Sefton Partnership

NHS
Cheshire and Merseyside

Sefton Plan

2023 - 2025

Contents

Introduction

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

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

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

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

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

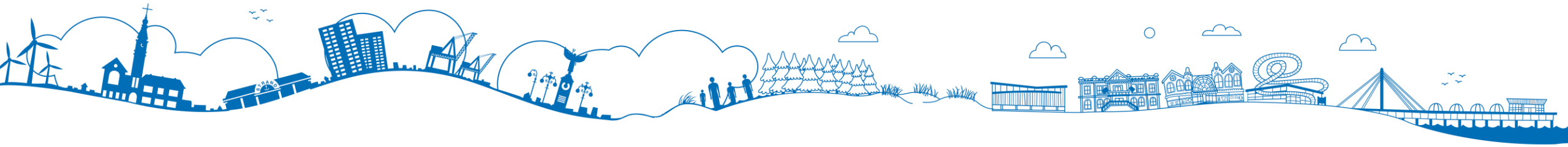
A new two-hour urgent community response service that has been highly effective in reducing the need for our most vulnerable patients to be admitted to hospital

Introduction

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

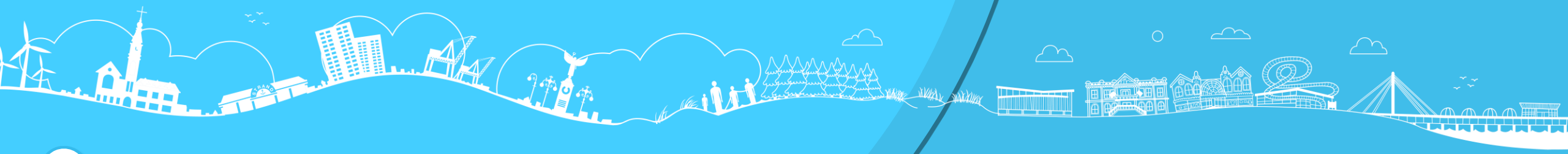
Given that health and life chances are impacted by a wide range of factors, **we know that we will only achieve our objectives by strengthening how we work together as a Partnership over the next two years.**

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

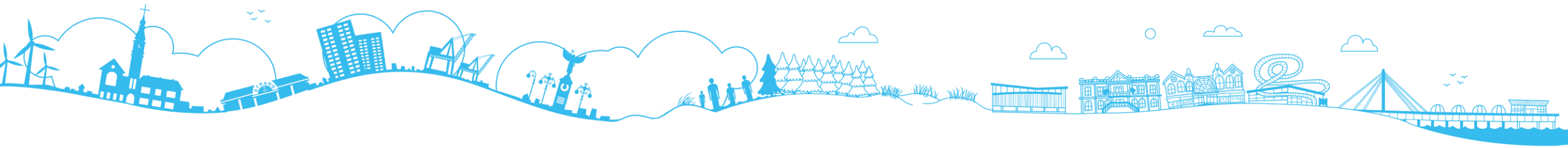


Our starting point in 2023

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



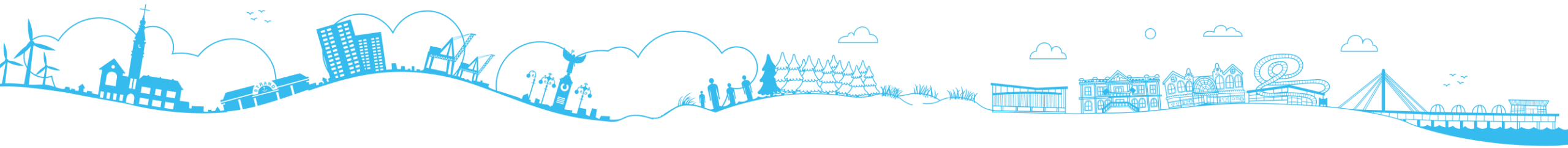
Our vision



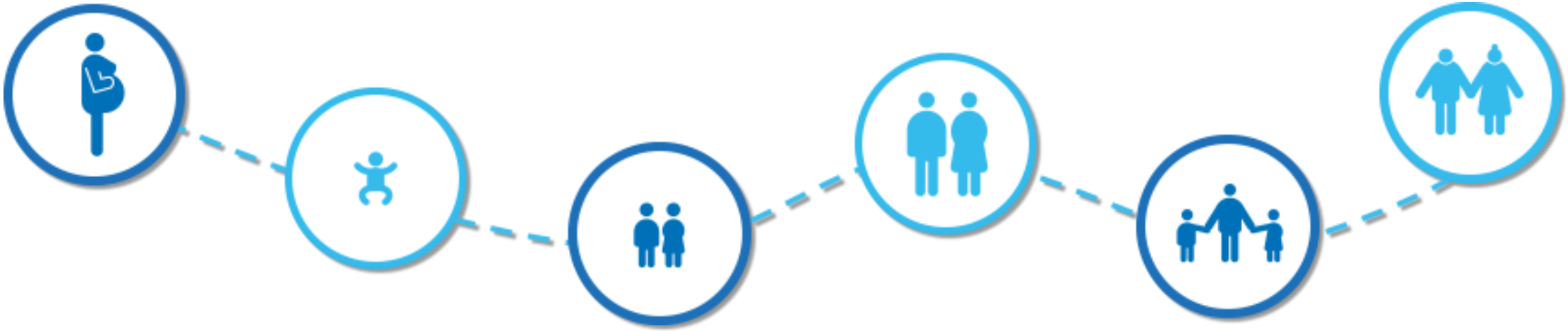
Our vision

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

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



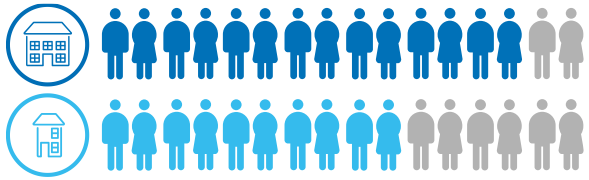
Our vision



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

Our vision

Theme 1
Health inequalities



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

Theme 2
Service transformation

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

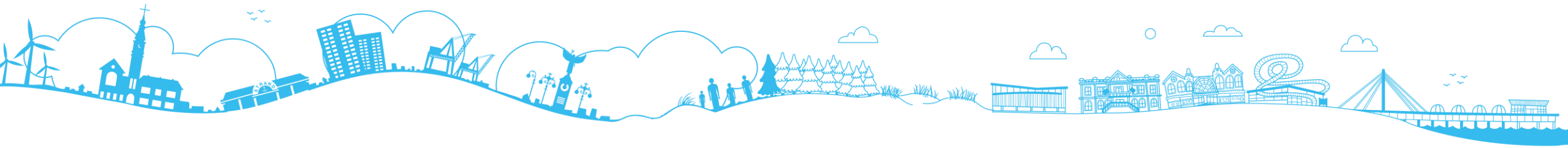
Theme 3
Community first

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

Our vision

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

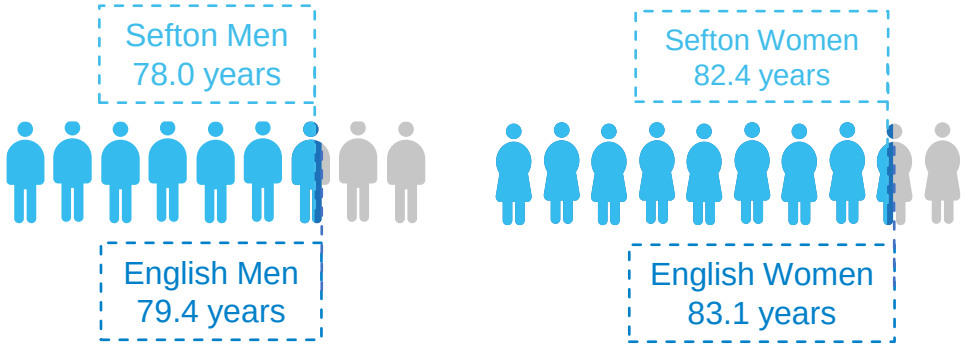
Our population



Our population

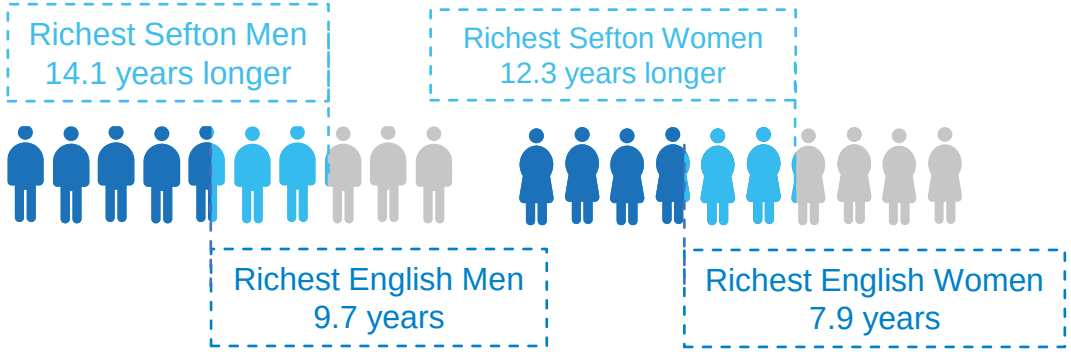
Sefton is unhealthier than England

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



Sefton is much more unequal than England

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



Our population

Why?

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

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

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

Our population

Sefton has a larger than average population of senior residents.

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

The biggest causes of poor health in Sefton

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

The biggest risks for long-term illness in Sefton

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

Our population

The big root causes of poor health in Sefton

Poverty
Too high cost of living

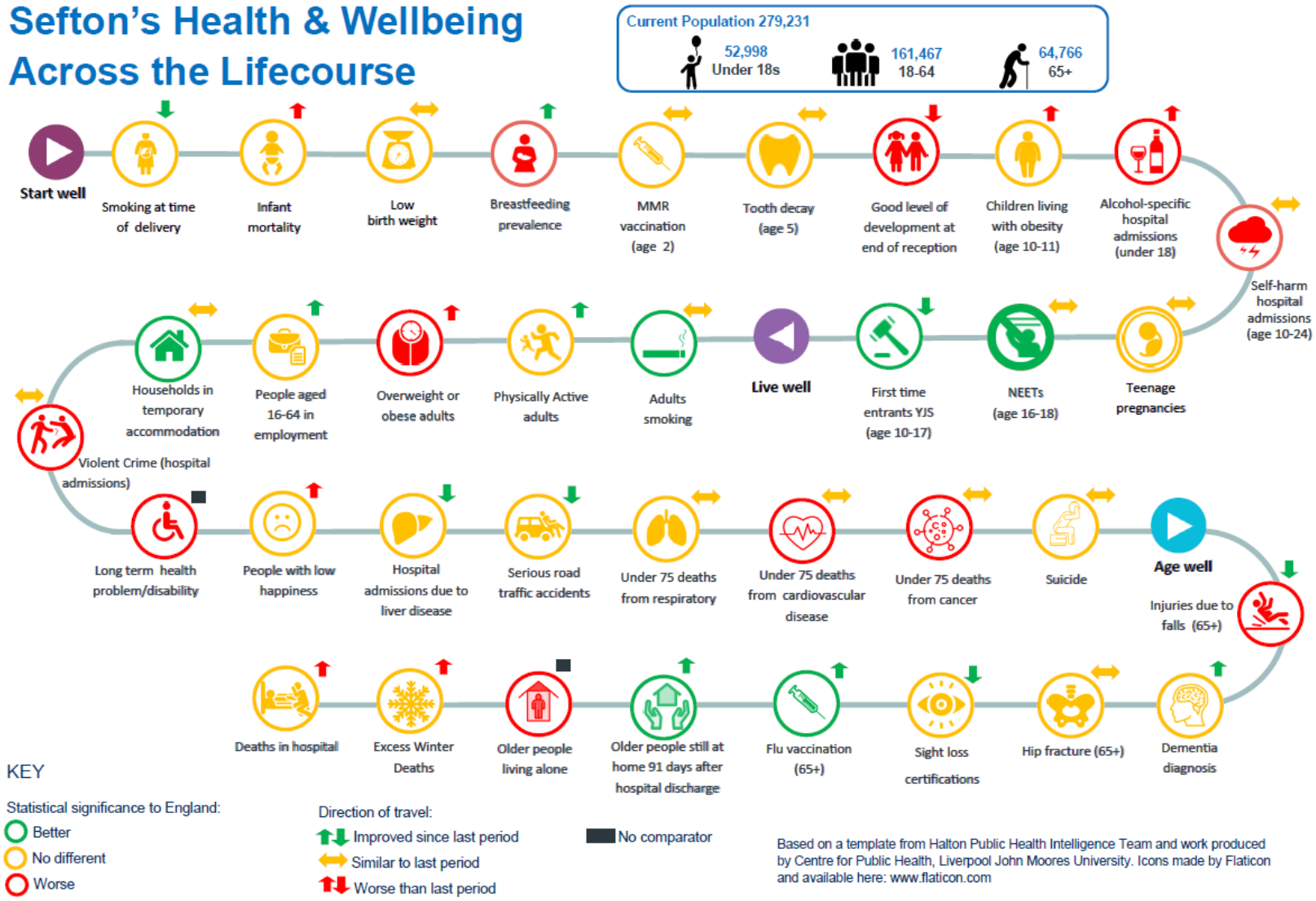
Social
Isolation, loneliness

Housing
Problems with poor housing, neighbourhood environment, transport

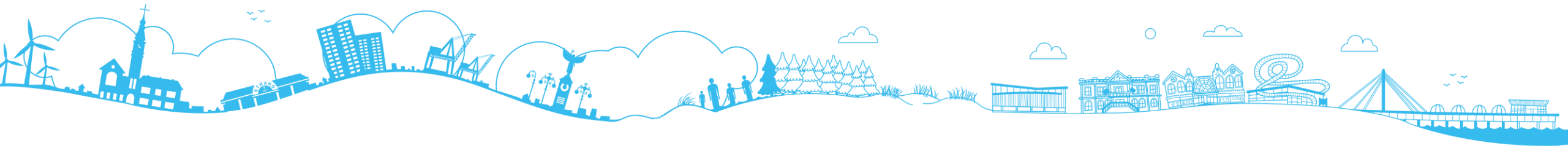
Education
Disadvantages in education and employment

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

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



Our achievements



Our achievements

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

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

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

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

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

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

Our achievements

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

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

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

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

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

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

Our achievements

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

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

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

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

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

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

Our achievements

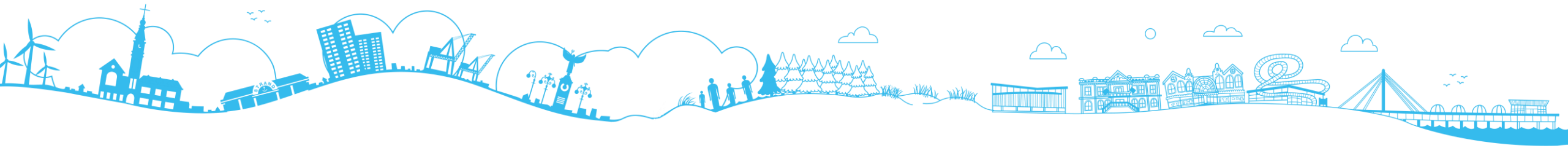
We have been working together with Knowsley and Liverpool to improve interpreter services for D/deaf patients.

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

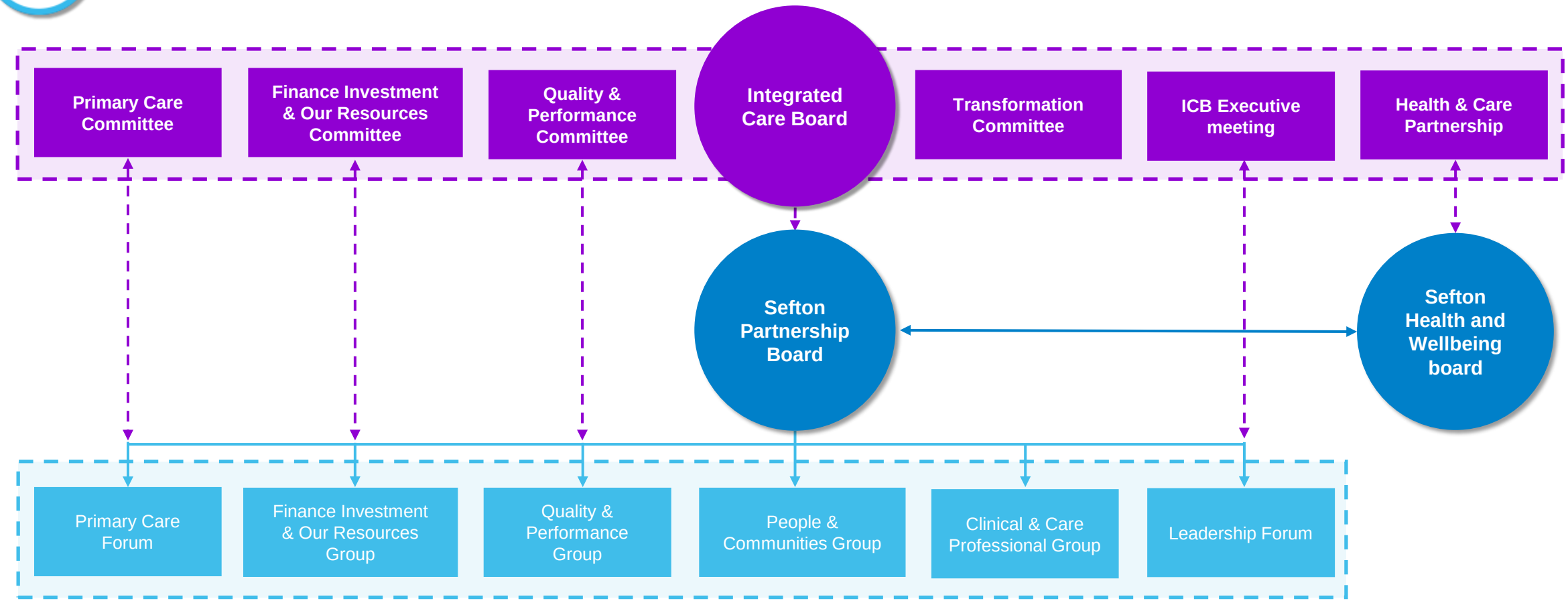
We are working with our local GP practices to improve access based on their views and experiences of their patients. More than 10,500 Sefton residents responded to our initial GP access survey.

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

Our governance



Our governance



Our governance

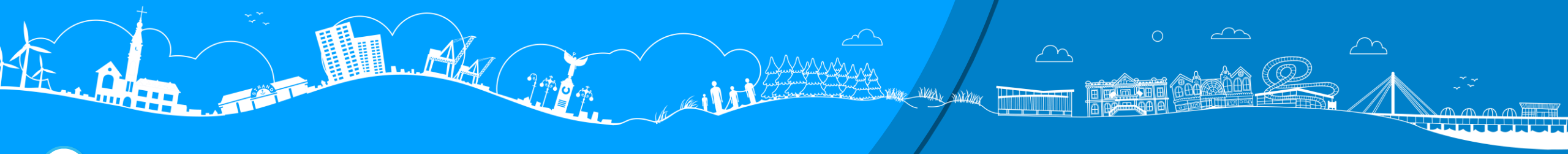
Board, Group or Forum	Role
Health and Wellbeing Board	• A statutory committee of Sefton Council that provides a basis for joint working where political, clinical, professional and community leaders come together to improve the health and wellbeing of local people and reduce health inequalities. • Sets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

Our governance

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

Our objectives for 2025

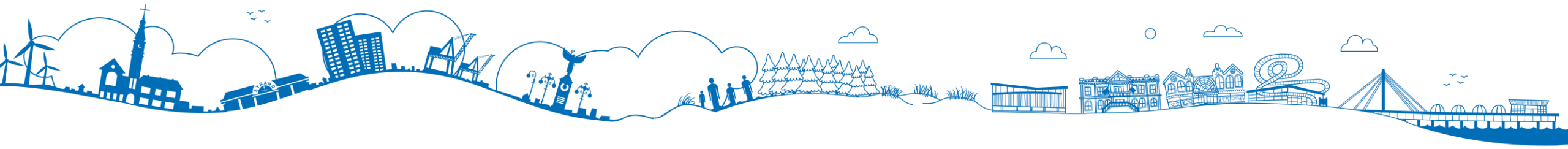
1. Cross cutting themes
2. Life-course priorities
3. Enablers



1. Cross cutting themes

- Reducing health inequalities
- Service transformation
- Community first

Reducing health inequalities



Reducing health inequalities

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

The principles behind our approach to reducing inequalities are twofold:

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

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

Reducing health inequalities

This demonstrates our commitment to:

Proportionate universalism

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

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

Core20PLUS5

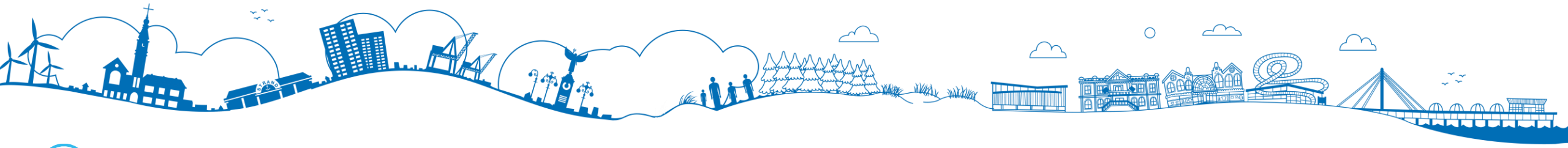
A national NHS England approach to reducing inequalities that is focused on the most 20% deprived communities, those groups who suffer particular disadvantage, and across priority areas for action and for both adults and children.

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

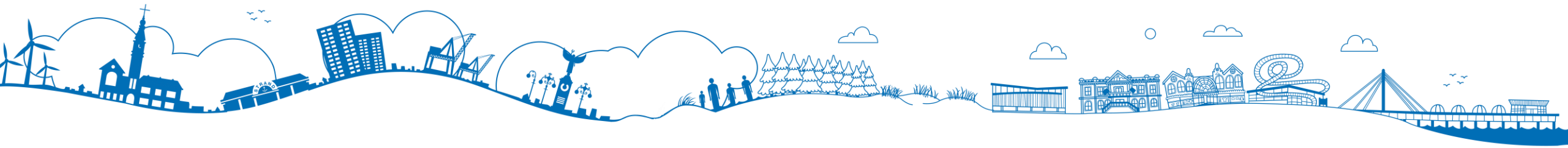
Reducing health inequalities

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

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



Service transformation



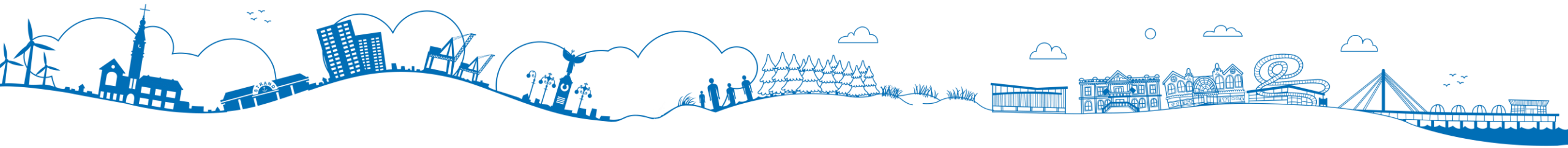
Service transformation – Shaping Care Together

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

Service transformation – Shaping Care Together

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

Community first



Community first

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

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

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

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

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

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

Community first

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

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

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

Community first

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

Community first

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

2. Life-course priorities

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

Start well

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

Start Well – Children & Young People (CYP)

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

Start Well – Children & Young People (CYP)

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

Start Well – Early Help

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

Start Well – Early Help

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

Start Well – Maternity

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

Start Well – Maternity

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

Start Well – Maternity

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

Start Well – Maternity

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

Live well

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

Live Well - Cancer

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

Live Well - Cancer

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

Live Well – Complex Lives

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

Live Well – Complex Lives

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

Live Well – Diagnostics

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

Live Well – Diagnostics

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

Live Well – Diagnostics

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

Live Well – Learning Disabilities & Autism

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

Live Well – Learning Disabilities & Autism

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

Live Well – Learning Disabilities & Autism

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

Live Well – Long Term Conditions (LTCs)

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

Live Well – Long Term Conditions (LTCs)

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

Live Well – Mental Health

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

Live Well – Mental Health

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

Live Well – Planned Care

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

Live Well – Planned Care

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

Live Well – Women's Health

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

Live Well – Women's Health

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

Age well

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

Age Well – Community Services

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

Age Well – Community Services

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

Age Well – Community Services

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

Age Well – Dementia

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

Age Well – Dementia

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

Age Well – Urgent & Emergency Care (UEC)

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

Age Well – Urgent & Emergency Care (UEC)

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

All age

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

All age – Carers

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

All age – Obesity

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

All age – Obesity

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

All age – Primary Care

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

All age – Primary Care

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

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

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

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

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

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

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

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

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

3. Enablers

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

Enablers – Clinical & Care Leadership

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

Enablers – Communications & Engagement

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

Enablers – Communications & Engagement

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

Enablers – Digital

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

Enablers – Digital

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

Enablers – Digital

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

Enablers – Estates

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

Enablers – Estates

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

Enablers – Medicines Optimisation

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

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

Enablers – Medicines Optimisation

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

Enablers – Organisational Development (OD)

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

Enablers – Population Health Management (PHM)

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

Enablers – Population Health Management (PHM)

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

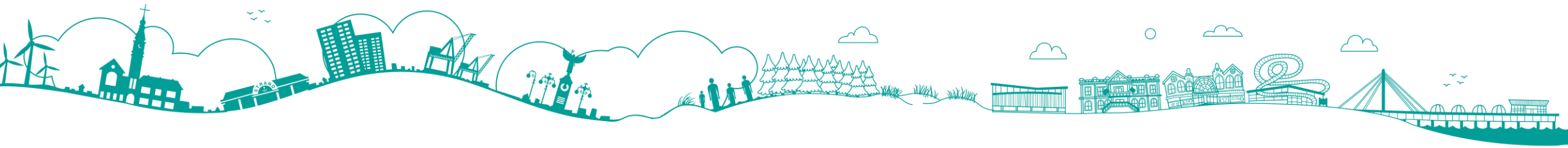
Enablers – Workforce

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

Delivering our objectives

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

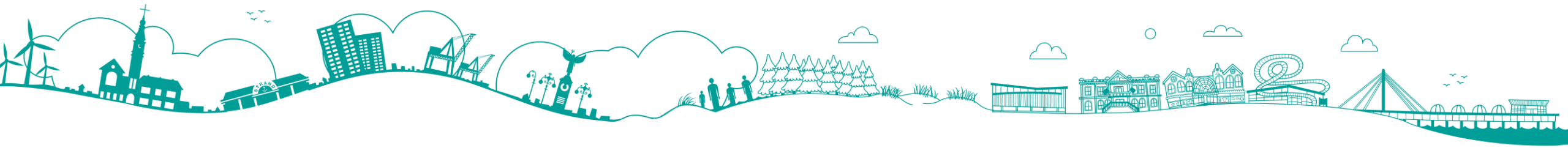
Monitoring & reporting



Monitoring & reporting

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

2023 / 24 Financial Plan

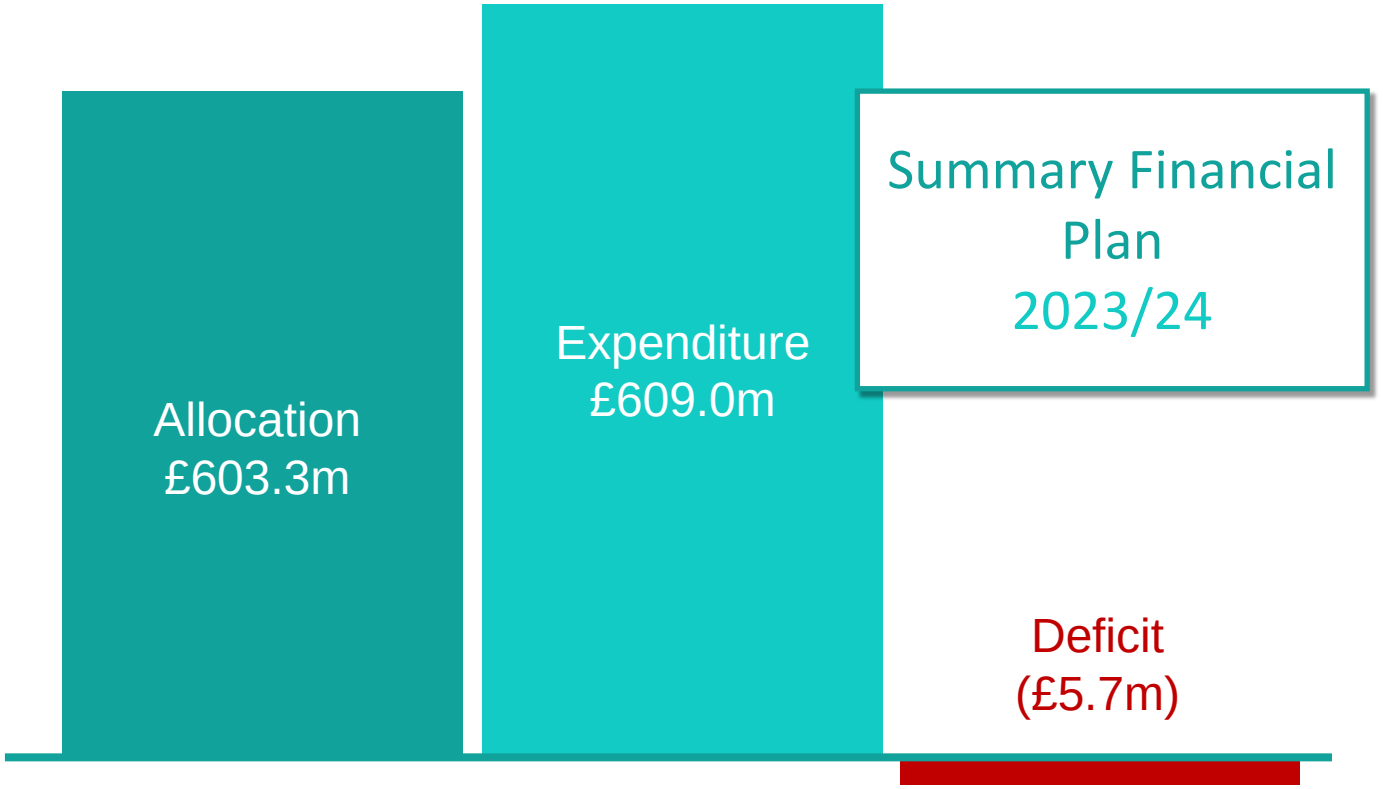


2023 / 24 Financial Plan – Summary

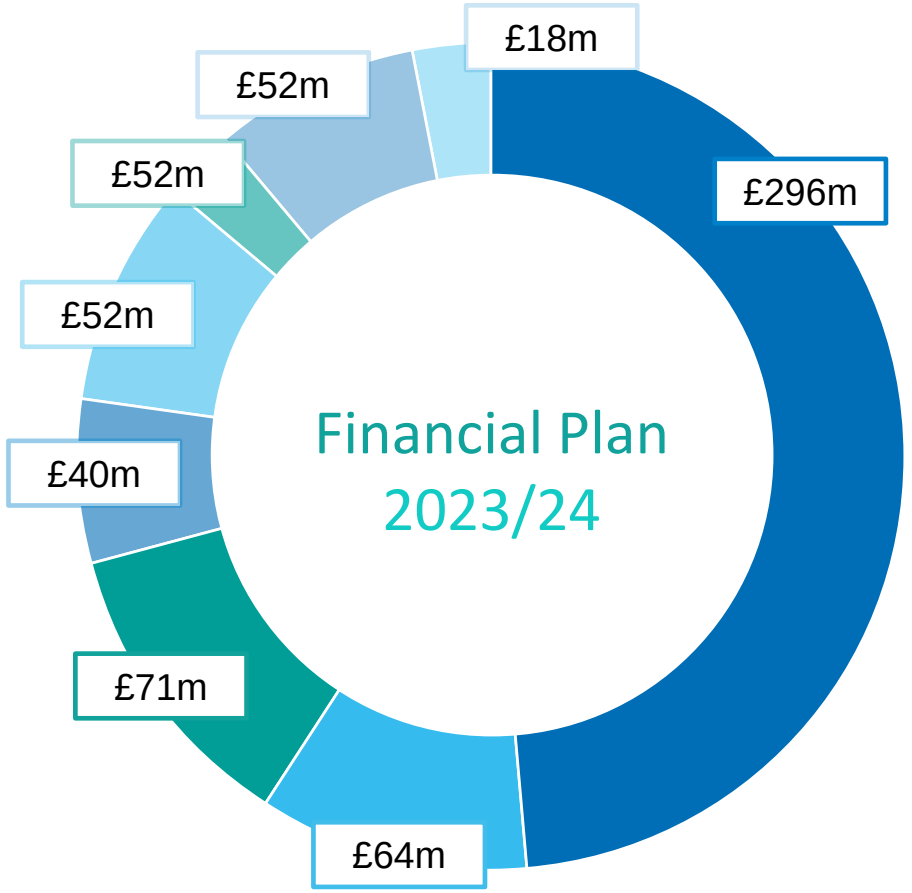
Sefton's financial allocation is **£603.3m**

The expenditure commitment is **£609.0m**

resulting in a (£5.7m) planned deficit



2023 / 24 Financial Plan – Spend allocation

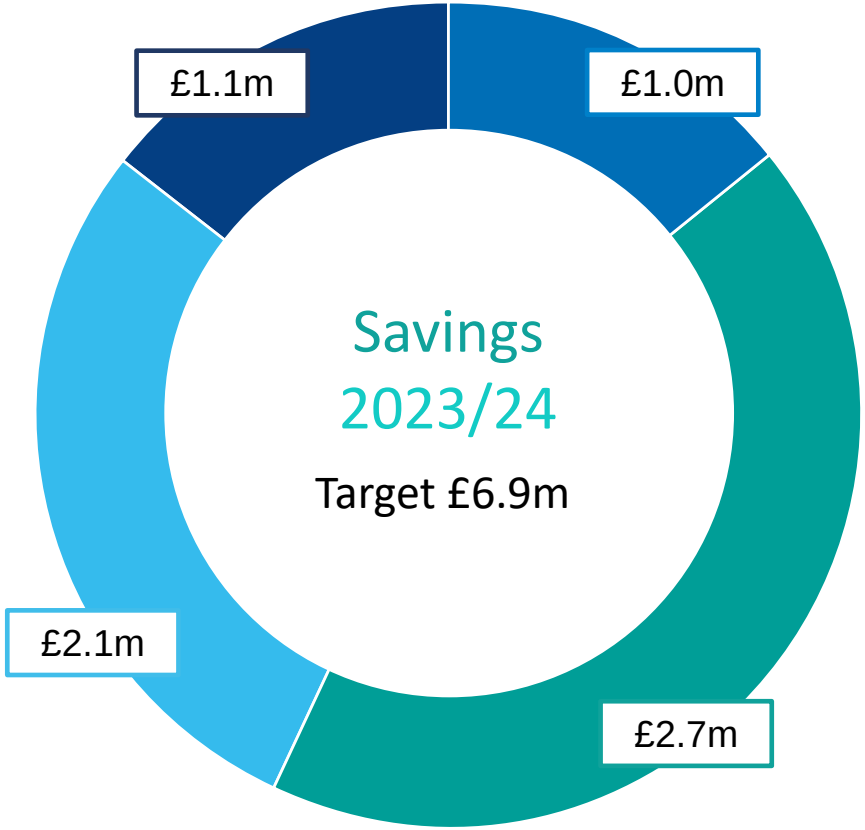


£609m	Expenditure commitment
£296m	Acute Services
£64m	Mental Health Services
£71m	Community Health Services
£40m	Continuing Care Services
£53m	Prescribing
£18m	Primary Care Services (Other)
£48m	Primary Care Co-Commissioning
£18m	Other Programme Services

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

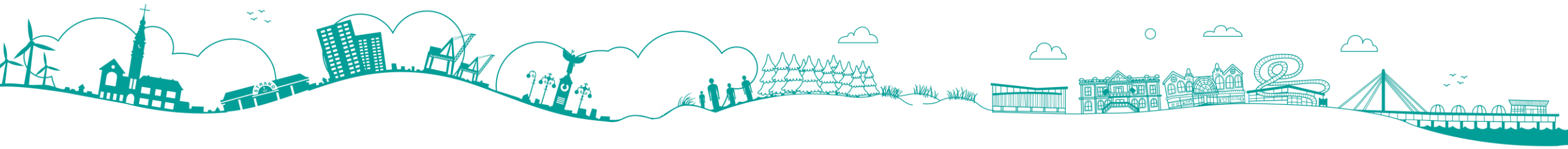
2023 / 24 Financial Plan - Savings

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



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

Quality Improvement



Quality Improvement

Key principles for quality and safety

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

Management of risk and quality operating frameworks

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

Quality Management

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

Developing a single shared view of quality

Quality assurance for NHS Cheshire and Merseyside

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

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

Quality Improvement

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

Quality Improvement

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

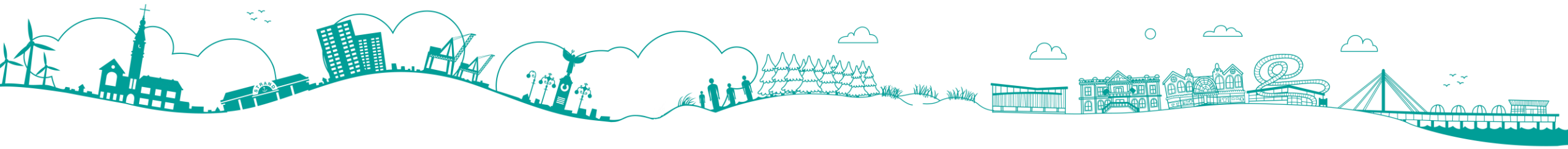
Quality Improvement

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

Quality Improvement

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

Quality & Safety Leadership



Quality & safety leadership

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

Quality & safety leadership

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

Quality & safety leadership

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

Quality & safety leadership

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

Quality & safety leadership

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

Quality & safety leadership

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

Delivering personalised care

Patient Choice

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

Social Prescribing & Community Based Support

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

Personalised Care & Support

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

Patient Activation & Supported Self Management

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

Shared Decision Making

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

Personal Health Budgets

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

NHS
Cheshire and Merseyside

NHS
Southport and Ormskirk Hospital
NHS Trust

NHS
Liverpool University Hospitals
NHS Foundation Trust

NHS
Alder Hey Children's
NHS Foundation Trust

Southport & Formby Primary Care Network

NHS
Mersey Care
NHS Foundation Trust

OneVision Housing

South Sefton Primary Care Network

Sefton CVS
Supporting Local Communities

Sefton Council

healthwatch Sefton