SEFTON COUNCIL

A whole life approach to person centred care and support

Personalisation Strategy 2015 - 2017

FINAL DRAFT

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Foreword

Councillor Paul Cummins

This strategy provides direction for education and social care services set within the context of a **whole life approach** to person centred care and support. The intention is to describe how we can meet the personalisation agenda in Sefton whilst keeping people safe.

The Children and Families Act focuses on putting children and young people at the heart of planning and decision making through co-production and person-centred practice. It emphasises the importance of engaging young people and their families in all processes from developing and planning, particularly in relation to the Local Offer and Education, Health and Care Plans, and also in the commissioning of services and strategic decision making.

The Care Act places a duty on all Local Authorities to prevent, delay and reduce the needs for care and support and it is vital that our care and support system is person centred and actively promotes well-being and independence. Wherever possible this system should not wait to respond to people reaching crisis point. Sefton needs a care and support system that intervenes early to support individuals, promotes wellbeing and independence and reduces dependency.

Social care professionals are expected to work in partnership with health and education to find creative ways of ensuring that individuals are able to express their views and are supported to engage in decision making, including arranging independent advocacy if required.

Developing person-centred, measurable outcomes across different areas of the lives of vulnerable people is a challenge that is common to both Acts.

We need to ensure Sefton has a care and support system that is capable of intervening early to provide or arrange services, facilities or resources which would prevent, delay or reduce an individual's need for care and support. This is especially challenging in the difficult economic climate however there are many things, both big and small, that we can all do to keep improving services and people's lives.

This Strategy sets out Sefton Council's Personalisation Strategy, adopting a whole life approach.

CLLR Paul Cummins
May 2015

Our strategic objectives

Personalisation is a way of thinking about education, health and care services that puts people at the centre of understanding their needs, choosing their support and having control over their lives. It also means people have the support they need to develop, and live independently and actively in their communities. Personalisation also ensures that people are safe in all aspects of their life including health, wellbeing and human rights and that they can live free from harm, abuse and neglect.

Personalisation means recognising people as individuals who have strengths and preferences and putting them at the centre of their own care and support. The traditional service-led approach has often meant that people have not been able to shape the kind of support they need, or receive the right kind of help. Personalised approaches such as self-directed support and personal budgets involve enabling people to identify their own needs and make choices about how and when they are supported to live their lives. People need access to independent information, advice and support so they can make informed decisions.

Personalisation is also about making sure there is an integrated, community-based approach for everyone. This involves building community capacity and local strategic commissioning so that people have a good choice of support regardless of age or disability, including support provided by user-led organisations (ULOs). It means ensuring that people can access universal services such as transport, leisure, education, housing and health, as well as employment opportunities. All systems, processes, staff and services need to put people at the centre.

Personalisation means:

- tailoring support to people's individual needs whatever the care and support setting
- adopting person-centred approaches children with SEND, adults and their families are put at the centre of processes, enabling them to express their views, wishes and feelings and be included in decision making.
- personalising the support that families receive by working holistically in partnership with services across education, health and social care ensuring that people have access to independent information, advice and support , including peer support and mentoring, to make informed decisions about their care and support, or personal budget management
- finding new collaborative ways of working (sometimes known as “co-production“) that support people to actively engage in the design, delivery and evaluation of services
- developing local partnerships to co-produce a range of services for people to choose from and opportunities for social inclusion and community development
- developing the right leadership and management, supportive learning environments and organisational systems to enable staff to work in emotionally intelligent, creative, person-centred ways
- embedding early intervention, reablement and prevention so that people are supported early on and in a way that’s right for them

- recognising and supporting carers in their role, while enabling them to maintain a life beyond their caring responsibilities
- ensuring all citizens have access

The Local Context

Sefton is a Borough in Merseyside. Our population is approximately 275,000 and is centred on 5 townships.

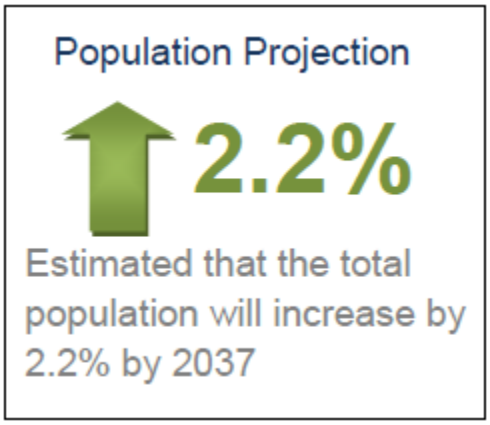
The number of 0-19 year olds living in Sefton by 2021 is predicted to reduce by almost 2% from 60,686 in 2011 to 59,542 in 2021 Overall population is predicted to rise by 1% by 2021 to 276,821, compared to a 4% increase across the North West and an almost 8% rise across England. Longer term projections show that the 0-19 year old population of the borough is set to fall to 57,000 by 2037, a further reduction from 2021 of 3%.

In 2014 18% of school aged pupils had SEN which is a marginal decrease from 20% in 2010 and in line with the national figure of 17.9%. 2.4% of pupils in Sefton have an Education Health and Care Plan/Statement of SEN compared with the national figure of 2.8%.

In 2013 the proportion of social care referrals that went on to initial assessment was 71%, which, is below the proportion for North West (77.9%), Statistical Neighbours (80.7%) and across England (74.4%).

The Borough faces particular challenges with regards to its significantly ageing population, with multiple long term conditions, compounded by unacceptably high health and wellbeing inequalities. Between 2011 and 2021, while the overall population of the Borough is expected to remain largely unchanged (an increase of 1%), it is predicted that there will be a 16% (57,366 to 66,545) increase in our population aged 65 and over, and a 40.5% (7,633 to 10,723) increase in the numbers of people aged 85 years and over in the same period, with those over the age of 90 expected to increase by more than 55%. By 2035 the 65+ age group is set to account for almost 30% of Sefton's population.

Currently Sefton Adult Social Care provides some form of service to 10% of all those aged over 65 in Sefton and some form of service to over 33% of those aged 85+ in Sefton. If our service provision



remained steady as a proportion of the population we would anticipate needing to provide services to a significantly increasing number of older clients over the next decade.

Sefton faces significant future pressures on its Adult Social Care services due to the makeup of our local population. At 22% Sefton has the highest proportion of residents aged 65+ of all its statistical comparators and immediate geographic neighbours. Sefton also encompasses some of the most deprived areas in the UK with more than 18% of Sefton categorised as falling within the most deprived 10% of England and some areas as being within the most deprived 1% of the country.

Sefton also has financial challenges and the Council has to make savings of £55 million in the period 2015-17. The Council therefore needs to be more efficient and providers must be able to demonstrate they provide value for money.

Links to National Strategies

Over the last decade we have witnessed a national drive for change within education, health and social care. This has focused upon person centred approaches, empowering citizens to help shape their own lives and the services they receive. In 2007 the Governments paper "Putting People First" stated that people should have maximum choice and control over the support services they receive. This placed a responsibility upon Councils to adopt a personalised approach to the provision of social care for adults.

Personalisation is the process of enabling people to be more in control of the services they receive. Every person who receives support, whether funded by the Council or by themselves, will have choice and control over the shape of that support.

Personalisation is achieved by adopting a person centred approach to the assessment of need, care planning and service delivery. It places individual's abilities, skills and qualities at the heart of the processes in order to promote independence, community presence and inclusion. The intention is that this approach will both improve the quality of people's lives whilst reducing their dependency upon statutory services.

Personalised support can take a number of forms and can range from people taking total control over their care, including identifying and paying for services themselves, to having their care organised and paid for entirely by the Council.

Where care is funded by the Council, people are able to choose whether they would prefer for their care to be managed on their behalf (Managed Budgets) or to take payment in lieu services and to organise their own care provision (Direct Payment). In both cases Local Authorities must provide individuals with an assessment of need and a care plan. In the case of Managed Budgets Local Authorities are also required to provide people with a breakdown of the monetary value of their care package.

For 'individuals, families and carers' interventions may be aimed at individuals who have an increased risk of developing needs for care and support or, where there are existing needs for care and support, a local authority must provide or arrange provision of services, resources, or facilities that may help slow down any further deterioration. Examples of ways in which a local authority can identify these individuals include screening or case finding, to identify individuals at risk of developing specific health conditions or experiencing certain events (such as strokes, or falls) or those that have needs for care and support that are not currently met by the local authority. Interventions may be aimed at minimising the effect of disability or deterioration for individuals with established health conditions or complex social care needs or caring responsibilities. The focus for local authorities is on providing or arranging the provision of services, resources or facilities that maximise independence, for example, but not limited to, interventions such as rehabilitation / enablement services and joint case-management of people with complex needs.

Our Health Our Care Our Say, Putting People First and more recently 'Think Local, Act Personal' propose that the social care system should therefore be built around enhancing the independence of people who use services by giving them more control over how their support needs are met.

Social workers in all disciplines including mental health services are also well placed to be the lead professional to undertake assessment or review of an individual or their carer with complex social care needs. This involves helping carers to continue to care, enabling them to have a good quality life, to have breaks from their caring responsibilities, develop mechanisms to cope with challenging behaviour, and awareness of their own physical and mental health needs.

This may include, but is not limited to interventions and advice that;

- encourages self-help approaches and self-assessment, for example, cognitive behaviour approaches to tackling depression;
- provides universal access to good quality information,
- supports safer neighbourhood;
- promotes healthy and active lifestyles;
- reduces isolation; and
- encourages early discussions in families or groups about potential changes in the future, e.g. conversations about potential care arrangements should a family member become ill or disabled.

The Care Act 2014 received Royal Assent in May 2014 and it highlights the role the Local Authority play in all of the above. The Care Act represents a major re-write of social care legislation, the like of which hasn't been seen for over 60 years. Personalisation is a key concept underpinning the Act.The focus is for a local authority to provide, or arrange provision of services, facilities or resources that help an individual avoid developing needs for care and support needs, by maintaining independence and good health and promoting wellbeing.

The Act sets out when the local authority has a responsibility to meet someone's care and support needs and also says what must happen next to help the person make decisions about how their needs should be met.

The Act gives local authorities a new legal responsibility to provide a care and support plan (or a support plan in the case of a carer).

For the first time, the Act provides people with a legal entitlement to a personal budget, which is an important part of the care and support plan, or support plan. The personal budget must be included in every plan, unless the person is only receiving intermediate care or reablement support to meet their identified needs.

This adds to a person's right to ask for a direct payment to meet some or all of their needs. Provided that the direct payment is used to meet the needs identified in the plan, the person should have freedom over how the money is spent.

Even when an assessment says that someone does not have needs that the local authority should meet, the local authority must advise people about what needs they do have, and how to meet them or prevent further needs from developing.

The person concerned must be involved in developing their plan. The local authority will have to do everything it reasonably can to agree the plan with them.

It must also provide an independent advocate to help the person take part in the planning and review process, if that person would otherwise have substantial difficulty in doing so. Completing the planning process and putting in place care and support arrangements does not mean the end of the local authority's responsibilities. The local authority has a legal responsibility to review the plan to make sure that the adult's needs and outcomes continue to be met over time. If anything has changed, the authority must carry out a new assessment. The person themselves also has the right to request a review of their care and support plan, if they wish.

There are many policy changes occurring that will affect the lives of young people with SEN, disabled young people and their families, and will impact on the range and quality of support available to them as they prepare for adulthood. The two pieces of legislation that will have the greatest influence on support for disabled young people preparing for adulthood are Part 3 of the Children and Families Act 2014, which focuses on Special Educational Needs and Disability and came into force in September 2014, and Part 1 of the Care Act, which focuses on the care and support of adults with care and support needs and is due to be implemented in April 2015.

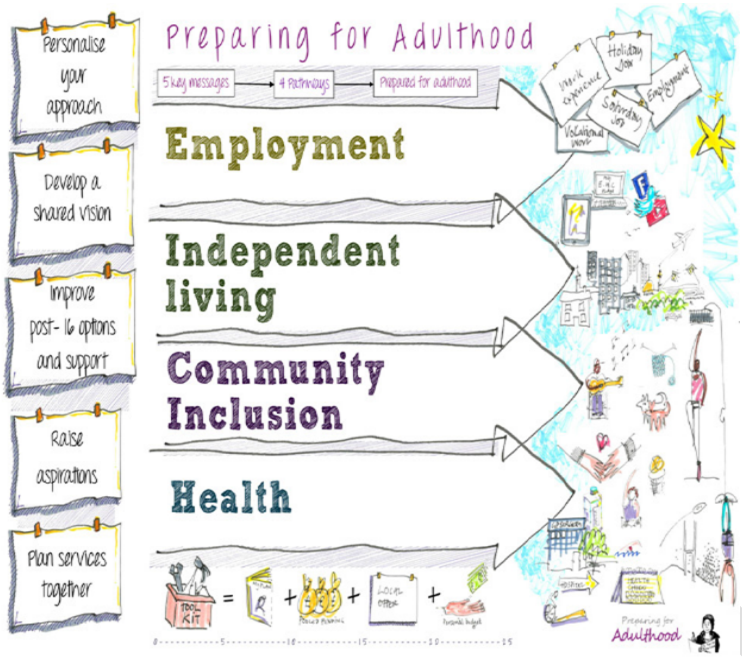
Importantly, the Children and Families Act 2014 introduces a system of support which extends from birth to 25, while the Care Act deals with adult social care for anyone over the age of 18. This means there will be a group of young people aged 18-25 who will be entitled to support though both pieces of legislation. The two Acts also have the same emphasis on outcomes, personalisation, and the integration of services. It is therefore essential that the planning and implementation of both of these Acts is joined up in Sefton

Part 3 of the Children and Families Act transforms the system for disabled children and young people and those with SEN, so that services consistently support the best outcomes for them. The reforms create a system from birth to 25 through the development of coordinated assessment and single Education, Health And Care Plans; improving cooperation between all services responsible for providing education, health or social care; and giving parents and young people greater choice and control over their support.

The SEND reforms focus on the following themes:

- Working towards clearly defined outcomes
- Engagement and participation of parents and young people
- Joint Commissioning and developing a Local Offer of support
- Coordinated assessments and Education, Health and Care Plans
- Personalisation and personal budgets

Preparation for adulthood is a key element of the reforms that cuts across all of these themes.



The transformation of the system for disabled young people and those with SEN is intended to ensure that services consistently support the best outcomes for them by making certain children, young people and their parents have greater choice and control in decisions and that their needs are properly met.

People with learning disabilities are amongst the most vulnerable and socially excluded in society. In 2001 the Government published *'Valuing People: A New Strategy for Learning Disability for the 21st Century'* which set out changes for people with learning disabilities must no longer be marginalised or excluded. *Valuing People* set out how the Government would provide new opportunities for children and adults with learning disabilities and their families to live full and independent lives as part of their local communities.

This was then reinforced by '*Valuing People Now: A new three-year strategy for people with learning disabilities' in 2009* which set out the cross-government strategy for three years. The strategy addressed what people said about the support people with learning disabilities and their families needed. It also reflected the changing priorities across government which impacted directly on people with learning disabilities. The plan also set out the Government's response to the ten main recommendations in '*Healthcare for All*', the report of the Independent Inquiry into access to healthcare for people with learning disabilities, chaired by Sir Jonathan Michael; and provided a further response to the Joint Committee on Human Rights report, '*A Life Like Any Other?*'

More recently *'Think Autism'*, the new autism strategy for adults with autism in England, was launched in 2014. It is an update to the first adult autism strategy, *'Fulfilling and Rewarding Lives'*, which was published in 2010. New statutory guidance, published in March 2015, supports the Think Autism strategy. The strategy outlines the Government's plan to make sure that adults with autism get the help that they need. The strategy also highlights how local councils and health services how they can help people with autism.

Links to Local Strategies

There are a number of local strategies that link to this strategy. These include:
The Sefton Health & Wellbeing Strategy 2013 – 2018 which this strategy seeks to support in the delivery of the six strategic objectives for Health and Wellbeing:

The Sefton Carers Strategy 2014-2019 - has been co-produced with partners, providers and the carers themselves (including young carers) and identifies a set of draft strategic objectives for Carers in Sefton, together with the creation of a model for working with Carers, and a whole life course approach to defining carers. A model of working with carers in Sefton has been created which shows that carers and those they care for are at the heart of the process and that those closest to them "their world" are also very important.

The model shows that all organisations should talk to each other and where ever possible share appropriate data in a secure way to ensure that services provided best meet the need.

Sefton Strategy for Older Citizens 2014 – 2019 - Sefton Partnership for Older Citizens (SPOC), continues to work with partners to create a better place where older people can

live, work and enjoy life as valued members of the community. The five year strategy for older citizens sets clear direction for our communities and strives to ensure that the needs of people are met. It also provides a framework of common outcomes that link directly to the ambition and vision within other strategies (Carers, Mental Health and End of Life) currently being developed and in this way helps to bring a shared focus and collaborative approach to service development in Sefton.

Sefton Mental Health and Wellbeing Plan - Work is also underway to develop a draft Sefton Mental Health and Wellbeing Plan based on feedback from service users as part of the consultation on the Health and Wellbeing Strategy.

End of Life / Palliative Care - A Sefton commissioning strategy is being developed that will enable patients, carers and families to access appropriate high quality care when facing the issues associated with life threatening illness. The strategy aims to ensure that all services involved in end of life care act in a compassionate way that treats, comforts and supports people who are living with progressive, chronic or life threatening conditions. All care services need to acknowledge and have a plan for the cultural, personal and spiritual beliefs, values and practices that need to be considered as part of their role in giving support up to and including the period of bereavement

These strategies and plans will be further consulted upon to ensure that this strategy and other strategies and plans are aligned, but do not duplicate activities and deliver value for money.

Education Strategy – The Sefton Education and Skills Strategy recognises the importance of education for all young people and highlights the impact on life chances if young people are not given the knowledge, skills and opportunity to fulfil their potential and the strategy outlines role that everyone involved in Education needs to play to ensure this happens. Of particular importance is the need to support children and young people with SEND to ensure that barriers to then accessing education and opportunity are removed.

Sefton Council Preparation for Adulthood: A Strategic Plan for Sefton 2014-2019 – The plan highlights Sefton's vision that all children and young people with special needs achieve well in their early years, at school and in college; lead happy and fulfilled lives; and have choice and control.

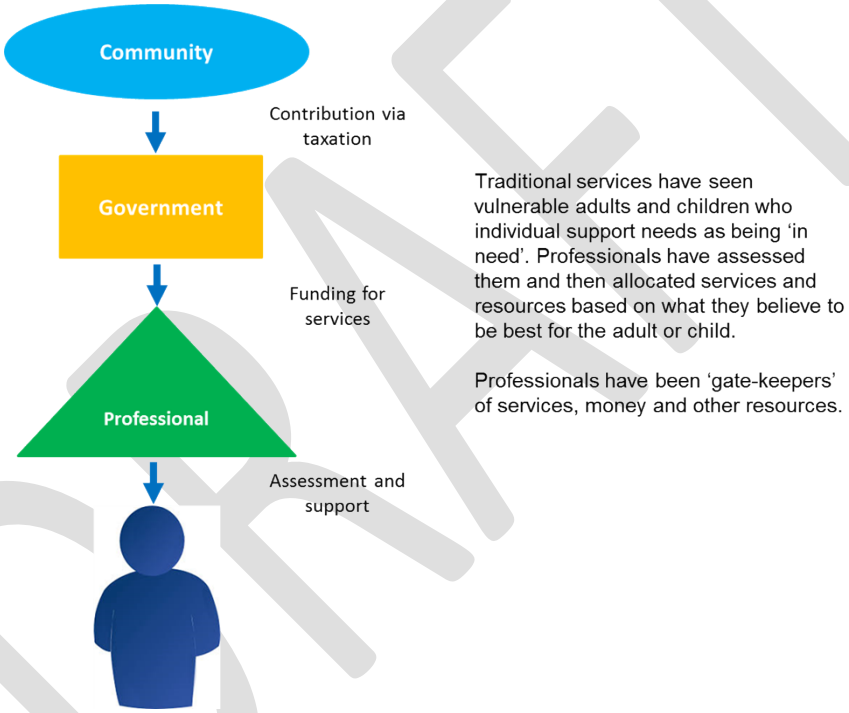
The plan reinforces the need for Adults and Children's services alongside partner organisation to work together to meet the strategic as well as the everyday demands and challenges. The strategic plan sets out how a young person with SEN, their families, friends, teachers and everyone else involved in their lives can work together during the journey into adulthood.

Sefton's Vision for a Whole Life Approach to Person Centred Care and Support

Personalisation is often thought about as simply to do with personal budgets that children, young people, adults and families can use to buy services and support to improve their outcomes.

Personalisation is about much more than this: it's about a fundamental change in how we think about and organise services and support, and particularly how we think about disabled children, young people, vulnerable adults, the elderly and their families.

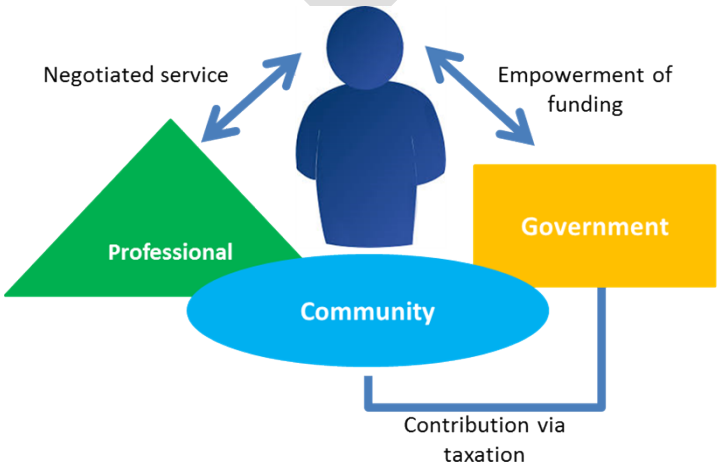
Sefton needs to move from….



Traditional services have seen vulnerable adults and children who individual support needs as being 'in need'. Professionals have assessed them and then allocated services and resources based on what they believe to be best for the adult or child.

Professionals have been 'gate-keepers' of services, money and other resources.

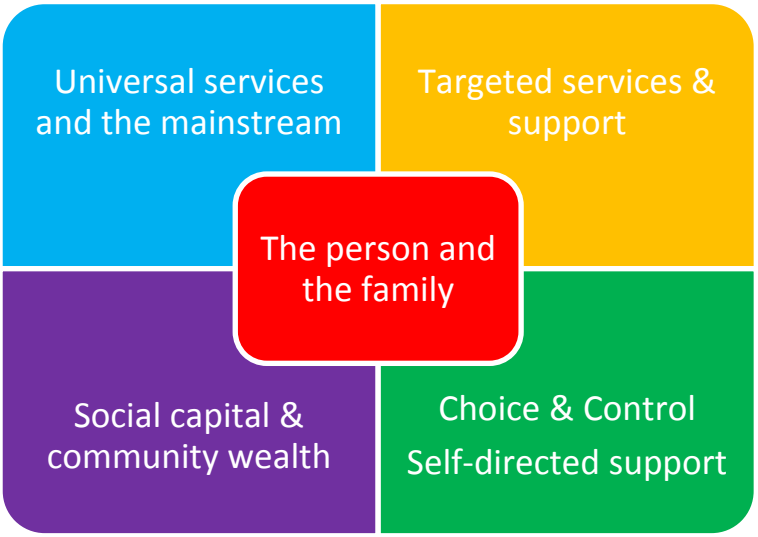
And towards…



Personalisation challenges this approach and see the individual adult, children and families as citizens who are empowered to take control of their lives and supported in ways which make sense to them.

It is about adults, children and families directing how they are supported.

Since 2007, the principles and practice of Personalisation have been embedded into Sefton's polices, practices and procedures. Sefton has both increased the use of Direct Payments and implemented person centred approaches to its assessment, care planning and review functions. Following an initial assessment, all adult service users are asked whether they wish the Council to manage their care or whether they wish to use a Direct Payment. In both instances people are given support they need to influence the support they receive.



Case Study: Jack

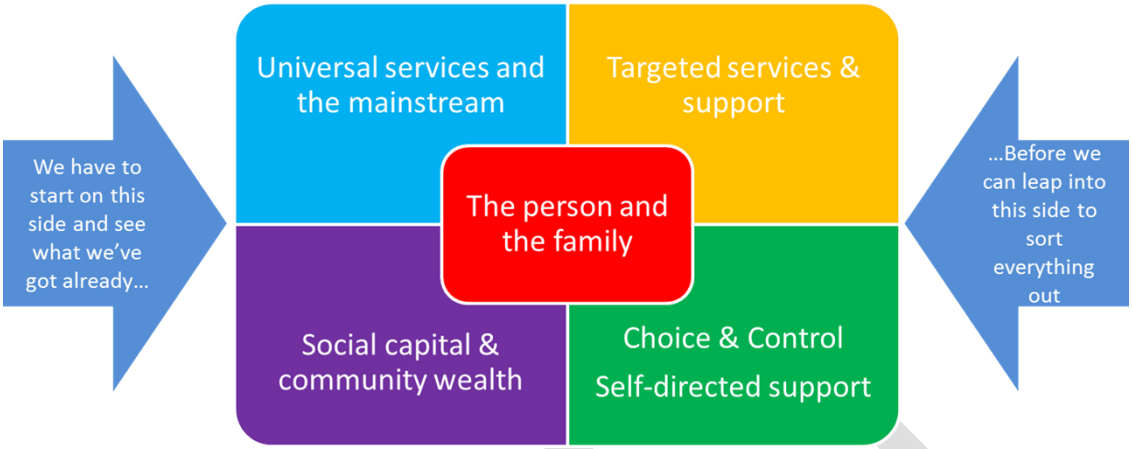
Jack is an older man and lives alone with some support from his daughter who works full time. He needs occasional personal care to remain living independently with dignity and it is likely that these needs will increase.

A strengths-based approach to assessment would consider all of his needs, including those being met by his daughter, along with the outcomes he and his daughter wish to achieve. There would be more emphasis on the daughter being valued as a 'partner in care', rather than as someone with unrelated support needs. As such the more holistic assessment would also look at issues such as whether the man was isolated and able to connect with others or be an active citizen.

The key shift in approach here (as well as looking at an individual with assets and gifts) is to look at the community assets. Therefore, support would be given to access the community, including community groups, voluntary organisations, charity organisations, buddying services, could be offered alongside the formal services needed to meet personal care needs. Both individuals could opt to plan as a family (or separately if they preferred) and should be able to choose their preferred planning support organisation and professional.

When assessing an individual's needs it is important to ensure that we understand the complete picture; the skills and knowledge the family bring and what exists in the local community. Sefton's approach to personalisation will ensure that we will understand the

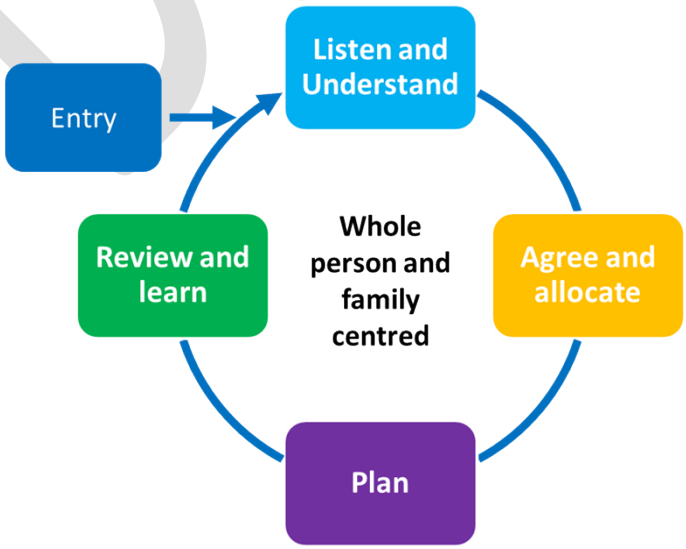
people, resilience, skills and knowledge and access to support on an individual basis. We will also ensure we understand our community, services which are available and how partners can work together to ensure they can be readily accessed.



To implement the Sefton vision we must ensure:

- The community, partners, providers and the Council are working together, delivering improved outcomes and reducing longer term reliance on public sector service;
- Individuals and families have primary responsibility for looking after themselves in order to remain fit and healthy whilst planning how they will personally financially contribute towards any care that may be required; and
- Social Care is sustainable and meets the needs of our most vulnerable.

We need to ensure our approach is underpinned by a common assessment and planning framework:

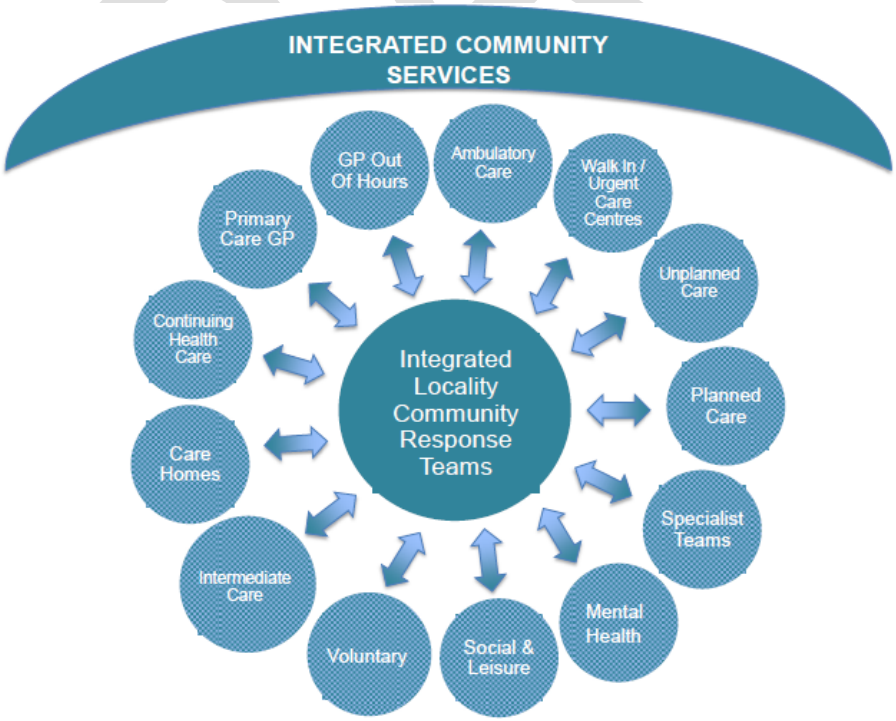


Sefton has been developing approaches to personalisation and the future vision has been shared with the Health and Well Being Board (HWBB). From an individual person's perspective the aim is for individuals living in Sefton to be able to recognise that they are part of a community that will:

- provide care, support and signposting to others when needed;
- have an awareness of preventative services and how to access them;
- have the knowledge to shape their own care and the belief that the available services are seeking to reduce inequalities;
- will receive flexible care at home or as close to home as possible;
- have access to primary care where appropriate and hospital based care where there is a genuine need;
- will be able to see and know that care is focused at the earliest point in their lives,
- and will give their details only once, which will be shared and used by all service providers involved with their care.

The Health and Social Care Act 2012 and Care Act 2014 set out the principles for integrated working focusing on person centred approaches and the Council, the two Clinical commissioning Groups and NHS partners have agreed a neighbourhood model of working which is described below. This will provide a platform to assist with the delivery of this strategy.

System Blueprint for Integrated Community Services



The Clinical Commissioning Groups have also adopted an approach to transforming their localities by reconnecting their teams. This mirrors the newly reconfigured Adult Social Care Services and both of these approaches are underpinned by collaboration as described within the Better Care fund. Their stated objectives are:

- Better outcomes for patients/carers/community
- Locality focused care to meet local needs.
- More integrated care across the whole age range and care spectrum
- Clinicians in the driving seat
- Service changes and developments shaped and influenced by the local community
- Involvement of community, voluntary, faith sector
- Improved relationships between care providers
- Integrated commissioning between CCG/Local Authority
- Political 'buy-in'

To deliver the vision we must ensure that the model has the following features:

- Person centred - this entails the active involvement of the individual and their carer or advocate in the design of flexible person centred approaches
- Information and advice - this means that there should be accessible information and advice services available 24 hours 7 days a week
- Partnership - the above can only be delivered in partnership with all Council services, health, housing, the independent and voluntary sector and the community.
- Community focused - it needs to be locally determined within the context of the national policy direction and promote an understanding of the role of communities in championing and supporting safeguarding within those communities.
- Asset based - it needs to focus on the individual as well as the community.

The outcomes required include:

- Having a good experience when seeking support which is focused on the individual and shaped by the individual.
- There is a coordinated approach to care planning which is balanced against the identified risks
- There should be local or accessible services available to manage long term conditions
- The systems in place to support people are not complex and are easy to understand
- People can find information easily and it is sensitive to the communication needs and is culturally sensitive.
- They have equal access to universal services to support people to live independently
- The contribution to the community is recognised and valued.
- People are treated with dignity and respect
- People can access support in a crisis
- That staff have the appropriate levels of information, knowledge and skills.

Case Study: David

David is a 45 year old man who has learning difficulties and also cerebral palsy. He attended traditional day services for 10 years and travelled independently to the Day Centre feeling reassured and safe having a stable routine. However he began to notice that there were less people attending the centre and he wondered what alternatives other people had been offered. He lives with his sister and her family and needs support with some practical and personal care tasks.

He became more actively involved with a group that was established in the day centre to deliver awareness and training in the field of learning disabilities. They delivered sessions to students and also provided placements for 1st year social work students. In going out to the different settings to share experiences and help with other people's learning.

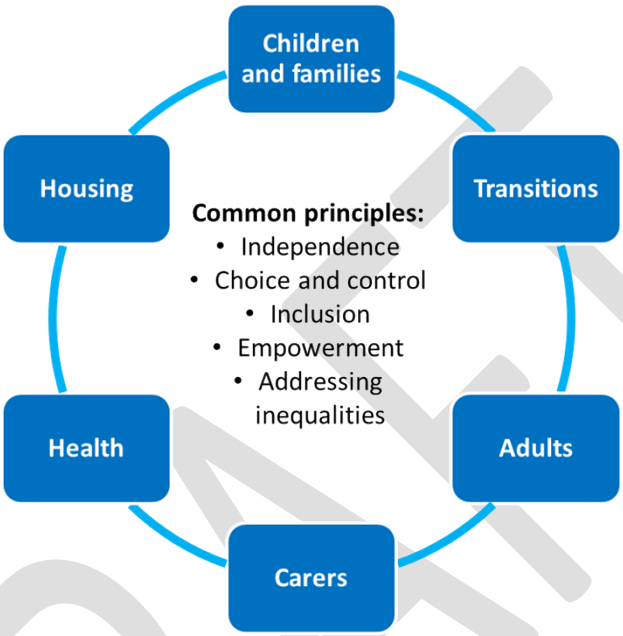
The key approach here was to work with others to develop innovative approaches and consider with the adult and the carer whether there are alternatives which provide some routine, are safe and ensure contact with other people whilst at the same time provide some opportunities to learn new skills and develop learning.

His support worker who also led the training group was involved in exploring options for the delivery of a scheme within a community based setting and this led to her setting up a social enterprise. David and some of his co-workers requested a direct payment (DP) and other DP recipients have since joined the social enterprise which has gone from strength to strength.

David made the decision that he did not wish to continue attending the Centre and instead opted to spend time with the friends he had made doing work for which he felt valued. This work included helping to reduce stigma.

Next Steps

To meet our aims and aspirations for this Personalisation Strategy we will need to look at the holistic delivery of support, information and advice, all underpinned by the strategic objectives of the Health and Wellbeing Strategy for Sefton and with the evidence of needs as presented in Sefton's Strategic Needs Assessment:



Our overarching goals are:

- Commissioning strategies should be informed by adults, young people, their families and the Local Offer. Adults, young people and families can play a valuable role in quality checking, the results of which should feed back into the strategy;
- Develop processes which to allow information from support planning (including the EHC plan and CAN), and from personal budget holders' choices, to inform commissioning strategies;
- Ensure that the work streams around developing joint commissioning across adults, the 0-25 age group and the Better Care Fund are joined up and that there is a common process being developed;
- Develop the market to ensure that there are quality services that people can purchase/procure with their personal budget. Local authorities should work with education and training providers, health, social care, employment and housing agencies to develop a range of post-16 support options that lead to better outcomes and more efficient use of resources;
- Explore how personal budgets across education, health and social care (and personal health budgets for young people eligible for NHS Continuing Healthcare post-18) can be integrated to develop personalised options and support that lead to better outcomes for adults and young people;

- Ensure that adults, young people and their families have access to good information, advice and support in relation to what is available and how to purchase it;
- Provide adults, young people and their families with opportunities to pool budgets and commission mutually beneficial support.

Action Plan 2015-17

Health and Wellbeing Strategy – Strategic Objectives	Objectives	Actions	Outcomes	Lead Officer
Ensure all children have a positive start in life	• The joint commissioning strategy and Joint Strategic Needs Assessment (JSNA) should be informed by young people, their families, information in a young person's EHC plan and the Local Offer. Young people and families can play a valuable role in quality checking, the results of which should feed back into the strategy; • Ensure that the work streams around developing integrated joint commissioning across the 0-25 age group and the Better Care Fund are joined up and that there is a common process being developed;	• Develop a process to allow the information from the EHC plan, including the CNA, and from personal budget holders' choices, to inform the Joint Commissioning Strategy; • Explore how personal budgets across education, health and social care (and personal health budgets for young people eligible for NHS Continuing Healthcare post-18) can be integrated to develop personalised post-16 options and support that lead to better outcomes for young people; • Ensure that young people and their families have access to good information, advice and support in relation to what is available and how to purchase it; • Provide young people and their families with opportunities to pool budgets and commission mutually beneficial support.	• Children and young people will have good physical and emotional health and wellbeing and will lead healthy lifestyles • Children and young people will be safe • Children and young people will be aspirational and achieving through the enjoyment of going to school and college • Parents will have the skills, support and infrastructure to enjoy being parents • Children and young people will have a voice, will be listened to and their views will influence service design, delivery and review	Children's Social care
Support people	• Invest in low-level, open-access	• Work with Careline, Police,	• There will be effective prevention	Health & Wellbeing

early to prevent and treat avoidable illnesses and reduce inequalities in health	prevention and early intervention services to support people with emerging or low level/moderate social care needs, through preventative approaches, public health, telecare, supported housing and an enhanced role for the voluntary sector	Fire, Ambulance and other out of hours services to deliver alternative care pathways to divert people from high-end services; • Develop and expand self-assessment opportunities for those with low to medium needs within an outcomes-based approach;	and early intervention with people being empowered to determine their own outcomes through the experience of quality services • There will be improved health and wellbeing against the wider factors that lead to poor health and wellbeing • There is education, skills and support for people to change their lifestyles and to do things for themselves • The population is protected from incidents and other threats, including infectious diseases, accidents, excess winter deaths whilst reducing health inequalities	
Support older people and those with long term conditions and disabilities to remain independent and in their own homes	• Review the delivery mechanisms to provide personal budgets • Build on the national Outcome Based Framework in order to provide evidence of effective support and intervention and develop a performance management framework that is rooted in delivering the best possible outcomes;	• Outline a Personal Budgets Policy for Adults • A review of the direct payments system and managed budgets; • Work with Health colleagues to integrate care pathways, starting with long-term conditions and mental health and focus on locality planning; • Identify how advanced assistive technologies such as telehealth and telecare can further support integrated working, integrated systems, extra care and self-care with particular regards to people with long-term conditions or those who are predicted to	• There will be system wide improvements across social care and care pathways, supported with access to information about early diagnosis and prevention • There will be effective management of long term conditions for all adults, including mental health and dementia • There will be outstanding end of life services • There will be access to information about early diagnosis and prevention services • There will be increased physical, emotional and economic wellbeing. There will be access to appropriate, high quality housing across Sefton	Adult Social Care and Commissioning Support & Business Intelligence

		require intensive health or social care support in the future;		
Promote positive mental health and wellbeing	• Provide a quality assessment framework which enables providers to improve service quality and policies such as safeguarding;	• Ensure a revised person centred approach process is rolled out in a phased way for new referrals and existing service users • Develop personal support plans in partnership with the individual, detailing their own focused packages of support;	• The infrastructure will be place so that all people can access information, preventative and treatment services • People will be empowered, have a sense of purpose and take care of themselves and their family • The mental health services that are commissioned will be fit for purpose • We will have stronger communities involved in their own wellbeing and wider community's mental health services • There will be an increase in physical and emotional health and wellbeing	Adult Social Care
Seek to address the wider social, environmental and economic issues that contribute to poor health and wellbeing	• Develop the market to ensure that there are quality services that people can purchase/procure with their personal budget.	• Work with 'think local act personal', partners, people who use services and carers to develop and shape this person centred care approach into a consistent and sustainable framework; • Work with GP partners to increase social care and social intervention commissioning, prescribing through practice-based commissioning and ensuring information and leisure prescribing becomes mainstream; and exploring	• The appropriate infrastructure is in place to improve opportunity, maintain health and wellbeing and the quality of life for all • There will be improved access to services and information for all, including leisure facilities, parks and open spaces • There will be opportunities to access new skills, training enterprise, employment and progression • There is infrastructure and investment is in place to improve opportunity, maintain health and	Adult Social Care and Commissioning Support & Business Intelligence

		new toolkits such as the NHS House of Care toolkit;	wellbeing and quality of life for all • There will be access to high quality housing across Sefton	
Build capacity and resilience to empower and strengthen communities	• Engage with providers to develop a flexible marketplace; • Work with key stakeholders to develop approaches to volunteering and developing the capacity of the community; • Design and maintain a universal information and advice service through co-production with key partners;	• Mobilise universal, mainstream services to ensure that they are open to all citizens, including adult learning, leisure, sports, libraries and cultural services, training and employment, housing and counselling and that they provide a wider range of occupational, daily living, health and wellbeing activities; • Develop a Workforce Development and Training Strategy that supports the roles, responsibilities, skills and behaviours required to deliver the personalisation agenda;	• There will be stronger communities involved in and responsible for their own wellbeing and of the wider community with reduced dependency on services • There will be Improved access to services and information for all, including leisure facilities, parks and open spaces • The value of clean, safe, healthy environments in promoting health and wellbeing will be recognised • The health benefits of borough wide activities through parks, the coast and countryside will be valued, encouraged and promoted • Increase the physical and emotional health and wellbeing of all residents • There are clean safe environments and quality of place	Strategic Support

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