the scope of this for Sefton Council and the detail of this will be brought to the board for future meetings.

(B) Capital Costs

None identified within this paper.

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets):
None identified within this paper.

Legal Implications:

The Health and Social Care Act 2012
the Health and Social Care Bill 2021

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 the report have neutral impact on climate change, although the eventual operation of the Health and Wellbeing Board it contributes to will need to ensure climate impact is considered when reviewing items.

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 strength the role of Strategic Commission at a Sefton borough level and encourage greater collaboration for better

outcomes.
Place – 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 Corporate Resources & Customer Services (FD.6504/21) and the Chief Legal & Democratic Officer (LD.4705/21) 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.

Contact Officer:	Eleanor Moulton
Telephone Number:	07779162882
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Appendices:

None

Background Papers:

There are no background papers available for inspection.

1. Introduction

1.1 The report follows the update on the development of the Sefton Integrated Care partnership received on June the 8th 2021. Which set out the progress made since the last report received by the board in March. It detailed Integrated Care Partnership progress, key milestones, deliverables, and the expectations and time scales communicated by the Cheshire and Merseyside Integrated Care

System. The report also provided information on the Governance review currently underway in partnership with Hill Dickinson Solicitors.

1.2 This report will provide the board with an overview of the work led by Public Health to develop key priorities for the Sefton Integrated Care Partnership.

1.3 The report will provide reflections of the Local Government Association led development session held on the 2nd August 2021 and proposals for the next steps

1.4 The report updates the committee on the required Governance developments to ensure readiness for the implementation of the Health and Social Care Bill in April 2021.

2. Background

2.1. Sefton Health and Wellbeing Board was established under the Health and Social Care Act 2012 (the Act). It is a statutory committee of the Council with its terms of reference being part of the Council's Constitution.

2.2. The White Paper "Integration and Innovation": working together to improve health and social care for all" was published on 11th February 2021 and was followed by the publication if the Health and Care bill on 6th July. This paves the way for new legislation, due in April 2022, which will include powers to establish Integrated Care Systems (ICS) across England. This new system will have two elements, being a formal NHS body with an NHS Board; and a wider health and care partnership.

2.3 "Integration and Innovation" reinforces the commitment to health and care planning at localities (or "place") and sees health and wellbeing boards as the catalysts to drive locally defined, place-based partnerships.

2.4. Health and Wellbeing Boards (HWBs) and the new Integrated Care Systems will be supported to work together to complement each other, with ICS being required to work closely with HWBs and have regard to the local joint strategic needs assessments and health and wellbeing strategies within the ICS footprint.

2.5 Following discussions with the Local Government Association (LGA), the Sefton Health and Wellbeing Board agreed to hold a development session as an opportunity for the Board to consider what it needs to do to become the driver for the "Place" of Sefton. This would position the board as the primary advocate for Sefton with the soon to be established Cheshire and Merseyside ICS.

3. Sefton ICP Priorities

3.1 As part of the Agenda the board will receive a full presentation on the development of the proposed. Sefton ICP priorities to date

3.2 To summarise the priorities work began by considering a thematic review of the existing Sefton health and Wellbeing Startegy and NHS 5 year plan – Sefton2gether.It consider the wider determinant that impact on health inequalities

in Sefton, the impact of the pandemic, and how poverty affects health and wellbeing in Sefton.

3.3 This has led to the identification of three main priorities: Mental Health, Obesity and Community Resilience. It is proposed these are adopted and a life course approach to the development of a Sefton place plan

4. Reflections of the HWBB development sessions

4.1 Members will recall the Informal session of the Health and Wellbeing Board on the 2nd August was led by Steve Bedser, an experienced Organisation Development profession with an extensive Health and political background.

4.2 The session set the context of the importance of the Health and Wellbeing board in the emerging landscape set out by the Health and Care Bill.

4.3 Health and Wellbeing Boards are the only statutory bodies where political, commissioning, professional and community representatives are able to come together to find common purpose as equal partners. Through their elected Members, they are democratically accountable to their communities.

4.4 They are uniquely placed to link with other place-based strategies such as housing, regeneration, planning, community safety, in order to address the wider determinants of health. Importantly, they cover a geographical area that means something to people.

4.5 Moving to effective place-based leadership will require the Board to demonstrate, for example:

- 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

4.6 The Health and Wellbeing Board will be pivotal in setting, monitoring and driving the long-term vision for health and wellbeing in the Borough, ensuring oversight, assurance and demographic accountability. The Joint Strategic Needs Assessment (JSNA) will be an important platform. The Board will enhance its responsibility for the oversight, review and development of the JSNA and the Place Plan, taking account of the wider determinants of health and wellbeing.

4.7 Discussion during the day identified the following key themes the Board felt it required to supports its development into the required ask of the system:

- 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

5. Next Steps for the boards development

5.1 The Board articulated and demonstrated willingness, energy and appetite to deliver the changes and outcomes needed to improve Health and Wellbeing for the people of Sefton.

5.2 To take this forward, the Health and Wellbeing Board must be clear on its priorities and impact of governance and membership changing. Once the priorities and governance are refreshed, the Board must establish how it will ensure its best performance- this should be developed by a focused group to recommend to the Health and Wellbeing Board.

5.3 As a group, the Health and Wellbeing Board is in the right place and should use ICS development as the opportunity to 'Be More Sefton'; promoting Sefton voice and identity in Cheshire & Merseyside, whilst finding common ground with neighbouring authorities.

5.4 It is proposed that the next two informal Health and Wellbeing Boards are extended to 2.5 hour session facilitated by Steve Bedser, to focus on Governance at its 1st November session and on 'making it happen' in its session on the 7th Feb 2022.

6. Governance update

As part of the Sefton Integrated Care Partnership development work overseen by the Strategic Task and Finish Group, Hill Dickinson legal partners, continue to support with advice on the required governance structure to meet the ask of the Bill and the transfer of functions following the disestablishment of the CCG in April 2022. This work is ongoing, and a draft proposal was presented to the Health and Wellbeing Board Executive at its meeting on the 26th August 2021. Following agreement of the final model through council governance arrangements, a review of the terms of reference of the Health and Wellbeing Board will be required. It is proposed a full report on this received by the December Board. Over view and Scrutiny health will be fully consulted and any final proposals will be brought to Cabinet and appropriate health governance.

7. Conclusion:

7.1 This is a pivotal moment in the development of Sefton place based partnership arrangements and the report asks the following of the Board:

7.1.1 The Board is asked to recognise that a priority for action is for the Board to be clearly accountable for the oversight, review and delivery of the Joint Strategic Needs Assessment and the Place Plan within the Sefton ICP.

7.1.2 The Board is asked to consider the nature and sequence of a programme of further informal development sessions for the Board

7.1.3 The Board is asked to agree the proposed future Agenda item around terms of references and governance structure

7.1.4 The Board is asked to extend the best thanks of the Board to the Local Government Association and Steve Bedser of FD Associates for their valuable support in running the development session and commitment to future events.

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Report to:	Health and Wellbeing Board	**Date of Meeting:**	Wednesday 8 September 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 9th June 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. / The equality Implications have been identified and mitigated. / The equality Implications have been identified and risk remains, as detailed in the report.
(Please delete as appropriate and remove this text)

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.6498/21) and the Chief Legal and Democratic Officer (LD.4699/21) 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

Contact Officer:	Eleanor Moulton
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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

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 (SENDCIB)

At the last Health and Wellbeing Board a report was provided on the meetings that had taken place since the previous update. Since that report there have been two further meetings of SENDCIB these were on 25th May 2021 and 29th June 2021.

At the May meeting the following items were discussed: Short Breaks, Re-visit by the DfE planned for 22.06.21, the Ofsted Focused Visit outcome.

The report on Short Breaks updated the Board on the progress of the review of Aiming High and Springbrook services. This review had included the processes that determine how many nights a child would benefit from Springbrook overnight short breaks. It was reported that on the whole parents were supportive, some children will still access 28 nights, but others may have less. It was noted that Aiming High did not run timetabled sessions for a period due to Covid, however, outreach support was delivered which was welcomed by parents. The Board was informed that a blended approach will be

delivered going forward of timetabled sessions and outreach as there are some young people who don't want to attend in person at the moment.

A discussion took place on the approaching DfE visit (to be held by Microsoft Teams) and the evidence that was to be provided in advance of the meeting. It was also confirmed who would be attending the meeting as officials did not want a full Board but rather representatives of the various sectors e.g. Parent/ Carers, Schools, Health.

Vicky Buchanan informed the Board of the outcome of the Ofsted Focused visit that had taken place earlier in the year as we had received the letter. It was noted whilst there were areas of strength there were two priority actions and three areas for improvements. An action plan will be drawn up to respond to the findings.

On 22nd June 2021 we had a further meeting with the DfE/ NHSE to review the progress of the SEND Improvement Plan and following the visit we received notification that the Improvement Notice has been lifted. The letter noted:

The evidence from the review demonstrates the significant progress Sefton and partners has made and its success in addressing and embedding the improvements identified in Ofsted's/CQC revisit in 2019. Leadership has improved its operational oversight, the workforce is dedicated and engaged in delivering quality outcomes, there is improved partnership working and there is a collective commitment across the council to improve and achieve the best possible outcomes for children and young people with SEND.

Whilst this is a good outcome in terms of the improvements made in the lead up to the visit members of SENDCIB had discussed what would happen if the notice was lifted and it was unanimously agreed that the Board would continue in order to maintain the focus on this area of work.

At the SENDCIB meeting in June 2021 items for consideration were the Passenger Transport Framework, Day Service Opportunities, Supported Living and Transitions. There was also a discussion on the likely outcome of the visit by the DfE/ NHSE that had taken place the previous week.

The report on the Passenger Transport Framework was to inform the Board of the tender exercise to establish a Framework Agreement for transport service providers. This is part of the usual procurement and commissioning cycle as the current framework is due to expire in December 2021.

The report on Day Opportunities was to advise the Board of the long-term vision and commissioning approach for these services in Sefton building on the previous models agreed. The report also noted that we need to consider the subsequent impact of Covid 19 and the changing aspirations of young adults transitioning to Adult Social Care. The report continued in stating that to ensure the market is responsive to the needs of our communities that the council would undertake a procurement process to establish a purchasing agreement for Day Opportunities.

Supported Living was to inform the Board of the approach to the commissioning and delivery model which focusses on the asset of the individual, to maximise choice and to control and reduce reliance on long term formal care that can intentionally reduce an individual's independence and resilience. For both these reports it was noted that there

were a number of phases and throughout consultation will take place and work will start shortly.

It was agreed that we need to consider how children and young people transition into adult services and although a lot of work already takes place there needs to be discussions on what else we could do to increase capacity, it was agreed a report will be brought back to a future Board for fuller discussion.

Each meeting reviews the Risk Register and the Improvement Plan which looks at the actual data against the expected performance and targets.

Although Board meetings had been scheduled for July and August 2021 it was agreed that these would be cancelled due to the none availability of all sectors of the Board. The next scheduled meeting is now 28th September 2021. Although the Board meetings will not take place it was confirmed that this was not a suspension of activities and the various workstreams would continue.

2.2 Children and Young People Partnership Board (CYPPB):

Since the time of writing the last update to the Health and Wellbeing Board three meetings have taken place of the CYPPB on 26th May 2021, 23rd June 2021 and 4th August 2021. From June 2021 the meetings moved to bi-monthly.

At the May 2021 meeting the following items were discussed: Review of Headteachers Experiences of Covid; Ofsted Focused Visit, the Dashboard and Youth Custody data.

The Review of the Headteachers item was an open discussion with several additional Headteachers from a range of schools invited to the meeting to discuss their experiences with regard to Covid19. It was noted there had been a lot of work undertaken on the loss of learning, but the past period had also highlighted the crucial role of schools as a centre for children, young people and their families, particularly for vulnerable. Working with the School Cell has emphasised the partnership approach and they have looked at the impact on children's lives. Headteachers agreed they (schools) need to look at their practice, there is a massive focus on academic gap for children and young people in primary schools and it was felt the focus for catch up at the moment is wrong. One Headteacher commented that the loss of time in terms of academic progress is nothing compared to the work and energy that will need to go into rebuilding routines, relationship, resilience, cultural capital across all our schools and communities. Without these building blocks, 1 hour tutoring after school will not even register. Mental health was a huge issue raised as well as the impact on school budgets in delivering support to families, there was some help from government, but it did not cover costs. It was acknowledged there is work taking place with regard to mental health and it is taking time to settle children back into routine things like getting to school on time.

The Head of Children's Social Care informed the Board of the outcome of the Ofsted Focused visit that had taken place earlier in the year as we had received the letter. Whilst it was noted whilst there were areas of strength there were two priority actions and three areas for improvements. An action plan will be drawn up to respond to the findings and a Children Improvement Board has been set up to move matters along and respond to next steps.

The Dashboard for Quarter 4 was shared, and it was agreed that a more narrative style would be useful. Youth Custody data was also shared, and discussion took place on the emerging mental health crisis and the response that we give to the child. Information on young people held in custody and the reasons for it were also discussed.

At the June 2021 meeting the following items were discussed: Passenger Transport Framework, Continuing Care Protocol, Strategic Safeguarding Arrangements and the Alan Wood Review; The Case for Change, and Services and targets on the impact of Covid.

The report on the Passenger Transport Framework was to inform the Board of the tender exercise to establish a Framework Agreement for transport service providers. This is part of the usual procurement and commissioning cycle as the current framework is due to expire in December 2021.

The report on the Continuing Care Protocol was provided for information which noted that the document had been approved by the Health and Wellbeing Board. A task and finish group will be set up to look at how we work with CAMHS and support social workers to navigate the process and make sure that the process of applying for continuing care is properly documented.

For the Case for Change item, it was noted that Josh McAllister had been appointed by Government Ministers to undertake the review which includes quite an extensive consultation and engagement process with 700 different organisations and people consulted. McAllister had chaired an independent Panel of different organisations including the voluntary sector, some public sector partners, health partners and some professional bodies. The Review concluded that Children's Social Services are bureaucratic, risk averse, financially strained and over-focused on investigation at the expense of providing practical support. There is evidence that partners do a lot of investigations but that nothing happens at the end of the process. It was noted that Organisations feel vulnerable to regulatory, public and Government scrutiny if things go wrong and this is driving some of the risk-aversion mentioned. 10% of the most deprived areas are more likely to have children on Plans. This is certainly borne out in Sefton. It was agreed that the Early Help Partnership will look at the Review with school's involvement and report back to CYPPB and this needs to look at the connection to poverty.

The Strategic Safeguarding Arrangements and the Alan Wood Review report was to inform the CYPPB of the invitation of the review to Ofsted to inspect any new safeguarding arrangements from the Autumn. A tripartite meeting has been set up to discuss how Sefton is going to work together more strategically in terms of safeguarding children. The review says that the three statutory partners must take shared accountability for multi-agency arrangements and it was noted there is a real commitment and willingness to do whatever is required in Sefton and the statutory partners were urged to grow the partnership and step up to drive things forward.

For the final item for June the Services and targets on the impact of Covid. It was noted that the Chief Executive of Sefton and the Director of Public Health are to meet to establish a call for evidence from partners to analyse and map against what is already in existence and the impact on children and families. This is important as an evidence base for good outcomes for children depending on their circumstances.

At the August 2021 meeting the following items were discussed: SEND Improvement Notice; Sefton Integrated Care Partnership; Start Well; Children Social Care Partnership; Education – Impact of Covid and Early Help Quarterly Report.

The CYPPB was informed of the outcome of the recent visit by DfE/ NHSE with regard to the SEND Improvement Notice, which was to lift the notice.

The role of the new CSC Improvement Board was also provided in the form of a presentation and Lisa Lyons, Interim Executive Director of Children's Services, provided a quick tour on the work that will take place with regard to Children's Social Care Improvement. CYPPB was informed that the new improvement board has been set up with an Independent Chair, Paul Boyce, and a DfE Advisor Clive Jones. A report is due with the DfE in November 2021. There will be an Improvement Team and a number of key changes have taken place: work is taking place on reviewing thresholds, step up and step down and exit plans as well as other areas such as team structures and data to ensure sufficient line of sight.

A presentation on the work of the Sefton Integrated Care Partnership took place which noted that this is a work in progress, however, three themes have been identified which are Mental Wellbeing, Obesity and Community Resilience. It was also noted that no targets have been set as yet but there is a focus on reducing health inequalities around early intervention. The work will be at a population level, across the life course. The Sefton ICP focused on Covid during the Pandemic and some data was not collected so they are planning to catch up and can look at what the data was before Covid to build up the picture with the assumption Covid has made health inequalities worse. There were also wider determinants such as poverty as an underlying key factor.

The item on Start Well was connected to the Sefton Integrated Care Partnership in that it was around the Children's Integrated Commissioning Group and the work on the priorities of the Sefton Integrated Care Partnership. This also follows a life course approach and it was noted that a lot of commissioning is not condition specific but there are thematic items, mental health, complex needs vulnerable groups etc. and information was provided on the services against these headings. The report provided a list of cross cutting themes as well as enablers such as improvement and actions plans.
.
The Early Help Partnership Quarterly Report was provided to the CYPPB for information.

The final written report for August was a report to inform the Children and Young People Partnership Board (CYPPB) on the impact of Covid on schools and settings. The report highlighted a number of issues which included:

- throughout this period the LA has operated a first day response for all vulnerable pupils who did not attend school.
- In partnership with schools, social care and early help all children were visited on the first day of absence. As a result of the partnership working attendance for our most vulnerable children was generally above local and national averages throughout. This is continuing although in a less intensive way.
- Since April 2021 all schools within Sefton have had at least one bubble closed due to a child or member of staff testing positive.
- The number of pupils self-isolating at any one time has reached over 3000 on any one day.

- Schools have worked extremely hard to ensure that all the measures are in place to keep staff, pupils, parents and visitors safe.
- Throughout Covid we have operated a Schools and Social Care Cell on a weekly and latterly monthly basis. This has been invaluable in ensuring that excellent communications between schools, LA and organisations has been two way. Issues and concerns have been swiftly dealt with and schools have benefitted from the opportunity to discuss at first hand key issues.
- As a result of the general feeling amongst attendees the meetings will continue on a termly basis with a different focus.
- Ofsted undertook remote visits in the autumn term 2020 to gain an understanding of remote learning.
- In the spring term remote monitoring visits took place in several of our schools. No grade was given for these visits. The focus was on the curriculum and how far the schools were ensuring a broad and balanced curriculum for all pupils whether at home or in school. All letters were positive.
- In the summer term 2021 full onsite monitoring visits were undertaken in a range of schools, grades were given. All schools were able to demonstrate positive aspects and the letters received reflected this.
- In September 2021 full inspections will resume,
- From September 2021 all restrictions are being lifted in schools, although this could change if advised by the government and Public Health. Many schools however have found benefits in some of the measures in place and will continue to use them.
- The LA has worked with schools to provide free school meal vouchers and food parcels throughout lockdown and when bubbles have closed.
- All pupils entitled to free school meals have received vouchers for the summer holidays,
- Our early years partners in nurseries and childminders have remained open throughout Covid. Many have struggled financially as parents/carers were working from home and did not send their children. They have manged to continue despite additional pressures of staff self-isolating. The majority of our settings have also seen bubbles close and children and staff needing to self-isolate
- The out of hours provision has also been badly impacted on by Covid particularly financially. Many providers found that due to lockdown, bubbles and parents/carers that they were not required. There is a concern that provision will not be there when required/

At every meeting the Risk Register is reviewed.

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

The next Children and Young People Partnership Board (CYPPB) is scheduled for October 2021.

2.3 Adults Forum

The Adults forum terms of reference and membership is under review as part of the design of the Sefton Integrated Care Partnership

2.4 Health and Wellbeing Executive

The Executive has met once since the last report on the 17th June 2021. The Better Care Fund performance and financial reporting was received and noted. The proposal for Governance support from Hill Dickinson was reviewed and emerging principles for the financial management within a integrated system were considered.

There is a meeting scheduled for the 26th August were proposals for potential Sefton Integrated Care Partnership Governance will be discussed and an item on GP offer as forward planning for the December Board will also be considered.

2.5 Health Protection forum

The health protection forum's work has been superseded during this time by the outbreak board. It is anticipated that the Health Protection Forum will reconvene in 2021, developments on this will be reported to the HWBB.

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.

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Report to:	Health and Wellbeing Board	**Date of Meeting:**	Wednesday 9 December 2020
Subject:	Sefton Joint Local Authority & CCGs Care Home Strategy		
Report of:	Executive Director of Adult Social Care and Health	**Wards Affected:**	(All Wards);
Portfolio:			
Is this a Key Decision:	N	**Included in Forward Plan:**	No
Exempt / Confidential Report:	N		

Summary:

As part of the integration agenda, the Local Authority and the two Sefton Clinical Commissioning Groups (CCGs) have developed a draft Care Home Strategy for the period 2020/23, in order to outline a strategic direction for the sector and to outline future work plans.

Recommendation(s):

The Health & Wellbeing Board are asked to consider the draft strategy and;

(1) Make recommendations on any amendments to it, in advance of it potentially being submitted to governance structures such as Cabinet and the CCGs Leadership Team for approval;

(2) Note that following any approval, detailed plans relating to workstreams identified within the strategy will be developed and implemented, with oversight by the Integrated Commissioning Group. Progress on these plans will be regularly reported to the Health & Wellbeing Board; and

(3) Note that engagement with key stakeholders (such as Care Home Providers) will take place on the strategy and its implementation.

Reasons for the Recommendation(s):

A key workstream of the Integrated Commissioning Group has been to develop an implement a joint Local Authority and CCGs Care Home Strategy.

The strategy has been produced in recognition of the vital role care homes play in the Sefton Health and Social Care system and it represents the joint Local Authority and CCGs joint commitment to develop, support, invest and engage with the Sefton care home market.

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

1. **Not producing and implementing a strategy** – this option was considered and rejected as this category of commissioned services / expenditure is significant in terms of risk (services to vulnerable people), budget oversight and Council and CCGs reputation. There is a need for greater oversight for this service category and budget, as the sector remains an integral element of meeting the needs of vulnerable people in Sefton.

What will it cost and how will it be financed?

(A) Revenue Costs

There are no direct costs arising from the implementation of the Strategy.

Should any actions contained within the Strategy have resource implications, then implementation of those recommended actions will be the subject of future formal Council decision making processes.

(B) Capital Costs

There are no direct capital costs arising from the Strategy.

Should any actions contained within the Strategy have capital funding implications, which have not previously been agreed, then implementation of those recommended actions will be the subject of future formal Council decision making processes.

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets): Staffing resources
Legal Implications: • Care Act 2014 • Care and Support Statutory Guidance • The Care and Support and After-Care (Choice of Accommodation Regulations) 2014 • National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (October 2018 revised)
Equality Implications: The equality Implications have been identified and mitigated.

Contribution to the Council's Core Purpose:

Protect the most vulnerable: Sefton care homes support some of the most frail and vulnerable people in Sefton so it is therefore essential that the care they provide meets the needs of the population, if of a high quality and is delivered by staff who are highly trained and recognised for their important role. The strategy reflects the overall objectives of improving the outcomes for care home residents and ensuring that they receive high-quality services.
Facilitate confident and resilient communities:
Commission, broker and provide core services: The strategy outlines the need for a category management approach to the sector, including effective commissioning of services, supporting the market and services being commissioned to meet required needs of the population.
Place – leadership and influencer: The strategy outlines an approach to influence and develop the care home market.
Drivers of change and reform: The strategy outlines how the Local Authority and CCGs wish to develop and influence the care home market.
Facilitate sustainable economic prosperity: Implementation of the strategy will support work relating to viability of the market, which in turn is a significant employer in Sefton.
Greater income for social investment:
Cleaner Greener

What consultations have taken place on the proposals and when?

(A) Internal Consultations

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

(B) External Consultations

Consultation on the strategy has taken place with the Sefton CCGs and stakeholders.

Implementation Date for the Decision

Immediately following the Committee / Council meeting.

Contact Officer:	Deborah Butcher
Telephone Number:	Tel: 0151 934 3329
Email Address:	Deborah.Butcher@sefton.gov.uk

Appendices:

Appendix A - Draft Local Authority and CCGs Care Home Strategy 2020-2023

Background Papers:

There are no background papers available for inspection.

1. Introduction/Background

1.1 Sefton care homes support some of the most frail and vulnerable people in Sefton so it is therefore essential that the care they provide meets the needs of the population, if of a high quality and is delivered by staff who are highly trained and recognised for their important role.

1.2 In Sefton there are 131 care homes, with in the region of 3,750 beds, and of these around 1,400 are utilised by the Local Authority and 500 utilised by the two Sefton CCGs. The remainder of the utilised beds as commissioned by other CCGs, other Local Authorities and also be 'private' funders.

1.3 Combined expenditure on care homes is around £60m, thus representing a significant element of current budgets.

1.4 The Sefton Integrated Commissioning Group has identified that a strategy is required as part of the wider integration agenda with respect to the Local Authority and CCGs working together to manage the care home sector.

2. Key Elements of the Strategy

2.1 The strategy has been jointly developed by the Local Authority and the Sefton CCGs.

2.2 The strategy has been produced to provide an outline of how we wish the care home market to operate, how we will engage and support the market to adapt to wider strategic aims and objectives.

2.3 The strategy has also been produced to acknowledge that Sefton care homes need to be supported by Commissioners and given a clear sense of direction

around current and future needs and co-ordinated services which can support them, and the outcomes we jointly need to achieve for our residents.

2.4 The strategy outlines the following key themes and associated aims and objectives;

- **Service Users:**
  - Services continue to meet needs and adapt to changes in levels of need
  - Service Users will have equitable access to high quality safe Health and Care services, with a good personal experience of those services
  - Service Users remain part of their local communities
  - Intention to see reduction in care home placements / Increased focus on Independence at Home and providing short-term interventions
  - Family Members and Advocates are involved in service delivery arrangements and are kept informed

- **Care Homes and their workforce:**
  - Enhanced Health in Care Homes embedded to support homes
  - Scoping exercise of current workforce and vacancy numbers and types
  - Promotion of the role of the carer
  - Engagement with Colleges and Learning Providers
  - Staff development a priority and staff the necessary training and support they require
  - Staff are supported by technological solutions that help them in their day-to-day delivery of care and support

- **Quality:**
  - Realise the ambition of getting care homes to an Outstanding rating
  - Robust Quality Assurance mechanisms in place, supported by technological solutions that streamline reporting.
  - Safeguarding processes which encompass identifying any trends
  - Updated service specification which reflects drive to increase quality
  - Continued intelligence sharing with partners such as CQC
  - Development of a Sefton Quality Mark

- **Consultation and Engagement:**
  - Mechanisms are put in place to ensure more active engagement with the market - operating in a spirit or openness and partnership working
  - The market is clear about what services are needed / commissioning intentions
  - Timely engagement and consultation
  - Partnership working takes place to develop / adapt the market to best meet needs - including supporting people with most complex needs
  - Engagement mechanisms established at start of COVID-19 pandemic is continued and further developed

- **Commissioning/Finance/Analysis:**
  - Category Management approach adopted for the sector
  - More Integrated Commissioning opportunities developed and implemented

- Contracts and Service Specifications are updated to better reflect desired outcomes
- Financial arrangements are reviewed to ensure they are as streamlined as much as possible, reflect current costs and represent Value for Money. New tools also created to formulate costings for specific placements

2.5 However, it is acknowledged within the strategy that detailed workplans for the above activities / objectives will need to be developed as at this present time, due to the uncertainty around the ongoing COVID-19 pandemic, definitive plans with detailed timescales cannot be developed.

3. Recommendations / Next Steps

3.1 The Health & Wellbeing Board to consider the draft strategy and;

3.1.1 Make recommendations on any amendments to it, in advance of it potentially being submitted to governance structures such as Cabinet and the CCGs Leadership Team for approval;

3.1.2 Note that following any approval, detailed plans relating to workstreams identified within the strategy will be developed and implemented, with oversight by the Integrated Commissioning Group. Progress on these plans will be regularly reported to the Health & Wellbeing Board; and

3.1.3 Note that engagement with key stakeholders (such as Care Home Providers) will take place on the strategy and its implementation.

Sefton Local Authority & Sefton's Clinical Commissioning Groups Joint Care Home Strategy

2021-2024

Sefton Council

NHS

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Abstract

A strategy to set out an integrated approach to Care Homes in Sefton. How we will work as one to support our Homes to achieve outstanding care and support, refresh and reset for future delivery and deliver a Care Market built around the needs of Sefton's population.

Contents

1. Forewords

"We are delighted to jointly launch this strategy which represents a shared commitment across the Health and Social Care system to further develop and support the Sefton care home market. Care homes have, and continue to, experience significant challenges and we recognise the vital work that they have conducted and the dedication that their staff have demonstrated during the Covid 19 pandemic.

The strategy builds on existing work and has been developed to describe how we will work in a continued integrated way with all stakeholders.

Care homes have, and will always be, an important element of the Health and Social Care system, caring for some of our most vulnerable residents. This strategy outlines how we will continue to support and develop the market with a strong focus on the provision of high quality services and improving outcomes for care home residents.

The strategy will be a working document, subject to regular review and engagement, in order to reflect factors such as impending changes to the Health and Social Care system. We are pleased that we have developed this strategy in advance of these changes as it demonstrates within Sefton our ability to build on our established commitment to working together.

This strategy is ambitious, and we will all work hard to deliver it"

Deborah Butcher
Executive Director of Adult Social Care & Health
&
Fiona Taylor
Chief Officer, NHS South Sefton and NHS Southport and Formby CCGs

"I am pleased to endorse this strategy which represents a shared commitment to working together on important issues. Now more than ever there is a need to focus on the Sefton care home sector and I feel that this strategy represents a clear direction of travel for this work.

Care homes support some of the most vulnerable people in Sefton and it is important that we have an ongoing commitment to developing and supporting the sector so that it continues to do so.

At the heart of this strategy are the people that require care home placements and ensuring that services meet their needs and deliver safe, good quality and outcome focussed services to them"

Councillor Paul Cummins
Cabinet Member, Adult Social Care

"Care and support to people when they need it in the community is a vital part of our health and care system. Care homes play a very important part in people's lives whether they are people with long-term conditions and disabilities, older people or people nearing the end of their life
I am very pleased to have been involved in the development of the Sefton care home strategy. This strategy sets out a vision for care homes of the future. It aims to ensure that people are enabled to live in their own homes where ever possible for as long as possible, but it also places clear emphasis on the vital role that care homes play in our community.
This strategy shows how health and social care systems are going to work together to ensure that our care homes in Sefton are fit for the future and deliver excellent quality of care and an excellent experience for the people who use their services. I look forward to working with our partners to deliver it over the next three years"

Chrissie Cooke
Chief Nurse, NHS South Sefton CCG and NHS Southport and Formby CCG

2. Executive Summary / Key Themes

This strategy has been produced in recognition of the vital role care homes play in the Sefton Health and Social Care system and it represents our joint commitment to develop, support, invest and engage with the Sefton care home market.

Whilst progress has been made to date, especially during the COVID-19 pandemic, we recognise that there is more to do, and we can build on this progress to achieve further outcomes and ensure that the market is supported to adapt to changes and to continue to support commissioning needs.

Sefton care homes support some of the most frail and vulnerable people in Sefton so it is therefore essential that the care they provide meets the needs of the population, if of a high quality and is delivered by staff who are highly trained and recognised for their important role. Whilst this strategy may address issues such as technology, finance and market management it is important to highlight that underpinning all of this is the overall objectives of improving the outcomes for care home residents and ensuring that they receive high-quality services.

Following on from this, Sefton care homes need to be supported by Commissioners and given a clear sense of direction around current and future needs and co-ordinated services which can support them, and the outcomes we jointly need to achieve for our residents.

This strategy has been produced to provide an outline of how we wish the care home market to operate, how we will engage and support the market to adapt to wider strategic aims and objectives.

At the inception of the development of this strategy it was proposed that it would cover the five-year period of 2020-25, however it is recognised that at the present time the Sefton care home market, as with the national market, is operating in a time of unprecedented change. As a result, the timeframe for this strategy was reduced to the three-year period of 2021-24 in order to reflect the uncertainty around the impacts on the sector, but also to outline a vision for the sector and a co-ordinated structure and approach to various workstreams, which once embedded will inform longer-term work on the sector and future decisions. As a result, this strategy should be viewed as a 'working document' which outlines a future direction for the sector but will be regularly reviewed in order to take into account progress made, feedback from key stakeholders and wider national and local determinants.

The key themes of this strategy are summarised in the following diagram, but are also highlighted throughout this document;

Residents

- Services continue to meet needs and adapt to changes in levels of need
- Residents will have equitable access to high quality safe Health and Care services, with a good personal experience of those services
- Residents remain part of their local communities
- Intention to see reduction in care home placements / Increased focus on Independence at Home and providing short-term interventions
- Family Members and Advocates are involved in service delivery arrangements and are kept informed

Care Homes & Their Workforce

- Enhanced Health in Care Homes embedded to support homes
- Scoping exercise of current workforce and vacancy numbers and types
- Promotion of the role of the carer
- Engagement with Colleges and Learning Providers
- Staff development a priority and staff the necessary training and support they require - for example My Home Life
- Staff are supported by technological solutions that help them in their day-to-day delivery of care and support
- Staff are supported to deal with the impact of the COVID pandemic

Quality

- Realise the ambition of getting care homes to an Oustanding rating
- Robust Quality Assurance mechansisms in place, supported by technological solutions that streamline reporting.
- Safeguarding processes which encompass identifying any trends
- Updated service specification which reflects drive to increase quality
- Continued intelligence sharing with partners such as Care Quality Commission
- Development of a Sefton Quality Mark

Consultation & Engagement

- Mechanisms are put in place to ensure more active enagement with the market - operating in a spirit or openness and partnership working
- The market is clear about what services are needed / commissioning intentions
- Timely engagement and consultation
- Partnership working takes place to develop / adapt the market to best meet needs - including supporting people with most complex needs
- Engagement mechanisms established at start of COVID-19 pandemic is continued and further developed

Commissioning / Finance / Analysis

- Category Management approach adopted for the sector
- More Integrated Commissioning opportunities developed and implemented
- Contracts and Service Specifications are updated to better reflect desired outcomes
- Financial arrangements are reviewed to ensure they are as streamlined as much as possible, reflect current costs and represent Value for Money. New tools also created to foormulate costings for specific placements

3. Introduction

Care Homes provide a crucial role in the Health and Social Care landscape delivering care to some of the most vulnerable people in Sefton. It is essential that the provision of care within Care Homes is high quality and meets the needs of the people who live there.

During the COVID-19 response we have been further reminded of the vital role care homes play in the Health and Social Care system and how vital it is to adopt a supportive and facilitative wrap around offer from the wider system to maintain services and ensure that care homes are supported and do not operate in isolation. It is clear that any strategy we have must detail how all parts of Social Care and Health must work together to engage understand and respond to the needs of the Care Home Market.

Looking forward we must work with the market to remodel and face the future financially and in terms of offer. The Market will need to adapt, and we will need to clearly articulate what we need from them supporting the market to evolve, considering alternative delivery where required. This will need to include working with Care Homes on resilience plans for the short, medium and long term. This will need to include aspects relating to workforce, finance, PPE, re-deployment of staff etc

The current Care Home Market in Sefton is uncoordinated in terms of development or strategic direction. This strategy describes a 3-year approach to this sector of care, providing a direction of travel for existing care Providers and a clear indication to new Providers wishing to become part of the Sefton Care Home market.

Essential to the success of this strategy is strong leadership at all levels and across all agencies. Success will revolve around a commitment to supporting and delivering high quality care and the development of trusting, committed partnerships. The strategy will enable us to develop and communicate the long-term commissioning intentions of Sefton Local Authority (SLA) and the Southport and Formby and South Sefton Clinical Commissioning Groups (CCGs).

As Commissioners we need to improve the communication of strategic visions around Care Home Development. Currently new Care Homes are built within the Borough with little discussion regarding the provision being offered nor consideration of the required support from community, primary or secondary care.

It is important to highlight that a key theme running through this strategy is improving the experiences of people that live in care homes and ensuring that people receive good quality care and support. The strategy also outlines the development of a model of care provision that leads to the individual remaining in their own home for longer. This will require a fundamental improvement in the availability of Intermediate Care related services, Domiciliary Care services, Extra Care housing, Community Equipment Services, access to adaptations in the home, wider use of Telecare and Telehealth tools and other community provision that supports people to live at home for longer.

4. High Level Vision / Desired Outcomes of this Strategy

Current Sefton Market

- High number of care homes in the borough
- Lack of engagement on proposed new care homes being built / opened in the borough
- High number of placements made (including out-of-borough placements)
- Commissioners working separately and operating under different frameworks and contractual arrangements
- Lack of clarity on fee rates and how they are formulated / historic payment arrangements still in place
- Low use of TECS and I.T. solutions to support service delivery / issues with timely updating and exchange of information
- Low level of engagement and consultation - including Commissioners outlining future needs and market engaging with Commissioners when seeking to develop new services
- Commissioners having in place separate commissioning / contract / monitoring / finance arrangements
- Un-coordinated 'support offer' to care homes, including training, staff support and wrap-around services

Strategy Delivery

Sefton Market of the Future

- Reduced number of long-term placements made, with increased focus on providing more short-term care to aid maintaining independence, such as through Intermediate Care and Extra Care services
- Greater integrated working between Commissioners
- Improved engagement - market is aware of commissioning intentions and needs, where approriate, works with Commissioners to re-model services and is actively involved in the implementation of this strategy
- Updated cost-of-care exercise completed which implements new fee models and payment arrangements, which take into account different levels of Resident complexity
- Greater use of TECS and I.T. solutions to support independence and service delivery
- Enhanced Health in Care Homes embedded
- Focus on improving / maintaining quality - including workforce development and support issues and drive towards Outstanding CQC ratings
- Robust arrangements to review any proposals for new services and how any new developments can support meeting wider aims

5. Definitions

Care at home

Care at Home or Domiciliary care is care provided in the patient's home. This can be general or nursing and may be funded by the patient (depending on their financial status) or local authority. It generally includes a number of visits during the day but does not provide 24-hour support. In Sefton we will work to ensure access to high quality Care at a Fair cost of care that allows people to remain in their own home wherever possible, utilising the resource of residential or nursing home by those whose needs require it most.

Technology Enabled Care Services (TECS) & Equipment

Technology Enabled Care Solutions (TECS) is fast becoming the accepted description for a range of health and care technologies such as Telecare, Telehealth, Environmental Controls, mHealth and Telemedicine. The reason for developing a generic term for these technologies is to ensure that the patient or end user can benefit from the correct technology which they require at any time, and not be restricted by services or funding streams which are not person centric or do not meet the individual's needs.

However, it is important that Professional prescribers, Patients, Residents and Carers understand the different terms that make up the TECS and information.

In summary, the different elements of TECS and Equipment are;

- **Telecare** - Developed from Social Alarms services which have been supporting elderly and vulnerable people live more independently. Telecare services provide a 24/7 monitoring service which will escalate alarm activations to a named responder or, if appropriate, the emergency services.
- **Telehealth** - Telehealth systems support people with Long Term Conditions (LTC's) to self-manage their conditions, remain more independent, reduce hospital stays, allow early hospital discharge and reduce the dependency on primary health and GP services.
- **mHealth** - A number of the services described under Telehealth can also be accessed via mobile phone technology and Apps, these systems are often used by younger Residents and patients to allow them greater flexibility to access these services. Another mHealth application is the use of GPS and GPRS to provide safe walking services to people with dementia, early stage Alzheimers and learning disabilities.
- **Assistive Technologies (Environmental Controls)** – These allow people with severe disabilities to function as independently as possible by using devices that allow them to carry out day to day activities such as switching on lights, opening curtains, turning on the TV and using a computer though a range of switches and sensors which can be operated with only limited movement. Environmental Controls can also be used in conjunction with Telecare and Telehealth systems.
- **Telemedicine** – this is the use of video technology to enable specialists and consultants to support patients and other professionals remotely by making a diagnosis and recommending treatments. Vital signs data, x-rays and other information can also be transmitted to

enable a speedy diagnosis when a patient is located in a remote area or the expertise is not available locally. Telemedicine systems are mainly employed in an acute health environment.

- **Community Equipment** – Daily living aids to support independence in the home, it may be things like loo seat raisers or walking aids.
- **Adaptations to an individual's home** – This may include installing level access showers, Ceiling track hosts or stair lifts to support an individual's daily life and informal or formal care providers maintaining care provision.

Residential Homes

A Care Home is a residential setting which enables individuals to maintain their relationships and interests within a single site.

In addition to the accommodation, residents receive help and assistance with:

- Personal Hygiene, including help with washing, bathing, shaving, oral hygiene and nail care.
- Continence management, including assistance with toileting, skin care, incontinence laundry and bed changing.
- Food and Diet, including preparation of food and fulfilment of dietary requirements and assistance with eating.
- Counselling and support, including behaviour management, psychological support
- Simple treatments, including assistance with medication (including eye drops), applications simple dressings, lotions and creams.
- Personal assistance, including help with dressing, surgical appliances, mechanical or manual aids, assistance getting up or going to bed.
- Medication, Support with medication administration

Nursing Homes

These homes provide the same help and assistance as a general /residential care home but they also have professional registered nurses (although some residential homes do actually have Nursing staff) and experienced care assistants who can provide 24-hour nursing care services for more complex health needs.

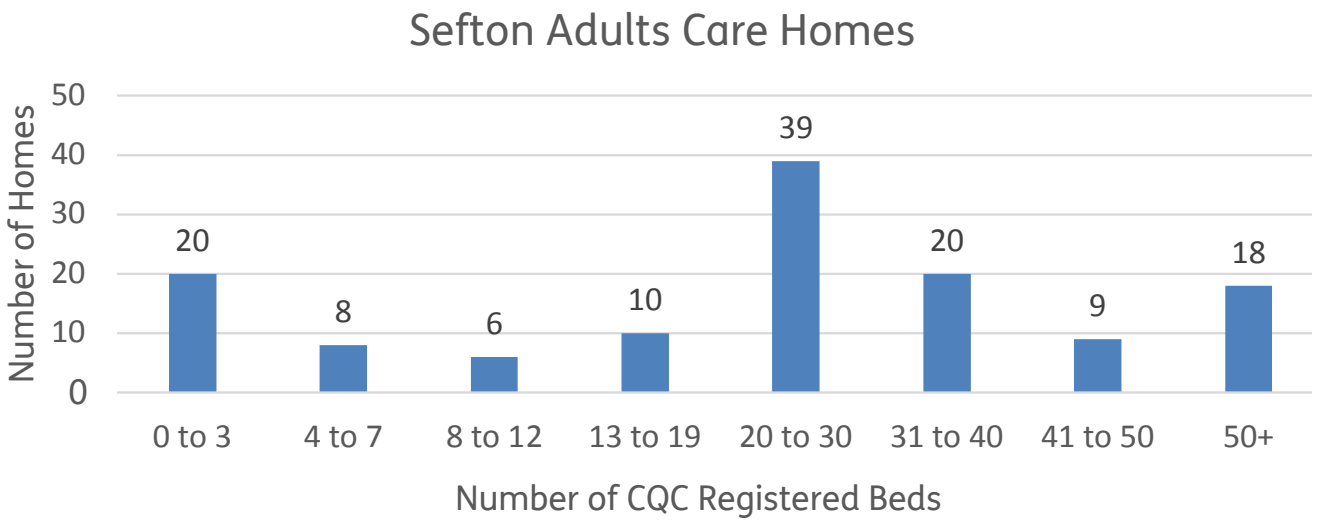
In addition to being registered to provide general nursing care, many homes also offer rehabilitation services; different therapies, including physical, speech and pain therapies; and specialist health care including, dementia care, EMI nursing care, cancer care, services for younger people with physical disabilities (usually aged 18 - 64). These homes are for people who are very frail or for people who are unable to care for themselves, who have numerous health care requirements.

For the purpose of this strategy Nursing homes and Residential homes will be referred to collectively as Care homes

6. The Sefton Care Home Market / Current Commissioning Activity & Arrangements

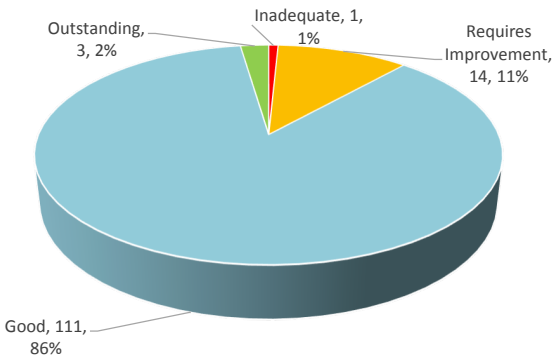
The Sefton Care Home Market

There are 133 Care Homes in Sefton with approximately 3,775 CQC registered beds (as at June 2021). There is a diverse number of services, including a mixture of small, and large homes, with homes consisting of on average 28 beds. The chart below shows the current breakdown of care homes by size;



Sefton has a high number of care homes, when compared to other (such as neighbouring) Local Authority areas and around 43% of care home beds are utilised by the Local Authority and 14% utilised by the Sefton CCGs. The remaining beds are typically utilised by self-funders (occupying around 1,000 of the beds) and placements made by other Local Authorities and other CCGs.

As summarised below, in general Sefton has a high proportion of Care Homes rated good or outstanding by the Care Quality Commission (CQC). This partly reflects the structure of the Care Home market in Sefton which relies on a significant number of small and medium independent providers rather than a single large national provider. Research suggests that in general small to medium homes receive better ratings than larger ones. We hold an ambition to get all our homes to good or outstanding and will work with Health colleagues and providers to develop a joined-up approach to supporting Quality and delivering the best we can to our older population.



(Source: CQC Active Locations Data, June 2021 – Services inspected under current inspection regime)

(Source: CQC Active Locations Data, March 2021 – Services inspected under current inspection regime)

Local Arrangements

The Local Authority footprint of Sefton has two CCG's:

South Sefton CCG

South Sefton Clinical Commissioning Group (SSCCG) is made up of 30 GP practices in the area. Together, their aim is to improve the health and wellbeing of their 156,500 patients by commissioning services better tailored to their needs. The NHS is changing and SSCCG is leading local reforms. From April 2013 SSCCG's became responsible in deciding what health services should be provided for the population of South Sefton.

Southport and Formby CCG

NHS Southport and Formby Clinical Commissioning Group (SFCCG) bring together 19 doctors surgeries covering an area stretching from Ince Blundell in the south to Churchtown in the north. Together, their aim is to improve the health and wellbeing of their 122,000 patients by commissioning services better tailored to their needs. From April 2013, S&FCCG became responsible in deciding what health services should be provided for the population of Southport and Formby.

Primary Care Networks (PCNs)

PCNs will play a pivotal role, with local authority and community partners, in improving population health and reducing inequalities. They will assess localised populations who are at risk of unwarranted health outcomes and, working with local community services, make support available to those who need it most.

This includes making the social prescribing of community services and other activities more widely available and accessible.

In Sefton, the four characteristics of our Primary Care Networks (PCNs) are:

- Provision to a defined registered population of approximately 30 – 50,000
- An integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care
- A combined focus on personalisation of care with improvements in population health outcomes
- Aligned clinical and financial drivers

There are already seven PCNs across our eight long established GP practice locality footprints, which cover a population of around 30–50,000 people.

Integrated Care Teams

One of the key aligned priorities for Sefton Adult Social Care and the Sefton Provider Alliance is to develop highly effective Integrated Care Teams (ICTs) that serve a population of 30,000-50,000. Teams include social workers, primary care mental health practitioners, medicines management, voluntary sector, community matrons, district nurses, allied health professionals, and integrated care co-ordinators etc.

They will support a joined-up Sefton model of care and support that offers an aligned approach of wrap around support based on need of the individual from an ICT/Care Home and Complex Lives perspective. In addition, the progression of the Integrated Commissioning model will ensure services are designed and delivered to meet need, achieve outcomes and maximise independence. This will include intermediate care offer, falls service, increased telecare, community equipment and adaptations, as referenced later in this strategy.

Sefton Provider Alliance

This includes a number of organisations who are involved in joint community service delivery (GPs, social care and the voluntary sector) and pathway partners (acute trusts, out of hours services and care homes) who are linked to or impacted by community services and the way they are delivered.

The Alliance responds to the strategic commissioning strategy, delivers services as specified and agreed to improve outcomes, embeds population health management, develops and redesigns pathways and Implements integrated care models.

Current Commissioning Arrangements & Processes

Sefton Local Authority typically supports around 520 clients in long-term nursing and 1,040 clients in long-term residential on any one day. Combined Local Authority and Health annual gross expenditure is in the region of £63m (£53m by the Local Authority and £10m by Health) of which, 20% is spent on clients under 65 years of age.

At the time of writing this strategy (August - September 2020) average unit costs vary widely from £390 per week for clients aged 65+ with primarily physical disabilities in a residential home to £930 per week for clients aged 18-64 with primarily learning disabilities in a nursing home.

For **Sefton Council commissioned placements**, when an individual is assessed as requiring care and support, the person must be able to exercise their right to choose between different providers that offer a suitable care package. They should be presented with all the available options, including those beyond the council's geographical boundaries, on the condition that;

- The accommodation meets the person's needs;
- None of the services exceeds the amount specified in the person's personal budget for accommodation of that type;
- The accommodation is available; and
- The provider of the accommodation is willing to offer the service at the rate identified in the person's personal budget and agree to the council's terms and conditions

In exercising a choice, the Local Authority must ensure that the accommodation is suitable to meet a person's assessed needs and identified outcomes established as part of the care and support planning process.

For **CCG commissioned placements**, the Guidance and Regulations define NHS continuing healthcare (CHC) as an ongoing package of health and social care that is arranged and funded solely by the NHS where an individual is found to have a 'primary health need'. This includes accommodation. Such care is provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. It is paid to people living in any setting to meet their assessed health and personal care needs.

The legislation gives CCGs the discretion to provide services which they consider are necessary to meet the reasonable requirements of the individuals for whom they have responsibility and appropriate for them to provide as part of the health service. Where individuals have needs or wants which do not flow from the primary health need, such as purely social, leisure or education needs, these could fall to the local authority to meet.

CCGs should carry out a needs assessment to determine if the quantity and/or quality of

care needed to manage an individual's needs is beyond the limits of a local authority's responsibilities and thus fulfills the criteria for a primary health need. The question of whether or not someone is eligible for continuing healthcare turns on factors including the nature, intensity, complexity and unpredictability of their needs.

When a patient is deemed fit for discharge from the hospital, but requires long term nursing care, the patient's assessment is sent to the CCGs' Commissioning Support Unit for screening. The application is processed via their ADAM Dynamic Purchasing System. The health needs are available for the care homes to view. Care homes then submit an expression of interest in being able to accommodate and meet the patient needs.

A number of homes may submit an expression of interest at any one time. Where this is the case the patient and their relatives will be advised of the homes that are available. Factors taken into consideration are quality, cost and location. And relative can then visit homes should they so wish to, and then choose their preferred choice.

Key Theme / Objective

As detailed later in this strategy, a key workstream will be commissioners exploring how commissioning, contracts, service specifications and quality and compliance arrangements and processes can be better aligned

Care Home Placement Activity

For **Sefton Council commissioned placements**, recent analysis has shown that;

- Up until April 2020 on average there were approximately:
  - 16 new Long-term Nursing Placement client starts each month
  - 39 new Long-term Residential Placement client starts each month
  - 43 new Short-term Placement client starts each month
- In June 2020 to July 2021 on average there were approximately:
  - 13 new Long-term Nursing Placement client starts each month
  - 39 new Long-term Residential Placement client starts each month
  - 49 new Short-term Placement client starts each month
- Over the last two years numbers of Nursing Placement has gradually fallen in general from 560 in April 2018 to 393 at July 2021.
- With respect to Out-of-Borough placements, and their Primary Support Reason, recent data shows that there are 157 placements, of which;
  - 20 Learning Disability Support
  - 35 Mental Health Support
  - 71 Physical Support
  - 29 Support with Memory and Cognition
  - 2 Sensory Support

For **CCG commissioned placements**, recent data shows that;

- Southport & Formby CCG;
  - 321 placements made in 2018/19
  - 426 placements made in 2019/20
- South Sefton CCG;
  - 400 placements made in 2018/19
  - 426 placements made in 2019/20

Analysis of the level of out-of-borough placements highlights the issue of the need to ensure that the Sefton market can respond to local needs and adapt to changes in dependency levels.

This is especially pertinent when looking at out-of-borough placements for people with complex needs. Sefton does have some homes that can meet the needs of these Residents, however it is sometimes the case that when Residents become more complex / have increased needs, they have to move to other care homes, such as those outside of Sefton.

We therefore want to reduce this occurring and support care homes to better manage increased needs. Placements made outside of Sefton also raise concerns with respect to how Commissioners can monitor the quality of care being provided and of contract monitoring of the placements.

Key Theme / Objective

Working with the Sefton care home sector to reduce the requirement for out-of-borough placements (particularly for complex Residents) and working to ensure that care homes can adapt to increases in need

Impact of the COVID-19 Pandemic

In addition to the above, we also need to assess the impact of the COVID-19 pandemic on placement activity of not just ourselves as Commissioners but also by other sources into the Sefton market, such as placements by self-funders.

To this end, a key workstream is to look at these issues, and is outlined in section 10 of this strategy.

7. Local and National Context

The Demographics of Sefton

Sefton has a population of approximately 274,600 (0.5% of the English population).

In summary;

- 52% of the Borough are female and 48% are male (slightly different to the 51% - 49% split seen across England).
- 23.1% of Sefton's population is 65 years old or over (63,300), with approximately one in five being aged under 18 (53,514).
- Sefton is ranked 18th out of 326 local authorities for the number of residents aged 65 or over.

Sefton faces significant challenges over the coming years because of the structure of its population. We have a much higher than average proportion of older people and we expect over the next few years to have increasing numbers of;

- People living alone with an increasing risk of social isolation, loneliness and depression.
- People with dementia.
- People with multiple and complex long-term needs.
- Unpaid carers, many of whom will be older people with their own care needs.

National Context

One in seven people aged 85 or over permanently live in a care home. People residing in care homes account for 185,000 emergency admissions each year and 1.46 million emergency bed days, with 35-40% of emergency admissions potentially avoidable.

Evidence suggests that many people living in care homes are not having their needs assessed and addressed as well as they could be, often resulting in unnecessary, unplanned and avoidable admissions to hospital and sub-optimal medication regimes.

Current / Future Needs and Aspirations

Older Peoples Mental Health

Given Sefton's high proportion of older people, and an aging population dynamic, it is unsurprising that there is and is likely to remain a need for nursing and complex support around memory and cognition (dementia).

Estimates are that 80% of Care Home Residents have Dementia or a memory related condition.

These needs can be divided into 2 elements:

- Functional mental health needs such as depression and anxiety disorders
- Organic mental health needs such as dementia and Parkinson's disease.

Many care home residents, like the elderly population in general may have more than one condition often increasing significantly the complexity of care. Delirium is also a frequent presentation with residents often becoming confused or more confused and unwell as a result of physical health problems. This high prevalence of mental health issues in the care home population requires a specific and coordinated response.

One in six people aged 85 or over are living permanently in a care home yet data suggest that had more active health and health and rehabilitation support been available some people discharged from hospital from could have avoided permanent admission. Similarly,

the Care Quality Commission and the British Geriatrics Society have shown that many people with dementia living in care homes are not getting their health needs regularly assessed and met. One consequence is avoidable admissions to hospital.

Older people and particularly older people living in care homes are disproportionately affected by COVID-19. There are more than 400,000 people living in care homes in the UK, more than 70% of which are living with some form of dementia. Many of these people also have other underlying health conditions (Alzheimer's Society, 2020).

The COVID-19 pandemic has required a change in practice in care homes which may be increasing the confusion and distress being experienced by residents. Most care homes have had to prohibit or severely restrict visiting and it is likely people living in care homes will be amongst the last group where restrictions will be lifted; isolating within a care home environment is challenging both physically and mentally; PPE whilst essential for safety can be disorientating particularly for residents living with dementia and residents are experiencing the death of their peers whilst fearing for their own and their families safety.

Particularly in residents living with dementia, where communication is harder, the factors listed above are likely to lead to increases in behaviours that challenge. If there is not psychologically informed support for these behaviours then the only alternative will be medicating residents to decrease distress which increases the risks of mobility issues, cerebral vascular problems and death. Simple and clear psychological strategies can be applied in care homes to support staff in understanding and responding to residents needs thereby reducing the frequency of distressed behaviours (Duffy, 2019). These strategies can include consultation to understand behaviour as well as activities to proactively promote wellbeing.

Mental Health

The Joint Strategic Needs Assessment outlines that Mental Health needs are increasing in Sefton. 10% of our population have diagnosed depression and 1.2% have a Severe Mental Illness. We have an excess rate of under 75 mortalities in our Adults with serious Mental Illness. We have a lower than national average rate of people with a Mental Health Condition in paid employment (at 2.5%).

Nationally the demand for social care related support is increasing and we see the demand outstrips supply, this may be due to factors such as;

- Better awareness and diagnostic practices amongst professionals.
- Increased opportunities for joint working and the integration of operational teams across health and social care.
- Increased access to NHS Mental Health services, subsequently resulting in higher referrals to social care.

Evidence shows that people with severe mental illnesses die between 15-20 years earlier than the average. Causes of premature death are mainly from chronic physical conditions such as coronary heart disease, type 2 diabetes and respiratory disease. All associated with external risk factors such as obesity, smoking and high blood pressure, and also the side effects of psychiatric medication.

The COVID-19 Pandemic will also impact on prevalence of Mental Health conditions, with the *Direct and indirect impacts of COVID-19 on health and wellbeing Rapid evidence review - July 2020* report produced by the Public Health Institute at Liverpool John Moores University highlighting that the measures taken to control the spread of coronavirus (including the social distancing and lockdown measures, school closures and the

cancellation or delay of routine healthcare) have had wide ranging impacts on a number of the wider determinants of health.

Whilst we have the overall aim of further developing models of service relating to supporting Residents through a 'housing with care' offer, such as independent housing or shared accommodation, we recognise that Residential and nursing care will still be required for those with the highest care needs and where independent living is not possible.

These forms of care will need to meet specialised Mental Health needs, particularly with respect to conditions such as Korsakoff's and early on-set Dementia.

Learning Disabilities / Autism

According to national population estimates the total population in Sefton aged 18-64 predicted to have a learning disability will reduce from 3,799 in 2019 to 3,594 by 2030. Of these, the total predicted to have a moderate to severe learning disability (and hence likely to be in receipt of services) will change from 861 in 2019 to 824 by 2030.

Internal predictions indicate that Sefton will continue to have an above average age of Learning Disability Residents aged above 55 as well as younger people in transition and by 2025 we will see 350 extra people aged 18-64 with a Learning Disability or Mental health Concern. An identified issue is in relation to the growing number of people over the age of 65 who have a learning disability and associated frailty and an increasing number of people with complex and challenging needs.

In Sefton we are looking to reduce the numbers of people under the age of 65 in long-term residential care provision and look to provide alternative, appropriate support for those who need this level of care, locally in the Borough. We are also looking to develop an enhanced short-break service for clients with complex Learning Disabilities / Autism to provide better care respite and allow carers to maintain their caring role and reduce the number of admissions to residential services going forward. For those complex Residents with Autism we will endeavour to have bespoke care home services with appropriate sensory surrounding and higher skilled staff teams to meet their needs and improve outcomes.

End of Life

Every year approximately half a million people die in England. 75% of these deaths are felt to be 'expected' and therefore with appropriate identification, conversations and planning there is an opportunity to maximise the care afforded to most of our patients as they approach the end of their lives.

When surveyed on where they would prefer to die, 65% of people state they would prefer to die where they usually live. We know that in South Sefton 2018 54% of deaths occurred in hospital in 2018.

The number of expected deaths is expected to increase by 3% per annum by 2030 as people live longer with more long-term conditions.

For Sefton, this translates to an additional 250 deaths per annum by 2030 **in each** of the Southport & Formby and South Sefton areas.

A key objective is for every individual and their family to retain their personal dignity, autonomy and choice throughout the years and months towards the end of their life, regardless of gender, ethnicity, race, religion, disability, sensory impairment, sexual orientation, diagnosis, or status.

We have been working on an End of Life Strategy, however recently it has been announced that there will be fundamental changes to the national focus on End of Life care with a

requirement to include children and young people in all palliative and End of Life care planning. In addition, there will also be a national long-term strategy for palliative and End of Life Care. This is due to be published in September 2021. There will be 6 national work streams which Sefton will need to engage and align to and this will supersede any local strategy, however a key priority will be to localise any national document to the needs of Sefton's population.

Falls

Falls are multifactorial and a major cause of morbidity and mortality among those aged 65 years and over in the UK. Falls and fall related injuries are a major challenge to health and care systems and to the older people who suffer them.

Key national statistics are;

- The number of people aged 65 and over is projected to rise by over 40% in the next 17 years to more than 16 million.
- Thirty percent of people aged 65 and over will fall at least once a year. For those aged 80 and over it is 50%.
- In around 5% of cases a fall leads to fracture and hospitalisation.
- As the majority - around two thirds - of people aged >65 suffer from two or more long term conditions (multimorbidity), falls and fractures should not be viewed in isolation, but as particular events and injuries which have an adverse effect on an older person's overall health and wellbeing.

In Sefton, the issue of falls becomes even more prevalent as the over-65s share of the population is more than 25% higher than the national average and is anticipated to grow by almost a half by 2037, when the over-65s will account for 1 in 3 residents, with a consequential effect on the level of hospital admissions.

South Sefton and Southport and Formby CCGs both have a higher incidence of injuries from falls in this section of the population than either their peers or the national average. South Sefton has a higher incidence of falls than all of its comparator group of CCGs, with a third higher hospital admissions, and Southport and Formby rank 8th amongst its group of 11 and has 14% higher Hospital admissions.

All of this will have an impact on the Sefton Care home market. With an increasing ageing population and increasing number of people entering long term care, AED attendances / NEL hospital admissions / NWAS calls and Conveyances for falls and fragility fractures will continue to increase from care homes which will impact across both health and social care. Hospital admissions for falls, AED attendances and ambulance calls and conveyances will continue to rise. Increase in falls which could be reduced through meds reviews and physiotherapy assessments. Opportunities for recognising and documenting falls and falls interventions may be missed, there will be a failure to optimise residents' quality of life, there will be decreased confidence and mobility amongst residents as well as a lack of empowerment and lack of connectedness to other services. Residents will remain unable to maintain and maximise their independence. Care will continue to be reactive rather than proactive.

We will also be members of the Cheshire & Merseyside Falls Collaborative which seeks to ensure an integrated end to end falls pathway across Primary, Community, Secondary and Voluntary services utilising an evidence-based approach to managing falls.

Key Theme / Objective

Implement applicable elements of the Sefton Falls Strategy and Cheshire & Merseyside Falls Collaborative work, in care homes

Linkage to Local & National Strategies and Plans

This Care Home Strategy will therefore seek to support and deliver on the above. However, it is important to highlight that it will not be delivered in isolation. This strategy will inform, be informed by, and influence other strategies and plans of which the care home sector will play a vital role in.

In summary, the following diagram outlines some of the key associated strategies;

These linkages have contributed to the development of this Strategy, which in turn will also support the aims and objectives outlined in these other strategies.

The **Sefton Adult Social Care Vision** includes the achievement of the following three key aims;

Help people to help themselves: We work alongside people to help them to keep well and do as much as possible for themselves, for as long as possible;

Help people when they need it: Working with people in a timely way when they are in need of some intensive support for a short period OR providing people with some low-level support, such as equipment or assistive technology to prevent or reduce the need for ongoing support;

Help people live their lives: For those people who have needs that require longer term care and support we will ensure that services are focussed on what is important to them and on restoring, enhancing or maintaining their independence;

The vision also highlights that another key area is to work with Health partners to have a shared understanding of demand and supply, and to commission services where this makes sense, based on need and best practice and in the most effective way to meet outcomes.

These three aims, together with the above have therefore informed the development of this and other associated strategies and will be factored into work that takes place with the care home sector.

The **NHS Long-Term Plan** makes a commitment to guaranteed NHS support to people living in care homes and includes a commitment as part of the Ageing Well Programme to roll-out Enhanced Health in Care Homes across England by 2024, starting in 2020.

The Long-Term Plan states:

'We will upgrade NHS support to all care home residents who would benefit by 2023/24, with the EHCH model rolled out across the whole country over the coming decade as staffing and funding grows. This will ensure stronger links between primary care networks and their local care homes, with all care homes supported by a consistent team of healthcare professionals, including named general practice support. As part of this, we will ensure that individuals are supported to have good oral health, stay well hydrated and well-nourished and that they are supported by therapists and other professionals in rehabilitating when they have been unwell. Care home residents will get regular clinical pharmacist-led medicine reviews where needed. Primary care networks will also work with emergency services to provide emergency support, including where advice or support is needed out of hours. We will support easier, secure, sharing of information between care homes and NHS staff. Care home staff will have access to NHS mail, enabling them to communicate effectively and securely with NHS teams involved in the care of their patients.'

(The NHS Long Term Plan)

A key deliverable of the aims an objective is therefore to implement EHCH in Sefton, as outlined later in this strategy.

The White Paper **"Integration and Innovation: working together to improve health and social care for all"** outlines the Government's legislative proposals for a Health and Care Bill, with many of the proposals within it building on the NHS recommendations in the Long Term Plan.

The paper highlights that a central theme in the NHS Long Term Plan is the importance of joint working between Health and Local Government in order to reflect that neither party can address all the challenges facing the whole population on their own and that the ambitions (which are also outlined in this care home strategy) of supporting people to live more independent lives will require joint and cohesive efforts.

In summary, the White Paper outlines the aims of;

- Promoting integration of Health and Care System focused on health of the population not patients,
- Seeking to ensure that Health and Care operate seamlessly without artificial silos. Integrated Care Systems (ICS) will be

funded to support Health outcomes in their area, held to account by CQC,

- Implementing integrated decision making at a local level by the NHS and Local Authority, removing bureaucracy, encouraging innovation and technology and is built on collaboration and strategic decisions; and
- Reducing inequalities, support people to live longer healthier and more independent lives through closer working at Place and system level, a data strategy for Health and Social Care and stronger financial arrangements.

As Commissioners we will need to work together to prepare for the legislative proposals outlined in the White Paper being implemented in 2022 and ensure that this strategy (which already heralds a commitment in Sefton to further integrated working) adapts to any new legislation and specific requirements around integration.

8. Future Commissioning Intentions / Proposed Care Home Market of the Future

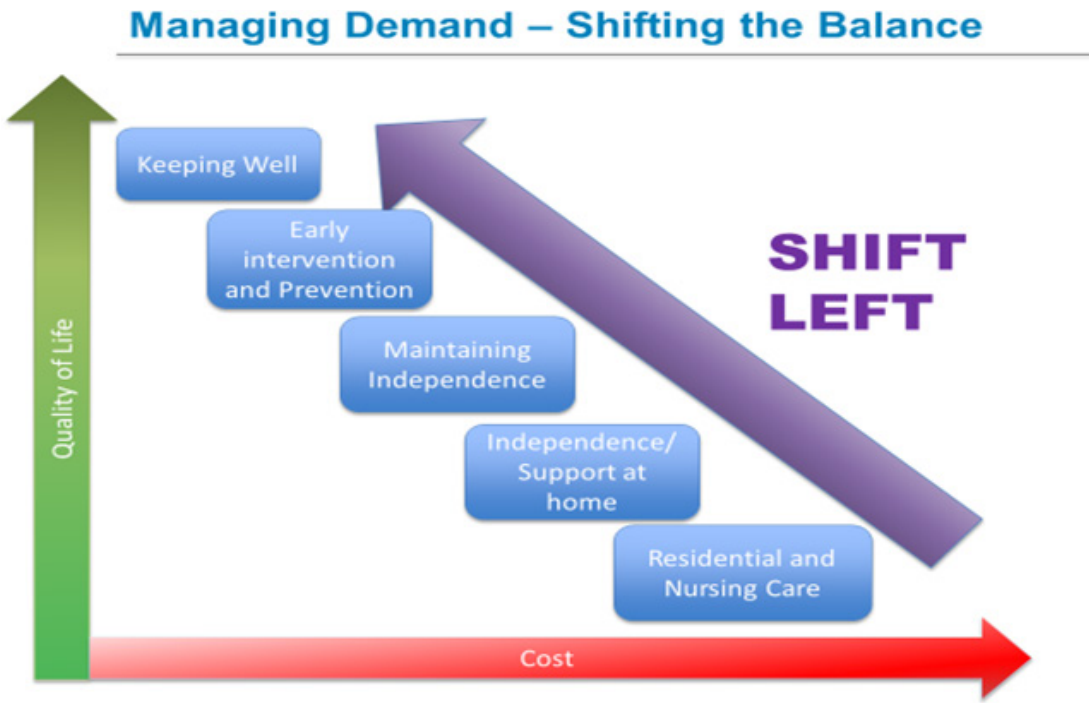
The intention in Sefton is to see less people being placed in care homes. At present we support and admit many more clients in Care Homes for all ages than the national average, suggesting a structural issue with over provision or insufficient levels of preventative or diversionary activity and a lack or underuse of alternatives.

We will therefore further develop community-based services to support people to remain living independently at home for as long as possible supplemented by responsive Social Care, Primary and Community Care services that are supported by Secondary Care and Intermediate Health Care Services.

Key Theme / Objective

Manage demand and shift the balance of services

This is summarised in the following diagram;



Key Theme / Objective

Ongoing Commitment to the Care Home Sector

This will reduce the reliance on Care Homes, in that this option is not seen as the first port of call when a person starts to deteriorate, has a hospital admission or a significant life change.

People in Sefton will be able to remain living in their own homes for as long as possible and will

only be admitted to a Care Home when all other community options have been exhausted.

In addition, the under-utilisation of community-based services which aim to maintain people's independence is also highlighted when looking at the 'performance' of Sefton against the following Hospital Discharge pathways;

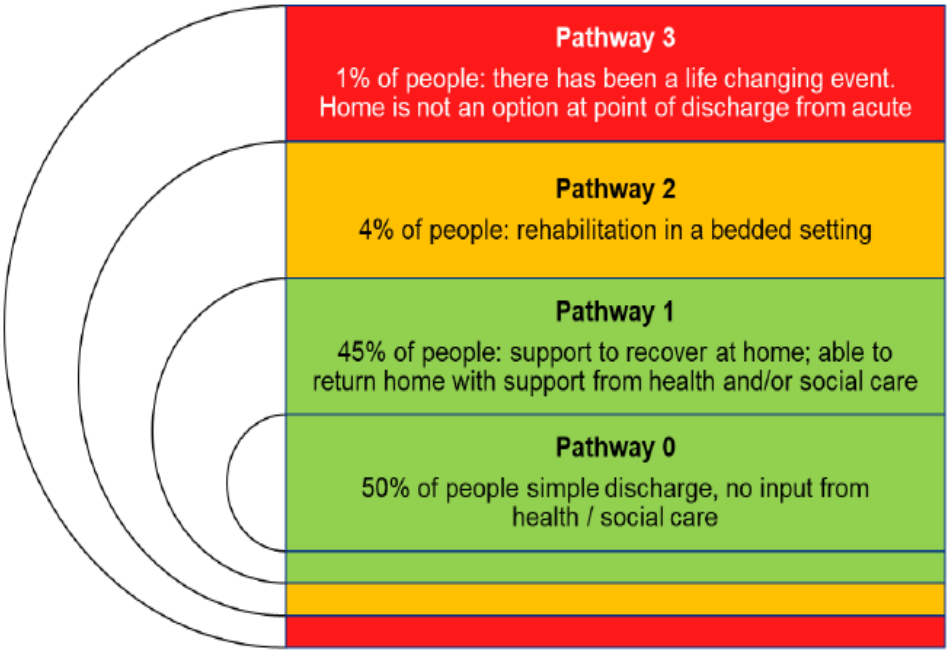


Figure 1: Discharge to Assess model

(Source: NHS COVID-19 Hospital Discharge Service Requirements, 2020)

We need to work on ensuring that the current numbers of people going into Pathways 3 and 2 are reduced and the number of people going into Pathway 1 is increased.

The implementation of **Sefton's Intermediate Care Strategy** will see the development of 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.

We will develop **Home Based Intermediate Care** which are community-based services that provide assessment and interventions for people in their own home or a care home setting, whether that is an older person or someone with a learning difficulty or other assessed needs. The aim is to prevent hospital admissions, support faster recovery from illness, support timely discharge from hospital, and maximise independent living. Care will be provided through a multidisciplinary health and social care approach with agreed goals and support tailored to individual need.

We will seek to expand the provision of the **Reablement** service. Fundamental to the objective of this service is the principle of helping people to support them rather than 'doing it for them' or 'doing it to them'. Evidence shows that timely bursts of Reablement, focusing on skills for daily living in people's own homes, can

enable people to live more independently and, in most cases, appropriately reduce their need for ongoing longer-term services. We want to ensure that such services become the default pathway for people, thereby ensuring that when people do receive services, in the first instance they are supported to regain their independence as much as possible.

We will also develop **Bed Based Intermediate Care** in order to help people avoid hospital or get home sooner, recover from illness, and plan their future care.

In addition, we will also work on the development of **Extra Care Housing** across the borough as an alternative housing option. Extra care housing is recognised nationally as a welcome choice for older people since it offers suitable accommodation, with flexible care and support available when needed, and a sense of community to reduce the risk of social isolation. It combines accommodation with care and support services. There are many different types and sizes of extra care housing, from small communities of flats and bungalows to large retirement villages. The facilities and care provided will vary, but extra care housing schemes usually include:

- Self-contained adapted flats or bungalows
- On-site care and support staff, providing personal care and domestic services
- Assistive Technology throughout the scheme, with 24-hour help available
- Communal facilities and services, such as a lounge, food offer and communal garden's

It is intended to enable and support older and vulnerable people to live independently for as long as possible, but with the reassurance that care and support services are available should they need them, either now or in the future.

We want to ensure we have enough provision that can support the residents of Sefton. Our goal is to deliver 1,306 extra care units by 2035 and this will then have significant impacts on our reliance on other services.

We also wish to expand the use of **Technology Enabled Care** (Telecare and Telehealth) as well as **Community Equipment** services, again, in order to support people to maintain their independence and remain at home as long as possible – as detailed later in this strategy.

9. Support to Care Homes and their Residents

However, the aims outlined in Section 4 of this strategy do not mean that we are seeking to reduce the pivotal role that care homes play in supporting the most vulnerable people in Sefton.

Key Theme / Objective

Ongoing Commitment to the Care Home Sector

In recognition of the continued important role that the care home sector will have in supporting the boroughs most vulnerable people, both now and in the future, a major element of this strategy is how we can support care homes. We are committed to supporting and developing the sector (as further outlined later in this strategy) and will work to ensure that;

- There will be a spread of Care Homes throughout the Borough to promote choice;
- There will be a range of Care Homes that can accommodate and care for people with a range of conditions such as dementia, neurological and degenerative conditions;
- People with a high level of need and complex conditions will be cared for and remain living in the Borough – thus reducing the need for the current level of out-of-borough placements;
- Care homes will be able to support people with complex needs through training and the implementation of mechanisms to support Residents to better manage their behaviours;
- There will be more homes that have dual residential and nursing registration to avoid people having to move if their needs increase; and
- Care homes are better able to adapt to changes in need, thus reducing the requirement for people to move out of their original care home placement when their needs increase. This will include care home staff being sufficiently trained to support residents who need more support in areas such as Moving & Handling, with care homes also accessing equipment and adaptations to help deliver this aim.

A key deliverable on meeting the objectives outlined in this strategy is the ongoing implementation of **Sefton2gether.** This is Sefton's response to the NHS Long-Term Plan and encourages a partnership approach between the NHS, Sefton Council, the voluntary, community and faith (VCF) sector and the people of Sefton. It represents a further commitment to Health and Social Care working closely wherever possible to link up where ambitions align, and work will be carried out under the umbrella of Sefton Health and Wellbeing Strategy and working within the finances available.

Having assessed the requirements of the NHS Long Term Plan, alongside other evidence around the health and care needs of the people of Sefton, such as the Joint Strategic Needs Assessment, and the feedback and evidence gathered throughout the engagement and development of the Sefton2gether plan, a priority is working to support the provision of care homes for the benefit of residents who live in them.

Key Theme / Objective

Implementation of Enhanced Health in Care Homes (EHCH)

To achieve this, a key element of this is the local implementation of **Enhanced Health in Care Homes** (EHCH) by the Primary Care Networks. In summary, EHCH reflects an ambition for the NHS to strengthen its support for the people who live and work in and around care homes.

To implement this locally, the following five elements will be developed;

Enhanced Primary Care Support - Access to a consistent named GP and wider primary care services, establishing the offer for care home residents by working with the identified GP Primary Care Networks to support delivery of NHSE GP contract and Primary Care Network specifications as part of the Integrated Care Team offer.

Multi-disciplinary Team (MDT) Support - Including Coordinated Health and Social Care - to establish dedicated CHAMP Teams to provide clinical leadership for personalised care and case management collaboratively with primary care and the care home staff. This will include;

- **Care Home Matron role** – further development of this role to provide accountability using a person-centred structured approach delivering responsive and proactive care. This will improve patient outcomes, quality of care, partnership working and will lead to a more effective use of resources.
- **Medicines Management** - The pharmacy technician roles focus on medicines safety and governance and review of care home medicines systems. The medicines safety audits completed are based on the key lines of investigation used within CQC inspections and provide clear insight of where care homes may be able to improve medicines standards to reduce medicines errors. Training on medicines reconciliation and medicines governance is delivered to care homes on an individual basis and adapted based on audit outcomes or reported incidents to ensure learning is consistent with training needs. The pharmacist's primary role centres on complex medication optimisation either during the MDT or outside of the MDT.
- **Mental Health In-Reach Team** – who would take referrals and triage them based on low, medium and high intensity needs and then offer the care home a number of session with a team member to assess, formulate and develop a person-centred intervention plan and strategies to meet the underlying needs of the resident whilst training the care home staff and developing capacity within the care homes. This would enable the development of individualised person-centred plans for people with dementia experiencing distressed behaviours which the care home then implement with support from the team. The team would be locality based – North, South and Central and would be multidisciplinary consisting of nursing, psychology and Occupational therapy with oversight from consultant psychiatrist and may include nurse prescribers.

Workforce Development - The Care Home Matron will also provide and enable training and education with Care Home staff, providing an opportunity to empower the care home workforce by enhancing their knowledge and skills in order that they can support their care home residents and potentially lower the number of hospital admissions and avoidable harms.

High quality End of Life and Dementia Care - this will be delivered through the local implementation of the impending national strategy and the joined-up approach of this integrated care model, bringing together physical

and mental health provision, and working collaboratively with other providers including the voluntary sector, hospices, and acute services.

Data, I.T. and Technology - To implement a digital offer, including shared information systems, telemedicine/ virtual triage and assistive technology to support timely, high quality clinical care.

Elements of the above aims are reflected in the following sections of this strategy.

Infection, Prevention & Control / Community Health Provider Offer

The COVID-19 Pandemic has highlighted the vital role that the local Community Infection Prevention & Control Team (delivered by a Community Provider) has in supporting care homes.

The team operate Monday-Friday 9-5 with wrap around out-hours support delivered by the local Public Health England Health Protection Team on-call over the weekend. The Team provide remote and on-site support and advice on a priority triaged basis. They support the reporting and oversight of outbreaks in Sefton and provide direct support to those experiencing an outbreak. This offer has been supplemented through support to care homes delivered by Sefton Council Environmental Health Officers, who work with the Community Infection Prevention & Control Team, supporting care homes with single suspected COVID-19 cases and outbreaks.

In addition to the funds allocated for to support the local COVID-19 community outbreak response, there is a planned permanent increase in the Community Infection Prevention and Control Service, that will include a focus on the management and prevention of COVID-19 outbreaks in care home settings.

In order to deliver on surge capacity mutual aid has been provided both within the community provider trust and from the Local Authority through Environmental Health

Public Health has provided assurance to our community provider that it will underwrite the required surge capacity to support IPC across care homes during the pandemic, however Public Health and Adult Social Care have also committed to work together to build on the existing Infection Prevention Control service to expand to include dedicated care home elements.

In addition to exploring future sources of surge capacity support the Sefton Outbreak Plan will also include plans for utilising additional funding to develop the local offer for health protection, supporting contact tracing and outbreak response in complex and high-risk settings such as care homes, including consequence management.

Key Theme / Objective

Further Development of Community Infection, Prevention & Control Team

Training, Education & Support

Linked to EHCH, it is crucial that front line staff in care homes receive readily accessible support and training and that they have key relationships with other providers in primary, community and secondary care.

We recognise that it is essential to support Care homes to enable them to care for their residents in their home and prevent unnecessary

attendances and admissions to a hospital setting.

We have recently developed a multidisciplinary training offer that gives access to Care Homes to support and training resources from NHS Providers, the Council, SCIE, the Hospice sector and other national and local resources. We will continue to work with Care Homes to ensure an integrated offer is built on to support Care Homes to deliver the best quality care.

We will firstly map all training opportunities available to care homes in order to then explore the development of a co-ordinated offer of training for the EHCH model for care homes.

We will also explore and build on the concept developed during the COVID-19 Pandemic of buddy homes or establishing teaching Homes to help us spread the significant pockets of outstanding or good homes we have in Sefton.

We will also need to ensure that care home staff are sufficiently trained on issues such as Mental Capacity and the implementation of the **Liberty Protection Safeguards** and associated issues such as consultation with care homes and with those interested in the person's welfare.

We also wish to continue with support to care home staff with respect to them dealing with the impact of the COVID-19 Pandemic. We recognise that the pandemic has had a significant impact on health and wellbeing of care home staff, and we have implemented support mechanisms such as the QWELL online counselling service, but we need to assess the impacts more and engage with care home staff on this issue to identify what further mechanisms they feel can help them to deal with any more longer-term effects that the pandemic has, or may be beginning to have on them. This work will be a key element of our ongoing response to the pandemic and assessing the impacts that it has had.

As part of the above commitments, we will firstly implement **My Home Life**. This is a Leadership Support Programme for Care Home Managers / Leaders with a focus on real issues with the intention of achieving improvement and transformation in their care service. It recognises that individuals learn best when they learn with and from each other, by working on real issues and reflecting on their own experiences.

The content of the programme will reflect what has happened and is happening in response to COVID-19 and part of the programme will focus on working together with the wider system to learn together and plan for the future.

The initial programme will support Providers to achieve the following;

- Improved confidence and resilience, both personally and professionally.
- Improved engagement and involvement for people who live and work in the home and those connected with it.
- Improved leadership and responsiveness to change.
- Improved practice including consideration of equality, diversity, inclusion and human rights.
- Reflection and connection back to regulation requirements, quality improvement and local systems and relationships.

Following the initial phases of My Home Life we will also then explore the implementation of a further phase which would support care homes and wider groups to;

- Widen networks and open opportunities using our tools and resources including links to our own dedicated network.
- Reflect on the difference between a 'closed' and 'open' care home culture.

- Better understand what living and working in a care home is like and the contribution they bring.
- Create connections now and into the future as communities adapt to the impact of the pandemic.
- Participate in ongoing research which continues to develop evidence that community connections improve the quality of life for all involved.
- Develop care home community champions in local areas.

We will also seek to ensure that care homes adopt the **Queen's Nursing Institute** "Standards of Education and Practice for Nurses New to Care Home Nursing (2021)." This outlines specific education and practice standards required for a Registered Nurse new to working in the care home sector to enable them to work safely and effectively and we will factor these, and other standards into any new contract and service specification developed (as referenced in section 11) in order to better reflect the specialist roles required within care homes and that such roles encompass not only adherence to professional standards, but also a requirement to have additional skills such as that of leadership, management, facilitation and relationship building.

Key Theme / Objective

Further Development of Training 'offer' to Care Homes

Workforce Related Issues

The Care Home workforce is of vital importance. They will provide an invaluable contribution to meeting the aims and objectives outlined in this strategy as well as them continuing to deliver care and support to care home residents.

Workforce Development is a key enabler to ensure that Sefton achieves its vision for the Care Home sector by ensuring:

- The effective supply, recruitment and retention of our current and future workforce;
- A strong, confident and skilled workforce fit for the future:
- A vibrant and responsive health and social care sector able to meet the changing expectations of people using health and social care support

We want to work in partnership with providers as effective workforce planning can facilitate the development of new roles, support the recruitment of staff with the right values and attitudes, and ensure those people have the skills and knowledge to deliver high quality services.

Skills for Care estimates that Sefton had 9,900 jobs in adult social care in 2017 with Social Care employment accounting for around 18% of total employment in the Liverpool City Region.

In summary, in Sefton;

- About 8.1% of jobs remain unfilled, i.e. approximately 800 roles are open at any time (this compares to 7.8% nationally)
- We have 130 CQC regulated care home services
- The social care Workforce is ageing, with 28% aged over 55
- 81% of the social care workforce is female with an average age of 44.1 years, 93% have a British nationality, with 5% from the EU and 2% with non-EU nationalities.
- Only 54% of the adult social care workforce in Sefton holds a relevant qualification
- There are too many unfilled jobs meaning Sefton can pay more for care.
- There is excessive use of Agency staff,

which results in higher costs for Providers and sometimes increased safeguarding and quality issues

- The DWP continue to report social care vacancies as "hard to fill" despite continuous marketing. Sefton@work also report little interest from workless residents seeking jobs in this sector.
- There are a greater number of people leaving the industry than joining
- High Turnover rates persist, with employers experiencing loss of qualified staff as "churn" to other areas of health/social care or to other sectors of employment.
- Pay, conditions, lack of investment in staff are cited among the reasons for poor retention in the workforce and can affect the quality of care. Sefton has an ageing workforce.
- Whilst turnover of staff is high, in Sefton we have a core of experienced workers, with an average rate of experience of 9 years. 73% of workers in the sector have been retained for more than 3 years but the workforce profile is ageing and to few younger workers are entering the sector.
- The over-reliance on EU workers may be an issue post-Brexit. Although this is considered low risk in relative terms, and along with arrangements for right to remain for Care Workers.

In addition, Sefton experiences the same following issues as other areas;

- Increased demands for care from an ageing population
- Welfare reform – the effect of Universal Credit and other changes have impacted on working patterns in this sector and beyond and have placed new obligations on people seeking work
- Perceptions from jobseekers continue about the sector being low skilled with low prestige and poor prospects for advancement. This affect application rates of potential new entrants, especially among graduates.
- Employer behaviours with respect to terms & conditions, pay, hours, etc contribute to the negative perceptions
- Ongoing financial constraints have required difficult choices to be made by commissioners, constraining growth for service delivery rates

In order to address this, we will firstly conduct a scoping exercise to map the current workforce and level/type of vacancies.

We will also work across the organisation and with stakeholders to shift perceptions about what working in this sector is really like, highlight great employment practice and promote better understanding of how much difference good care can make, making the sector more attractive to more people. We work closely with Skills for Care and actively encourage dialogue with the sector on how we work together with the sector to address these local and national challenges.

For example, through the *"Everyday is different campaign"* which will link local case studies and vacancies to this national campaign. promotion activities with employers to encourage applications, particularly among those supplies working for the Council, negotiation with employers on terms and conditions and Recruitment support programme for SMEs or utilising Social value aspects of Care Commissioning.

In terms of addressing the ageing population challenge work will be done to promote work placements to students on social care programme through employer engagement, visits, summertime working etc.

We will engage with our Colleges and learning providers to make social care a sector of choice for more of our younger residents, promoting work experience, work trials and other initiatives with our commissioned suppliers.

As Commissioners we will ensure that we optimise the benefits of social value requiring employers to work proactively with Sefton@work on improving terms and conditions and Invest Sefton on local supply chain benefit. Including consideration of the adoption of the Unison Ethical Care Charter.

We will seek to work with our workless residents to ensure they have greater information about the sector, and they have access to bespoke second chance learning to help them enter or re-enter the sector. For example, through Intelligence sharing with DWP on unfilled vacancy rates and Retention and productivity support for care employers

In summary, we want to see;

- More local residents will access better quality employment in the Borough.
- An increased availability of staff able to enter the sector in Sefton.
- A more reliable delivery of care packages commissioned by Sefton Council and greater confidence in control of costs.
- A more systematic involvement of commissioners with Sefton@Work on generating social value employment impacts and wider use of Employment related KPIs across other service areas.

Key Theme / Objective

Implementation of Workforce Strategy to improve retention and promote the role of the carer

Technology & Support Tools in Care Homes

Now more than ever we recognise the importance of technology and how it can support the care home workforce, aid the timely exchange of information, reduce the need for paper-based systems, ensure availability of real-time information and support interaction between people who can no longer rely on face-to-face contact. Practical support tools are also of great benefit in supporting day-to-day service delivery and wider objectives such as personalised care planning and the timely identification of any issues with Residents health conditions.

As part of a commitment to enhance service delivery arrangements in care homes we have already issued all Care Homes with Accurex technology to support virtual GP Appointments, and equipment and training to take vital observations to support this process. We will look to build on and expand this offer.

We have issued care homes with phones and supported the national roll-out of free Ipads in order to provide further support and to ensure that technology can be used to ensure that alternative arrangements are in place for visits to care homes from relatives, friends and advocates.

All Care Homes are now signed up to the national NHS Capacity Tracker and reporting functionality will support our oversight of quality and delivery of the market.

We continue to support the roll out of NHS.net mail to all homes to support the safe sharing of care records and information.

We have established a **Digital Task & Finish Group** to advise and assist in the development of Digital Assistive Technology to ensure that it meets the present and future needs of

Residents, operational delivery staff, therapists and clinicians and it will support Sefton Council's overarching Digital Strategy. Care homes will therefore be an important element of this work and Commissioners will be members of this group in order to identify future opportunities.

However, all of the above is only the start and we know that the implementation of more technological solutions can further support care homes, as well as Commissioners, to improve service delivery information and meet wider objectives.

Work is being progressed on the following initiatives

EMIS - We will pilot the use of EMIS in Care Homes as part of the work to further implement EHCH in Sefton and will explore and develop a sustainable long-term model to roll this out to support dynamic care planning, end of life and discharge processes. There are currently no I.T. infrastructures in any of the Care Homes across Sefton that allows systems to be interoperable with community service and Hospital Trusts and EMIS provides a solution to this. During the COVID-19 response it was clear that the residents of Care Homes need to have equality of access to the wider system of Care and Health that electronic links, that support dynamic Care Planning and the roll out of the impending national End of Life Strategy, Care Home Strategy and Intermediate Care Strategy. The outcomes of this pilot will be used to identify scope for wider roll-out to all care homes and if proven to provide quality, safety and value for money the scheme will be provided to all homes across Sefton. Other systems will be considered with input from care homes to ascertain what systems will work best in as a whole system approach.

Falls Application Technology – in order to support delivery of the Sefton Falls Strategy, we will seek to explore the implementation of a digital tool / app to assist with the management of risk and the occurrence of falls. this will be issued to care homes (potentially initially on a pilot basis to a small number of homes to assess its impacts). It is a secure, digital falls prevention web-based tool which helps manage the risk and occurrence of falls. It offers the following benefits;

Provides a full multifactorial risk assessment - enabling early identification of risks

Gives care homes a real-time dashboard - to understand at a glance what is happening across your care home, helping to identify trends and drive continuous improvement.

Creates a personalised action plan (from 50+ proven interventions) to reduce those risks

Tracks actions and interventions to prevent falls

Collects evidence of falls when they do occur - to drive continuous improvement

Creates a digital audit trail to satisfy regulatory inspection requirements (Health & Social Care Act 2008)

RESTORE2 & NEWS2 – this is a physical deterioration and escalation tool specifically designed for care/nursing homes based on nationally recognised methodologies including early recognition (Soft Signs), the national early warning score (NEWS2) and structured communications (SBARD). This will help improve communication between care homes and their serving GP practices to help reduce admissions where inappropriate. It has been designed to help care and nursing professionals to:

Recognise when a resident may be deteriorating or at risk of physical deterioration

Act appropriately according to the resident's care

plan to protect and manage the resident

Obtain a complete set of physical observations to inform escalation and conversations with health professionals

Speak with the most appropriate health professional in a timely way to get the right support

Provide a concise escalation history to health professionals to support their professional decision making

We will ensure our **Telecare and Assistive Technology Strategy** works alongside our care home to ensure the most effective and efficient use in our care homes, but also to ensure that care homes that deliver more short-term / Intermediate Care type services are aware of technology that Service Users they are currently supporting can access when they return to their own home and that care homes play an active role in making recommendations regarding longer-term care and support requirements.

Key Theme / Objective

Evaluate existing initiatives around technology supporting care homes and further explore how technology can support service delivery

Equipment & Single-Handed Care

Care homes must ensure that they meet CQC standards with regards to equipment provision. Care homes are required to have assessed that, for any potential new admission of a Service User, they can meet the person's needs in a regulation compliant way. Equipment considered essential for carrying out regulated activity should be available in sufficient quantity and type to meet the safety, independence, welfare and comfort needs of all the residents. Staff working in care homes play an important role in identifying equipment needs when a person commences living in a care home and also when their support needs change.

Whilst care homes need to have a variety of equipment and furniture to meet most needs, there will be some Residents that may have needs that require a specialist piece of equipment to be made. People living in care homes have the same rights to services, including the assessment for and provision of some equipment, as those living in their own homes. The Sefton Community Equipment Services (CES) is commissioned jointly to provide community equipment on loan to individuals (both adults and children) following assessment by a health and/or social care practitioner. Any equipment issued is for the exclusive use for the Service User for which it is prescribed. The purpose of providing any such equipment is to increase or maintain functional independence, safety and wellbeing of residents and care staff as part of a risk management process. The CES also does important work on ensuring the safe and effective use of equipment.

As with other services the CES remains a vital element of the care home sector and we want to ensure that it continues to operate in a way which supports the sector continues to meet the present and future needs of Residents, Therapists, Clinicians and Providers.

Recently we have conducted an 'amnesty' of equipment, which was well supported by Sefton care homes, however we recognise that we may need to periodically do such exercises again in order to ensure that equipment provided remains fit for the purpose of which it was originally issued and to ensure the best use of resources, given the overall intention to support more people in their own homes.

As a result, we want to ensure that care homes;

- Have staff appropriately trained on the use of equipment;
- Conduct the required operational cleaning / disinfection of equipment and that they follow the required instructions and guidance for its use; and
- Are aware of their obligations around any loaned equipment and support the CES to ensure the best use of equipment resources.

However, we recognise that the use of equipment and the creation of greater independence applies just as much in care homes as it does in people's own homes. In Sefton the **Single-Handed Care** has been successfully implemented with Providers of community-based services where it was identified that good risk assessments, followed by suitable equipment and adaptations provided in a timely manner can ensure people are able to remain in their own home and reduce the need for double-handed (two carer) care packages.

We therefore want to explore the implementation of applicable elements of Single-Handed Care project in care homes.

Key Theme / Objective

Continue to ensure that equipment is provided (where required) to support care homes and to explore the implementation of Single-Handed Care in care homes

Capital Grants Programme

As part of the wider 'offer' of support to care homes we have implemented the opportunity for Sefton care homes to apply for capital grants to improve their homes in the following ways;

- Making physical improvements to care home environments
- Implementing technological solutions

The initial focus has been to make care homes more dementia friendly, to increase the positive experiences for Residents and their families/ advocates and to support the wider aim of homes achieving and maintaining *Outstanding* Care Quality Commission ratings.

Examples of the types of proposals related to;

- Improvements to gardens /outdoor spaces/ communal areas to afford Residents and their Families improved opportunities to access outdoor spaces and use areas for improved social interaction and activities
- Improvements to communal areas within the care home to support greater social interaction
- Improvements to areas within the care home in order to make them more dementia friendly and to provide an environment which reduces Service User anxiety/ distress
- The purchasing of technological solutions/ equipment (for example Interactive Tables, Robotic Pets and technology to support reminiscence therapy and contact with family) for use by Residents in order to improve their quality of life

Once these initial grants have been fully allocated and assessments conducted on the impacts that the improvements have made, we will continue to explore the potential for further capital investment into the sector and also opportunities for Commissioners to benefit from their 'buying power' to procure technological solutions / equipment for subsequent issuing to care homes.

We want to explore how any such funding can be used to support care homes, such as with respect to the provision of specialist equipment to meet prevalent / emerging needs.

Key Theme / Objective

Continue to ensure that equipment is provided (where required) to support care homes and to explore the implementation of Single-Handed Care in care homes

Enhancing the 'voice' of Residents, Families and Advocates

We also want to ensure that there is a continued focus on gathering the views and opinions of people that receive services.

Whilst this can be addressed through quality monitoring work, we also want to work with partners such as **Healthwatch Sefton** to develop **Thematic Reviews** of the sector based on feedback gathered from Residents, Families, Carers and Advocates on what are the most important issues for them and what factors they think are important for the effective delivery of services.

10. Market Management

Over the next three years we will build a robust joint route for managing the market in terms of Quality, resource, supply and demand and building a strong culture of communication, openness and working together to deliver shared aims of robust high-quality serviced offers at a best valuable sustainable price.

It is recognised that a category management approach for this sector is required to provide assurances to Governing Bodies, Elected Members, Stakeholder and Interest Groups that this service area is effectively managed, and quality is effectively monitored with risks managed and mitigated.

This category of commissioned services / expenditure is significant in terms of risk (services to vulnerable people), budget oversight and Council and CCGs reputation. There is a need for greater oversight for this service category and budget, as the sector remains an integral element of meeting the needs of vulnerable people in Sefton.

We also need to address issues such as new care homes being built within the Borough with little discussion regarding the provision being offered or whether this provision falls within the commissioning direction of both health and social care. When considering such issues, we will also take into account the impact of any new care homes on the demands on primary and community care services which would result from the increased number of Residents needing to access such services.

This strategy, together with other associated strategies and policy documents, will be used to inform decisions on any new provision as well as being a document that potential new Providers can review, together with associated documents such as the Local Authority Market Position Statement, to ensure that their proposals meet the aims and objectives within it. When considering any new planning applications, we will also explore the potential for any new developments to also include the provision of new GP premises in order to meet wider aims.

We will therefore engage with our Planning partners to discuss proposed future developments and to outline our views as Commissioners on their ability to meet needs and the actual demand for any new services.

Whilst we are aware of each of our own commissioning activity information (as outlined in section 6 of this strategy) we recognise that this work needs to be expanded upon, to gain a better understanding of the market and to inform other pieces of work such as the review of fee structures (see section 10).

A key element of the approach to market management will be **Viability Work.** At the time of writing this strategy our Care Homes are facing a significant challenge as they deal with the COVID-19 pandemic and look towards recovery from the pandemic.

The void rate within care homes has historically been in the region of 6-7% but is currently higher with some homes having experienced void levels more in the region of 15-20%. This, together with potential future decreases to the level of placements typically made by Commissioners, coupled with reduce demand from the 'private' sector, will have an impact on care home Providers.

A key immediate activity is therefore the ongoing monitoring of these issues and exploring how the Sefton care home market can adapt. We

will continue to conduct work on assessing the impact on the market which will include analysis of;

- Local Authority and CCG commissioning trends / activity;
- Referrals and new placements being made into care homes – but not just referrals made by the Local Authority and the CCG. We also need to understand any changes to the 'private / self-funder' market for care home placements and quantify any changes between pre-COVID-19 and current referral levels;
- Financial matters such as analysis of Providers financial 'health' and cost pressures;
- Gathering more information on factors such as the physical condition / age of care homes in order to ascertain whether the building and facilities are well maintained and if there is flexibility / adaptability within the physical structure, e.g. the opportunity to create annexes for different client groups or needs; and
- Working with other Local Authorities and CCGs in order to reflect that we may 'share' the same Providers.
- Working with the market to develop its ability to respond to a higher level of acuity and ensuring we build on lessons learned during the COVID response to ensure we maximise the use of wrap around health offers to help support this.
- Working alongside the Sefton provider Alliance to deliver Enhanced Health in Care Homes as per our key objective detailed on page 26

Once we have an overall picture of the market and Providers, we will engage with them further to explore the issues and how we can offer further support.

In addition to local work, we will also work on a regional footprint to ensure we able to strategically manage the market and continue to meet the needs of individuals whom Care Home placements are the correct service offer for. This will include looking at specialist delivery and a higher acuity of residents. Market shaping and diversification of the market will need to be part of our future landscape.

Key Theme / Objective

Continued focus on assessing viability in the care home market

Dealing with Provider Failure

Linked to any work on viability is the potential that provider failure may occur. Withdrawals from the market may take place as a result of the impacts of the COVID-19 pandemic and other factors which lead to a reduce demand for care home placements, either in general or for certain types of placements.

Both the Local Authority and the CCGs work closely with the Care Quality Commission to ensure that effective quality control and monitoring systems are in place for Providers, however it is recognised that there may be instances where Providers fail, and this issue is more pertinent than ever.

The Care Act 2014 makes provision for ensuring that if interruptions to care and support services occur, Local Authorities have powers and duties for ensuring that the support needs of those receiving services continue to be met.

The Care Act also sets out Local Authorities duties to gather market intelligence which is also relevant to responding to business failure and other service interruptions. Where alternative services need to be put in place, a thorough

knowledge of the market is required. In addition, Local Authorities need to understand how their providers are coping with trading conditions. This includes Sefton Local Authority having good knowledge of the Provider market in the borough, offering assistance to Providers if it is possibly facing closure and what happens when a provider closes.

Whilst Sefton MBC and the CCGs have endeavoured to conduct commissioning which is sustainable, and which is based on a robust understanding of the market, it is recognised that instances will occur where Providers fail for various reasons.

In order to meet its Care Act 2014 obligations Sefton Local Authority and the CCGs will continue to;

- Develop a proactive and reactive role when working with providers and will proactively help anticipate and if appropriate work with a provider to prevent or delay closure.
- Share concerns they have about a Provider with other relevant organisations e.g. CQC, CCGs.
- Gather intelligence and information on providers and will share this with relevant stakeholders as appropriate e.g. CQC, other CCGs.

Sefton Local Authority and the CCGs will maintain a relationship with the CQC with a view to early warnings where Provider compliance issues may lead to CQC enforcement action or threaten the ongoing operation of a CQC regulated service. Safeguarding Teams will seek to identify early warning signs in regard to a Provider through safeguarding adult alerts.

In order to support this work, we will;

- Have awareness of the diversity of local providers to facilitate the transfer of care of individuals to another provider or owner in the event of market exit;
- Have good relationships with all providers serving their local population and through market intelligence and reporting be aware of any company financial distress;
- Have plans in place agreed with other relevant commissioning bodies to cope with the closure of a provider and to be clear about roles and responsibilities where the care people receive is commissioned by CCGs;
- Ensure that local people including Elected Members are informed about the change of a provider as appropriate, involve individuals, their families and carers in all decisions affecting their care;
- Ensure views of individuals and their families are taken into account to minimise disruption and act in line with their preferences wherever possible, making a best interest decision where this is relevant;
- Ensure that efforts are made to reduce stress and anxiety for individuals, their families and carers.

Market Exits

Should Providers need to withdraw from the Sefton care home market then we will work with them through this process and seek to support their workforce to identify future employment opportunities.

Needs Analysis

In order to manage the market, we need to continue to look at current and future needs. Work such as the Market Position Statement will support this as well as gaining feedback from Practitioners and Providers on trends they are seeing and changes in dependency levels.

We then need to share with information with Providers to support them to better understanding these needs and how their services can meet them.

11. Contracting, Quality, Compliance and Performance

As Commissioners we both wish to contract with the Care Homes delivering the highest quality care for people in Sefton.

As identified in this strategy, we recognise that as Commissioners we are asking Providers to operate under different frameworks, contractual arrangements and service specifications. Whilst some of this is 'beyond our control' we recognise that we can work together more, for both the benefit of us both as Commissioners, but also for the benefit of Providers with respect to providing a 'common voice' to the market, more streamlined business processes and shared monitoring arrangements.

We need to explore opportunities for;

- **Aligning commissioning arrangements** – including a shared 'brokerage' function for making placements and/or the establishment of joint working arrangements in order to consider requests for high-cost services and to ensure that any services in scope to be commissioned will achieve the best outcomes for Residents and represent Value for Money or whether alternative services are available that better meet these aims. This in turn will then provide intelligence on emerging needs in order to then inform engagement with the Provider market on how they can adapt and meet these needs. However, given the anticipated statutory changes to the abolition of Clinical Commissioning Groups and the emerging Integrated Care System (ICS), it is highly likely that statutory responsibility for delivery of the National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care will be placed at ICS level. There will however need to be place-based considerations in terms of how assessments and reviews will be undertaken, and care provision brokered. In this regard we will continue in the meantime to work together on plans as and when further direction from NHSE&I emerges.
- **Creating a new joint contract** – or at best aligning contractual arrangements with updated clauses to reflect factors such as;
  - New fee structures
  - Performance and outcomes measures
  - Information governance
  - Use of technological solutions
  - New legislative requirements and good practice – including those relating to information governance
- **Implementation of a shared service specification** – linked to the above, there is also the desire to implement an updated service specification which reflects a revised focus on;
  - Quality;
  - Outcomes for Residents / Carers;
  - Changes occurring due to the COVID-19 pandemic – such as the development of the Trusted Assessor model;
  - A partnership commitment to workforce development, including training and professional standards;
  - Any legislative and good practice changes such as the Liberty Protection Safeguards; and
  - Quality and performance measures and requirements.

As a result, we will have new arrangements in place with Care Homes that reflect aims and

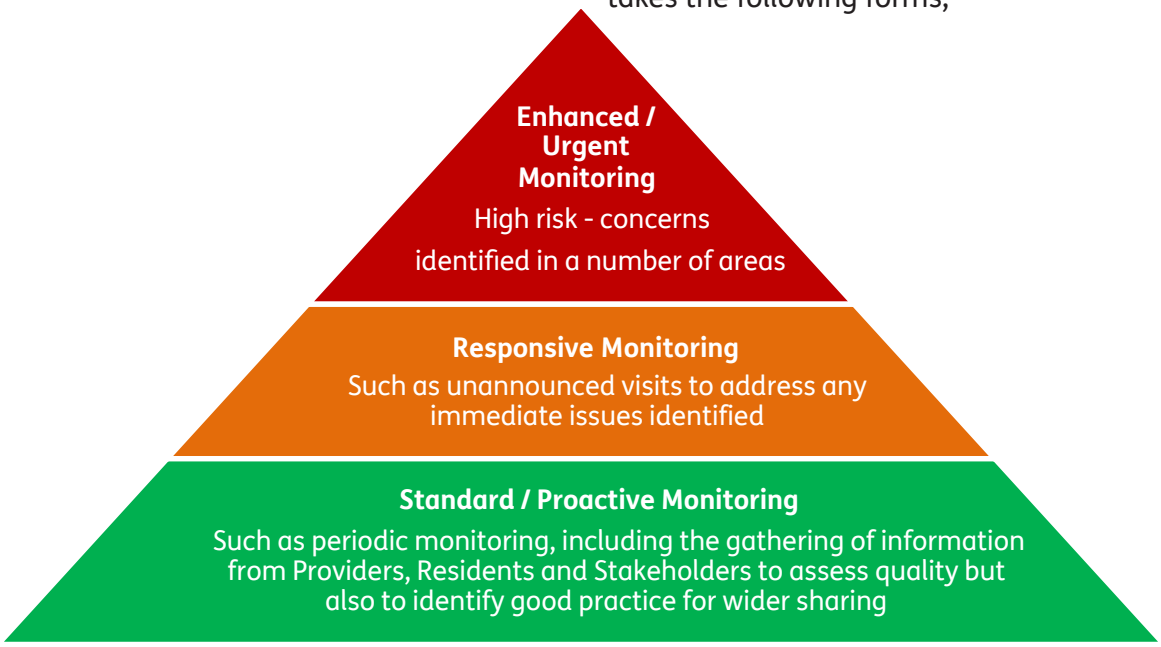
objectives outlined in this strategy, are fit for purpose and promote high quality care and improvement that is supported by a robust improvement and quality monitoring processes.

Linked to these objectives and also the review of financial arrangements, we will explore the implementation of a **'Preferred Provider List'** of homes which have signed up to any new contract, which can then be made available to Residents and their Families. Should this be implemented, it is important to highlight that choice directives will still remain in place.

Compliance, Performance & Quality Monitoring

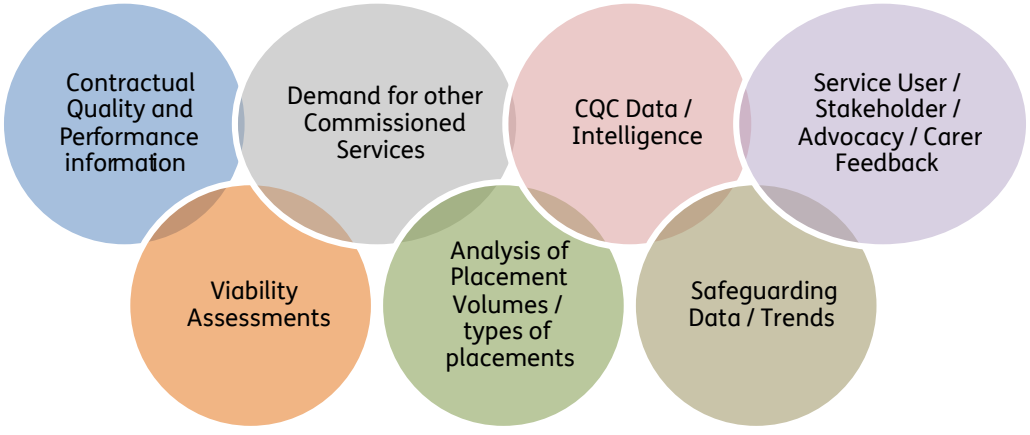
Monitoring the effectiveness of care homes and the services they provide is of vital importance. It enables us to identify any issues and risks and then to focus support on where it is needed. It also supports the aims of identifying and sharing good practice.

We want to enhance our monitoring so that it takes the following forms;



In order to support this work, and also our market management work, we will also work together on the development of a shared quality and performance monitoring function.

Assessments of Quality, performance and compliance are not just about analysing data. Data can only tell us so much and other intelligence needs to be gathered to support the overall assessment process, as summarised below;



We therefore need to ensure that we have robust arrangements in place which;

- Support the sharing of intelligence;
- Provide mechanisms for Residents, Families, Advocates, Staff, Professionals and Stakeholders to inform quality and performance monitoring activities;
- Enable real-time analysis of the market and individual Providers;
- Collate analysis of Safeguarding issues, as these are one of the key sources for the identification of concerns in care homes, in order to identify trends and also support the sharing of good practice; and
- Ensure that the quality monitoring process is not administratively burdensome for Providers.

To this end, we will seek to implement new tools for the collation and analysis of information to support and inform the Quality and Compliance process. This will also include the implementation of I.T. solutions to support this work and the timely exchange and submission of information.

We also wish to explore the development of a **Sefton Quality Mark** which would reflect the following elements;

We want to celebrate and promote good quality care homes and acknowledge the work they do to support their residents and staff.

Key Theme / Objective

Development of Shared Contracts, Service Specification and Quality Monitoring functions

12. Finance Related Issues

We recognise that financial matters will always be an important element of how the sector is managed, meets needs, adapts to changes in needs and links to work around managing the market, improving quality and assessing viability.

We also recognise that Care Home Providers have experienced significant cost pressures, both with respect to new expenditure as a result of the COVID-19 pandemic and reduced income through less placements being made, and other factors such as the EU Exit.

However, it is also important to acknowledge that funding also needs to be looked at in relation to the care home market that we want for the future, the focus on making less care home placements and the increased demand for other services. We will need to be open and honest with Providers on such issues given that we are working to constrained budgets.

Whilst previous market oversight exercises have resulted in cost of care tools being used, we recognise that there is a need to re-visit these. We need to understand Providers current costs as well as wider financial information such as levels of Third-Party Top-ups and how these are formulated. Currently, detailed information on fee rates levied is unclear and this leads to issues when analysing Value for Money and ensuring that rates reflect different levels of need.

As part of joint working, we will commence a project to review existing fee structures, which will include the scoping of the potential implementation of;

- Tiered pricing approach to reflect differing levels of Service User dependency and factors such as;
  - Behaviour
  - Cognition
  - Psychological and Emotional needs
  - Communication
  - Mobility
  - Nutrition & Hydration
  - Medication / Pain Management
- Costing tools to formulate costs which are based on individual Service User assessments and/or where additional 1:1 care is required to meet specific needs such as those related to Moving & Handling;
- Arrangements for assessing costs relating to S117 Aftercare and Joint Funded placements; and
- Fee rates against the availability of, and the accessing by, care homes of community based wraparound support services, I.T. solutions and Equipment, which can be utilised to address certain needs thereby reducing costs.

We want to have open and transparent dialogue with care homes on their costs in order to seek to implement fee structures and payment systems which are clear and reflect best practice in terms of;

- Commissioners assessments being clear to care homes in terms of level of assessed care and support needs, their decisions and rates to be paid;
- Considering requests for high-cost services and to ensure that any services in scope to be commissioned will achieve the best outcomes for Service Users and represent Value for Money or whether alternative services are available that better meet these aims;
- Greater transparency of existing costs when decisions such as that of CHC eligibility arise; and

- Reducing the requirement for specific negotiations to take place around costs for individual placements in order to streamline decision making and placement processes.

Linked to the above, is the Local Authority also reviewing its current payment arrangements with care homes. The current contractual arrangement is to pay providers the Local Authority contribution only; net of the client's personal financial contribution toward their assessed care needs and any agreed third-party top-ups for additional services. Care Home Providers are required to collect the client contribution and top-ups direct and feedback received as part of consultation on fee rates has highlighted this as an issue. We will therefore commence a specific workstream around the potential implementation of the Local Authority paying gross costs to Residential and Nursing Care Home Providers for all Residents placed by Sefton (including those with a deferred payment agreement in place).

We will also explore the further pooling of budgets in order to make the best use of resources, support other work on further integration and also to provide more seamless funding / payment mechanisms for Providers.

Key Theme / Objective

Review of Fees / mechanisms to calculate placement costs and exploration of further pooling of budgets

13. Consultation & Engagement

Key to the delivery of this Strategy is to enable the Sefton Care Home Market to be fit for the next 3 years and beyond. Engagement and approaching this challenge in partnership is key and a crucial part of this is increasing the dialogue between Commissioners, Providers and Stakeholders. This is something that has happened sporadically in Sefton historically and it is recognised that it needs to improve.

During the COVID-19 response, this galvanised into a co-ordinated, sustained, positive and proactive system of provider forums, bulletins, direct telephone calls, design thinking session and the production of system wide guidance and pathways to support the Care Home market. Providers and partners (such as Healthwatch Sefton, Advocacy services and Community Health Service Providers) have been engaged with in order to ensure that communications are timely and robust and that all parties are supported, and their expertise is utilised.

We wish to build on this and ensure that impetus gained so far is not lost and to also expand this work to promote the sharing of good practice and homes supporting each other through initiatives such as 'buddying' arrangements.

We also want to ensure that we engage with Groups established by care home Providers themselves so that we can communicate our commissioning intentions and proposals for supporting and developing the sector.

Key Theme / Objective

Consultation as part of delivery of this strategy and building on Consultation & Engagement mechanisms implemented to date

14. Implementation of this Strategy / Keeping it Under Review / Governance

This strategy is ambitious, and it has also been produced at a time of unprecedented change for everyone involved in the care home sector. Therefore, this strategy at this present time cannot outline definitive timescales on future work and dates for implementation.

However, a high-level implementation plan is included at the end of this section, which summarises key project workstreams and current proposed timescales.

The strategy needs to be a working document with detailed plans being developed and consulted upon relating to the specific aims and objectives we want to deliver.

This strategy will be reviewed on a periodic basis to ensure that it remains fit for purpose and to report progress on its delivery to established groups and governance structures such as the Sefton Health & Wellbeing Board, the Integrated Commissioning Group, Leadership Teams, Elected Members and Provider groups.

15. High Level Action Plan

Workstream	Activity	Quarter 2 - 2021/22	Quarter 3 - 2021/22	Quarter 4 - 2021/22	Quarter 1 - 2022/23	Quarter 2 - 2022/23	Quarter 3 - 2022/23	Quarter 4 - 2022/23	Quarter 1 - 2023/24	Quarter 2 - 2023/24	Quarter 3 - 2023/24	Quarter 4 - 2023/24
Strategy Implementation	Engagement with key Stakeholders on strategy implementation											
	Establishment of dedicated project groups to take forward strategy priorities											
	Development of linkages into emerging Integrated Care Partnership											
	Implementation of associated Strategies (Intermediate Care etc)											
	Engagement with LCR to explore issues such as Dynamic LCR DPS and alignment of LCR objectives											
	Year 1 review of Strategy / Production of Progress report / Formalisation of Year 2 priorities											
	Year 2 review of Strategy / Production of Progress report / Formalisation of Year 3 priorities											
COVID-19 Response / Analysis of Impact	Continued joint LA and CCGs response to the pandemic											
	Ongoing assessment of impact on market - vacancies, referrals etc											
	Further development and updating of market management / viability tools											

Workstream	Activity	Quarter 2 - 2021/22	Quarter 3 - 2021/22	Quarter 4 - 2021/22	Quarter 1 - 2022/23	Quarter 2 - 2022/23	Quarter 3 - 2022/23	Quarter 4 - 2022/23	Quarter 1 - 2023/24	Quarter 2 - 2023/24	Quarter 3 - 2023/24	Quarter 4 - 2023/24
Finance Related Issues	Ongoing analysis of impact of 2021/22 fee decisions											
	Analysis of Historic and current placement activity and costs - including Out-of-Borough placements											
	Cost of Care exercise / Development of Tiered Pricing Approach											
	Review of DPS system / Options appraisal on future placement brokerage arrangements											
	Further scoping of implementation of Gross Payments (LA)											
	Potential Implementation of Gross Payment - including potential pilot programme											
Technology / Capital Improvements	Mapping of current national and regional technology working groups and funding streams											
	EMIS Pilot - Delivery / outcomes measurement / proposals for next steps											
	Research on applications available to support Falls monitoring											
	Exploration of exercise to centrally procure technological solutions identified in grants programme											
	Outcomes analysis for Capital Improvements Grant Programme											
	Scoping of opportunities for further capital investment - including care planning I.T. solutions											

Workstream	Activity	Quarter 2 - 2021/22	Quarter 3 - 2021/22	Quarter 4 - 2021/22	Quarter 1 - 2022/23	Quarter 2 - 2022/23	Quarter 3 - 2022/23	Quarter 4 - 2022/23	Quarter 1 - 2023/24	Quarter 2 - 2023/24	Quarter 3 - 2023/24	Quarter 4 - 2023/24
Contracting / Quality Monitoring / Commissioning Arrangements	Scoping of current Commissioners activity / commissioning arrangements											
	Formulation of proposals for integrated Quality Monitoring Team - including shared BI function											
	Exploration of implementation of Quality Monitoring I.T. systems											
	Development of revised contract and service specification - including joint working on a regional level											
	Implementation of new contract and service specification											
Support to Care Homes / Workforce Development	Further implementation / embedding of Enhanced Health in Care Homes											
	Delivery and evaluation of My Home Life programme											
	Exercise to gain feedback from staff on impact of pandemic and training / development needs											
	Mapping of current training opportunities available & review of training offer											

Workstream	Activity	Quarter 2 - 2021/22	Quarter 3 - 2021/22	Quarter 4 - 2021/22	Quarter 1 - 2022/23	Quarter 2 - 2022/23	Quarter 3 - 2022/23	Quarter 4 - 2022/23	Quarter 1 - 2023/24	Quarter 2 - 2023/24	Quarter 3 - 2023/24	Quarter 4 - 2023/24
Consultation & Engagement	Ongoing pandemic Provider engagement - including gaining Provider feedback											
	Formulation of proposals on consultation & engagement approach											
	Dedicated engagement with care homes to discuss Strategy progress to date and future priorities											
	Development of Thematic Reviews											

Agenda Item 8

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

Summary:

This report presents to the Board the Sefton Joint Intermediate Care Strategy 2021-24 for approval. 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.

Recommendation(s):

(1) To approve the Sefton Joint Intermediate Care Strategy 2021-24

(2) To note that that further reports will be submitted to the Board throughout the life of the strategy in order to provide updates on delivery of the strategy.

Reasons for the Recommendation(s):

The implementation of a joint Local Authority and Clinical Commissioning Groups (CCGs) Intermediate Care strategy is a key workstream of the Sefton Integrated Commissioning Group and the Health and Wellbeing Board will play a key role is supporting and overseeing its delivery.

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

1. **Maintain the Status Quo** – this option was considered and rejected as the Integrated Commissioning Group have identified that a key priority is an expansion of integrated working relating to the delivery of updated models of service delivery, which the strategy outlines and seeks to implement, which in turn will improve outcomes for Sefton Residents, including maintenance of their independence.

What will it cost and how will it be financed?

(A) Revenue Costs

There are no revenue costs associated with this report. Any proposals arising from the delivery of the strategy which result in revenue costs will be subject to separate reports in line with Council governance and approval processes.

(B) Capital Costs

There are no capital costs associated with this report. Any proposals arising from the delivery of the strategy which result in revenue costs will be subject to separate reports in line with Council governance and approval processes.

Implications of the Proposals:

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

There are no resource implications arising from this report at this stage.

Legal Implications:

- Care Act 2014
- Care and Support Statutory Guidance
- The Care and Support and After-Care (Choice of Accommodation Regulations) 2014
- National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care

Equality Implications:

The equality Implications have been identified and mitigated.

Climate Emergency Implications:

The recommendations within this report will

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

Contribution to the Council's Core Purpose:

Protect the most vulnerable:

The strategy outlines how services will be delivered so that they continue to meet the needs of vulnerable people.

Facilitate confident and resilient communities: Delivery of the strategy will encompass a key focus on ensuring that the needs of the local population are met, and that people are supported to maintain their independence and remain part of their communities.
Commission, broker and provide core services: The strategy outlines the approach to joint strategic commissioning at a Sefton borough level and encourage greater integration and collaboration between Social Care and Health in order to achieve better outcomes.
Place – leadership and influencer: The strategy outlines to the market how Social Care and Health will work with the Provider market and ensure that it continues to meet needs.
Drivers of change and reform: The strategy is a key document outlining how change and reform in the delivery of services and patients / Service Users experiences will take place.
Facilitate sustainable economic prosperity:
Greater income for social investment:
Cleaner Greener

What consultations have taken place on the proposals and when?

(A) Internal Consultations

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

(B) External Consultations

This strategy has been informed by ongoing discussions with patients, carers, local residents and a wide range of stakeholders through the CCGs' "Big Chats", "Mini Chats" and other listening activities.

Implementation Date for the Decision

Immediately following the Board meeting.

Contact Officer:	Neil Watson

Telephone Number:	Tel: 0151 934 3744
Email Address:	neil.watson@sefton.gov.uk

Appendices:

Appendix A – Sefton Joint Intermediate Care Strategy 2021-24

Background Papers:

There are no background papers available for inspection.

1. Introduction/Background

1.1. The overarching aspiration of the previously approved “Making it happen” Cabinet paper was that integration would become “business as usual” by 2020.

1.2. Integration was described as being clear why partners stand together, stepping outside institutional siloes and navigating multiple meanings of ‘place’. It means redesigning the health and social care landscape together, decommissioning services as well as creating new ones, sharing risks and jointly being responsible for what may be difficult decisions within a complex, challenging and changing system.

1.3. The Sefton Integrated Commissioning Group has previously defined the principles of integrated commissioning and identified areas of potential focus. The Group framed its ambition as the need to move towards a strategic commissioning approach by focusing on shared values including maximising population health outcomes, developing trust and transparency of the whole budget position, and supported by an open, positive culture.

1.4. A key focus of the Integrated Commissioning Group was the delivery of Intermediate Care services. 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.

1.5. To drive and support this work, the development of a joint strategy was a key identified workstream of the Integrated Commissioning Group and that its implementation should be subject to formal approval.

2. The Rationale and Development of the Strategy

2.1. The strategy has been produced in order communicate and outline how Sefton will deliver the overall aims of encouraging independence, avoiding unnecessary admission to hospital and to accelerate discharge from hospital, while ensuring that no long-term decisions about care and independence are taken in a hospital setting.

2.2. The strategy was developed following the alignment of a strategic vision for the borough or the place of Sefton via the Health and Wellbeing Strategy, Sefton2together and the NHS 5-year delivery plan.

2.3. The strategy outlines a joint health and social care commitment to making a real difference to the way services are delivered and the quality of the patient's individual experience of health and social care provision in Sefton.

2.4. As detailed in the strategy, its development was needed in order to address how Health and Social Care will meet the current and future needs of the Sefton population, and take into account the ageing population and the associated impact on the demand for services, as well as the COVID impact on services which has seen a greater demand for Care delivered outside of a Care Home Setting.

2.5. Delivery of the Strategy will form a key part of the Sefton Integrated Care Partnership and is an excellent example of what can be achieved through aligned commissioning, demand management and a focus on outcomes for the local population. It also has a role in ensuring providers of Health and Care understand intermediate care and its importance to the system as a whole.

3. Key themes and Objectives within the Strategy

3.1. The strategy focusses on the following four models of intermediate care and how they will be delivered in an integrated way so that people can move easily between them, depending on their changing support needs;

- Home-based intermediate care
- Reablement
- Bed-based intermediate care
- Crisis response

3.2. The strategy highlights that care will largely be provided in the person's own home, but for those assessed as at risk if 24-hour care is not provided or their home is unsuitable, an intermediate care bed in a residential setting, or with some nursing care may be the only viable option to avoid hospital admission.

3.3. A key theme within the strategy is working to achieve the following outcomes;

- Ensuring individuals receive care at the right time in the right place, reducing acute hospital admission and managing the projected increase in demand;
- Ensuring decisions about long-term care are made only when individuals have had an opportunity for rehabilitation and recovery; and
- Increase individual satisfaction and maximise independent living

3.4. The strategy also highlights that a key element of its delivery will be activities relating to commissioning and also engagement with key stakeholders throughout its life, in order to ensure that all partners are aware of required services and to

ensure that any services commissioned meet the needs and aspirations of the local population.

3.5. The strategy is included as Appendix A of this report, however please note that it may be subject to further design changes in advance of it being fully published and disseminated to key Stakeholders.

4. Delivery of the Strategy and Governance Arrangements

4.1. As detailed in the strategy, its oversight ultimately rests with the Health and Wellbeing Board, however oversight will be conducted by the Programme Delivery Group.

4.2. In terms of the practical delivery of the strategy, an Operational Group will ensure that action plans and individual projects are managed, with this group including Providers delivering services, with a range of measures in place to ensure impact. This group includes clinical representation.

4.3. This is an area of significant collective spend in Sefton. The delivery of an integrated strategy would help facilitate its full inclusion in the Better Care Fund going forward and a more detailed report on impact of spend to the system will be brought to the board at a later date. It will be a significant area of investment though future Cheshire and Merseyside Health Care Partnership funding Streams.

5. Conclusion & Recommendations

5.1. The Intermediate Care Strategy has been developed to outline how key deliverables of the Health and Wellbeing Board will be realised. It takes into account that the elderly and frail population is projected to rise significantly and there are an increased number of people living longer with more complex health needs.

5.2. Health & Wellbeing Board are asked to approve the strategy and note the delivery and governence arrangements associated with it.

5.3. The Health & Wellbeing Board are also asked to note that it is intended that further reports will be submitted to the Board to report progress against the delivery of the strategy and any identified issues and themes.

Sefton Council

NHS
South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Sefton Joint Intermediate Care Strategy 2021-2024

Master Version
Date: July 2021

Contents

1. Executive Summary

This strategy is the product of collaborative working with a range of professionals in both health and social care organisations from 2017 to date within the Integrated Community Reablement and Assessment Service (ICRAS). It is a combination of recommendations, values and beliefs, an understanding of what works well and what offers value for patients and these will shape the future development of an Intermediate Care Model for adults within Sefton, including ensuring that model implemented in Sefton is conversant with national discharge models and operating policies.

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.

This strategy sets out work undertaken to date and will lead to the delivery of an updated model of service delivery, designed to rebalance hospital and community care, provide home based intermediate care, reablement, bed based intermediate care and crisis response. The aim of which is to encourage independence, avoid unnecessary admission to hospital and accelerate discharge from hospital, while ensuring that no long-term decisions about care and independence are taken in a hospital setting.

This strategy will be underpinned with associated action plans to ensure adequate and timely delivery, and as a result the strategy will be a working document, subject to regular review in order to ensure that it reflects action plan progress and any newly emerging themes, findings and objectives.

Both health and social services are committed to making a real difference to the way services are delivered and the quality of the patient's individual experience of health and social care provision in Sefton.

	
Fiona Taylor Chief Officer NHS Southport and Formby CCG NHS South Sefton CCG	Deborah Butcher Executive Director of Adult Social Care and Health

2. Vision

Both Sefton Clinical Commissioning Groups and Sefton Council envisage a seamless intermediate care service designed to enable and support people to remain in their own homes for as long as possible; living independently, increasing time spent with family and friends and reducing the need for longer term care provision.

3. Context

Sefton now has established an aligned strategic vision for the borough or the place of Sefton via the Health and Wellbeing Strategy, Sefton2together and the NHS 5-year delivery plan.

There is a clear ambition to grow its integration and build on the success of its established Better Care Fund, delivery of the services described in this strategy are key to this. Other interdependent strategies to be considered alongside this are described in section 3.3.

Governance oversight to this ultimately rests with the Health and Wellbeing Board and its delivery will be driven by Sefton's Integrated Commissioning Group.

The 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. Sefton health and social care integrated team have committed to work collaboratively to develop the model and supporting infrastructure needed for effective and efficient delivery.

3.1 *Current and Future Demand*

The Sefton Population Projections[1] identifies the following key facts.

- The estimated population of Sefton in 2018 was 275,396. The latest 2018 based population projections suggest an increase in population year on year rising over 6% to 292,176 in 2043. The biggest percentage increase is estimated to be among residents aged 65 and over, with this age group expected to rise by a third from 64,032 in 2018 to 85,198 by 2043 (from 23% of the population to 29% of the population). Every quinary age group above 65 is projected to have a significant increase, in particular those aged 85-89 projected to increase by 61% and those aged 90 and over by 95%.

- Sefton's 65+ population is 64,032 accounting for 23% of the total population and largely accounts for the projected future increases in the total population.

- Sefton already has a sizeable population of older people. As this grows, it will have a large impact on services and their ability to cope.

- Sefton has the highest proportion of residents aged 65+ and 75+ than the other local authorities within Liverpool City Region.

[1] Sefton Population Projections – 2018, Business Intelligence & Performance on behalf of Sefton Council

- An increasingly elderly population are likely to attend A&E and be admitted to hospital as a result of falls - 36% more by 2035[2].

- By 2035, it is projected that 38% more people aged 65 and over will have dementia. This will impact on their wider health and their care needs[2].

- In 2019, over 2,800 people are forecast to be living in a care home (with or without nursing) – there will be an increase of over 40% by 2035[2].

- Like most of the country Sefton has a growing and ageing demographic. By 2043 Sefton will have an overall forecast increase of 33% of residents who are 65+ and is set to account for 29% of Sefton's population

- Current statistics show Sefton having the largest cohort of residents 65+ within the Liverpool City Region[3].

Borough	**Sefton**	**Wirral**	**St Helens**	**Halton**	**Knowsley**	**Liverpool**
Age 65+	23.1%	21.3%	20.4%	17.9%	17.0%	14.6%

- A further analysis of the 23.1% of older Sefton residents by sub-areas is as follows;

Sefton	Southport	Formby	Maghull	Crosby	Bootle	Netherton
Age 65+	26.6%	31.4%	26.5%	21.7%	15.5%	17.5%

By way of summary, the Sefton Strategic Needs Assessment identifies Sefton as having a growing elderly population. Older people are more likely to develop complex and long term health conditions, which lead them to require increased health and social care.

Managing such increased demand will necessitate a new approach to service planning, enabling people to maximise their independence and decrease reliance upon acute and social care services.

3.2 Strategic Aims and Objectives

This strategy has been informed by ongoing discussions with patients, carers, local residents and a wide range of stakeholders through the CCGs' "Big Chats", "Mini Chats" and other listening activities and is congruent with the CCGs' strategic priorities of:

3.2.1 Frail Elderly: to support the frail elderly, with long term conditions, to optimise self-care based in the community or home setting, while preventing unnecessary and unplanned admission to hospital;

[2] Projecting Older People Population Information System correct as 01/07/2020

[3] Mid-Year Estimates 2018

3.2.2 Unplanned Care: to support patients of all ages to manage their healthcare needs at home or in the community setting, while preventing unnecessary and unplanned admission to hospital;

3.2.3 Primary Care Transformation: to support the healthcare needs of the population through enhanced primary and community care services, supporting self-care and enabling appropriate intervention at home or in the community and preventing unnecessary and unplanned admission to hospital.

Further, as part of the Intermediate Care and Reablement Scheme of the Better Care Fund for Sefton, the main scope of this scheme is to reduce hospital admissions and readmissions, reduce the need for ongoing care and support and to reduce the number of admissions into long term residential and nursing care.

3.3 Linkage with Other Strategies and Priorities

This strategy will both link to, and be informed by associated strategies, plans and priorities, including, but not limited to;

3.3.1 **Sefton Care Home Strategy 2021/24** – this developing strategy outlines a 3-year approach to this sector of care, providing a direction of travel for existing care providers and a clear indication to new providers wishing to become part of the Sefton Care Home market. Essential to the success of this strategy is strong leadership at all levels and across all agencies. Success will revolve around a commitment to supporting and delivering high quality care and the development of trusting, committed partnerships. The strategy will enable us to develop and communicate the long-term commissioning intentions, of which Intermediate Care services will be a part of;

3.3.2 **Sefton2gether** – this joint Council and CCGs plan has a focus on Early Intervention, Self-Care and Prevention and having Integrated Care Teams to ensure targeted care coordination.
https://www.southportandformbyccg.nhs.uk/media/4044/sefton2gether-final-print-version-2020.pdf

3.3.3 **Seftons Health & Wellbeing Strategy 2020-25** – this identifies that the Sefton health and care system, including wider partners, works together to meet the needs of our entire population. This means focusing on the areas of greatest need and ensuring the best use of available resources.
https://www.sefton.gov.uk/media/1648266/sefton-health-and-wellbeing-strategy-2020-2025.pdf

3.3.4 **Sefton's Market Position Statement** – this is currently in draft and will be published shortly and sets out a direction of travel including strategic and legislative drivers that are influencing change. It provides information to the social care market on population needs, service demands, commissioning priorities and resource availability, to facilitate the effective planning and development of services and opportunities to meet the needs of our residents – both now and in the future, of which Intermediate Care type services will be a key element.

3.3.5 **Sefton's Dementia Strategy** – in development due to be published September 2020, this outlines that positive, proactive approaches to service development providing individualised support can help ensure that physical and mental health are sustained as long as possible, that people live at home for as long as possible and that crises and unnecessary use of intensive costly services are minimised. It outlines the intention to ensure that older citizens experiencing dementia can access appropriate, joined-up services that are provided safely and effectively to maximise independence, choice and quality of life.

3.3.6 **Sefton Older People's Strategy** – a key element if this strategy is the identification of the need to ensure that Older People are supported to keep independent and that improving Health and Social Care services is one of the biggest things that Older People identified can help them. The aims and objectives outlined in this Intermediate Care strategy support these aims.

https://www.sefton.gov.uk/your-council/plans-policies/adults.aspx

3.3.7 Extra Care Housing – The development of extra care across the borough as an alternative housing option to other more costly and restrictive options such as residential and nursing care is a key driver for Sefton. Extra Care Housing offers a self-contained home of your own where social activities are easy to find, and help is on hand if you need it. It is intended to enable and support older and vulnerable people to live independently for as long as possible, but with the reassurance that care and support services are available should they need them, either now or in the future. Our goal is to deliver 1,306 extra care units by 2035 this will then have significant impacts on our reliance on other more costly services across the spectrum.

http://www.housingcare.org/jargon-extra-care-housing.aspx

4. The National Model and Operating Policy

Underpinning and driving the delivery of this strategy will be the need to ensure that it supports and delivers a model in line with the *"Hospital discharge and community support: policy and operating model"* (July 2021).

This document sets out the hospital discharge service operating model for all NHS trusts, community interest companies, and private care providers of NHS-commissioned acute, community beds, community health services and social care staff in England.

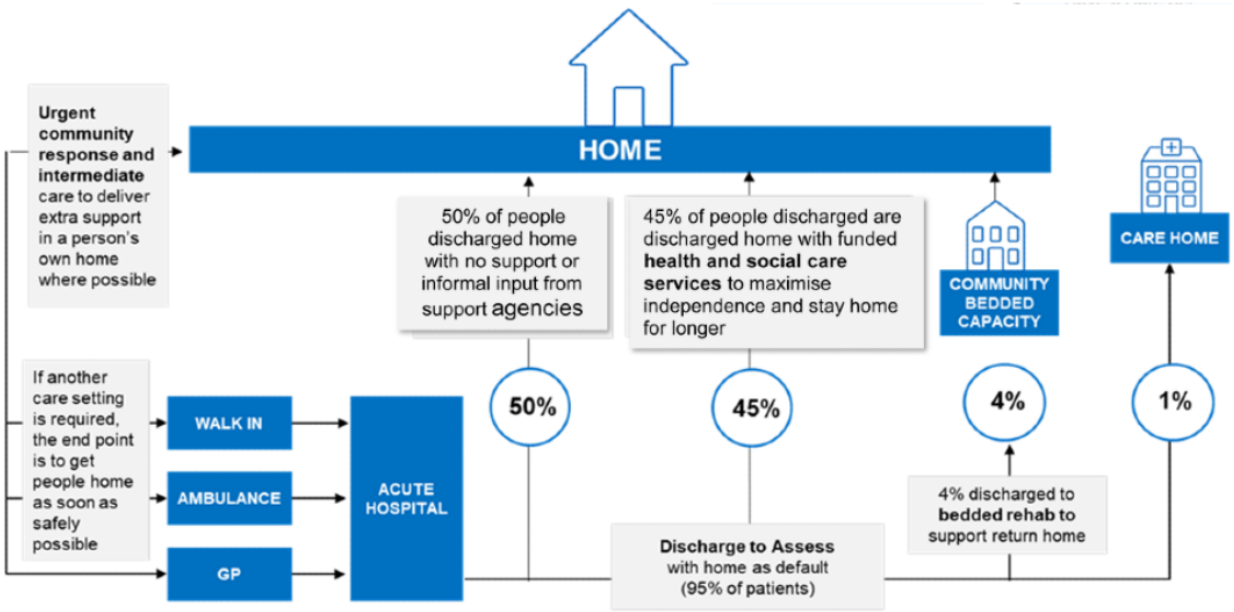
In summary, this model outlines the following four discharge pathways;

- **Pathway 0**
  - Likely to be minimum of 50% of people discharged:
  - simple discharge home
  - no new or additional support is required to get the person home or such support constitutes only:
  - informal input from support agencies

- a continuation of an existing health or social care support package that remained active while the person was in hospital

- **Pathway 1**
  - Likely to be minimum of 45% of people discharged: able to return home with new, additional or a restarted package of support from health and/or social care. This includes people requiring intensive support or 24-hour care at home.
  - Every effort should be made to follow Home First principles, allowing people to recover, reable, rehabilitate or die in their own home.
- **Pathway 2**
  - Likely to be maximum of 4% of people discharged: recovery, rehabilitation, assessment, care planning or short-term intensive support in a 24-hour bed-based setting, ideally before returning home
- **Pathway 3**
  - For people who require bed-based 24-hour care: includes people discharged to a care home for the first time (likely to be a maximum of 1% of people discharged) plus existing care home residents returning to their care setting (for national data monitoring purposes, returning care home residents will count towards the 50% figure for Pathway 0).
  - Those discharged to a care home for the first time will have such complex needs that they are likely to require 24-hour bedded care on an ongoing basis following an assessment of their long-term care needs.

The following diagram also summarises the model;



(Source: Hospital discharge and community support: policy and operating model - July 2021)

People with Mental Health conditions such as delirium or dementia will better recover in their own home/care home as this is an environment that is familiar to them. Additionally, it is far more likely that an accurate assessment of long-term health and social care needs will be possible once they have returned to their own home as opposed to an unfamiliar and often confusing environment.

It is our commitment to continue to embed some of the principles of the discharge to assess and home first adapted for mental health care pathways, such as;

- Assessment of long-term care and support needs in the most appropriate setting and at the right time for a person.
- Instigation of care packages as soon as a person is ready to leave hospital, doing what is right by them and crucially removing delays and disputes over funding and responsibilities (and if needed resolving these after the discharge support has started).

The first few days and especially nights following discharge home of someone with dementia or delirium are usually the most challenging and therefore we will endeavour to ensure that the package of care is tailored to individual need and that we utilise other resources to support independence such as assistive technology.

5. Supporting Infrastructure

At present Sefton has the following four schemes / services of intermediate care to support delivery of the overall model;

- Home-based intermediate care
- Reablement
- Bed-based intermediate care
- Crisis response

However, a key deliverable for this strategy will be to review these schemes / services to ensure that their individual operating models are in line with the national model and to ensure that they have sufficient capacity within them to meet demand.

We are committed to implementing a Discharge to Recover model and ensuring that long-term care needs assessments not being performed in an acute hospital setting as such assessments will not reflect the abilities of a person and may lead to an over-prescription of care and support, persons should be allowed a period of recovery to give an accurate picture of their future needs.

These services will be delivered in an integrated way so that people can move easily between them, depending on their changing support needs. For most people interventions last up to 6 weeks. Services are delivered by a multidisciplinary team and most commonly by healthcare professionals and/or care staff.

4.1 Intermediate Care

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.

(https://www.nice.org.uk/guidance/ng74/chapter/recommendations#intermediate-care, 2017)

Intermediate care services are usually delivered for no longer that 6 weeks and can be as little as 1 to 2 weeks in duration. Four service models of intermediate care are available: bed based intermediate care, crisis response; home based intermediate care and reablement.

4.2 Core principles of intermediate care, including reablement

Collaborative working to develop goals which optimise independence and well being
Person centred approach, taking into account cultural differences and preferences

Ensure good communication at all stages of assessment and delivery between intermediate care practitioners, other agencies, people using the service and their families and carers.

Intermediate care practitioners should

- Work in partnership with the person to find out what they want to achieve and understand what motivates them
- Focus on the person's own strengths and help them realise their potential to regain independence
- Build the persons knowledge, skills, resilience and confidence
- Learn to observe and guide and not automatically intervene, even when the person is struggling to perform an activity, such as independent dressing and meal preparation.
- Support positive risk taking

Ensure that the service user and or their family or carers know who to speak to if they have any questions or concerns about the service, and how to contact them.

Offer the person the information they need to make decisions about their care and support, and to get the most out of the intermediate care service. Offer this information in a range of accessible formats, for example:

- Verbally
- In written format
- In other accessible formats, such as braille or Easy Read
- Provided by a trained, qualified interpreter

4.3 Assessment of need for intermediate care

- be provided on the basis of a comprehensive assessment, resulting in a structured individual care plan that involves active therapy, treatment or opportunity for recovery;
- have a planned outcome of maximising independence and typically enabling patients and service users to resume living at home
- be time-limited, normally no longer than six weeks and frequently as little as a few days;

- involve cross-professional working, with a single assessment framework, single professional records and shared protocols;
- Inclusive of older people with mental health needs, either as a primary or secondary diagnosis.
- Intermediate Care services may also:
- form part of the pathway for end of life care, if there are specific goals for the individual or carer that could be addressed in a limited time; or
- link with longer term plans for support.

6. The Models of Care

The four models of care within the pathway will ensure a flow through intermediate care for the patient at a time and level as their need dictates. To be effective, the pathway relies on the interdependence and close alignment of health and community services, together with third sector services to ensure there all gaps in services are bridged and there are no delays in transfers of care.

Home based intermediate care

Home based intermediate care are community-based services that provide assessment and interventions for people in their own home or a care home setting, whether that is an older person or someone with a learning difficulty or other assessed needs. The aim is to prevent hospital admissions, support faster recovery from illness, support timely discharge from hospital, and maximise independent living. Care will be provided through a multidisciplinary health and social care approach with agreed goals and support tailored to individual need.

There will be access to and the further development of assistive technology to promote independence at home e.g. telecare (such as pendant alarms and falls detectors), community equipment (such as beds, hoists and walking trolleys), and minor and major adaptations to the home (such as hand rails and ramps). The introduction of other forms of digital assistive technology such as telehealth and teletriage will be explored to support people to remain in their chosen place of home for as long as possible.

The Sefton Integrated Commissioning Group will ensure that the home-based intermediate care offer will allow professionals to build a package of care and support around individual needs therefore enabling independence. In addition, we will work with the voluntary, community and faith sector in the development of community centred models of support which can be utilised by individuals in the longer term to enable transition from intermediate care.

Reablement

Fundamental to the objective of this service is the principle of helping people to support them rather than 'doing it for them' or 'doing it to them'. Evidence shows that timely bursts of Reablement, focusing on skills for daily living in people's own homes, can enable people to live more independently and, in most cases, appropriately reduce their need for ongoing longer-term services.

As a result, the Sefton Integrated Commissioning Group will seek to expand the provision of such services so that they become the default pathway for people, thereby ensuring that when people do receive services, in the first instance they are supported to regain their independence as much as possible.

Bed Based Intermediate Care

Bed based intermediate care is designed to help people avoid hospital or get home sooner, recover from illness, and plan their future care. It is a model of care which sits at the heart of Sefton's vision for an integrated health and social care system.

Assessment and interventions provided in a bed-based setting are designed to reduce the risk of further deterioration in the person's condition which can lead to reduced independence.

Sefton integrated commissioning group will ensure bed based intermediate care services are provided in a range of appropriate environments to meet the needs of the individual. We aim to ensure sufficient capacity to ensure that adults can start the service within 2 days of referral from hospital or the community setting. The aim of this is to maximise outcomes, prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and support timely discharge from hospital.

Crisis / Rapid Response

Such services build on other existing short-term intervention services by also offering another mechanism to provide Domiciliary Care, Reablement tasks and practical support to enable Service Users who are medically stable, to remain safe and secure in their own homes when an acute situation occurs and who, without such support, may normally be admitted to Hospital or access other services such as longer-term care at home or in a care home setting.

As part of the implementation of this strategy, opportunities to develop such services will be considered, which will also encompass how such services can link with other services and provide timely interventions to people, thus reducing the need for an acute hospital admission and/or longer-term service.

5.1 WHO will deliver the care?

The intermediate care offer within Sefton will be provided through multidisciplinary teams and services working through an integrated model of service delivery to provide holistic short-term care interventions and rehabilitation. Key to the delivery of this model will be a single point of access for those referring into the service and a single assessment and care planning process approach. There is a need for further review and consideration of these enabling processes as part of the implementation of this strategy.

The intermediate care model will comprise:

- Nurses and health care assistants
- Allied health professionals e.g. occupational therapist, physiotherapist
- GP or Geriatrician
- Social workers
- Care workers e.g. within reablement and crisis response

There will be clear routes of referral and engagement with commonly used services, for example:

- General practice, pharmacy, podiatry
- Mental health and dementia services
- Housing services
- Voluntary, community and faith services

The intermediate care model will encompass a broad range of disciplines and skills and competencies to support effective service delivery. There will be flexible utilisation of the intermediate care workers between community and bed-based care; and greater interaction of

health and social care to enable education and development opportunities for care workers to create a robust workforce to support reablement and crisis response.

The intermediate care model will link closely with other developments within Sefton. This will include the integrated care teams which are delivered at a local level and whose remit is to proactively support service users and avoid reactive interaction with the urgent primary and secondary care systems. The integrated care teams will identify and refer individuals to intermediate care where required and will also provide follow on support after intermediate care. The intermediate care model will also establish links with a variety of additional key health and social care community services to include, *inter alia*, stroke, falls, continence and respiratory services, together with Continuing Health Care Teams, to ensure that each individual's care is person-centred and that their journey through the Intermediate Care pathway is timely and seamless.

5.2 WHERE care will be provided

Intermediate care will largely be provided in the person's own home, but for those assessed as at risk if 24-hour care is not provided or their home is unsuitable, an intermediate care bed in a residential setting, or with some nursing care may be the only viable option to avoid hospital admission.

5.3 WHEN care will be provided

Step up: the service will provide a proactive "rapid response" assessment within two hours of referral, providing an intervention in people's homes (or place of residence) with a view to avoiding admission to hospital.

Step down: the service will also 'in reach' into local acute services with a view to facilitating early discharge. Decisions relating to long term care will not be made in a hospital environment, but in the patient's home environment to promote and sustain independence and wellbeing.

5.4 How long will care be provided for?

Intermediate care should last no longer than 6 weeks and is a time-limited service with the intention of preventing unnecessary hospital admission, reducing lengths of stay in hospital and enabling patients to return home quickly by providing support in the community for a short period while on-going packages of care are commissioned from Adult Social Care.

It is goal-focussed and provides time for assessment and intervention based on specific, agreed outcomes to be achieved within days and weeks, supporting people to return to self-care.

5.5 Transition of Care

Transition of care will be effectively planned within the 6 weeks service duration and will run parallel with intermediate care interventions. This will enable the service user to exit the service smoothly and transition into any ongoing service provision, the aim of which is to enable and maximise independence at home.

Persons needing ongoing support will have had an equal partnership with the multidisciplinary team to enable them to make choices about their own care. They will be treated with dignity and respect throughout their transition.

A clear plan will be provided to the service user on transition with good communication between intermediate care teams and other agencies and on other types of support available.

A contingency plan will be agreed equally between parties with Information readily available about how to self-refer back to the service and how to contact the team if needed.

6 Outcomes

6.1 Ensuring individuals receive care at the right time in the right place, reducing acute hospital admission and manage the projected increase in demand

- We will agree a model across Sefton, in partnership between health and social care, independent sector and the third sector to agree a single model for intermediate care.

- We will review and develop team capacity in the community, together with community bed provision to take account of the projected increase in the elderly and frail population, while demonstrating value for money and effectiveness in reducing hospital admission.

- Organisational boundaries will not be allowed to obstruct or delay operation of the system. A cohesive team will ensure effective co-ordination and accountability for all members of the intermediate care teams.

- Develop clear and consistent referral pathways between intermediate care services, primary and secondary care and the Social Services, ensuring the single point of access is promoted widely.

- The strategy will be delivered through a patient-centred approach and implemented through working in a collaborative manner.

6.2 Ensuring decisions about long term care are made only when individuals have had an opportunity for rehabilitation and recovery

- We will ensure that patients are not transferred directly from a hospital ward to residential care (unless in exceptional circumstances) without being offered a period of intermediate care and reablement.

- We will ensure that individuals with complex health needs are treated fairly and offered rehabilitation prior to any decision being made about their long-term needs.

- In Sefton we will work to ensure access to high quality Care at a Fair cost of care that allows people to remain in their own home wherever possible, utilising the resource of residential or nursing home by those whose needs require it most.

6.3 Increase individual satisfaction and maximise independent living

- We will continue to monitor and review the pathway to ensure a fully integrated service.
- We will ensure our services are individual centred.
- We will introduce a new series of measures to performance manage the operation and delivery of the service, which will include continuous assessment of the individual experience.
- We will ensure individuals do not become delayed in the system or access intermediate care services for longer than necessary.

6.4 Ensuring that models and services work for people with mental health problems, dementia and delirium

- We will deliver services that reflect that an accurate assessment of long-term health and/or social care needs will be possible once someone with dementia or someone recovering from delirium is back in their own home/care home and very unlikely if undertaken in the unfamiliar and confusing environment of a hospital.
- We will ensure that when following the principles of Discharge to Assess and Home First for people with mental health conditions on mental health care pathways, there will be in place the delivery of more supportive care packages than usual, which will be person-centred and planned in conjunction with the person and any identified carers, family and/or friends.
- Care coordinator or relevant mental health clinician will be involved in the discharge planning for people with a pre-existing mental health concern who are known to mental health services, to ensure their mental health needs are considered as part of duties under the Mental Capacity Act (2005). For people where new mental health concerns are considered in light of discharge psychiatric liaison teams should be contacted by Case Managers in the first instance to review and assess as appropriate

7 Commissioning Approaches

7.1 A key element of this strategy is the service models for Intermediate Care services, and as a result Commissioners will need to ensure that services commissioned reflect these models, meet the desired outcomes and have sufficient capacity within them to meet demand.

7.2 Commissioning intentions and options will be outlined as part of the ongoing development of this strategy and the associated action plans, however it is important to initially highlight that these options could include;

7.2.1 Reconfiguring existing contractual arrangements to ensure that services are aligned to multi-disciplinary Teams in order to ensure that efficiencies are achieved and that there is the best use of available resources; and

7.2.2 Reviewing existing services in place to ascertain whether they can be expanded and/or remodelled in order to better meet the required models of service.

7.3 When commissioning proposals are formulated, both the CCGs and Council will ensure that the appropriate approval and procurement processes are adhered to, and that these intentions are outlined to all stakeholders.

8 Consultation & Engagement

8.1 Through the life of this strategy, all stakeholders will be consulted and engaged with to ensure that the strategy continues to identify emerging needs and remain aligned to other associated strategies and plans.

8.2 In addition, as part of the implementation of associated action plans, consultation and engagement will take place, for example with Service Users and Care Providers to ensure that commissioning activities take into account identified needs, desired outcomes, feedback on current services being delivered and Provider market factors.

9 Governance

9.1 As outlined earlier, oversight of this strategy ultimately rests with the Health and Wellbeing Board, however oversight will be conducted by the Programme Delivery Group.

9.2 As part of the implementation and delivery of the strategy an Operational Group will ensure that action plans and individual projects are managed, with this group including Providers delivering services.

9.3 Oversight and governance will also take place through other mechanisms such as the Better Care Fund and internal CCGs and Council bodies, for example when procurement activities are proposed.

9.4 The quality of the services provided will be monitored via contractual arrangements and regulated by the care quality commission who monitor, inspect and regulate service to ensure they meet fundamental standards of quality and safety.

10 Conclusion

10.1 Delivery of this Intermediate Care Strategy will be crucial in supporting the delivery of the CCGs and Councils aligned strategic aims. The strategy also represents key deliverables of the Health and Wellbeing Board and takes into account that the elderly and frail population is projected to rise significantly and there are an increased number of people living longer with more complex health needs.

10.2 Our challenge is to commission services upon which there will be growing demand, which offer a high standard of care within the current financial constraints.

10.3 The benefits for the Sefton population will be an increased quality of care and an environment where they are not admitted to hospital unless it is absolutely necessary and if admitted to hospital, ensuring that they are discharged quickly with services put in place to support them to resume independent living.

Appendix 1 - Terms used in this Strategy

Bed-based intermediate care

Assessment and interventions provided in a bed-based setting, such as an acute hospital, community hospital, residential care home, nursing home, stand-alone intermediate care facility, independent sector facility, local authority facility or other bed-based setting. Bed-based intermediate care aims to prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and to support timely discharge from hospital. For most people, interventions last up to 6 weeks. Services are usually delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Crisis response

Community-based services provided to people in their own home or a care home. These services aim to avoid hospital admissions. Crisis response usually involves an assessment, and may provide short-term interventions (usually up to 48 hours). Crisis response is delivered by a multidisciplinary team but most commonly by healthcare professionals.

Home-based intermediate care

Community-based services that provide assessment and interventions to people in their own home or a care home. These services aim to prevent hospital admissions, support faster recovery from illness, support timely discharge from hospital, and maximise independent living. For most people interventions last up to 6 weeks. Services are delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Home care

Care provided in a person's own home by paid care workers which helps them with their daily life. It is also known as domiciliary care. Home care workers are usually employed by an independent agency, and the service may be arranged by the local council or by the person receiving home care (or someone acting on their behalf).

Intermediate care

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. Intermediate care services are usually delivered for no longer than 6 weeks and often for as little as 1 to 2 weeks. Four service models of intermediate care are available: bed-based intermediate care, crisis response, home-based intermediate care, and reablement.

Person-centred approach

An approach that puts the person at the centre of their support and goal planning. It is based around the person's strengths, needs, preferences and priorities. It involves treating them as an equal partner and considering whether they may benefit from intermediate care, regardless of their living arrangements, socioeconomic status or health conditions.

Positive risk taking

This involves balancing the positive benefits gained from taking risks against the negative effects of attempting to avoid risk altogether.

Reablement

Assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and confidence and maximise their independence. For most people interventions last up to 6 weeks. Reablement is delivered by a multidisciplinary team but most commonly by social care practitioners.

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Report to:	Health and Wellbeing Board	**Date of Meeting:**	Wednesday 8 September 2021
Subject:	Sefton Technology Enabled Care Solutions Strategy 2021 – 2024		
Report of:	Executive Director of Adult Social Care and Health	**Wards Affected:**	(All Wards);
Portfolio:	Adult Social Care		
Is this a Key Decision:	N	**Included in Forward Plan:**	No
Exempt / Confidential Report:	N		

Summary:

The report presents to the Board the Sefton Technology Enabled Care Solutions Strategy for 2021 – 2024 for the Boards Approval.

This strategy has been written in response to the development of Sefton's Digital Strategy 2021- 2023, to ensure that Technology Enabled Care Solutions (TECS) can contribute to meeting the needs of individuals to ensure independent living at home and within the wider community.

Recommendation(s):

(1) The Board are asked to review and consider approval of the final version of the Sefton Technology Enabled Care Solutions Strategy 2021-24

(2) The Board are asked to approve proposed reporting pathway

Reasons for the Recommendation(s):

The TECS strategy supports Sefton's overarching Digital Strategy to achieve and promote Sefton's digital offer over the next 3 years.

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

Not applicable

What will it cost and how will it be financed?

(A) Revenue Costs

The Strategy does not identify additional revenue cost requirements

(B) Capital Costs

The budget for TECS capital equipment and associated costs is £458,000. Any resource requirements can be contained within existing resources and the Strategy will be subject

to annual review. Joint funding and external applications for additional monies will be maximised in line with Sefton's financial procedure rules.

The other priorities around partnership building, training and promotion of independence will not be covered and alternative funding options will be considered to achieve these priorities without additional revenue cost being incurred.

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

The use of TECS will support a reduced carbon footprint by allowing care to be delivered closer to the home.

Contribution to the Council's Core Purpose:

Protect the most vulnerable: The Strategy details how TECS can support this group
Facilitate confident and resilient communities: The Strategy details how TECS can support communities.
Commission, broker and provide core services: The Strategy details future commissioning intentions in this area.
Place – leadership and influencer: The Strategy seekers to drive development across the place of sefton in relation to TECS
Drivers of change and reform: The Strategy details a shift in delivery of support and in the approach to meeting needs.
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.6499/21.) and the Chief Legal and Democratic Officer (LD4700/21.) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

The Strategy has been developed through a task and finish group including a range stakeholders representing Health, Social Care, Education, Housing Providers, and Service users.

Implementation Date for the Decision

Immediately following the board

Contact Officer:	Diane Clayton
Telephone Number:	07773096538
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Appendices:

The following appendices are attached to this report:

Appendix A: TECS strategic priorities
Appendix B: Governance and Structure Chart
Appendix C: TECS Strategic Objectives table
Appendix D: Consultation Partners and Stakeholder Groups
Appendix E: Overview of TECS Activity 2021-2022
Appendix F: Technology Enabled Care Solutions Strategy 2021-2022

Background Papers:

There are no background papers available for inspection.

1. Introduction

The Strategy was written in response to the development of Sefton's Digital Strategy 2021-2023.

Within Sefton's Digital Strategy 2021 -24 there are three identified themes:

1. Connected Council: We will use digital technology and solutions to transform and improve how the council operates.
2. Empowered Communities / Empowered Residents: We will use digital technology to consolidate and transform the relationship between the Council and its residents so that residents have better access to online services and benefit from improved digital inclusion
3. Business Growth: We will ensure that Sefton residents and businesses benefit from high-speed internet connectivity, access to digital skills learning and the ability to leverage the opportunities afforded by digital technologies.

The TECS Strategy 2021-2024 has been written in response to Theme 2 - Empowered Communities / Empowered residents.

2. Strategy Content

2.1 Our Ambition is to:

- To connect TECS into the heart of our adult social care and support services
- To include consideration and implementation of TECS whenever we design and develop services.
- To use the benefits of modern technology to create a service user experience which is flexible, enabling, responsive and re-assuring.
- To put technology to use to make it possible to deliver our services in the most efficient and effective way.

2.2 The TECS Strategy details the outcomes that Sefton Council want to achieve in developing and delivering TECS across Sefton. It identifies actions that will support local priorities and that are supported by the Government's health and care policies and it responds to Sefton's Vision that we want to help people to help themselves, we want to help people when they need it and we want to help people to live as independently as possible for longer.

2.3 The Strategy set out 9 strategic priorities (See Appendix A) and it identifies 10 key areas for focus:

1. Intermediate Care / Independence at Home
2. Partnerships
3. Early Help, Prevention and Promotion of Independence
4. Information and Choice – Raising Awareness & Culture Change
5. Community Services – Day Care, Supported Living, Mental Health and Community Support
6. TECS and Falls Prevention
7. Adaptations Without Delay / Demand Management
8. Children, Young People - SEND/Autism, Education & Transition
9. Value: Commissioning, Finance, Budget
10. Measuring Outcomes and Social Value

2.4 In order to drive the TECS strategic priorities over the next 3 years, a TECS Strategy Working Group has been established and this consists of 7 TEC Subgroups that will report into the Working Group on a bi-monthly basis. TECS Strategy Working Group meetings will be scheduled bi monthly from September 2021 and all sub group activity will be reviewed. A summary report of sub group

activity will be submitted to the ICG and SEND CIB Board, ASC Demand Management/DMT, Executive Leadership Board (Programme Board), and the New Ways of Working Board and any highlighted issues escalated accordingly for appropriate resolution.

(See Appendix B for Governance and Structure Chart and Appendix C for TECS Strategic Objectives table)

2.5 The Strategic Support Officer for Independent Living and the newly appointed TEC Officer will communicate all TEC activity, opportunities for collaborative and joint working opportunities, and potential funding streams for regional and local TEC development (where appropriate) with Cheshire and Merseyside Partnership Board, Liverpool City Region Digital Group and the Liverpool City Region TEC sub groups.

(See Appendix D for current and planned activity 2021-22)

2.6 Partnerships and consultation/engagement groups – See Appendix E:

We are currently consulting with a number of different groups across Sefton and consultation will be ongoing throughout the life of this Strategy and beyond. So far, we have delivered consultation workshops to the following groups:

- Sefton Parent Carer Forum
- Sefton Older People Consortium
- Sefton Supported Living Providers
- We are developing workshops for the young people of Thornton College, Aiming High and Speak Out – and consultation will begin Sept/October when new academic year begins.
- We are planning TEC Equipment Demonstration events with residents of Sefton and we are currently developing a TECs webpage.

3.Conclusion

The report details the impact the TECS Strategy can potentially have. The development process has been inclusive and there is real opportunity to make an impact on the Health and Wellbeing of the resident of Sefton by maximising the impact and opportunity presented by Technology enabled Care Solutions.

APPENDIX A: TECS STRATEGIC PRIORITIES 2021 - 2023

PRIORTY 1: We will ensure the provision of TECS for individuals to live in and an accessible and safe "home" environment, enabling them to retain independence, that also provides reassurance for formal and informal carers, often enabling them to continue with activities they might otherwise have to give up, including employment.

PRIORITY 2: We will build strong collaborative partnership approaches between health, social care, housing and wider community stakeholders to design seamless approaches to ensure that residents' care needs are well supported with the increased use of TECS.

PRIORITY 3: We will embed early help and prevention in everything we do. Prevention and early intervention are about enabling people to maintain the best health possible all the way through life.

PRIORITY 4: Social and Health care professionals will have the knowledge and digital skills they need to understand how TECS can best support people and, using an asset-based approach, they will deliver person centred assessments that will empower individuals to identify potential solutions for themselves.

PRIORITY 5: We will make TECS the default consideration for individuals that require staff support but can share group living. We will ensure that the implementation of TECS will work in shared settings to meet the full spectrum of individual care needs.

PRIORITY 6: We will reduce the number of falls related hospital admissions and discharges to residential placements and some supported living models encouraging residents and prescribing staff teams to consider the use of TECS in people's homes in line with Sefton's Early Help and prevention offer.

PRIORITY 7: We will align 'in house' TECS provision with Occupational Therapy assessments and our Home Improvement Service, expanding our TECS provision over the next 3 years to give greater choices to people to support independent living at home.

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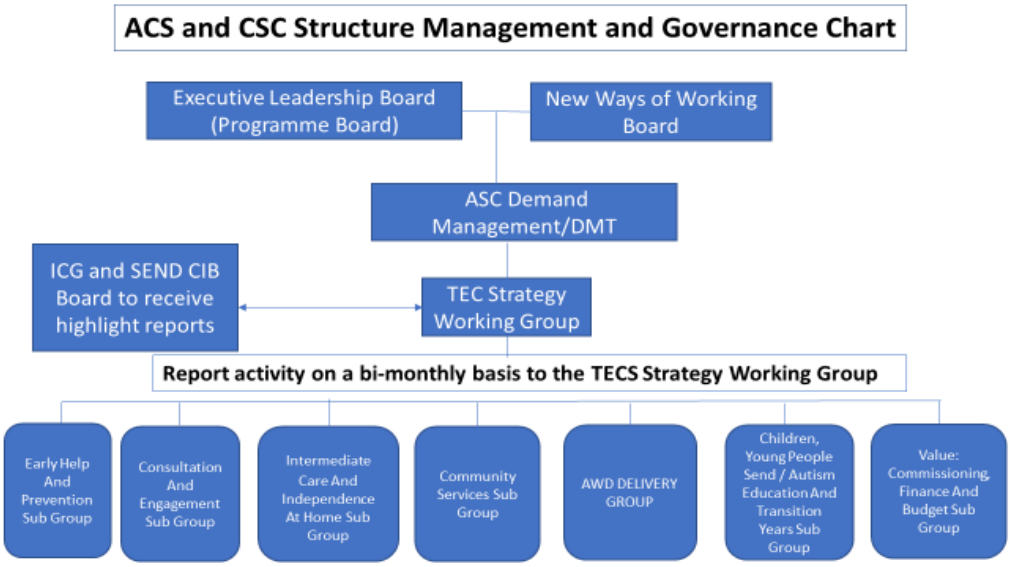
PRIORITY 9: We will ensure there is a readily available TECS budget within DFG capital monies, with sliding scales for cashflow outlay.

APPENDIX B: GOVERNANCE / DELIVERY STRUCTURE

This document outlines the proposed governance delivery structure for the Sefton Technology Enabled Care Solutions (TECS) Strategy 2021-24.

It is proposed that the following governance and delivery structure be followed with the specific routes for individual decisions being based on factors such as the constitution of organisations and the financial impact. The structure will be subject to regular review to ensure that any wider new governance arrangements are implemented as needed.



APPENDIX C: TECS Strategic Priorities and Objectives

Delivery / Task & Finish Groups	Strategic Priorities and Objectives	Strategy Key Themes Link
Intermediate Care/ Independence at Home/ Falls Prevention	• When designing new services, we will look at the opportunities available from TECS and seek to build these in to our offer. • The introduction of other forms of TECS such as telehealth and tele triage will be explored to support people to remain in their chosen place of home for as long as possible. • Work closely with all care home providers in Sefton to support implementation of TECS through national, regional and local initiatives • Mapping of current local / national groups and initiatives • EMIS pilot • Exploration of Falls applications • Potential procurement of technological solutions • Evaluation of Capital Improvement Grant awards • Scoping of further capital improvements – including care planning I.T. solutions • Develop a collaborative end to end falls pathway at place across Primary, Community, Secondary and Voluntary services, using an evidence-based approach such as Public Health England's eight-tiered approach to managing falls. • Develop clear and consistent referral pathways between intermediate care services, primary and secondary care and the Social Services, ensuring the single point of access is promoted widely.	• *Commissioning / Finance / Analysis* • *Residents* • *Consultation & Engagement* • *Digital development* • *Quality* • *Promotion of TEC*
Partnerships: Consultation and Engagement	• Develop approaches to consultation and engagement for all delivery projects • Formulation of Proposals on long-term engagement mechanisms • Improved access to information, advice and guidance to promote TECS • Engage with services which educate, entertain and stimulate social interaction linking people to networks and communities, to combat loneliness and social isolation. • Developing a robust TECS training and development programme. • LCR TECS Training programme development • Incorporate existing demographic data and mapping of the wider network of statutory and voluntary sector organisations that also support people to remain living independently and with whom referral pathways could be developed. • Implement an online guided advice tool for	• *Consultation & engagement* • *Residents* • *Commissioning / Finance / Analysis* • *TECS Workforce Devt*

	the public which will provide impartial advice about suitable TECS solutions	
Early Help, Prevention and Promotion of Independence. **Children, Young People SEND/Autism, Education and Transition Years**	• Introduce TECS which encourage people to adopt and maintain a healthy lifestyle, to prevent or delay the need for support. • Ensure that people have access to information about TECS provision as part of the front door triage service, that will help residents quickly find solutions for themselves that they are often happy to self-fund. • Work with our Education partners to ensure that innovative use of technology and continuous improvement of our offer around TECS remains on the Agenda for all our schools. • Expand use and resource of TECS to support and promote greater independent living for our Children and young people with SEND are supported at home. • Review current referral and assessment processes and ensure that TECS is considered within this process and that funding streams for equipment are clearly defined and understood for prescribing staff • Better aligned service provision between schools, local authority and health partners for specialist and TECS equipment. • OT assessments for SEND/ Transition Years children will include sections covering sensory and TECS assessment. • Develop Universal, Targeted and Specialised TECS packages for individuals' dependent upon their needs.	• *Quality* • *Workforce development and training* • *Commissioning / Finance / Analysis* • *All Age Strategic priorities*
Community Services : Day Opportunities/ Supported Living/ Mental Health	• Develop Home Improvement Team provision to include an advisory capacity for residents looking to adapt their homes – future proofing home living areas. • Invite collaborations with external housing development companies that specialise in TECS and SMART home planning. • Ensure that all SL properties and residential units are suitable to accommodate TECS provision as needed to support daily activities. • Liaise closely with all contracted housing providers to ensure that properties provided for SL tenants are easily adapted and suited to client needs to enable independent living where possible. • Continue to identify SL properties that would benefit from TECS • Regularly review care planning and assessments and subsequent reviews of assessment to ensure that the right TECS is recommended for individuals. • Liaise with RSL providers to develop a	• *Supplier engagement* • *Commissioning* • *Future proofing* • *Quality* • *Consultation & Engagement*

	Registered Social Landlord Social Care Pathway which will outline contractual housing obligations and we will also consider the Housing Strategy for Learning Disabilities and the Autism Strategy as part of this development. • Review our day centre provision and develop TECS for those individuals who are not attending day care services due to COVID restrictions.	
Adaptations Without Delay	• Encourage and promote more creative use of Disabled Facilities grants to consider TECS as part of any application to support people to remain independent in their homes • Map current service provision across Sefton and identify gaps in provision, delays in accessing equipment and we will work collaboratively with our partners to provide timely and effective solutions, promote DFG eligibility criteria and ensure that individuals have access to information so that they are also able to access equipment independently if needed. • Extension of warranties for some adaptations such as stairlifts and hoists. • Service delivery models both within our social care teams and external housing partners that are based on person-centred and preventative outcomes and organisations need to ensure that they take a safe and person-centred approach to providing adaptations to older and disabled people. • Implementation of an online rapid self-assessment and guided advice tool at the first point of contact.	• *Quality* • *Commissioning* • *Workforce Development* • *Accessible information* • *Consultation and engagement* • *Expansion of Digital offer*
Commissioning and Finance	• Development of revised contract and service specification to include TECS • Scoping of current Commissioners activity / commissioning arrangements • Commissioning activity will build care and support offers that are outcome focused, offering the right level of support at the right time from a range of TECS that is built around the person. • develop a broader joint commissioning framework across partner agencies to direct our commissioning intentions and maximise best value. • Ensure all stakeholders, have a voice at every stage of the commissioning cycle and provide feedback to measure and review impact. • Develop joint health and contract management tool kits, standards, intelligence log, shared existing data sources, a move toward contract management by	• *Integrated Commissioning* • *Consultation and engagement* • *Scoping suppliers and future proofing*

	supplier and not singular contract, and an outcome focused contract management approach. • Any future procurements will factor in TECS, with respect to how Providers will seek to utilise TECS and they will work with Commissioners on its implementation	
Digital Inclusion and Governance Group	Overarching Digital Strategy – objectives and activity related to TEC Strategy activity and progression. Reports to New Ways Of Working Board	

Appendix D: Current Overview of Activity 2021 - 2022

Sefton Council Digital and TECS Offer – Current Overview of Activity 2021 - 2022

Completed Activity:

- Establishment of TECS Steering Group
- Development of TECS Strategy 21/25
- Development of TECS definitions and guidance docs
- TECS delivery in care homes – pilot schemes
- Recruitment of TECS Officer

Developing Activity:

- ASC Online Portal/ TECS website development
- Ask SARA online rapid self assessment tool
- Capital Programme Development
- Digital switchover planning
- Staff training offer
- DFG – improve accessibility for funding adaptations and TECS

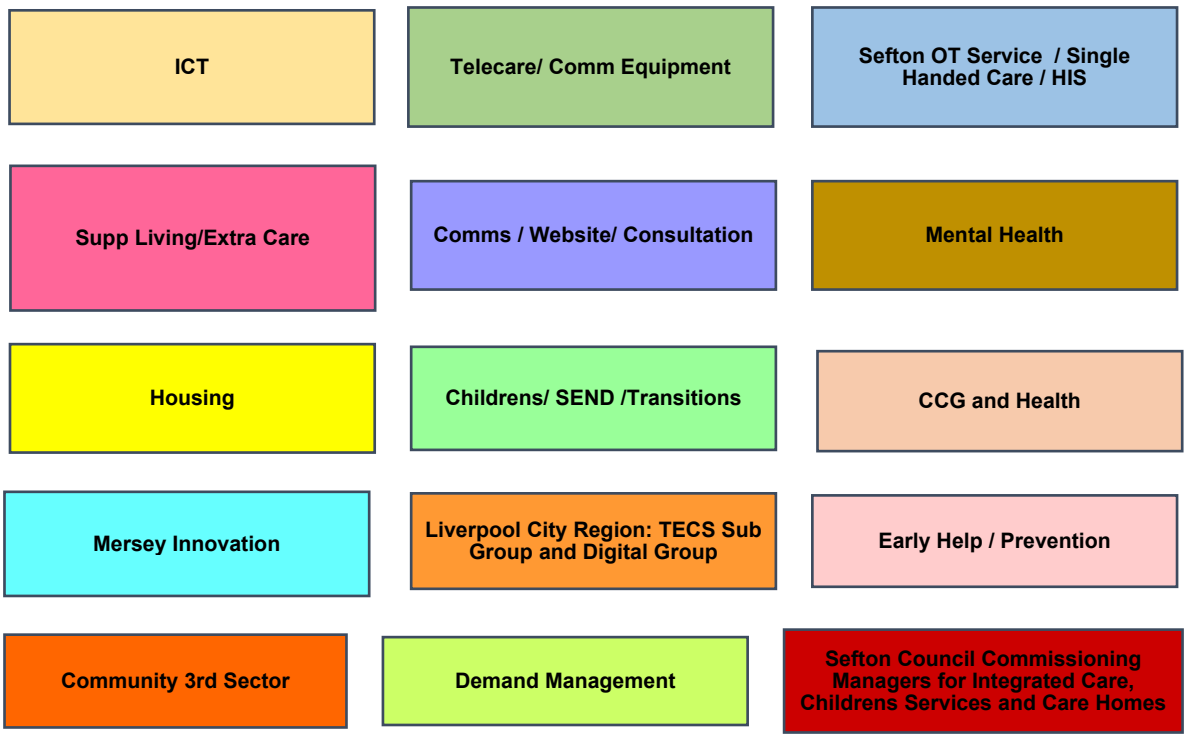
Planned Activity:

- Children's online portal
- Care homes, Supported Living homes and Children's Homes connectivity
- Day Services Development
- Supported Living TECS offer
- Service redesign – digital exclusion and education (Co-design digital inclusion and education Pilot from 4/5 priority areas)
- Social Care Assessment redesign
- Extended warranties and (Smart Home) voucher scheme
- TECS Consultation groups
- Collaboration / joint funding opportunities with Innovation Merseyside

Sefton Council

APPENDIX E: Consultation Partners and Stakeholder Groups

TECS Strategy Working Group membership:



Consultation Groups:

We consult with the following groups and these consultations will be ongoing throughout the life of this Strategy and as part of our commitment to fulfil the 9 strategic priorities highlighted throughout this document.

Practitioner consultations will also be facilitated with Sefton Council Social Care Teams including: Triage, Occupational Therapy, Social Work Teams from ASC and CSC portfolios.

We will ensure that the needs of individuals are well supported with TECS and we are committed to co-production. Sefton benefits from a strong network of Community and

Voluntary independent groups which we will work with to ensure that we deliver on our strategic priority to embed early help and prevention in everything we do and promoting independent living through TECS.

TECHNOLOGY ENABLED CARE SOLUTIONS (TECS)

Strategy 2021-2024

Sefton Council

NHS

South Sefton Clinical Commissioning Group
Sefton and Formby Clinical Commissioning Group

Contents

Foreword – Cabinet Member

This Strategy gives us the opportunity to be innovative and ambitious in how we plan to help all people to stay healthy and avoid complications. Technology Enabled Care Solutions (TECS) can be an effective tool in supporting people to manage their own health and enabling better coordination of care, personalisation and prevention.

In Sefton, we want the opportunity to innovate and improve services to achieve the best outcomes for the people we serve. Having effective digital capabilities which complement traditional care and support services, is fundamental to delivering the ambitions set out in our TECS Strategic priorities.

TECS alone can't deliver a transformation in care, but when embedded in a wider package of care and new ways of working, the combined innovation can have a powerful impact on improving outcomes for people and reducing inequality. That is why planning for technology enabled care services needs to take place at a whole social care and health economy level and involve social care, health, voluntary services, and our Sefton residents and carers, as part of integrated working and the development of our place-based partnerships.

The innovations described in this Strategy, together with the objectives of the Health and Wellbeing Strategy and Sefton Vision 2030 emphasise the strategic importance of closer working between health and social care organisations in Sefton. They are resolutely driven by our determination to put the needs of the person at the heart of everything we do. We aim to integrate health and social care services wherever such integration has the potential to deliver better benefits and improve outcomes for people. This document sets out our vision and ambitions for transforming the end-to-end care and support pathways which complement the delivery of services and supports the new operating models in Adult Social Care.

Co-ordinated advice and information is key to supporting people to take responsibility to plan for their future needs, including information about maintaining independence through the use of equipment, adaptations and AT. Promoting self-serve and effective self- assessment for those people who do not want to or do not need to access public services provision, alongside information that guides those people with more complex needs to appropriate referral points for access to specialised assessments, are fundamental for ensuring the right person gets the right support.

There is potential for the benefits of using TECS equipment and developing our TECS offer to residents of Sefton. TECS needs to be better understood by the public and our social care and staff teams. We also recognise that the opportunities that TECS equipment provide, particularly around re-ablement, recovery and assessment for long term support, should be made more integral to our social care assessment and commissioning processes.

The TECS Strategy sets our direction for the next three years with nine guiding strategic priorities to help us work towards the development of technology enabled care solutions that will promote and support independent living and improve health and well-being in all our families, neighbourhoods, workplaces and communities. Our intention is to continue to improve the experience of people who use services and for staff. We will do so through the effective implementation of key service changes and related projects during the lifetime of this strategy.

Having the right strategy is only the first step. The important next step is how we deliver it and how we embed our commitment to developing TECS in everything we do. If we want to improve health and wellbeing and reduce health inequalities, every single sector, organisation and community has a role to play. Together we can really make a difference to health and wellbeing and increased independent living for people in Sefton.

I am thrilled that the plans we have developed and that we are taking forward, with our key partners, will very much complement other forms of care and support and can bring about the maximum benefits to all. Technology has the power to radically transform the way we deliver care and support by enabling all individuals to take a more active role in their own health and increase prevention through supported self-care. By capitalising on new and emerging technology, we have the opportunity to provide a modern model of continuous, coordinated care centred on the individual, with professionals acting in partnership with the person to improve their health and wellbeing.

We need to harness the power of technology enabled care to provide better, safer and sustainable care. I believe that by embracing rapidly emerging TECS equipment to support independent living and self-care we can empower our residents to own their own care and transform the way we plan and deliver care and health services in the future.

Councillor Paul Cummins
Sefton Council

Sefton TECS Strategy 2021 – 2023

NHS
South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Sefton Council

Our Ambition

- Our ambition is to connect TECS into the heart of our adult social care and support services; we want to see a role for TECS whenever we design and develop services.
- We want to use the benefits of modern technology to create a service user experience which is flexible, enabling, responsive and re-assuring.
- We want to put technology to use to make it possible to deliver our services in the most efficient and effective way.

Our Priorities

- We will ensure the provision of TECS for individuals to live in an accessible and safe "home" environment, enabling them to retain independence, that also provides reassurance for formal and informal carers, often enabling them to continue with activities they might otherwise have to give up, including employment.
- We will build strong collaborative partnership approaches between health, social care, housing and wider community stakeholders to design seamless approaches to ensure that residents' care needs are well supported with the increased use of TECS.
- We will embed prevention in everything we do. Prevention and early intervention are about enabling people to maintain the best health possible all the way through life.
- Social and Health care professionals will have the knowledge and digital skills they need to understand how TECS can best support people and, using an asset-based approach, they will deliver person centred assessments that will empower individuals to identify potential solutions for themselves.
- We will make TECS the default consideration for individuals that require staff support but can share group living. We will ensure that the implementation of TECS will work in shared settings to meet the full spectrum of individual care needs.
- We will reduce the number of falls related hospital admissions and discharges to residential placements and some supported living models encouraging residents and prescribing staff teams to consider the use of TECS in people's homes in line with Sefton's Early Help and prevention offer.
- We will align 'in house' TECS provision with Occupational Therapy assessments and our Home Improvement Service, expanding our TECS provision over the next 3 years to give greater choices to people to support independent living at home.
- We will provide an opportunity for children and young people with SEND, their families and/or carers to have effective support in the home with increased use and promotion of TECS to improve mobility/safety and support independence.

Helping people to help themselves

1. Connecting people with information and support that is available within their local communities
2. Providing good quality advice and information at the first point of contact
3. Ensure relevant and current information is available for service users, practitioners and other stakeholders regarding TECS.
4. Provide timely and effective solutions, promote DFG eligibility criteria and ensure that individuals have access to information so that they able to access equipment independently if needed.
5. Develop a clearer and more integrated approach to the provision of TECS that will empower individuals to identify potential solutions for themselves
6. Ensure that there is a knowledgeable and confident workforce.
7. Developing staff/carer training and resources that are regularly updated and reviewed so that staff carers and family members are fully equipped to provide appropriate advice and choices to residents requiring TECS to enable independence in all settings

Helping People When They Need it

1. Providing Equipment, adaptations and TECS that prevents the need for personal care services
2. Changing culture and transformation to asset-based approaches
3. Working collaboratively with our partners to promote integrated working models, multi-agency teams and relocation of Trusted Assessors into Triage, Discharge and Reablement settings.
4. Support people to live independently at home using TECS equipment.
5. Supporting longer term attitudes to receiving health and telecare options.
6. Divert to less intrusive care initiatives using TECS
7. Support use of other services such as DFG and Direct payments to access equipment needed to ensure independent living at home

Helping People to live their lives as independently as possible

1. Ensure that care services explore and deliver new technology.
2. Exploration of TECS / Telecare Framework
3. Practitioners are required to think about the ethical considerations for use of TECS equipment

Early Help, Prevention and promotion of Independence

How we know if we've made a difference?

The Plan will be measured through indicators from Social Care, Public Health and Primary Care, Early Help, Active Sefton and Sefton CVS

Indicators to reflect each Theme include:

Helping people to help themselves:

- ✔ Empowering people to source self directed support.
- ✔ Reduction in number of people requesting formal referral at front door and signposting to alternative options re TECS equipment and Assistive technology
- ✔ reduction in high cost care packages
- ✔ Increase in the use of the on line rapid Self Assessment Tool
- ✔ Reduction in waiting times for adaptations to the home
- ✔ increase the number of TECS training sessions for health and social work practitioners by 10% each year.

Helping people when they need it:

- ✔ Reduction in Dom Care Packages by replacing with TECS
- ✔ Increased connectivity and knowledge of TECS
- ✔ Reduced high cost care packages and long tern financial savings with increased provision of TECS.
- ✔ More people living independently at home for longer.
- ✔ Improved health and well being outcomes.
- ✔ Reduction in longer term care packages. Increase in people living independently
- ✔ DFG funding is an area of continual growth
- ✔ Cost saving re reduction in high cost care packages and early help and prevention
- ✔ Reduction in falls reducing number of hospital admissions and admissions into permanent care home placements.

Helping people to live their lives as independently as possible

- ✔ Increased choice of TECS for individuals
- ✔ Expanded provision of equipment
- ✔ Increased number of referrals for telecare services

Introduction

This strategy has been written in response to the development of Sefton's Digital Strategy 2021-2023, to ensure that Technology Enabled Care Solutions (TECS) can contribute to meeting the needs of individuals to ensure independent living at home and within the wider community.

Within Sefton's Digital Strategy 2021 -23 there are three identified themes:

1. **Connected Council:** We will use digital technology and solutions to transform and improve how the Council operates

2. **Empowered Communities / Empowered Residents:** We will use digital technology to consolidate and transform the relationship between the Council and its residents so that residents have better access to online services and benefit from improved digital inclusion

3. **Business Growth:** We will ensure that Sefton residents and businesses benefit from high-speed internet connectivity, access to digital skills learning and the ability to leverage the opportunities afforded by digital technologies.

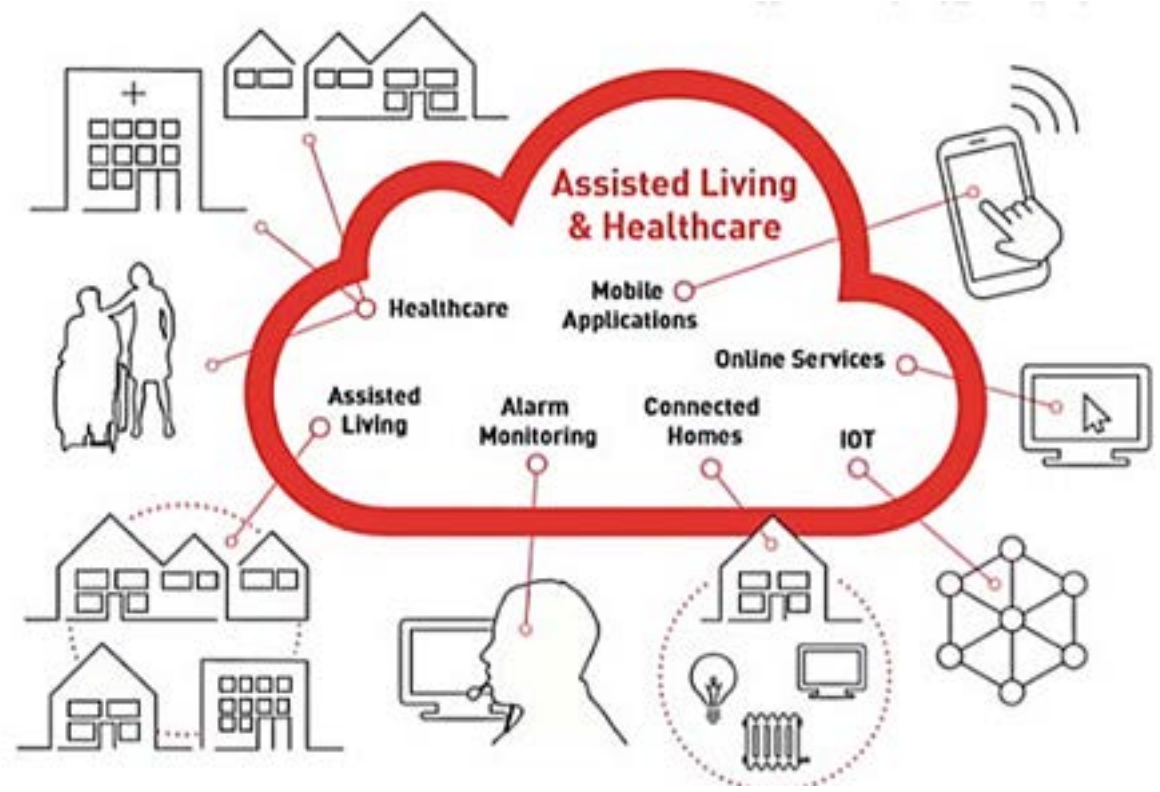
The Technology Enabled Care Solutions (TECS) Strategy 2021-2024 has been written in response to **Theme 2: Empowered Communities / Empowered residents.**

What is Technology Enabled Care Solutions (TECS)?

Technology Enabled Care Solutions (TECS) is fast becoming the accepted description for a range of health and care technologies. TECS range from the simplest information apps to sophisticated monitoring devices. It has the potential to transform how we care, especially making it possible for us and those we're looking after to have greater independence and peace of mind.

TECS refers to the use of assistive technologies, telehealth, telecare, telemedicine, tele-coaching and self-care in providing care for people with long term conditions that is convenient, accessible and cost-effective (See Appendix A for definitions). TECS has the potential to transform the way people engage in and control their own healthcare, empowering them to manage their care in a way that is right for them. It enables timely and efficient remote support and offers choice and personalisation; reducing, delaying and, in some cases, preventing dependence on services and high cost carer packages. TECS can improve the quality, safety and efficiency of health and care practice and it can help to identify individual and population social and health care needs and expectation to plan and deploy interventions.

If TECS equipment is used appropriately, it can support individuals to live independently within their own homes and local communities for longer. The role of TECS, adaptations and community equipment in helping people to live independently in their own home for longer is crucial to Sefton's vision for a model of social care which reduces, delays or prevents reliance on formal care and support services.

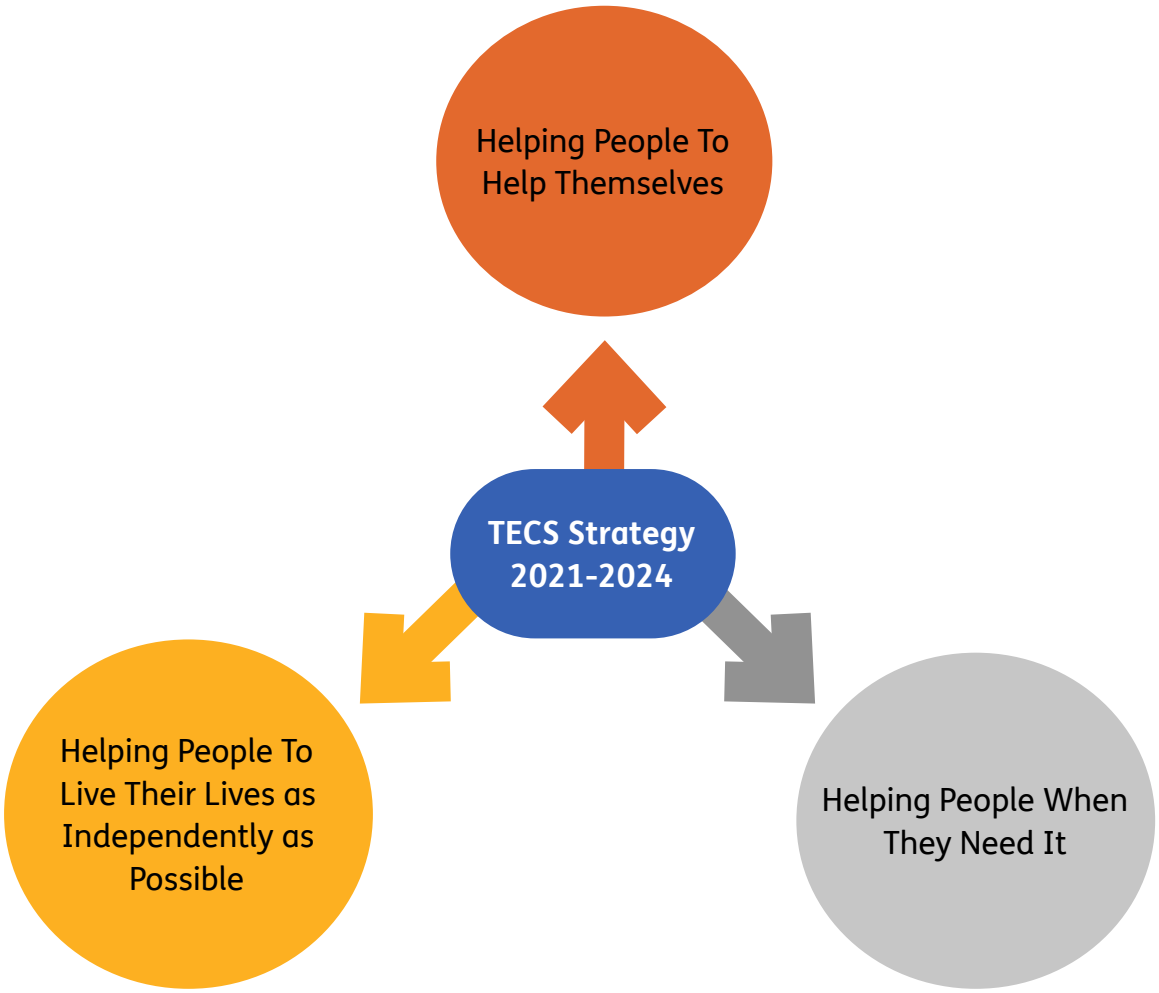


Ambition

Our ambition is to connect TECS into the heart of our adult social care and support services; we want to see a role for TECS whenever we design and develop services. The intention will be to use the benefits of modern technology to create a service user experience which is flexible, enabling, responsive and re-assuring. We also want to put technology to use to make it possible to deliver our services in the most efficient and effective way.

Sefton TECS Strategy 2021-24: Strategic Objectives

This Strategy details the outcomes that Sefton Council want to achieve in developing and delivering TECS across Sefton. It identifies actions that will support local priorities and that are supported by the Government's health and care policies and some of these are also outlined in the associated strategies highlighted below.



TECS Strategic Priorities

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PRIORITY 2: We will build strong collaborative partnership approaches between health, social care, housing and wider community stakeholders to design seamless approaches to ensure that residents' care needs are well supported with the increased use of TECS.

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PRIORITY 9: We will ensure there is a readily available TECS budget with sliding scales for cashflow outlay.

Adult Social Care Vision 2030

The delivery of this Strategy is a key contributor to the Councils overarching 2030 vision which can be found here: Vision and Core Purpose (sefton.gov.uk). The Health and Wellbeing of Sefton residents is a key deliverable of the Sefton Health and Wellbeing Strategy and Sefton2gether NHS 5 years plan found here:

https://modgov.sefton.gov.uk/documents/s94293/Enc.%201%20for%20The%20Health%20and%20Wellbeing%20Strategy%202020-2025.pdf

and here:

https://www.southseftonccg.nhs.uk/media/4179/sefton2gether-final-print-version-2020.pdf

These plans all highlight the need to enable resilience and maximise the impact of technology and digital solutions to continue to meet need based on the assets of those that need care and support.

Two pledges from the Vision are to work together:

- so that Sefton becomes a digital borough and improve access to digital technology.
- to promote digital inclusion

The 2030 Vision outlines the following objectives for Sefton Council and its partners:

- 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 individual's 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.

Adult Social Care Market Position Statement

The Market Position Statement for Sefton states that choice and control for our residents is key to achieving our vision. Our strategic direction is to move towards person centred services and to invest in innovative and creative services that can evidence personalisation, good outcomes as well as being effective and affordable.

We would estimate that current budget is £ 434.2 Million for our CCGs and £153 Million for Adult Social Care, illustrating the significant amount of potential we must combine the budget and deliver the most effective service for the people who live in Sefton.

This Strategy considers the ASC Market Position Statement and seeks to give clarity to the market, ensuring that we maximise, in all ways, what the market can offer. We will develop with providers and stakeholders, a predictive model of what we need the market to look like, and we will seek assistance with our appraisal of potential delivery models to achieve this.

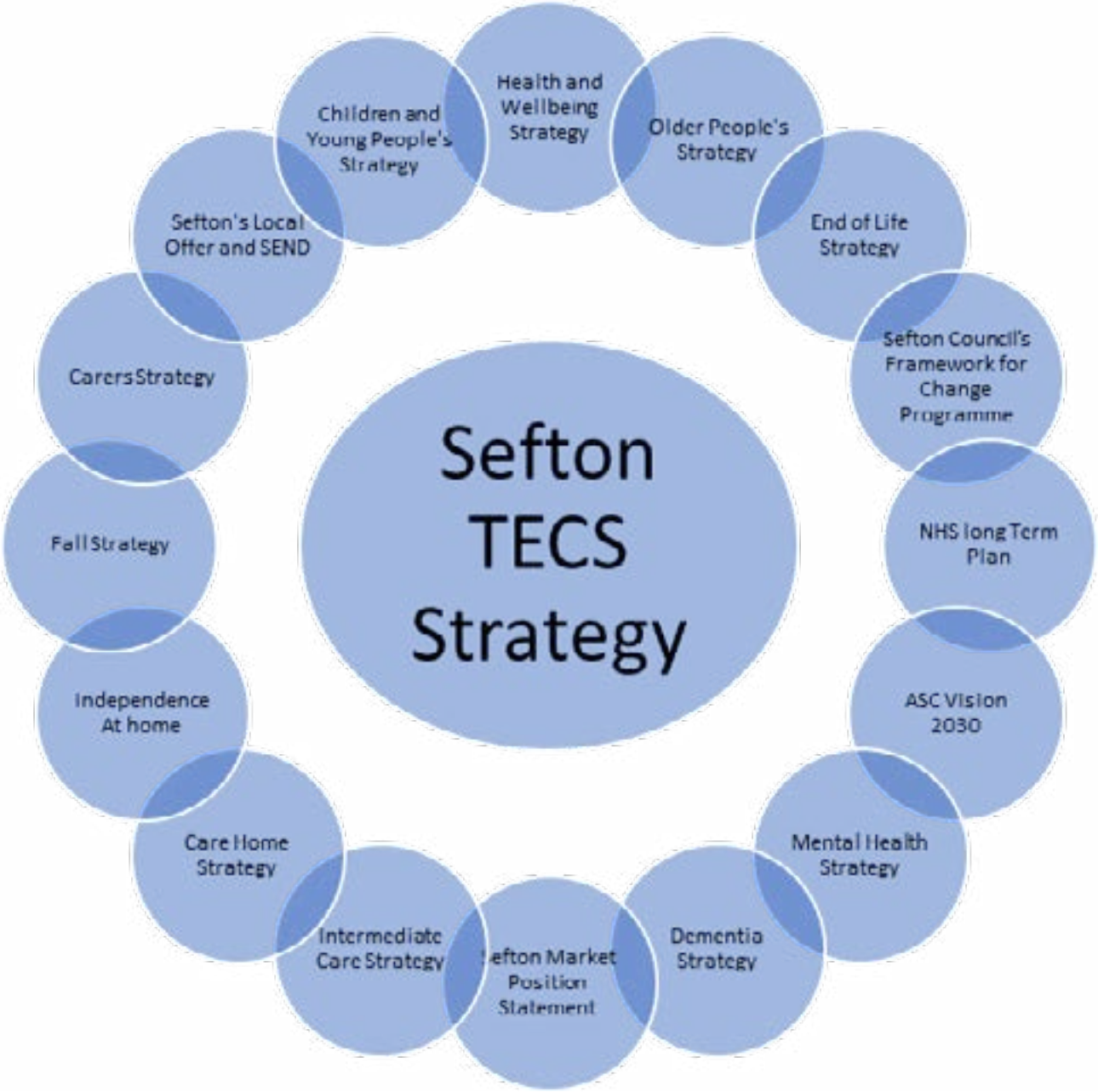
The Vision for Sefton is to embed the vital role of technology in social and health care and work with formal and informal care providers to support people to live independent lives in their own homes, stay connected with their local communities and stay fit and active for longer. Over the next 3 years and beyond we will develop and deliver a TECS service for Sefton residents, which is accessible across both social care and health. As services become more integrated and technology is developed, the aim is to include telehealth commissioning with our CCG colleagues.

As part of the ongoing development of our social care workforce, we will ensure that they receive information and training on TECS and how it can be accessed and utilised in service provision. Staff will be actively encouraged to consider TECS at the first point of assessment for anyone seeking support in the home to maintain independent living. We will ensure that all care staff are equipped with the correct information and knowledge to promote TECS to residents living in Sefton.

Linked Key Strategies

Other key linked strategies are highlighted in the diagram below and, again, they all seek to affect outcomes for the people who live in Sefton by increasing delivery of care at home wherever possible, improving the quality of care and support and maximising the independence of our older population. They can be found using the following link:

https://www.sefton.gov.uk/your-council/plans-policies.aspx



Context and Purpose

The National Context

Care Act 2014 requires local authorities to:

> *"consider the person's own strengths and capabilities, and what support might be available from their wider support network or within the community to help" in considering 'what else other than the provision of care and support might assist the person in meeting the outcomes they want to achieve."*[1]

Early intervention and prevention are key elements in the Care Act, which requires local authorities (and their partners in health, housing, and employment services) to take steps to prevent, reduce or delay the need for care and support for all local people. It also directs that services should promote the wellbeing of individuals. TECS is key in achieving this, as evidence has shown how, in many situations, it can be used to support and maintain people's independence, reduce or manage risk and will enable many people to remain living in their own homes.

Co-ordinated advice and information are key to supporting people to take responsibility to plan for their future needs, including information about maintaining independence by using equipment, adaptations and TECS. Promoting self-serve and effective self- assessment for those people who do not want to or do not need to access public services provision, alongside information that guides those people with more complex needs to appropriate referral points for access to specialised assessments, are fundamental for ensuring the right person gets the right support.

There is potential for the benefits of equipment, adaptations and TECS to be better understood by the public and, we also recognise, that the opportunities that equipment, adaptations and TECS provide, particularly around reablement, recovery and assessment for long term support, should be made more integral to our social care assessment and commissioning processes.

Think Local Act Personal

The transformation of social care and the personalisation agenda set out in 'Think Local Act Personal'[2] establishes that Councils need to offer and provide support in ways that ensure that people can exercise choice and design the support and care arrangements that best suit their specific needs. Personalisation is based on offering choice and control to our customers and working with them to co-develop individualised support plans. It puts people at the centre of the planning process and recognises that they are best placed to understand their own needs and how to meet them. Supporting people and carers to access and use the opportunities that

1 The Care Act 2014

2 Think Local Act Personal: See: http://www.thinklocalactpersonal.org.uk/Browse/careact2014

TECS can provide is a key aspect to enabling choice and the council's prevention strategy. For many people who access support and services, TECS will be one element of their support plan, which may also include regular visits by care staff and other workers.

TECS offers numerous possibilities depending on the customer's needs and desired outcomes ranging from simple devices to prevent sinks flooding, to GPS tracking and Smart-phone applications. By ensuring that telecare is considered during the development of every support plan we can support customers to find the best possible solutions and achieve the vision described in 'Think Local, Act Personal'. Many others, of course, are happy to sort out their own care and support and we need to increase awareness generally about the possibilities that technology can offer.

COVID 19 Pandemic and its Impact on Health and Social Care provision

Digitalisation aspects of the NHS phase 3 response to COIVD and the need to accelerate the digital and technological solutions.

COVID-19 is an unprecedented global crisis that is placing tremendous pressure on people, communities and businesses. Dealing with the social and economic effects of COVID-19 calls for both immediate and longer-term responses, so monitoring and measuring social value currently is more important than ever. However, COVID-19 has also completely changed the priorities for organisations and the resources available to them.

The Kings Fund: Five priorities for the health and care system post-Covid-19 Report[3] is considered within this strategy in line with future planning and TECS development across Sefton and across the region. It is essential to embed and accelerate digital change in the wake of recent progress during the last 18 months (2020/2021) in line with COVID 19 restrictions on movement and social distancing arrangements for the population. This includes innovative and new methods of service delivery for care professionals and Sefton residents, such as the increased use of video consultations, remote appointments and the accelerated wider roll out of digital technology.

Rapid evaluation of approaches and measures taken during the pandemic is needed to inform future digital change. This includes understanding the impact of the more permissive environment for innovation – covering changes to funding, procurement, information governance, and staff and peer support – and the consequences of the resulting changes for patients and staff, particularly in general practice and outpatient care, which have seen the greatest shifts.

3 The Kings Fund: Five priorities for the health and care system post-Covid-19 Report, July 2020

The Local Context

The Demographics of Sefton

Sefton has a population of approximately 274,600 (0.5% of the English population).

In summary:

- 52% of the Borough are female and 48% are male (slightly different to the 51% - 49% split seen across England).
- 23.1% of Sefton's population is 65 years old or over (63,300), with approximately one in five being aged under 18 (53,514).
- Sefton is ranked 18th out of 326 local authorities for the number of residents aged 65 or over.

Sefton faces significant challenges over the coming years because of the structure of its population.

We have a much higher than average proportion of older people and we expect over the next few years to have increasing numbers of:

- People living alone with an increasing risk of social isolation, loneliness and depression.
- People with dementia.
- People with multiple and complex long-term needs.
- Unpaid carers, many of whom will be older people with their own care needs.

Like most of the country Sefton has a growing and ageing demographic. By 2035 Sefton will have an overall forecast increase of 22% of residents who are 65+ and is set to account for almost 30% of Sefton's population.

Current statistics show Sefton having the largest cohort of residents 65+ within the Liverpool City Region[4].

Borough	Sefton	Wirral	St Helens	Halton	Knowsley	Liverpool
Age 65+	23.1%	21.3%	20.4%	17.9%	17.0%	14.6%

A further analysis of the 23.1% of older Sefton residents by sub-areas is as follows:

Sefton	Southport	Formby	Maghull	Crosby	Bootle	Netherton
Age 65+	26.6%	31.4%	26.5%	21.7%	15.5%	17.5%

At present we support and admit many more clients in Care Homes for all ages than the national average suggesting a structural issue with over provision or insufficient levels of preventative or diversionary activity and a lack or underuse of alternatives. We currently see

4 Sefton Strategic Housing Market Assessment (SHMA)

753 per 100k rate of Permanent Admissions of 65+ to Care Homes, the National Top Quartile is 458, and for 18 – 64-year olds, we see 29 per 100k of Permanent Admissions to Care Homes, the National Top Quartile is 9. In 2017/18, when compared to other Councils with Adult Social Care responsibility, we were the150th Highest Long Term Residential & Nursing Unit Costs out of 152.

Given Sefton's high proportion of older people and an aging population dynamic, it is unsurprising that there is, and is likely to remain, a need for nursing and complex support around memory and cognition (dementia) we need the market to be ready to meet these needs. However, there is also an increasing number of people who are currently placed directly into residential level care who might be better suited to alternative provision such as 'Extra Care' housing.

Sefton's Telecare Service, Occupational Health and Social Care Teams and the Community Equipment and Advisory Service

The provision of TECS is a key element of supporting independence at home and we want to increase the number of people using TECS as an alternative to more formal, costly and , often invasive, care provision, such as night care staff, for example. If deployed correctly, TECS can improve the quality of many people's lives, supporting them to remain independent in their own homes whilst managing and minimising risk.

TECS is integral to an Independence at Home Pathway of services that support independence at home, aligning with offers from associated services such as the Community Equipment Service, the Home Improvement Team and Occupational Therapy and Telecare Teams, to allow practitioners to build a package of support around the individuals outcomes and needs.

The Telecare Service currently offer 'traditional' telecare as a solution. During 2019 (Jan 2019 – Dec 2019 the Telecare Service received 1315 referrals and of these 1179 (89.7%) installations were completed. During 2020 (Jan 2020 – Dec 2020) the Telecare Service received 1150 referrals and of these 1096 (95.3%) installations were completed. We are confident that, as the choice of telehealth provision is increased and promoted across Sefton, demand for telecare equipment in homes across Sefton will increase significantly over the next 3 years.

We are a local authority that is moving forward with our digital offer. We need to consider the technologies that we use, and that we have the flexibility to accommodate increasing demand choices of aids and adaptations. People are increasingly comfortable operating in our ever-expanding digital world, and they can readily choose from a wide and rapidly expanding range and choice of TECS to assist and support them in their daily activities. TECS developments have the power to transform their worlds and ours.

Co-production

All services should be co-produced with users and carers, as they are directly impacted by services and have first-hand experience of what works well and what doesn't. While this is important for all services, it is essential that commissioning demonstrates excellence in this area. Far too often, people feel they are being paid lip service when consulted on service developments. Approaches based on ongoing engagement need to be at the heart of commissioning and service delivery.

In order to deliver this element of the strategy, an approach to co-production needs to be implemented across all services. For most services, this will serve as a reminder of best practice but for others it may provide the opportunity to refresh or develop their approach.

A digital infrastructure and a range of tools will be developed and built with transparency, and accountability and they will be data secure. This will involve collaboration with the public and health and care staff. We will build on existing best practice using coproduction and deliberative engagement processes and ensuring greater collaboration with our residents and the wider voluntary and community sector organisations.

Consultation & Engagement

Throughout the life of this strategy, all stakeholders will be consulted and engaged with to ensure that the strategy continues to identify emerging needs and remain aligned to other associated strategies and plans. (See Appendix B)

In addition, as part of the implementation of associated action plans, consultation and engagement will take place, for example with Service Users and Care Providers to ensure that commissioning activities consider identified needs, desired outcomes, feedback on current services being delivered and Provider market factors.

Intermediate Care / Independence at Home

PRIORITY 1: We will ensure the provision of TECS for individuals to live in and an accessible and safe "home" environment, enabling them to retain independence, that also provides reassurance for formal and informal carers, often enabling them to continue with activities they might otherwise have to give up, including employment.

The evidence base (Jan 19 – Jan 20)						
Average weekly home care hours delivered	3,983	710	1,914	2,417	2,352	2,766
Residential placements	690	115	216	275	247	270

The Intermediate Care Strategy outlines how Sefton will have an increased focus on providing short-term services and interventions, which 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.

This includes home based services, and TECS will be utilised to promote independence at home e.g. telecare (such as pendant alarms and falls detectors), community equipment (such as beds, hoists and walking trolleys), and minor and major adaptations to the home (such as hand rails and ramps).

It has always been recognised that the home environment is a key consideration for those with potential social care needs. TECS Equipment and adaptations to the home can support reablement, promote independence and contribute to preventing the need for care and support.

What we are doing:

- The Community Equipment Service and the Telecare Service are developing a customer facing facility that encourages people to consider what pieces of equipment they may like to try and to purchase themselves to support independence without the need for formal assessments.
- In partnership with Merseycare, Sefton Council has developed the Community Advisory Service. It will compliment Sefton's model of developing self-assessment in our Occupational Therapy service and strengthening the support and guidance function we are committed to offering. The Community Equipment Service also supports the development of a single-handed care model across Sefton, and it has supplied specific equipment to support Care being delivered by one person wherever possible. The service has supported 63 people to date, and this will be rolled out to Sefton Care Homes as part of the next phase of the

project.

- The authority is currently out to market for a Cloud telephony solution to replace its legacy infrastructure including analogue lines. The migration is planned before Summer 2021. Procurement has started on current call handling platform and how this will be upgraded. Plans are in place to replace old analogue units with new digital units.

What we will do:

- When designing new services, we will look at the opportunities available from technology and seek to build these in to our offer. This could include looking at how we can use TECS to prevent need from arising or escalating or to enrich service users' experience.
- The introduction of other forms of TECS such as telehealth and tele triage will be explored to support people to remain in their chosen place of home for as long as possible.
- We will improve access to information, advice and guidance to promote early awareness and wider use of the equipment available in the broader retail market place for anyone who may benefit from its use, their carers' and care and support providers.
- We will work to ensure that as part of the assessment processes for short- and long-term community based / care at home services, TECS becomes a key element of the process to ensure that Service Users are able to utilise it, reducing the need for services which are typically costly for them. We need to ensure that TECS does not become an "afterthought" and instead becomes one of the first things that is looked at during the assessment process and discussions with Service Users about their care and support needs.
- We will work closely with all care home providers in Sefton to support implementation of TECS through national, regional and local initiatives (eg roll out of NHS.net emails, use of Smart phone/tablets and potential for TECS and COVID 19 virtual wards monitoring)

Partnerships

PRIORITY 2: We will build strong collaborative partnership approaches between health, social care, housing and wider community stakeholders to design seamless approaches to ensure that residents' care needs are well supported with the increased use of TECS.

Cheshire and Merseyside Health Care Partnership: Integrating Care – Next steps to building strong and effective integrated care systems

This proposal details the use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care as one of its main overarching aims. The Proposal reinforces the need to use digital technology to

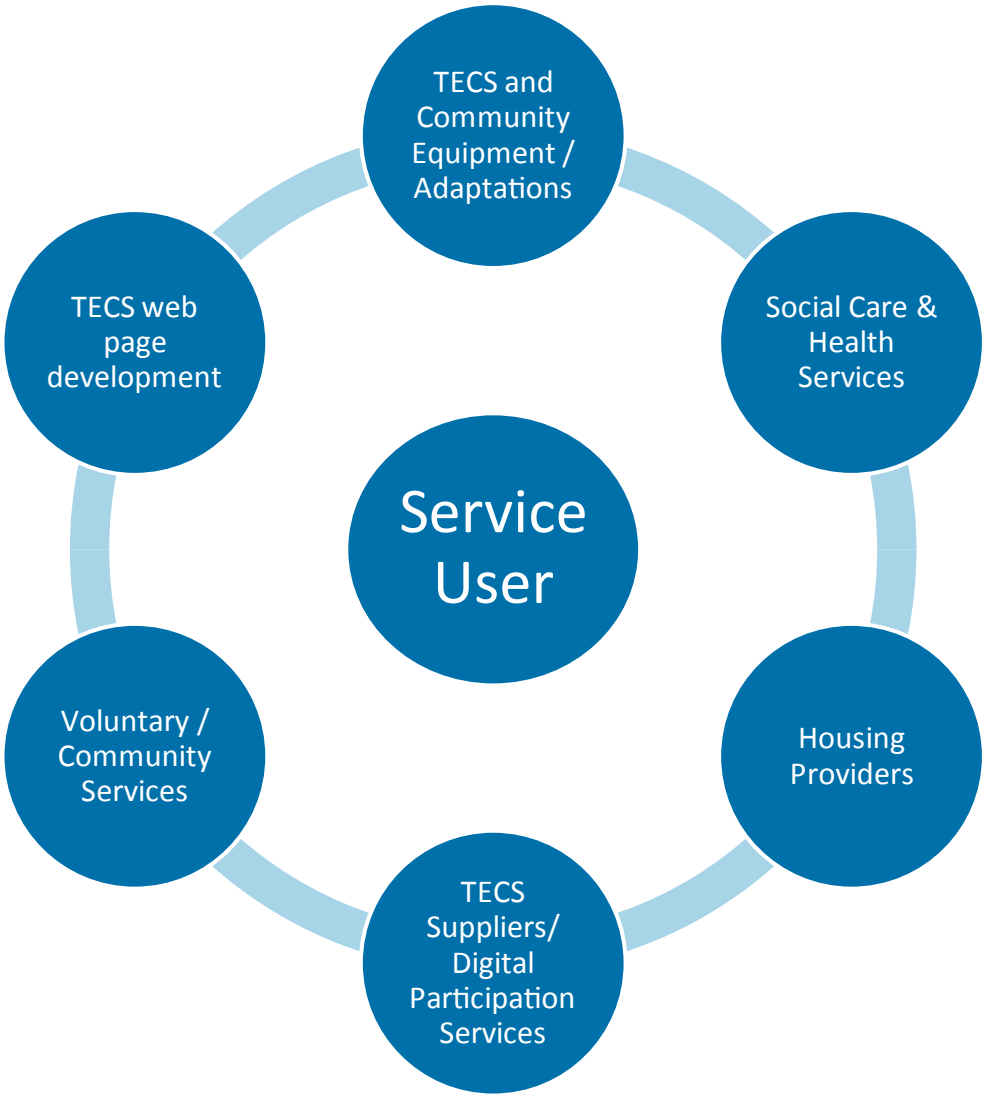
> *"reimagine care pathways, joining up care across boundaries and improving outcomes, developing shared cross system intelligence and analytical functions that use information to improve decision making at every level, ensuring that information is transparent about interventions and outcomes achieved to drive more responsive coordination of services, better decision making and improved research"*

It emphasises the need to put the citizen at the centre of their care by developing a road map for citizen centred digital channels and services, including access to personalised advice on staying well, access their own data and triage to appropriate health and care services. By using TECS and other digital tools this will allow citizens to stay safe at home for longer and help them to manage long term conditions independently.

It is important that our Sefton health and social care systems, and our partners, work together to meet the needs of our entire population. This means focusing on the areas of greatest need and ensuring we are doing the best we can with the resources available. We also need to increase our efforts on early help and prevention, prioritise both physical and mental health, and create connections across the public, private and voluntary, community and faith (VCF) sectors to make lives better for people in Sefton.

We are committed to driving forward our own strategy and, when opportunities arise, we want to do this in a co-ordinated way. Increased collaborative working between social care, health, housing partners and Sefton VCF leads to many opportunities for a more joined up approach to delivery.

The provision of care and support, that is integrated with an assessment of the home (including the consideration of TECS by prescribing professionals, person centred assessment and the general upkeep or scope for equipment and adaptations) could reduce the risk to a person's health, help maintain their independence and wellbeing, support their reablement or recovery, or provide a person with dignified end of life care.



TECS Strategy Working Group

The TECS Strategy Working Group has been established to consider Sefton Council's current TECS service provision - what our offer currently looks like, considering future planning for improved digital technology across both children's and adults services – an "All Age" TECS Strategy – and the expansion of TECS to support and promote independent living.

Areas for focus include how many people can, and will, benefit from improved digital provision, the development of operational pathways for the inclusion of TECS in care planning and to support independent living and to scope what our current TECS is for residents. The Group will identify current gaps in provision and areas for improvement including:

- ✔ TECS training for staff, residents of Sefton and their families/carers
- ✔ Mitigation of risk for implementation of digital technology
- ✔ Future proofing expenditure and future savings
- ✔ Promotion for independent living in the home and

- ✔ Potential for capitalising a post to assess, train and implement future provision against agreed and identified KPI's
- ✔ How care and support planning for individuals can be improved using technology
- ✔ The development of the responder and reablement TECS offer considering strategic and demand management priorities.

What we are doing:

- We are consulting with several Sefton's Community groups (See Appendix B) around the design and content of the TECS webpage, and in how to provide and make accessible all information related to our TECS offer.
- Promotion of Making Every Contact Count (MECC) training, aims to provide advice and support for behaviour change so that people can have better health and live longer healthier lives. We know that staff across health, local authority and voluntary sectors, have thousands of contacts every day with individuals and are ideally placed to promote health and healthy lifestyles. The aim of this training is to maximise the opportunities participants have to increase the number, and quality, of brief interventions in Sefton.
- We are working with commissioned Providers to ensure that they are aware of TECS and how they should factor its potential use into their own assessment processes.
- We have established Sefton's TECS Strategy Working Group, which will drive the TECS Strategic Objectives 3-year Delivery Plan.
- Sefton Council is represented at various local, regional and national groups to ensure that Sefton residents benefit from wide range of opportunities in promoting independent living and maximising their health and well-being. These groups include (but are not exclusive) the Liverpool City Region (LCR) Digital Inclusion Group, Sefton Provider Alliance, North West Association of Directors of Adult Social Services (NWADASS), Sefton Consultation and Engagement Board Care Commissioning Group (CCG) and Primary Care Networks (PCN's), Cheshire Merseyside Healthcare Partnership (HCP).
- We will continue to consult regularly with local partners, such Healthwatch and identified wider community groups (including and not limited to) Ability Plus, SAFE Regeneration, Sefton Carers, Living Well Sefton, Sefton Partnership for Older Citizens, Sefton Dementia Alliance, Younger People with Disabilities and Sefton Community and Voluntary Sector (Sefton CVS) and Sefton Voice.

What we will do:

Acknowledging current significant financial challenges, our main priorities for TECS and Community Equipment services are as follows:

- We will engage with services which educate, entertain and stimulate social interaction to enrich lives of people whilst linking them to networks and communities, to combat loneliness and social isolation.

- We will regularly consult with Sefton residents, staff and stakeholders about any project developments, pilot schemes and accessible grant to purchase TECS as needed. As part of co-production of our TECS service provision, we will work with peer and personal support networks alongside professional networks and facilitate services by helping organisations to become agents for change rather than just being service providers.
- We will carry out our statutory responsibilities for people with eligible needs through our contractual arrangements for equipment and adaptations.
- We are committed to working with partners to improve access to TECS and we will work closely with health and housing colleagues to join up developments in TECS to the benefit of our mutual customers.
- We will work with our Education partners to ensure that innovative use of technology and continuous improvement of our offer around TECS remains on the Agenda for all our schools.
- To ensure that we can take a holistic and tenure neutral approach to this commission, we propose to survey Sefton's Housing Provider/s to understand the patterns of delivery of adaptations to their own stock.
- We will incorporate existing demographic data and mapping of the wider network of statutory and voluntary sector organisations that also support people to remain living independently and with whom referral pathways could be developed – cross referenced with feedback from the structured interviews.
- We will create a system that ensures that practitioners can use TECS to support individuals as often as possible, developing staff training and resources that are regularly updated and reviewed so that staff are fully equipped to provide appropriate advice and choices to residents requiring TECS to enable independence in all settings.

Early Help, Prevention and Promotion of Independence

PRIORITY 3: We will embed early help and prevention in everything we do. Prevention and early intervention are about enabling people to maintain the best health possible all the way through life.

This Strategy supports, and aims to bring together, the work being done around children and adult emotional health and wellbeing, suicide prevention, social isolation, dementia and the needs of carers.

Transition to modern TECS offers a great opportunity to help achieve the ambitions of keeping people safe, healthy and connected. By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate its effects when it does.

This Strategy, will take a life course approach, recognising that the foundations for lifelong wellbeing are already being laid down before birth, and that there is much we can do to protect and promote wellbeing and resilience through our early years, into adulthood and then on into a healthy old age, where functional mental health needs are addressed in addition to those identified in responding to dementia.

Sefton was recently granted Age Friendly Borough status by the World Health Organisation Extra Care, which represents a significant contribution to building on the offer to our Older population to be supported to lead the lives they want to in Sefton.

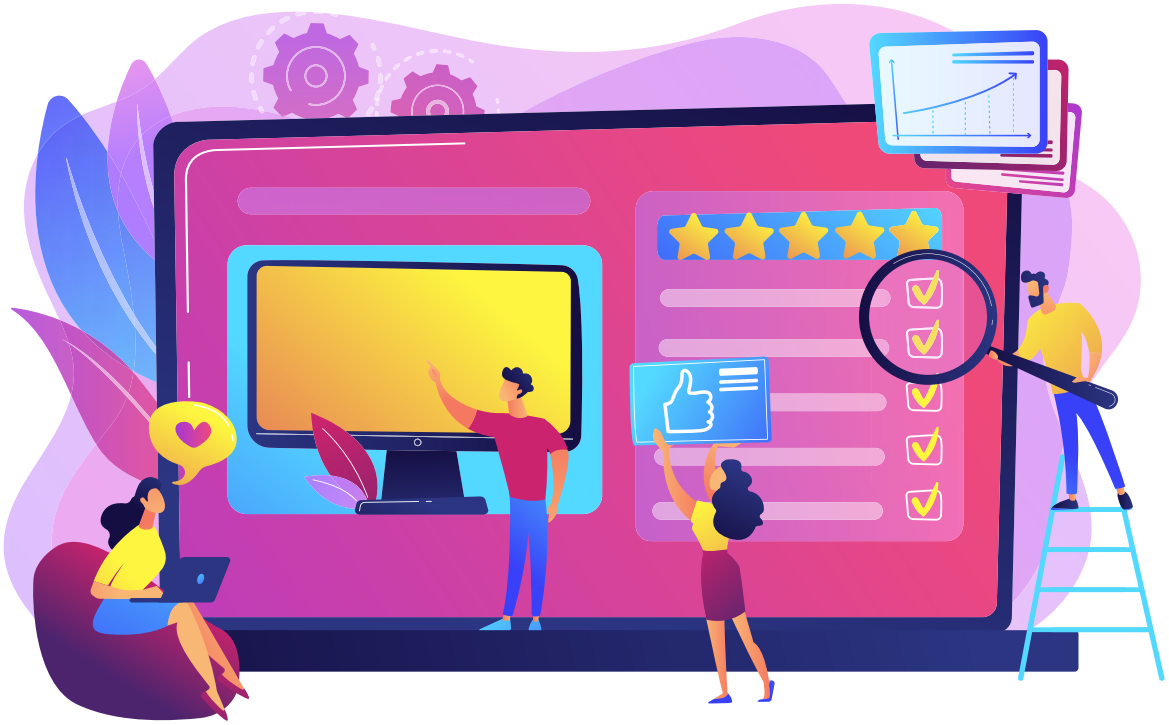
We want to invite providers and stakeholders to express their thoughts and ideas and we welcome new ways of working and innovation to further inform our strategy and commissioning intention.

What we are doing

- The development of TECS in the Borough will make a significant contribution to the key outcomes we want to achieve through the delivery of our Health and Wellbeing Strategy.
- We are building in opportunities when we design and develop services such as the development of our Extra Care Schemes.
- A wealth of data and information can be produced by TECS systems and from wearables and devices.

What we will do

- We will look at the 'wellness of people' and introduce TECS which encourage people to adopt and maintain a healthy lifestyle, to prevent or delay the need for support.
- We will ensure that people have access to information about TECS provision as part of the front door triage service, that will help residents quickly find solutions for themselves that they are often happy to self-fund.
- We will do this by implementing an online guided advice tool for the public which will provide impartial advice about suitable TECS solutions taking a life course approach to support people to live independently and maintain their chosen lifestyle. This will reduce the number of people requesting a formal referral for assessment and will, in turn, allow those with more complex needs to access formal assessments more quickly and efficiently.



Information and Choice - Raising Awareness and Driving Behaviour Change

PRIORITY 4: Social and Health care professionals will have the knowledge and digital skills they need to understand how TECS can best support people and, using an asset-based approach, they will deliver person centred assessments that will empower individuals to identify potential solutions for themselves.

There are a wealth of apps, kit and technologies designed to make home life more manageable or to provide reassurance to family and carers. which although positive in terms of availability and accessibility, can cause confusion and may be difficult for both customers and professionals to navigate due to the various access routes and criteria.

People need to have timely access to information and advice which will enable them to self -assess, self-select and purchase TECS.

Positive and targeted awareness raising, and promotion is required to ensure the best TECS opportunities are available for people who would benefit from TECS. This includes the facilitation of practical demonstrations of TECS equipment, TECS equipment training and advice sessions for carers and family members, the types of TEC equipment that is available to buy “off the shelf”, up to date supplier information and lived experience case studies made available to Sefton residents and prescribing staff teams.

Sefton’s Local Offer helps people to understand what services they can expect from a range of local agencies, including your statutory entitlements, eligibility and referral criteria. We want to encourage and support people to use technology with their Direct Payments and widen the eligibility criteria of DFG applications to include TECS and assistive technology in their homes.

Activity in this area will work towards providing simple, clear and straightforward guidance and advice about what TECS support is available and to promote and signpost appropriate apps which promote wellbeing, social inclusion, prevention and facilitate care and support.

What we are doing:

An Online Adult Social Care Portal has been developed and launched in June 2021. The portal provides access to an online referral and assessment service for Sefton residents and for social care professionals. It will also offer the following facilities which will empower individuals to find their own care solutions offering advice and guidance to access a wide range TEC equipment:

- An equipment and technology area
- A link to a catalogue of equipment and living aids
- A link to an online assessment tool

- Areas where product suppliers and retailers can advertise.
- Guidance and information regarding the Disabled Facilities Grant and the referral processes, equipment and catalogue provision and links to independently access suppliers if no further care and support services are required/needed to support independent living and delay further social care intervention or care home placement.

The Adult Social Care Portal links into other projects across the council, and it will also link in to the council's newly designed website and to the current Service Directory. The Service Directory is required to offer links to appropriate information advice and guidance. Linking with these wider projects will ensure a consistent approach to design and a One Council view for the citizen accessing the portal.

The availability of a digital assessment is also being explored to maximise opportunities for the public to self-determine their own requirements, and to source solutions with consideration of those people who prefer to, or are able, to self-serve and self-fund.

People will be able to upload personalised reports relating to equipment and TECS. It will offer independent advice and it will signpost people to suppliers where they can purchase minor equipment aids for themselves without the need for formal care and occupational therapy assessments to be undertaken.

What we will do:

- TEC Officer post has been established with the objective of raising TECS awareness across SW, OT, Early Help, Voluntary Sector, delivering and facilitating training for all frontline staff and acting as a TECS specialist for Sefton residents offering TECS advice and support.
- We will review and continuously develop the portal content. We will explore the opportunity for the development of a supplier account facility where providers of equipment and technology enabled care solutions along with care support services can register for a free account and advertise their services directly to Sefton residents on the Council website.
- We will develop a TECS web page on Sefton's Your Sefton, Your Say website which will provide information, and regular updates about TECS opportunities and development that is easily accessible to staff and Sefton residents and which is regularly reviewed.
- We will link in with Hospital Discharge and Reablement teams, Housing Providers, Sefton CVS and wider community services, Libraries, Public Health and our Council My Sefton website and the ASC Portal to do this.
- We will ensure that TECS provision is flexible and meets the demand of the population of Sefton and that people are aware of the availability and choice of TECS by ensuring up to date and accurate information, TECS equipment demonstration videos.
- We will ensure staff teams are well informed and can offer advice and guidance to individuals seeking TECS in their homes by developing a robust TECS training and development programme. Prescribing social care staff including social workers, occupational therapists

and front care workers will have the knowledge and digital skills they need to understand how TECS can best support people and how to help individuals' access TECS equipment.

- We will continue to work with our Liverpool City Region partners in pursuing a robust TECS training offer for all prescribing social care staff teams across the region which will ensure that they have a good working knowledge of TECS and that consideration of TECS is embedded in current assessment practice.

TECS in Community Services – Day Care, Supported Living, Mental Health Provision and Community Support

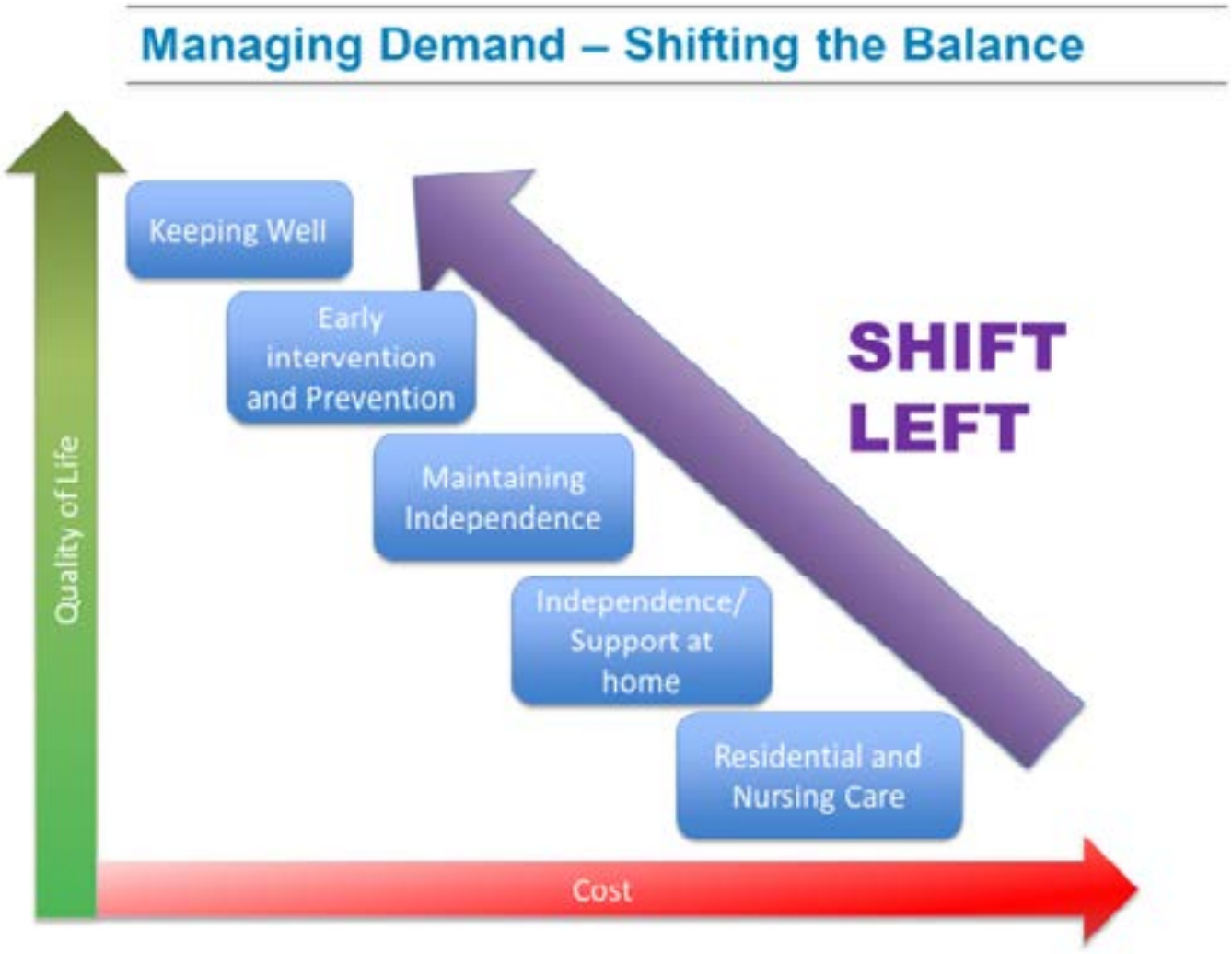
PRIORITY 5: We will make TECS the default consideration for individuals that require staff support but can share group living. We will ensure that the implementation of TECS will work in shared settings to meet the full spectrum of individual care needs.

- How TECS can be used in learning disability (LD) settings to support independent living, or how technologies can be used to connect people who feel lonely and isolated?
- Can the technology enable the person, carer or their family to do something that would not be possible without it?
- Can the technology complement the care and support already being provided by carers in certain situations?

What we will do:

- We will develop our Home Improvement Team provision to include an advisory capacity for residents looking to adapt their homes – future proofing home living areas; considering design of homes to accommodate future needs of client and incorporation of TECS in designs.
- Invite collaborations with external housing development companies that specialise in TECS and SMART home planning.

Demand Management



Adults with Learning Disabilities (Complex Support, 18-64 and Older people under Demand Management) should be supported to be as independent as possible, to be offered excellent care at home supported within their own communities. If a higher level of care is required such as complex support, then alternatives such as extra care schemes, and lower level supported living services such as key ring type schemes should be the first option. We will utilise TECS to reduce the need for people to require personal care and for them to be able to better manage

their own long-term conditions to continue to promote independence at home in the first instance.

Supported Living (SL) services enable local people to live the lives they want to lead and retain their independence. TECS can be utilised to reduce restrictions imposed by over supporting a person and creating dependency on support to improve independence and increase individual outcomes for people.

Current service provision in Sefton

According to national population estimates, the total population in Sefton aged 18-64 predicted to have a learning disability (LD) will reduce from 3,799 in 2019 to 3,594 by 2030. Of these, the total predicted to have a moderate to severe learning disability (and hence likely to be in receipt of services) will change from 861 in 2019 to 824 by 2030.

Internal predictions indicate that Sefton will continue to have an above average age of LD clients 55+ as well as younger people in transition and by 2025 we will see 350 extra clients aged 18-64 with a Learning Disability or Mental Health concern.

Sefton Council currently spends £28 million supporting people with LD (where this is recorded as their primary support need). This number will increase as young people move to adulthood and as people require independent accommodation with support as parent carers grow older (We know we have a significant number of older parents caring for this population). There are also challenges in relation to the growing number of people over the age of 65 who have a learning disability and associated frailty and an increasing number of people with complex and challenging needs.

According to national population estimates the total population in Sefton aged 18-64 predicted to have a learning disability will reduce from 3,799 in 2019 to 3,594 by 2030. Of these, the total predicted to have a moderate to severe learning disability (and hence likely to be in receipt of services) will change from 861 in 2019 to 824 by 2030.

Internal predictions indicate that Sefton will continue to have an above average age of LD service users aged above 55 as well as younger people in transition, and by 2025, we will see 350 extra people aged 18-64 with a LD or mental health concern. An identified issue is in relation to the growing number of people over the age of 65 who have a learning disability and associated frailty and an increasing number of people with complex and challenging needs.

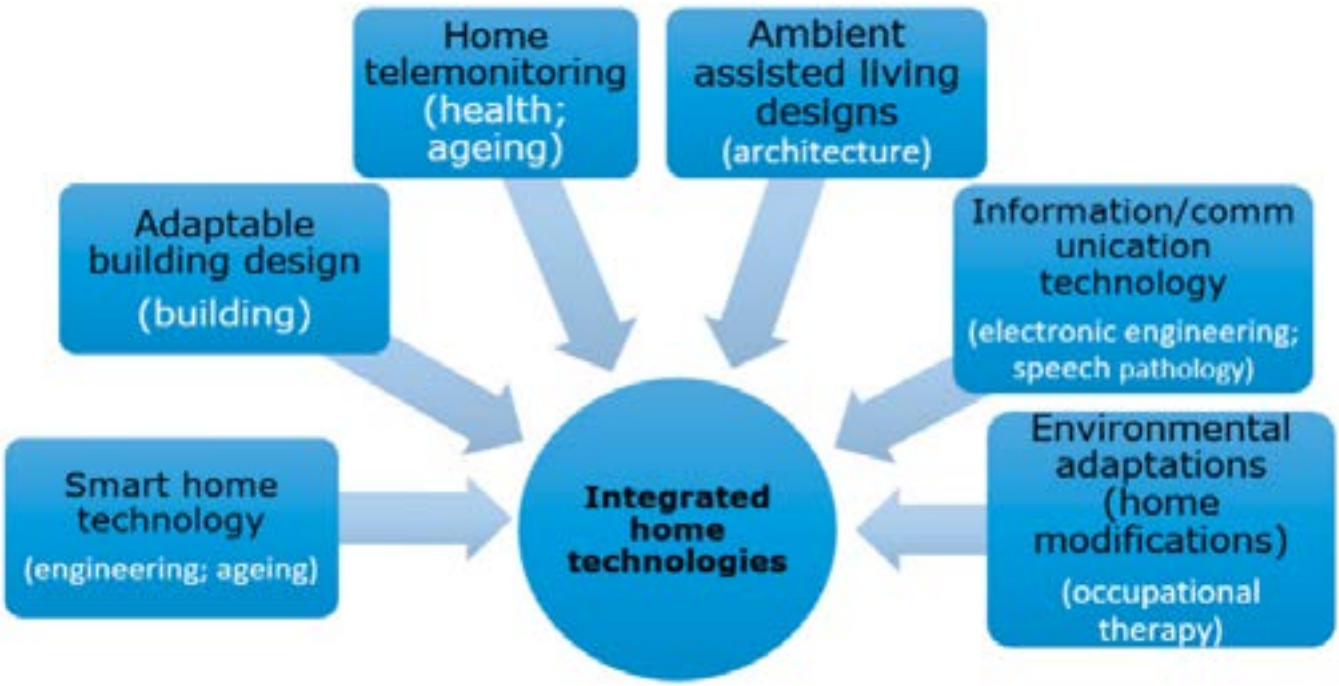
In Sefton, we want to reduce the numbers of people under the age of 65 in long-term residential care provision and look to provide alternative, appropriate support for those who need this level of care, locally in the Borough. Long term residential and nursing care should be the last resort when all other options exhausted. We are developing an enhanced short-break service for clients with complex LD's / Autism to provide better care respite and allow carers to maintain their caring role and reduce the number of admissions to residential services going forward.

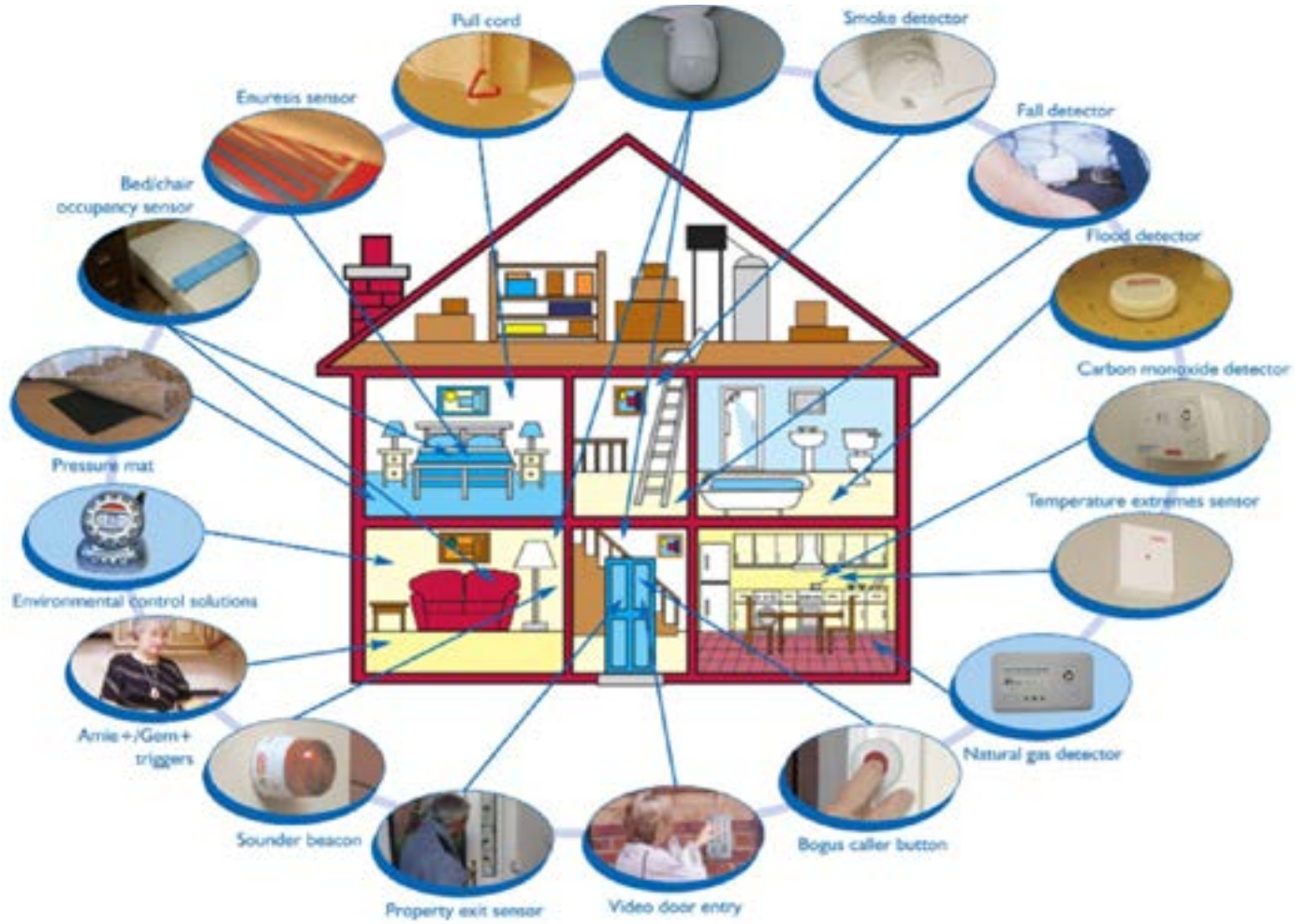
In 2021, there are approximately 626 people in Sefton with a learning disability, mental health diagnosis or physical disability that are receiving Supported Living and Community Support. Approximately 450 people are currently living in 125 supported tenancy settings (72 of these has as sleep in) and 176 people receiving Community Support. This support is currently delivered by approximately 24 supported living care providers and they are a mix of local, national and charitable providers.

1/3 of supported living services are in the North of the Borough and 2/3 of services are in the South. There are also currently 279 clients with a diagnosis of learning disability, mental health or physical disability in residential services in Sefton.

Our residents with physical disabilities, learning disabilities and/or mental health issues must also form part of this need to ensure appropriate housing provision is delivered. By ensuring we look at all options for long term supported living and short-term respite extra care developments from the outset we can ensure local need is addressed by not only inter-generational models of extra care but in the wider developments which include houses, apartments and bungalows.

SL services have, on average, over the last 24 months accommodated 526 residents across the Borough and the cost of open Supported Living services is approximately £421k per week.





Future Proofing

From 'wearables', voice-activated technology, automation, and robotics, to artificial intelligence and beyond, TECS regularly offers new opportunities to improve or transform provision and the aim is to be well placed to understand the opportunities and implement them these where the case to do so is strong.

In considering new supported living accommodation development, the Floating Support and Community Support service must be more flexible moving forward. The specific requirements or interventions that can support specific service user groups need to be identified. Helping to automate basic chores such as lighting, heating and curtains/blinds increases physical and mental well-being as well as promoting independence. Remote monitoring of boilers, pumps etc can create real and actionable insight.

Smarter housing can really make a difference and TECS creates a pathway for housing providers to start integrating a host of exciting technology. The case for smart home technology in housing has never been stronger. For example, during the COVID pandemic, when shielding took place, the ability for staff to make changes in a property remotely, protected both those vulnerable individuals in their homes and those providing the care.

What we are doing?

There are currently 72 supported living services across the Borough that have a sleep-in member of staff to provide a "safety net" of support in case of accident or emergencies during the night.

A review of these requirements is being undertaken, utilising motion monitoring sensors to assess the extent of night time activity, whether a person is required on site, or whether alternative less restrictive options can be deployed such as the use of TECS that promote a person's independence.

This would manage potential risk, rather than funding a preventative service, and further allows future innovation and development with individuals and care providers to ensure all assessed needs are met within a strengths-based approach.

What we will do

- We will ensure that all supported living properties and residential units are suitable to accommodate TECS provision as needed to support daily activities.
- We will liaise closely with all contracted housing providers to ensure that properties provided for SL tenants are easily adapted and suited to client needs to enable independent living where possible.
- For people with low, medium and high levels of need, TECS aids and adaptations can be installed easily and successfully as a bare minimum requirement. We will continue to identify SL properties that would benefit from TECS and we will regularly consult with tenants and their families, service providers, their staff teams and landlords to identify TECS to promote and enhance independent living where possible.
- We will regularly review care planning and assessments and subsequent reviews of assessment to ensure that the right TECS is recommended for individuals.
- We will review TECS that we provide to ensure that equipment and technology is updated and appropriate for all service users and that staff have the right skills to advise and recommend TECS as part of their ongoing assessment process.
- We will work closely with Fire Safety colleagues and TECS suppliers to ensure that tenants are living safely in their homes and that all TECS reflects fire and safety requirements and adhere to an agreed minimum standard.
- We will liaise with RSL providers to develop a Registered Social Landlord Social Care Pathway which will outline contractual housing obligations and we will also consider the Housing Strategy for Learning Disabilities and the Autism Strategy as part of this development.
- TECS installation and consideration of TECS being implemented in Supported Living services will be in contractual obligation/requirements for any new and existing Supported Living providers. We will review all Service Agreements and contracts in the next 12 months to enable TECS considerations and requirements as a minimum.
- We will review current properties and the suitability for TECS installation and new

builds, as standard, will have TECS installed. This will include any future mental health accommodation developments for crisis, rehabilitation, which will support the avoidance of hospital admissions and re admissions.

- We will review our day centre provision and develop TECS for those individuals who are not attending day care services due to COVID restrictions.

Tecs and Fall Prevention

PRIORITY 6: We will reduce the number of falls related hospital admissions and discharges to residential placements and some supported living models, encouraging residents and prescribing staff teams to consider the use of TECS in people's homes in line with Sefton's Early Help and prevention offer.

Falls are multifactorial and a major cause of morbidity and mortality among those aged 65 years and over in the UK. Falls and fall related injuries are a major challenge to health and care systems and to the older people who suffer them.

Key national statistics show that:

- The number of people aged 65 and over is projected to rise by over 40% in the next 17 years to more than 16 million.
- Thirty percent of people aged 65 and over will fall at least once a year. For those aged 80 and over it is 50%.
- In around 5% of falls lead to fracture and hospitalisation.
- According to Public Health England, the implementation of TECS and home adaptations can increase people's ability to perform everyday activities by 49%[5].
- Public Health England has developed a falls prevention Return On Investment (ROI) Tool, which will help to assess return on investment for a number of falls prevention interventions for older people where there was supporting evidence around both clinical and cost-effectiveness. There is a financial return on investment to the NHS and Social Care of £3.17 for every £1 invested into small home modifications and a social ROI of £7.34 for every £1 invested. Further, for every £1 invested there is a return on investment of £1.26 for the intervention addressing loneliness and social isolation in older people and an ROI of £39.11 for interventions addressing suicide prevention[6].
- There are around 255,000 falls-related emergency hospital admissions in England among patients aged 65 years and over each year. Further, an audit by the Royal College of Physicians found that fractures and falls in people aged 65 and over account for over 4 million hospital beds each year in England. It is estimated that fragility fractures cost the UK around £4.4 billion, of which 25% is for social care[7].

5 Public Health England (2018) A Return on Investment Tool for the Assessment of Falls Prevention Programmes for Older People Living in the Community. Available at: https://www.gov.uk/government/publications/falls-prevention-cost-effective commissioning

6 www.gov.uk/government/publications/health-matters-health-economics-making-the-most-of-your-budget/health-matters-health-economics-making-the-most-of-your-budget

7 https://www.gov.uk/government/publications/health-matters-health-economics-making-the-most-of-your-budget/health-matters-health-economics-making-the-most-of-your-budget

In Sefton, the issue of falls becomes even more prevalent as the over-65s share of the population is more than 25% higher than the national average and is anticipated to grow by almost a half by 2037, when the over-65s will account for 1 in 3 residents, with a consequential effect on the level of hospital admissions.

South Sefton and Southport and Formby CCGs both have a higher incidence of injuries from falls in this section of the population than either their peers or the national average. South Sefton has a higher incidence of falls than its comparator group of CCGs, with a third higher hospital admissions, and Southport and Formby rank 8th amongst its group of 11 and has 14% higher Hospital admissions.

What we are doing:

A Falls Strategy has been developed, which includes;

- Implementation of digital falls prevention/planning tools across Cheshire & Merseyside
- Development of a collaborative end to end falls pathway at place across Primary, Community, Secondary and Voluntary services, using an evidence-based approach such as Public Health England's eight-tiered approach to managing falls.
- Falls offer in Care Homes as part of the implementation of the Enhanced Health in Care Homes

There is a key role for TECS in enabling people to live independently, and to re-able and support people when coming out of hospital. TECS needs to be to be reliable so that it supports both service users and offers strong reassurance to carers so that they can continue in their caring role. It has always been recognised that the home environment is a key consideration for those with potential social care needs. Equipment, adaptations and assistive technology can support reablement, promote independence and contribute to preventing the need for care and support.

Responder services are a fundamental part of the TECS offer. This is the immediate response and aftercare that people need, rebuilding their confidence and helping them stay at home rather than needing to recover elsewhere. To achieve these aims our response needs to be of high quality and reliability, well linked in to communities.

What we will do

- We will ensure that individuals receive care at the right time in the right place, reducing acute hospital admission and effectively manage the projected increase in demand for TECS equipment and adaptations to their homes.
- We will develop clear and consistent referral pathways between intermediate care services, primary and secondary care and the Social Services, ensuring the single point of access is promoted widely.
- We will be members of the Cheshire & Merseyside Falls Collaborative which seeks to ensure an integrated end to end falls pathway across Primary, Community, Secondary and Voluntary services utilising an evidence-based approach to managing falls.

We want to put systems in place to pick up when a trend might be starting that should trigger a short intervention to prevent someone's condition from deteriorating.

Adaptations Without Delay

PRIORITY 7: We will align 'in house' TECS provision with Occupational Therapy assessments and our Home Improvement Service, expanding our TECS provision over the next 3 years to give greater choices to people to support independent living at home.

Adaptations Without Delay is a Royal College of Occupational Therapists Framework based on a robust national study that identifies that delays in delivering adaptations results in unnecessary admissions to high cost care placements, and reduces outcomes and experiences for people. It identifies that we often over complicate application process, assessment process and don't streamline process and procedure between Occupational Therapists, Home Improvement Services and Community Equipment Services. The framework allows us to explore ways of maximising the assets we have in Sefton through our Registered Social Landlord (RSL) partners, Home Improvement Service, Handy Persons Service, Community Equipment Service and Occupational Therapy service.

The House of Lords Select Committee Report on 'Ageing: Science, Technologies and Healthy Living', published January 2021, states that the Government aims to increase the availability of accessible housing. The 'Home of 2030' project, a cross-departmental initiative funded by the Government, is seeking house designs that meet a range of criteria, including being:

> *"able to respond to different and changing needs as people move through their lives ... being well set up for people to be able to care for children and ageing relatives, such as through multi-generational homes that can accommodate changing caring responsibilities."*[8]

The Report states that, many existing homes do not have adequate space to move around with walking aids or wheelchairs, and often lack loadbearing beams for the installation of hoists. Central Government has made available the £500 million Disabled Facilities Grant that is available to "help people make adaptations to their homes." The Director for Care and Transformation at the Department of Health reported that adapting a home "leads to people potentially staying about four years longer, on average, independently at home."[9]

Integrated services are needed that have established the right skills mix in the workforce in order to provide a proportionate response to reduce delays in the installation of adaptations. There is sometimes misinterpretation of legislation pertaining to the funding of adaptations by prescribing staff and a lack of awareness from individuals around eligibility for the application of a Disabled Facilities Grant (DFG). Further, there appears to be relatively little guidance on defining the

8 House of Lords Select Committee Report on 'Ageing: Science, Technologies and Healthy Living' Jan 2021

9 House of Lords Select Committee Report on 'Ageing: Science, Technologies and Healthy Living' Jan 2021

difference between simple issues and complex situations that need the expertise of an OT.

Triage and Duty systems at first point of contact can be used to identify whether the input of an OT is required to support a more proportionate and timely response. There are some situations where an OT does not need to be involved in the assessment for an adaptation. There is an assumption that if an adaptation is 'major' it is complex and must involve an occupational therapist.

The greatest demand is for adaptations such as showers, stair lifts and ramps, which are often classed as major adaptations but can often be simple and straightforward.

In 2019/20 Sefton Council's core Disabled Facilities Grant budget was £1,824,000 and the wider programme was £975,000 with planned growth in 2020/21 to £3,076,000 and in 2021/22 to £5,363,000. From 1st April to 31st October 2021 there were 183 referrals made by Occupational Therapists. During the same period 154 referrals had costs approved and 134 adaptations were completed on behalf of clients including items such as stair lifts, vertical lifts, bathroom adaptations, extensions and hoists. The wider programme activity includes: Care Home Improvement grants, increasing OT capacity, supporting Community equipment and single-handed care, installing changing places, supporting TECS in supported living, support to the development of Extra Care, wider use of the Telecare service, a retail outlet for community equipment, and short breaks review.

We want to encourage and promote more creative use of DFGs to consider TECS as part of any application to support people to remain independent in their homes, and look to create a whole path way approach to supporting our social workers and Occupational Therapists to use the service alongside other elements to support independence and reduce the reliance on more substantial packages of care or residential or nursing home placements.

What we are doing

- Sefton is working towards the standards in the Royal College of Occupational Therapist Adaptations Without Delay Report.
- We are mapping current service provision across Sefton and identify gaps in provision, delays in accessing equipment and we will work collaboratively with our partners to provide timely and effective solutions, promote DFG eligibility criteria and ensure that individuals have access to information so that they are also able to access equipment independently if needed. We will also ensure that all information is accessible and TECS is promoted from first contact.

What we will do

- We will reduce waiting times for assessments for all Sefton residents requiring major adaptations to the home and who are eligible for DFGs.
- We will provide Level 3 and 4 Trusted Assessor training and Sensory training for Community Care Practitioners working within Occupational Therapy Teams and for identified staff in Home Improvement Service, Telecare Team, Community Equipment Stores team, Triage teams, Mental Health teams and Hospital Discharge Teams, along with identified housing partners in Sefton. The Trusted Assessors will complete non-complex assessments which will help to reducing current waiting lists and it will free up OT's who will focus on more complex assessments for adaptations to the home. Trusted Assessors will be co-located in Triage and duty systems where they will be the first point of contact and can be used to identify whether the input of an OT is required to support a more proportionate and timely response.
- Extension of warranties for some adaptations such as stairlifts and hoists.
- We are planning to develop a SMART Home voucher scheme, specifically for the purchase and installation of TECS in the home if part of a more complex OT adaptations assessment where appropriate.
- We will develop Service delivery models both within our social care teams and external housing partners that are based on person-centred and preventative outcomes, and organisations need to ensure that they take a safe and person-centred approach to providing adaptations to older and disabled people.
- Individuals should also have access to flexible and responsive services, and we would encourage maximisation of this through the implementation of an online rapid self-assessment and guided advice tool at the first point of contact.
- Those with Direct Payments or Personal Budgets will be supported to purchase appropriate personalised support and equipment, and we will raise awareness around DFG and applications, and widen eligibility criteria to include TECS adaptations where possible.

Children, Young People Special Education Need (SEN) / Autism Education and Transition Years

PRIORITY 8: We will provide an opportunity for children and young people with SEN, their families and/or carers to have effective support in the home with increased use and promotion of TECS to improve mobility/safety and support independence.

As part of the Children and Families Act, Local Authorities were directed to produce a Local Offer. Sefton Council, health services and all our partners in the voluntary and private sectors are committed to working together to support the needs of children and young people with SEN and their families.

Sefton's Local Offer website provides clear and accessible information about the provision Sefton Council expects to be available locally for our children and young people from 0 to 25 who have SEN and/or disability. The Local Offer makes clear what is available from early years settings, schools (including Academies and Free Schools), colleges and other services including those from health and social care. We want to develop knowledge and skill with IT and TECS (assistive technology) in order to continue to provide specialist advice and service for individual pupils and their schools as this area continues to develop exponentially.

What we are doing

- We have worked closely with parents, carers and young people, as well as with colleagues in the services in Sefton to produce our Local Offer.
- Sefton's Local Offer website is currently being refreshed to improve user navigation and to enhance the look and feel of the website and it will be completed by the beginning of 2021. The improvements have been coproduced with young people and parents/carers.

What we will do

- We will expand use and resource of TECS to support and promote greater independent living for our Children and young people with SEN are supported at home.
- We will ensure those working with Children and Young People with SEN, and the families and young people themselves, can use TECS to provide effective support in the home through the increased use of adaptations and equipment in the home to improve mobility/safety in the home and support independence.
- We will raise awareness of DFG and the eligibility for families to apply who require and receive Children's SEN service provision.
- We will increase support offered to Looked After Children and Child in Need cases that are

not eligible for DFG and we will work creatively to use DFG funds to support a child to remain in their current placement usually a foster home.

- We will review current referral and assessment processes and ensure that TECS is considered within this process and that funding streams for equipment are clearly defined and understood for prescribing staff and that there is better aligned service provision between schools, local authority and health partners for specialist and TECS equipment.
- OT assessments for SEN / Transition Years children will include sections covering sensory and TECS assessment.

Value: commissioning, finance and budget

PRIORITY 9: We will ensure there is a readily available TECS budget with sliding scales for cashflow outlay.

2020/21 is the 11th year of the Government's programme of austerity. For Sefton, central government funding has reduced by 51% compared to 2010. Prior to the Covid-19 situation the Council anticipated that over the next 3 years (2020/21 to 2022/23) there will be a further gap in the budget of over £23 million. It will cost more to simply maintain services at their current level on the basis that prices are going up and demand for services is increasing as the older population grows. The total gross revenue budget for Adult Social Care in 2020/21 was £153 million and it is and likely to increase in future. It receives income of £594 million, resulting in a net budget of £947 million. Just over £107 m of the gross budget is allocated to the commissioning of care packages with 50% being allocated to Residential and Nursing Care provision. The Council will continue to explore all opportunities to make every pound count through the efficient delivery of services and commissioning practices in order to manage demand on the system.

What we are doing

Sefton delivers an integrated Community Equipment Service, jointly commissioned with our health colleagues, and this is delivered in-house. The service delivers an average of 3,300 pieces of equipment a month and in 2020/21 41,000 items of equipment were delivered to our residents. The Service supports hospital discharge, people to live entirely independently and support for Carers. The Minor works service is already delivered as part of the model making a more streamlined effective service for clients in need of support to remain independent. Occupational therapist from community-based teams, the NHS, Physios and Nurses will prescribe equipment.

The Council delivers several healthcare and security services under the operating banner of Sefton Arc, including Telecare, Telehealth, alarms, response and CCTV services. This in-house service provider also provides services to several other public and private sector companies and private individuals. Sefton Arc will continue to be considered as first choice provider for these services, where it maintains high quality, efficient and outcome-focused service delivery. When commissioning / procuring similar services, the Council will always consider whether those services could be provided by Sefton Arc. This consideration will always be undertaken within the context of the legal and constitutional parameters that apply to the commissioning/ procurement of services and with a focus on the quality and cost effectiveness of the service and outcomes delivered.

There is a wide range of available technologies that can be used in the home to aid independent living and to give confidence to older people—and their families—about living alone. The predominant technologies used for telecare include pendant alarms, pull cords and fall

detectors, which send alerts to family members or service providers in emergencies. There are 1.7 million telecare users in the UK but that "that figure has not moved for 10 years", even though there are over 4 million potential users.[10] In Sefton currently there are 2755 connections currently using Telecare and we have 1256 mobile/tracking devices out in the Borough.

The technology for many telecare systems is quite basic, but significant change is expected over the next few years. Most of the alarm systems use analogue technology (phone lines) to send the alerts. The digital telephone switchover in 2025 presents an opportunity for the industry, which should now "start looking beyond the pendant alarm" to "all the other technologies that are available".

For over 30 years, Sefton Careline/Sefton MBC has used TECS equipment to support those requiring care to live independently in their chosen home setting. The aim is always to balance independence with reassurance and provide tailored support which meets individuals' needs now, and in the future, ensuring that people can live independently at home for longer.

What we will do:

- Commissioning activity will build care and support offers that are outcome focused and support the needs of the individual allowing our Social Workers, OTs or Health Care Professionals to build an offer for the individual that is timely and appropriate, offering the right level of support at the right time from a range of TECS that is built around the person.
- We will ensure that the needs of individuals are well supported with TECS and we are committed to co-production. Sefton benefits from a strong network of Community and Voluntary independent groups which we will work with to ensure that we deliver on our strategic priority to embed early help and prevention in everything we do and promoting independent living through TECS. Understanding the lived experience and what matters to individuals will be reflected in all specifications and performance management frameworks.
- Planned Capital Fund Spend Allocation 2021/22 for TECS is £235k. We propose that we will use this for the expansion of TECS equipment and support that we will offer to all residents in Sefton. We will provide relevant and appropriate TECS training to all social care staff teams to ensure that consideration and utilisation of TECS is embedded in practice from the first point of contact.
- We will provide further investment in providing Occupational Therapy support with the allocation of £557k from Capital Fund planned spend during 2021/22. This will be invested in increased capacity to support uptake of major and minor adaptations and equipment and it will offer a solution to care and support needs, reducing long waiting times for occupational assessments and installations in line with Sefton's Adaptations Without Delay Delivery Plan.

10 House of Lords Select Committee Report on 'Ageing: Science, Technologies and Healthy Living'

The benefits that are hoped for include increased awareness of the use of TECS in care management, reducing the levels of demand for longer term complex packages of care that are costly and that can be avoided or delayed with early intervention and prevention objectives being prioritised.

In 2019, for Sefton, central government funding had reduced by 51% compared to 2010, and by 2022/23 it is anticipated that there will be a further gap in the budget of over £23 million. It is costing more to simply maintain services at their current levels on the basis that prices are going up and demand for services is increasing as the population grows. It is imperative that the Council continues to explore all opportunities to make every pound count through the efficient delivery of services and commissioning practices

- The council will continue to protect the most vulnerable people i.e. those who have complex care needs with no capacity to care for themselves and no other networks of support. We will also use asset-based models of practice and encourage individuals to do more for themselves and help one another to live as independently as they can for longer.

We are committed in the future to further develop jointly commissioned services with our Strategic Health partners, the CCGs. The Integrated Commissioning Group is the key vehicle for this, it is a formal sub group of the Health and Wellbeing Board and includes key commissioning, Directors and Finance representation from the Local Authority and the CCGs in Sefton. Joint commissioning will achieve economies of scale, savings and reduce duplication of services and most importantly drive improvements for our residents. The resources saved can be applied to any gaps in service delivery. This will include:

- Enabling, through established governance mechanisms, pooled resources to develop a broader joint commissioning framework across partner agencies to direct our commissioning intentions and maximise best value.
- Develop an intelligence led approach to commissioning that draws together key public funding streams to develop a broader joint commissioning framework across partner agencies.
- Ensure all stakeholders, have a voice at every stage of the commissioning cycle and provide feedback to measure and review impact and enable redesigned services that better meet the needs of our residents.

How we will work with the Market

Opportunities to work with the council are advertised through the NW Procurement portal the Chest. Our Health Partners contracting process is subject to different regulations although the NHS Long Term Plan is emphasising a move towards collaboration as opposed to competition and this has resulted in, for example, the formation of the Sefton Provider Alliance.

We want to encourage greater engagement with providers and give the opportunity to the market to hear their views before formal procurement processes, using PINS (Prior Information Notice), Bidder Events and reinvigorating regular provider forums, ensuring key stakeholders are part of the conversation.

Our detailed Adult Social Care Market Position Statement will assist in the development and procurement of models of delivery which meet the needs of the Sefton population and to enable long term business planning and stability for the provider network and which may include a partnership approach through the Sefton Provider Alliance.

Currently work is underway to look at joint health and contract management tool kits, standards, intelligence log, shared existing data sources, a move toward contract management by supplier and not singular contract, and an outcome focused contract management approach. This will support a more positive aligned approach to the market.

The main challenge faced by local authorities lies within the management of revenue to provide support. There needs to be an affordable market. There are many issues around where there are accessible budgets. Local authorities typically procure on a capital purchase model. The ever- increasing demand for TECS provision now needs to be considered and value assessment will need to be refreshed and reviewed to accommodate this. The Tech Refresh Model is a model that many companies choose to upgrade or replace certain infrastructure on a regular schedule instead of using systems until they can no longer function (software upgrade or upgrade of servers/ room units – old hardware can be recycled or upgraded and used again). This Model has worked well in the private sector and more work will need to be done by public services to investigate if this is a model that can be considered for use in the future.

What we will do:

- Frameworks should reflect TECS procurement and upgrades to software moving forward. Any future procurements will factor in TECS, with respect to how Providers will seek to utilise TECS and they will work with Commissioners on its implementation as part of their service delivery, review and development work, embedding the use of TECS within commissioning practices.
- Ensure we build in the TECS provision into other key demand management pathways such as Early Help, OT Teams, Adaptations, Extra Care and other housing for vulnerable adult developments, Reablement Teams, Support Living, Responder services, Intermediate Care, Care Homes, Home Improvement Service

- Develop Universal, Targeted and Specialised TECS packages for individuals' dependent upon their needs. This will be linked to the development of a single point of access for referrals, DFG criteria and spend and online portal development, staff training and awareness and TECS and Community Equipment Catalogue development.
- We will provide a transparent process to help procuring and reporting organisations monitor how bidders and suppliers can contribute to mitigating the effects of COVID-19 and responding to the emergency. We will also consider that the use of the National TOMs is applied with flexibility during these challenging times and with due consideration to the specific context for the contract, the ability of suppliers to deliver and the timescale over which this can take place.

Measuring Outcomes and Social Value

The principal benefits of a minimum and consistent reporting standard for social value are that it:

- Provides a consistent approach to measuring and reporting social value
- Allows for continuous improvement
- Provides a robust, transparent and defensible solution for assessing and awarding tenders
- Allows organisations to compare their own performance by sector and industry benchmarks and understand what good looks like
- Reduces the uncertainty surrounding social value measurement allowing us as a local authority, to make informed decisions based on robust quantitative assessments and hence embed social value into this Strategy and associated integrated.

What we are doing

- As part of Sefton Council's Framework for Change Programme and PSR10 Project (Commissioning and Shared Services), the Council has launched a dedicated Commissioning Academy to help staff foster a commissioning mind-set and work collaboratively with colleagues, other agencies and communities to achieve better outcomes. The aim of the Academy is to support the objectives of the Framework for Change Programme by guiding teams how to commission the right outcomes for their communities, improving staff awareness of the latest developments and innovations in commissioning practice and equipping people with the right skills to deal with the challenges facing public services.
- We are using Social Return on Investment (SROI) and Social Value tools such as TOMS to better understand economic costs and benefits and we are working closely with health and social care partners, and community led organisations to achieve the greatest sustainable

outcomes for people living in Sefton. We recognise that investment in TECS as part of our early help and prevention offer and in line with our health and wellbeing objectives can significantly reduce higher care costs further down the line.

The Ethical and Legal Considerations: Data Security And Citizen Ownership

The Internet of things (IoT) describes the network of physical objects - "things" - that are embedded with sensors, software, and other technologies for the purpose of connecting and exchanging data with other devices and systems over the Internet.[11]

The Cheshire and Merseyside Integrating Care Proposal highlights that while this will be mainly about embedding a culture of sharing data with appropriate safeguards, any legislative change is supported that clarifies that sharing data for the benefit of the whole health and care system is a key duty and responsibility of all health and adult social care organisations. This will require a more flexible legislative framework than currently exists to support further evolution and empower local systems to lead and drive that agenda.

Devices used in health and social care Internet of Things (IoT), will be collecting data about patients and customers to inform clinical teams and social workers, among others, about a range of different aspects of the person's life to improve health outcomes and support medical staff. This data collection needs to be compliant with all relevant data protection laws, National Data Guardian Guidelines and other good practice guidelines.

TECS related risks and ethical issues need to be understood and mitigated, but not become a barrier to action. TECS has the potential to threaten individuals' privacy and control. Social care and health professionals need to consider a range of ethical issues when supporting a service user in deciding whether to use these types of technology. These issues need to be considered before, during and after the installation of TECs such as sensors.

Interoperability standards are also key to any strategy moving forwards, as every device or set of devices tends to have its own portal and key to driving forwards with the sharing of data, and true citizen ownership is a way of bringing all that data together into a common platform. We will use identified National Government Open Standards Principles to support open data, IT and digital strategies as appropriate[12].

Individuals, can face a challenge retaining control over their data due to the scale, scope and complexity of systems that create, aggregate, and analyse personal health data. The inherent sensitivity of health-related data that is generated and the security risks associated with

11 https://en.wikipedia.org/wiki/Internet_of_Things

12 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/78892/Open-Standards-Principles-FINAL.pdf

connected devices require careful management, including compliance with the General Data Protection Regulation. There is also a role for voluntary guidance to help ensure good practice and that citizens are protected and reassured.[13]

What we are doing

- We follow standard best practices in general security for health and social care IoT devices.
- We implement effective authentication, deploying public key infrastructure and digital certificates which authenticate connections with the network, other devices and social care record systems and we will try to ensure data packages are not manipulated while in transit.

What we will do

- Our administrators will insulate devices that don't have built-in controls. If a device must be used for patient care, admins can turn off its capability to connect to the internet. If the device must connect, we will work with the vendor to identify where the device needs to connect and only allow those connections, creating an 'allow list'.
- We will also 'deny list' any known harmful sites from connecting to a device. System administrators will segment public networks from the rest of the network, restrict access to assets and events on a virtual Local Area Network (LAN), or segregate traffic by department.
- Legacy devices will be wrapped with gateways to secure the physical connection to the device.
- We will use the right tools that simplify IoT security. Some platforms automate the management of massive amounts of data and devices and can control authentication certificates. Manufacturers have also developed medical device tools that can identify what a device is, what data is collected from it and where it connects to the internet.
- We will ensure that IoT analytics platforms that are used by the local authority can help administrators monitor network traffic and approve or deny connections.

Next Steps

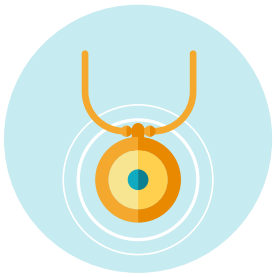
This Strategy covers a 3 Year period and it builds on Sefton's established Telecare and Community Equipment service provision. Much more development, creativity and innovation still need to be accomplished to ensure that Technology Enabled Care Solutions provision is utilised to its full extent across Sefton. We are committed to driving forward the TECS Strategic Objectives as highlighted in this Strategy and within the TECS Delivery Plan over the next 3 years (see Appendix B).

The Strategy will be monitored through Sefton's Health and Well Being Board and the Integrated Commissioning Group and the Delivery Plan will be overseen by Sefton's TECS Strategy Working Group (See Appendix C).

TECS will always be an option when considering how best to meet a person's social care needs;

13 https://iotuk.org.uk/wp-content/uploads/2017/11/IoT-in-Health-and-Social-Care.pdf

we will use TECS and equipment to provide the most appropriate support throughout the life journey, providing this at the optimal point that ensures continued well-being and minimises crisis and provides the right support at the right time to maintain independent living. Technology is around us in many different forms, and we are already using technology aids and equipment to connect with others, to support our health and well being and to assist us with daily living activities. The diagram below gives examples of everyday technology, that we may already be familiar with. In Sefton, our Digital Offer acknowledges that technology can work for everyone at any time to support independent living.


Smart Accessory Security


RunningWatch


Smart Glass


Activity Trackers


Tablet Computer


Smart Sneakers


MP3 Player


Digital Book


Healthcare Devices

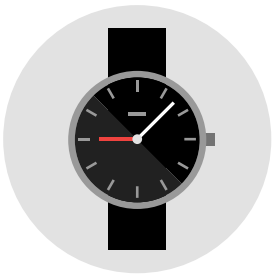

Portable Games


Smartphone


SmartWatch


MP3 Player


Digital Camera


SmartWatch


Smart Camera

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13. IoT-in-Health-and-Social-Care.pdf

Appendix A: TECS Definitions Summary

Telecare

Telecare was developed from Social Alarms services which have been supporting elderly and vulnerable people live more independently for over forty years. The original pull cord systems in sheltered schemes and dispersed alarms and pendants which are installed in the individual's home now offer a range of environmental and personal sensors which monitor their safety and well-being.

Telecare services provide a 24/7 monitoring service which will escalate alarm activations to a named responder or, if appropriate, the emergency services.

Wearable alarm systems – pendants, bracelets, watches – also enable the person using the technology to speak directly to a monitoring centre. Environmental sensors include smoke detectors, temperature extreme sensors which can detect fire or low temperature, flood detectors, door sensors, passive infrared (PIR) movement sensors and carbon monoxide detectors.

Personal sensors include fall detectors, bed and chair occupancy sensors, enuresis sensors, epilepsy sensors and medication reminders.

Telecare Services not only help elderly and vulnerable people live more independently but can also be used in conjunction with Telehealth systems to assist younger people with long term conditions or disabilities.

Telehealth

Telehealth systems support people with Long Term Conditions (LTC's) to self-manage their conditions, remain more independent, reduce hospital stays, allow early hospital discharge and reduce the dependency on primary health and GP services.

Telehealth services usually consist of a smart hub which allows the patient to enter vital signs data or have the data collected by various devices (blood pressures readers, pulse oximeters, and blood glucose monitors) which automatically transmits the readings to the hub. This data is then transmitted to a clinical or non-clinical monitoring service where the patient's health is observed, and any alerts addressed by the appropriate service.

Telehealth systems can also provide automatic coaching and mentoring to the patient through a series of questions and answers which are processed by the system's software algorithms.

Telehealth is used to support patients with Chronic Obstructive Pulmonary Disease (COPD), Chronic Heart Failure (CHF) Type 2 Diabetes, Cancer, Mental Health conditions and other long-term conditions.

'mHealth'

A number of the services described under Telehealth can also be accessed via mobile phone technology and Apps, these systems are often used by younger service users and patients to allow them greater flexibility to access these services. Another mHealth application is the use of GPS and GPRS to provide safe walking services to people with dementia, early stage Alzheimer's and learning disabilities.

Assistive Technologies (Environmental Controls)

AT is any aid that can assist the most frail and vulnerable members of our society to live safely and live well at home or in a care home environment. The role of assistive technology and how it can be used to support someone to live independently living varies greatly. Assistive Technology ranges from simple, standalone devices right through to complex, integrated systems that help a person to remain independent for as long as possible.

Assistive Technologies (AT) allow people to function as independently as possible by using devices that allow them to carry out day to day activities such as switching on lights, opening curtains, turning on the TV and using a computer though a range of switches and sensors which can be operated with only limited movement. Environmental Controls can also be used in conjunction with Telecare and Telehealth systems.

According to the Social Care for Excellence's Assistive Technology for Older People research briefing, some of the key benefits of assistive technology include:

- increased choice, safety, independence and sense of control
- improved quality of life
- maintenance of ability to remain at home
- reduced burden placed on carers
- improved support for people with long-term health conditions
- reduced accidents and falls in the home

Under the Equality Act 2010, Assistive Technology is recognised as a 'reasonable adjustment' which should be made available to prevent discrimination in a wide variety of contexts.

Telemedicine

Telemedicine is the use of video technology to enable specialists and consultants to support patients and other professionals remotely by making a diagnosis and recommending treatments. Vital signs data, x-rays and other information can also be transmitted to enable a speedy diagnosis when a patient is in a remote area or the expertise is not available locally. Telemedicine systems are mainly employed in an acute health environment.

APPENDIX B: Consultation Partners and Stakeholder Groups

TECS Strategy Working Group membership:

ICT	Telecare/ Comm Equipment	Sefton OT Service / Single Handed Care / HIS
Supp Living/Extra Care	Comms / Website/ Consultation	Mental Health
Housing	Childrens/ SEND / Transitions	CCGs and Health
Mersey Innovation	Liverpool City Region: TECS Sub Group and Digital Group	Early Help / Prevention
Community 3rd Sector	Demand Management	Sefton Council Commissioning Managers for Integrated Care, Childrens Services and Care Homes

Consultation Groups:

We consult with the following groups and these consultations will be ongoing throughout the life of this Strategy and as part of our commitment to fulfil the 9 strategic priorities highlighted throughout this document.

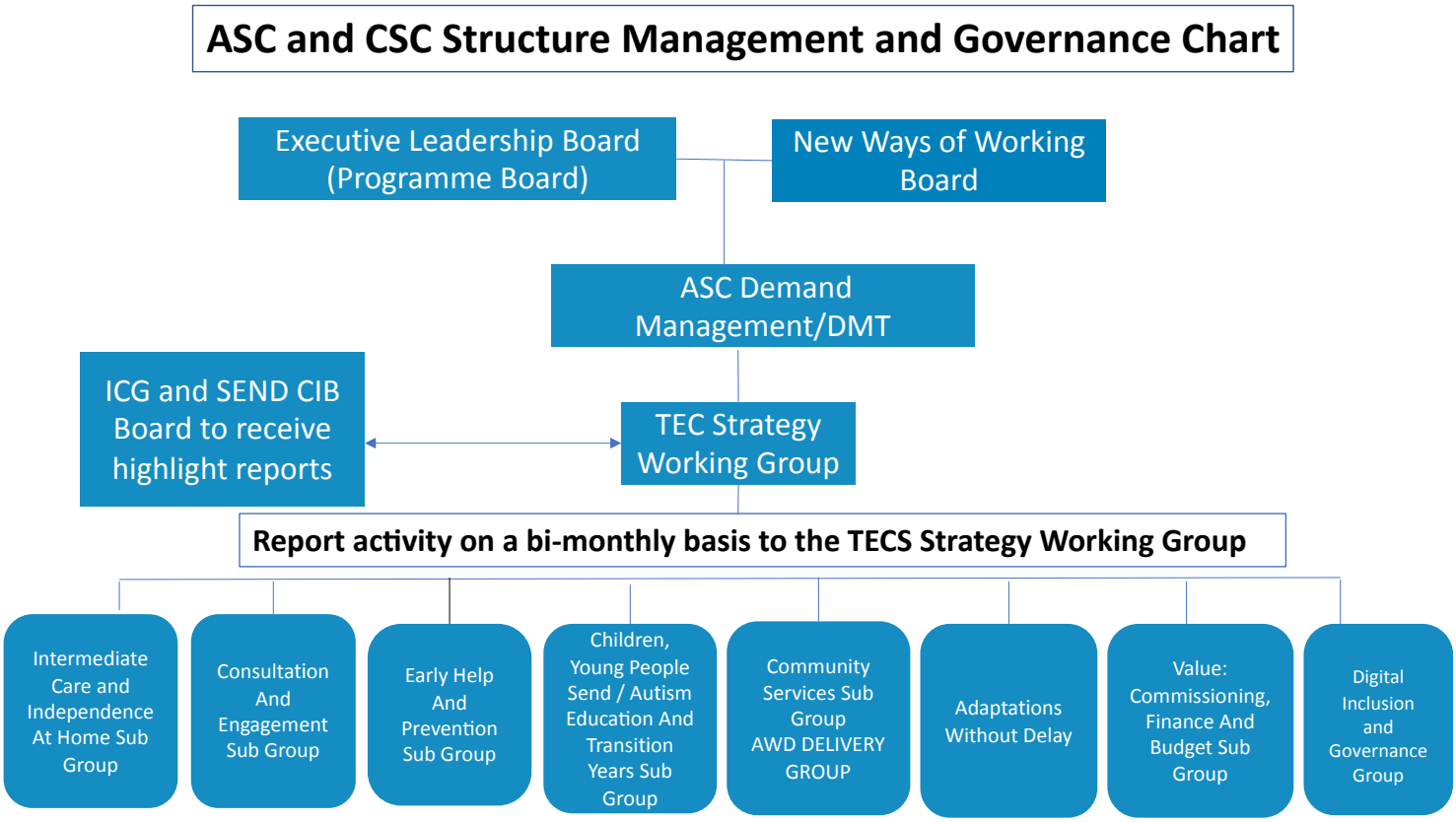
Practitioner consultations will also be facilitated with Sefton Council Social Care Teams including: Triage, Occupational Therapy, Social Work Teams from ASC and CSC portfolios.

Sefton Carers	Sefton Older People Forum	S.P.O.C.	Sefton CVS	Sefton Alzheimers Society
Sefton Dementia Friendly	Sefton Get Talking	Sefton Supported Living Providers	Housing Association Tenants Groups	Sefton Parent and Carer Forum
	Aiming High Group	Sefton Young People's Health Forum	Sefton Healthwatch	

APPENDIX C: GOVERNANCE / DELIVERY STRUCTURE

This document outlines the proposed governance delivery structure for the Sefton Technology Enabled Care Solutions (TECS) Strategy 2021-24.

It is proposed that the following governance and delivery structure be followed with the specific routes for individual decisions being based on factors such as the constitution of organisations and the financial impact. The structure will be subject to regular review to ensure that any wider new governance arrangements are implemented as needed.



Delivery / Task & Finish Groups	Strategic Priorities and Objectives	Strategy Key Themes Link
Intermediate Care/ Independence at Home/ Falls Prevention	• When designing new services, we will look at the opportunities available from TECS and seek to build these in to our offer. • The introduction of other forms of TECS such as telehealth and tele triage will be explored to support people to remain in their chosen place of home for as long as possible. • Work closely with all care home providers in Sefton to support implementation of TECS through national, regional and local initiatives • Mapping of current local / national groups and initiatives • EMIS pilot • Exploration of Falls applications • Potential procurement of technological solutions • Evaluation of Capital Improvement Grant awards • Scoping of further capital improvements – including care planning I.T. solutions • Develop a collaborative end to end falls pathway at place across Primary, Community, Secondary and Voluntary services, using an evidence-based approach such as Public Health England's eight-tiered approach to managing falls. • Develop clear and consistent referral pathways between intermediate care services, primary and secondary care and the Social Services, ensuring the single point of access is promoted widely.	• *Commissioning / Finance / Analysis* • *Residents* • *Consultation & Engagement* • *Digital development* • *Quality* • *Promotion of TEC*
Partnerships: Consultation and Engagement	• Develop approaches to consultation and engagement for all delivery projects • Formulation of Proposals on long-term engagement mechanisms • Improved access to information, advice and guidance to promote TECS • Engage with services which educate, entertain and stimulate social interaction linking people to networks and communities, to combat loneliness and social isolation. • Developing a robust TECS training and development programme. • LCR TECS Training programme development • Incorporate existing demographic data and mapping of the wider network of statutory and voluntary sector organisations that also support people to remain living independently and with whom referral pathways could be developed. • Implement an online guided advice tool for the public which will provide impartial advice about suitable TECS solutions	• *Consultation & engagement* • *Residents* • *Commissioning / Finance / Analysis* • *TECS Workforce Devt*

Early Help, Prevention and Promotion of Independence. **Children, Young People SEND/Autism, Education and Transition Years**	• Introduce TECS which encourage people to adopt and maintain a healthy lifestyle, to prevent or delay the need for support. • Ensure that people have access to information about TECS provision as part of the front door triage service, that will help residents quickly find solutions for themselves that they are often happy to self-fund. • Work with our Education partners to ensure that innovative use of technology and continuous improvement of our offer around TECS remains on the Agenda for all our schools. • Expand use and resource of TECS to support and promote greater independent living for our Children and young people with SEND are supported at home. • Review current referral and assessment processes and ensure that TECS is considered within this process and that funding streams for equipment are clearly defined and understood for prescribing staff • Better aligned service provision between schools, local authority and health partners for specialist and TECS equipment. • OT assessments for SEND/ Transition Years children will include sections covering sensory and TECS assessment. • Develop Universal, Targeted and Specialised TECS packages for individuals' dependent upon their needs.	• *Quality* • *Workforce development and training* • *Commissioning / Finance / Analysis* • *All Age Strategic priorities*
Community Services : Day Opportunities/ Supported Living/ Mental Health	• Develop Home Improvement Team provision to include an advisory capacity for residents looking to adapt their homes – future proofing home living areas. • Invite collaborations with external housing development companies that specialise in TECS and SMART home planning. • Ensure that all SL properties and residential units are suitable to accommodate TECS provision as needed to support daily activities. • Liaise closely with all contracted housing providers to ensure that properties provided for SL tenants are easily adapted and suited to client needs to enable independent living where possible. • Continue to identify SL properties that would benefit from TECS • Regularly review care planning and assessments and subsequent reviews of assessment to ensure that the right TECS is recommended for individuals. • Liaise with RSL providers to develop a Registered Social Landlord Social Care Pathway which will outline contractual housing obligations and we will also consider the Housing Strategy for Learning Disabilities and the Autism Strategy as part of this development. • Review our day centre provision and develop TECS for those individuals who are not attending day care services due to COVID restrictions.	• *Supplier engagement* • *Commissioning* • *Future proofing* • *Quality* • *Consultation & Engagement*

Adaptations Without Delay	• Encourage and promote more creative use of Disabled Facilities grants to consider TECS as part of any application to support people to remain independent in their homes • Map current service provision across Sefton and identify gaps in provision, delays in accessing equipment and we will work collaboratively with our partners to provide timely and effective solutions, promote DFG eligibility criteria and ensure that individuals have access to information so that they are also able to access equipment independently if needed. • Extension of warranties for some adaptations such as stairlifts and hoists. • Service delivery models both within our social care teams and external housing partners that are based on person-centred and preventative outcomes and organisations need to ensure that they take a safe and person-centred approach to providing adaptations to older and disabled people. • Implementation of an online rapid self-assessment and guided advice tool at the first point of contact.	• *Quality* • *Commissioning* • *Workforce Development* • *Accessible information* • *Consultation and engagement* • *Expansion of Digital offer*
Commissioning and Finance	• Development of revised contract and service specification to include TECS • Scoping of current Commissioners activity / commissioning arrangements • Commissioning activity will build care and support offers that are outcome focused, offering the right level of support at the right time from a range of TECS that is built around the person. • develop a broader joint commissioning framework across partner agencies to direct our commissioning intentions and maximise best value. • Ensure all stakeholders, have a voice at every stage of the commissioning cycle and provide feedback to measure and review impact. • Develop joint health and contract management tool kits, standards, intelligence log, shared existing data sources, a move toward contract management by supplier and not singular contract, and an outcome focused contract management approach. • Any future procurements will factor in TECS, with respect to how Providers will seek to utilise TECS and they will work with Commissioners on its implementation	• *Integrated Commissioning* • *Consultation and engagement* • *Scoping suppliers and future proofing*
Digital Inclusion and Governance Group	Overarching Digital Strategy – objectives and activity related to TEC Strategy activity and progression. Reports to New Ways Of Working Board	

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Sefton Council

NHS
South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

31/08/2021

Dear Health and Wellbeing Board Member,

Re: Southport and Ormskirk Hospital NHS Trust, Care Quality Commission Inspection.

Please see enclosed a report to the Board which details the latest Care Quality Commission Improvement Plan Report received by the Southport and Ormskirk Hospital NHS Trust Quality & Safety Committee (QSC) in June 2021. Southport and Ormskirk Hospital NHS Executive Director of Nursing, Midwifery and Therapies, Bridget Lees will present the report to the Board at the September meeting.

Kind Regards,

Eleanor Moulton.

Integrated Social Care and Health Manager.

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Title of Meeting	**QUALITY AND SAFETY COMMITTEE**	**Date**	**28 June 2021**
Agenda Item		**FOI Exempt**	**NO**
Report Title	**CQC UPDATE**		
Executive Lead	Bridget Lees, Director of Nursing, Midwifery and Therapies		
Lead Officer	Simon Regan, Deputy Director of Quality, Risk and Assurance		
Action Required	☐ **To Approve** ✓ **To Assure**	☐ **To Note** ☐ **To Receive**	

Purpose

To provide an update on progress against the action plan following the recent CQC inspection and other engagement with CQC.

Executive Summary

The report provides an update on the Care Quality Commission (CQC) action plan following the unannounced focussed inspection at the Trust on 3rd March 2021.

CQC identified seven actions we 'should do' to prevent the Trust from failing to comply with legal requirements in the future. However, it's positive to note that there were no 'must do' actions or breaches of regulation identified.

The seven should do recommendations have been reviewed and actions identified to demonstrate continuing improvement. In addition, there have been 10 actions completed in the Medicine division following positive external assurance as part of the inspection.

A date is being sought for a quality assurance panel to finalise updates on all actions.

Recommendations

The Quality & Safety Committee is asked to note current position of the action plan.

Previously Considered By:

☐ **Finance, Performance & Investment Committee**	☐ **Quality & Safety Committee**
☐ **Remuneration & Nominations Committee**	☐ **Workforce Committee**
☐ **Charitable Funds Committee**	☐ **Audit Committee**

Strategic Objectives

- ✓ **SO1** Improve clinical outcomes and patient safety to ensure we deliver high quality services
- ✓ **SO2** Deliver services that meet NHS constitutional and regulatory standards
- ☐ **SO3** Efficiently and productively provide care within agreed financial limits
- ✓ **SO4** Develop a flexible, responsive workforce of the right size and with the right skills who feel valued and motivated
- ✓ **SO5** Enable all staff to be patient-centred leaders building on an open and honest culture and the delivery of the Trust values
- ✓ **SO6** Engage strategic partners to maximise the opportunities to design and deliver sustainable services for the population of Southport, Formby and West Lancashire

Prepared By:	**Presented By:**
Simon Regan	Simon Regan

Care Quality Commission (CQC) Update – June 2021

1. BACKGROUND

The Care Quality Commission (CQC) carried out an inspection at the Trust between 10th July 2019 and 1st August 2019 and a well-led inspection between 20th and 22nd August 2019. The subsequent inspection report was published on 29 November 2019 where the Trust received a rating of Requires Improvement (RI).

An improvement plan was developed following the outcome of the inspection and progress has been monitored at Quality and Safety Committee and Trust Board.

CQC carried out and unannounced responsive inspection at the Trust on 3rd March 2021 and CQC published the inspection report on 13th May 2021. A copy of the full report was provided to the committee at the last meeting.

There were no breaches of regulation identified. However, there were 7 actions the CQC recommend the Trust should take.

This report provides an update on progress against the action plan following the 2019 inspection and additional 'should do' recommendations following the inspection in March 2021.

2. OVERVIEW OF INSPECTION FINDINGS

During this inspection, the Trust was inspected but not rated. The unannounced focused inspection was undertaken following information of concern received from the public.

The inspection was focussed on the Medical Care core service which includes medical wards and departments.

The inspectors noted in the report that:

- Patients are treated with compassion and kindness and their privacy and dignity is respected, and takes account of their individual needs
- Safety incidents are investigated and any resulting actions are implemented and monitored, and lessons learned are appropriately shared
- Staff say they feel respected, supported and valued and can raise concerns without fear
- Leaders have the skills and abilities to run the service, and patients and staff think they are approachable
- A small number of instances had been identified where a family had not been involved in meaningful conversation about their relative's care and treatment, however a recent audit demonstrated improvements in this area
- Assessments around the risks of patients falling have improved since the last inspection and staff identify and act upon patients at risk from their health further deteriorating, however staff don't always update risk assessments for each patient
- The service does not always have enough substantive medical staff, although locum and bank staff and new roles have been created to keep patients safe until long-term recruitment can be resolved
- Consultants lead daily ward rounds and are on site at weekends, with on-call consultants available during out of hours periods - an improvement in cover since the last inspection

- Nursing, medical, and other health professionals were found to keep separate patient records, but it was noted the Trust is continuing towards implementing electronic patient records to support record-keeping
- Patients have enough food and drink to meet their needs and improve their health, however inspectors found staff don't always complete patient fluid charts, although this has improved from the last inspection
- Staff provide emotional support and understand patients' personal needs and had provided contact with families and carers while visiting had ceased during the pandemic
- Complaints are treated seriously, patients are included in the investigation of their complaint, and lessons are shared with all staff

Outstanding practice

The medical care service had undertaken a quality improvement project in partnership with the local hospice to look at how fundamental care could be improved, based on the ethos of individualised patient centred care as experienced on the Oasis ward during wave one of Covid-19.

The remit of the team was to support staff and develop skills in relation to the delivery of the fundamentals of care and help develop holistic patient centred care as experienced on the Oasis ward. The Oasis team was also supporting the review and launch of the Care Certificate.

Areas for improvement

In the report, CQC identified seven areas for improvement where they identified the Trust 'should' take action. An overview is presented below of the actions against those areas and how they will be monitored (**in Green**).

The Trust should continue to improve the review of patient risk assessments. **This programme of work will be taken forward as part of the Trust quality priority programmes for 2021-22.**
The trust should continue to improve the involvement of patients and their families in decisions regarding care and treatment where DNACPR is considered. **The Trust will continue the improvement work through 2021-22 via the Resuscitation Committee which demonstrated an improvement in DNACPR decision-making in January 2021.**
The Trust should continue towards electronic patient records to promote accuracy of holistic record keeping. **The Trust has revised and implemented its Digital Strategy and has introduced an integrated communication platform for any web device to promote delivering faster clinical communication, improved governance, better collaboration and safer care.**
The Trust should continue to improve discharge arrangements to ensure safe patient discharge. **The Trust has initiated quality improvement events on safer discharge of patients during Q4 developing a revised discharge checklist, improved communication with provider stakeholders and patients; quality discharge forums with providers and follow up welfare checks of patients after discharge.**

The Trust should continue to act to address the high number of registered and unregistered nursing vacancies. **By the end of 2020/21, we have achieved the most improved vacancy rate for registered and non-registered nursing and midwifery staffing roles for several years. The international nurse recruitment work has supported this and we are on track to realise 92 nurses by the end of June 2021. However, we recognise the Covid-19 pandemic has led to some delays.**
The Trust should continue to improve the assessment of the nutrition and hydration needs of patients including the accurate completion of fluid and nutrition charts. **This action has been carried forward as one of the quality priorities programme of work for 2020-21.**
The Trust should continue to address the number of medical staffing vacancies across the medical care service. **During 2020-21 we have significantly reduced the number of medical vacancies, starting with 59, and ending the year with 27. Whilst this is a significant achievement, we need to ensure that we maintain the focus on filling these vacancies and are working a number of methods to generate applicants. This has involved working with partner organisations to generate joint posts with academic elements, extending the number of recruitment agencies we work with to source candidates for our difficult to fill roles and exploring how we can offer development opportunities to develop the talent within the organisation for the future.**

3. PROGRESS AGAINST OVERARCHING ACTION PLAN

As a result of the inspection, we have reviewed the full report and current position alongside the 2019 action plan to recognise some of the positive external assurances following this inspection.

Seven new actions have been added as a result of the recent CQC inspection and actions are being taken as shown above. A status update is provided below subject to validation at the Quality Assurance Panel.

A date is being sought for a quality assurance panel to finalise updates on all actions and get a full update on all other actions.

	April 2021			May 2021			Change
Rating	**Must Do**	**Should Do**	**Total**	**Must Do**	**Should Do**	**Total**	
Completed	6	48	54	11	53	64	+10
Progressing on schedule	24	41	65	19	43	62	-3
Slightly delayed and/or of low risk	1	3	4	1	3	4	
Significantly delayed and/or of high risk	0	0	0	0	0	0	
TOTAL	**31**	**92**	**123**	**31**	**99**	**130**	**+7**

4. CQC ENGAGEMENT

We continue to have regular engagement meetings with the CQC via MS Teams and we recently met with CQC on 10th June 2021. At the meeting we discussed:

- Update on Trust recovery and restoration plans
- Update in relation to Covid-19 pandemic / current trust position on compliance / key risks
- Update in relation to specific incidents
- Update on any governance process or senior leadership team changes

5. RECOMMENDATIONS

The Quality & Safety Committee is asked to note the current position against the action plan following the CQC inspection in March 2021.

6. REFERENCES

CQC Inspection Report – Southport and Ormskirk Hospital NHS Trust – Southport and Formby District General Hospital – Medical Care (including Older People's Care). Published 13/05/2021

https://api.cqc.org.uk/public/v1/reports/e9ed1194-4dbc-4aa3-ab85-1c640e1b6d9e?20210513010517

Report to:	Health and Wellbeing Board	**Date of Meeting:**	8 September 2021
Subject:	Children's Social Care Workforce Review		
Report of:	Executive Director of Children's Social Care and Education	**Wards Affected:**	(All Wards);
Portfolio:	Cabinet Member - Children's Social Care Cabinet Member – Regulatory, Compliance and Corporate Services		
Is this a Key Decision:	No	**Included in Forward Plan:**	No
Exempt / Confidential Report:	No		

Summary:

To agree additional posts within the structure of Children's Social Care. The additional posts outlined in this paper aim to provide some further injection into the workforce and begin further improvements in practice for children, as well as addressing costs.

The following report is for the Health and Wellbeing Board's Information, and was presented to Cabinet on the 2nd September.

Recommendation(s):

To confirm in consultation with the Cabinet Member – Children's Social Care and Cabinet Member – Regulatory, Compliance and Corporate Services that delegated authority be given to the Executive Director of Children's Social Care and Education Excellence and the Executive Director Corporate Resources and Customer Services to proceed with adaptations to the model of the department.

Reasons for the Recommendation(s):

Sefton Metropolitan Council is committed to delivering the best services for our most vulnerable children and families. There is a commitment by Members and Officers to make rapid improvement in the delivery of these services. There is a shared ambition for good and outstanding rated services.

Over the last 6 months a significant amount of diagnostic work has been undertaken and triangulation of the quality of services has been informed through the OFSTED focused visit of March 2021 and previous inspections into children's services and the experience of children in receiving those services. The Council accepts the issues raised by OFSTED in their visit and wishes to improve outcomes for children and families.

The Improvement notice issued by the DfE in June 2021 has led to the establishment of an Improvement Board, with an Independent Chair. The notice lasts for 12 months and is supported by a DfE Advisor. The activity and recommendations are not limited to this 12-month notice because the request and design of the services aims to provide long term sustainability, continuous improvement and capacity to manage increased demand for services. The recommendations are based upon "what good looks like" and to address critical issues in the delivery of successful outcomes for children.

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

N/A

What will it cost and how will it be financed?

(A) Revenue Costs

At the Cabinet meeting of July 2021, members agreed to the creation of a budget of £1.5m for Childrens Services for increased staffing levels. To date some temporary resources have been brought into the service that will be the first call on this amount.

The Phase 1 staffing proposal contained within this report will have a part year effect in this year and at this stage it is estimated that this will also be able to be funded by this temporary £1.5m allocation.

The full year effect of the Phase 1 structure will be £2.3m from 2022/23. This demand pressure will be built into the council's medium term financial plan for the period 2022/23 to 2024/25 and this will be reported to both Cabinet and Council in the autumn of 2021. The ongoing cost of the structure will therefore need to be met from options presented through the local government finance settlement or savings made within the councils existing budget. This will be included in the budget report for 2022/23 for council decision and will follow a similar path to previous demand led pressures which are identified mid year and have a longer term impact.

In addition to the staff requirement within Childrens social care there is also a need to increase resources in Early help (for a period of 6 months) and legal services (for a period of 2 years)- these costs will be met from existing cost of change resources or additional funding that the council already holds and will be subject to delegated decision.

(B) Capital Costs

N/A

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets): This report has staffing implications therefore the agreed processes and engagement with staff and Trade Unions will be followed. There will also be additional resource implications such as IT equipment.
Legal Implications:

Equality Implications:
There are no equality implications.

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 report sets out how the service supports children and young people and protects children at risk of harm.
Facilitate confident and resilient communities: Children's social care work with children and their families to improve outcomes for children
Commission, broker and provide core services: Children's Social Care supports the aspiration for all services for children to be good or better.
Place – leadership and influencer: N/A
Drivers of change and reform: N/A
Facilitate sustainable economic prosperity: N/A
Greater income for social investment: N/A
Cleaner Greener: N/A

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD.6493/21) and the Chief Legal and Democratic Officer (LD.4694/21) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

None

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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

Principles and Rationale for Additional Capacity:

1.1 Through diagnostic we have followed the journey of the child through the system, in other words the ability for services to effectively respond and meet children's needs at the earliest opportunity

1.2 Staff engagement has also occurred to look at the barriers and issues to delivering quality services in a timely and effective way.

1.3 By doing these things we have established gaps in function, capacity and barriers to meeting key activity.

1.4 The request is cognisant of the established model and does not propose a restructure but rather an adaptation and addition of resource which will drive quality and meet needs of children, families and the workforce. Any changes will be subject to appropriate consultation with Trade Unions and employees and subject to the existing policies that operate in respect of employees.

1.5 This request has been made as part of the development of a business plan/ vision for sustainable quality children's services over a 2021/23 financial cycle. The evidence bases for this are:

- Diagnostic and advice from OFSTED inspections and Partner in Practice reviews. (Cheshire West are the regional Partner in Practice which is a DfE collaboration between authorities to support practice improvement).
- Reviews of strengths and weakness in the social care delivery have been made since the 2016 Inspection of Local Authority children's services known as ILACS. We are due a repeat of this type of inspection and it can occur anytime from September 2021.
- Learning from complaints on service delivery and an analysis of service delivery issues.
- Workforce engagement sessions around practice issues and tools to do the job.
- Statutory compliance and functions.
- Data and finance analysis on areas of greatest spend, especially high cost placements and permanence.

1.6 In terms of the workforce, a phased approach is being considered and phase one is recommended on the basis that a wholescale restructure is counterproductive. A transformation of this sort would take at least 12 months to prepare and launch effectively. The timing of this is not aligned with our need to make immediate improvements. Staff need to see immediate relief in capacity and positive outcomes and there are many areas of the service where the structure works well but where more capacity is required to address demands.

1.7 The phase allows us to modify our capacity and take stock of how improvements have provided workload relief and better outcomes without necessarily disrupting existing arrangements.

1.8 Additionally, with the sequencing of the phases especially around Placement Commissioning and management of children in care cohorts in high cost arrangements, we can begin to reduce the spend in this area. Financially this is the biggest area of potential efficiencies and improved quality.

1.9 The other additional capacity in phase one provides for our workforce support and timely interventions for children which supports our ambition around a stable and permanent, high skilled workforce.

1.10 Phase 1 is key in providing critical support and improvements into the service. This means ensuring that there is function in the service which meets statutory compliance. These are also “spend to save” initiatives on workforce recruitment retention and permanent staff and reducing high cost packages and numbers of children in care. Subject to Council approvals a review of phase 1 will be undertaken before phase 2 is instigated to ensure it is providing effective assistance to children and families and is providing the necessary support to meet the OFSTED visit recommendations and the financial support is contained within the available resources for 2022/23 and beyond.

Phase 1

- Ongoing recruitment of social workers - this should continue throughout all phases
- Assistant team managers in social care locality teams
- Additional administrative capacity
- Case manager - overseeing care proceedings and Public Law Outline
- Additional team within the fostering service for assessment of new foster carers to develop in-house capacity, adoption support function and a support service for the assessment and support of Special Guardianship placements, Kinship and connected carers
- Family Support workers (children social care locality teams and corporate parenting)
- Pilot an assessment team within First Response and Multi-Agency Safeguarding Hub known as MASH.

Phase 2:

- On-going recruitment of social workers
- Development of the assessment team, this will be tested through piloting in the first instance
- Assistant team managers for other teams (i.e. corporate parenting, assessment team)
- Creating one family support worker per team for the remaining teams (for those teams who are identified that require support workers i.e. Children with Disability.
- Recruitment of an administrative manager.

Phase 3:

- On-going recruitment of social workers
- potential for a commissioned contact service to provide capacity but to review how we deliver some of our services
- Permanent recruitment to some posts currently filled by interim staff at a senior level such as the Executive Director of Children’s Social Care and Education.

2. The Financial Case

2.1 Members will recall that within the Council's outturn report of July 2021, a recommendation to create a £1.5m budget to increase staffing levels within the service was agreed. To date some additional capacity has been brought into the service and this will be funded from that sum.

2.2 If agreed, the phase 1 proposal will start in the current year and it is estimated that the part year effect of this could be up to £0.970m. It is estimated at this time that this can be contained within the £1.5m already approved.

2.3 The full year effect of the phase 2 structure is estimated to be £2.3m. As with previous years, when such a pressure is identified in year that is unavoidable, the Council reflects this immediately in its Medium Term Financial Plan (MTFP) for the following 3 years. As a result this future potential cost will be reflected in the upcoming MTFP that will be presented to Cabinet and Council in the autumn of 2021. Following this the Council's budget report for 2022/23 will reflect this cost and future financing which will be subject to decision at Budget Council. The additional cost will need to be met from either the options presented in the local government finance settlement or savings from existing budgets. With the additional investment in staffing it is anticipated that over the next 2-3 years the council's placements and packages budget which has been under unprecedented pressure could reduce. If this is the case, this will reduce the funding that needs to be found however this cannot be defined at this stage therefore this will be reported in future to members and will net off against this future budget increase. All additional costs will be contained within the budgets identified in this report

2.4 The proposals and costs reflected in this report reflect those in relation to Children's Social Care only, however additional support is also required in Early help (for a period of 6 months) and Legal Services (for 2 years to reflect increased caseload). As these are temporary posts, it is proposed that these teams will be funded from existing resources eg cost of change budgets or other external funding sources- these allocations will be subject to agreed delegations

3. Conclusion

3.1 The whole adaptions and additions to the workforce are proposed to be undertaken over three phases. The additional posts outlined in this paper are the first of those three, which will aim to provide some initial injection into the workforce and begin some improvements in practice, outcomes for children as well as driving down cost. Each phase will be reviewed to understand the impact this has on children and families, workforce and outcomes and the costs will be reviewed to ensure it sits within the available financial framework.

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