Sefton2gether Shaping Sefton II

Sefton's response to the NHS long term plan

Sefton2gether

This Sefton2gether plan is prepared on behalf of the local NHS as a response to the NHS Long Term Plan and encourages a partnership approach between the NHS, Sefton Council, the voluntary, community and faith (VCF) sector and the people of Sefton. It underpins elements of the Sefton Health and Wellbeing Strategy and builds on the successes of the original Shaping Sefton Strategy.

Our aim is to continually improve health and wellbeing for all in Sefton based on a partnership approach. The ambitions and priorities in the plan will need to be considered by partners in how they can be implemented over the next five years. As part of the annual planning process we will look to set targets based on available evidence and best practice.

Importantly, this plan is a 'system' based plan for the whole of Sefton. It brings together commissioners and providers from across different sectors, including community services, social care and the VCF sector, working together to improve the outcomes and experiences of our people. Working closer in this way will enable joined up coordinated care, planned and delivered around the needs and preferences of the individual, their carer and family.

Our agreed partnership vision:

"We want all of our health, care and wellbeing services to be more joined-up with as many as possible provided in our local communities. We want to empower you to make positive changes to the way that you live and make it easier for you to get the right support in the right place first time so that you can live longer, healthier and happier lives."

Sefton Health and Care Transformation Board, November 2018

The Sefton Transformation Board is made up of Chief Executives , Accountable Officers or representatives from NHS South Sefton and Southport and Formby Clinical Commissioning Groups (CCGs), Sefton Council, Mersey Care NHS Foundation Trust, Southport and Ormskirk NHS Hospital Trust, Aintree University Hospital NHS Foundation Trust, Lancashire Care NHS Foundation Trust, North West Boroughs Healthcare NHS Foundation Trust, Alder Hey Children's Hospital NHS Foundation Trust, Liverpool Women's NHS Foundation Trust, Sefton Primary Care Networks, Sefton GP Federations, NHS England and Improvement, the VCF sector and NHS West Lancashire CCG.

Successes since Shaping Sefton 2014 include:

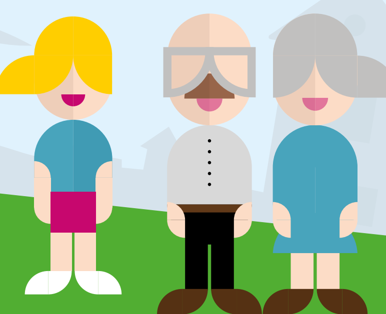
Much has been achieved over the last five years, since the development of the first Shaping Sefton Plan, which was developed by the two Sefton Clinical Commissioning Groups. We have listened to what you told us in 2014 and either put in place or are in the process of developing better and more focused health, care and wellbeing to meet your needs.

- Improved access to GP practices including access to general practice through out of hours services, seven days a week
- Development of Primary Care Networks (PCNs) to improve the sustainability of general practice and delivery of more joined up care in our GP practice localities (PCNs are groups of general practices working with community services the VCF sector and to provide more joined-up care for patients)
- Improving after care for those who have sought emergency treatment through A&E
- Better linking of cancer services with community-based support and improving awareness of cancer symptoms and screening opportunities for patients
- Laying the foundations for a community-based cardiology service which will bring services closer to people's homes and include diagnostics for patients. This includes the delivery of a cardiology hub in Southport which reduces the need for hospital appointments

- The development of children and young people's audiology services to improve the quality and experience of care
- Developing a community hub for diabetes in Litherland with all of the specialists, including a dietician, under one roof. A similar satellite hub has been developed in Maghull
- Working closely with the VCF sector to improve and encourage "social prescribing", where people are referred to a range of support groups for non medical activities, such as art programmes – particularly for those with mild to moderate mental health problems
- Carrying out a full review of mental health and dementia services particularly for Early Intervention Psychosis Hospital Mental Health Liaison and developing care for people who have a long-term condition and a common mental health illness
- Introducing the 'Integrated Community Re-ablement and Assessment Service' (ICRAS) which has improved access to community and social care services across Sefton, Liverpool and Knowsley
- Developed a model of proactive care, where professionals from different health and care services provide patients with individualised support in their home, or near to where they live. This has led to of Integrated Community Teams in south Sefton and the establishment of eight localities based on 30-50,000 populations from which our seven PCNs have been able to develop

You can see from the examples above we have made a great start and so we are now in a very good position to make greater strides, not just as individual organisations, but as one "system" for the whole of Sefton.

Unfortunately those living in Sefton can expect to have a shorter healthier life-expectancy than the national average.



A lot of work has been carried out, especially in the last 12 months, by the Sefton Health and Care Transformation Partnership. We want to build on the work we have done to support the development of Primary Care Networks as well as the strides we have made by bringing together community and social care services through the ICRAS programme.

We agree we cannot "jointly" deliver everything together. However, we are committed to working closely wherever possible to link up where our ambitions align. This will all be carried out under the umbrella of Sefton Health and Wellbeing Strategy and working within the finances available.

We also aim to cut delays, improve the quality of care, bring care closer to your homes and reduce both A&E attendance and hospital admissions.

In line with the ambitions of the national NHS Long Term Plan, we want to refocus our efforts and increase our investment in prevention rather than cure – this represents a significant change in the way we have prioritised our resources in the past.

We also know, from developing this plan with our partners and the public, we will not be able to change everything within five years. Some of the foundations we are building on will still take many more years to show their results. Delivering greater health and care results can take generations but that will not stop us planning and working now to make a positive change for the future.

This includes things like increasing vaccination and immunisation rates as well as identifying when we can intervene earlier to stop or reduce ill health getting worse. This will help you live longer, healthier lives and reduce your need for traditional medical services in the future.

By encouraging you to live a healthier lifestyle; such as eating and drinking more healthily, taking more exercise and not smoking, you will hopefully not have to rely on health and care services as much as you go through life.

We also want to help address some of the structural / wider determinants of health, to see how best we can work together with partners on things like poverty, housing, education, transport, skills, and employment.

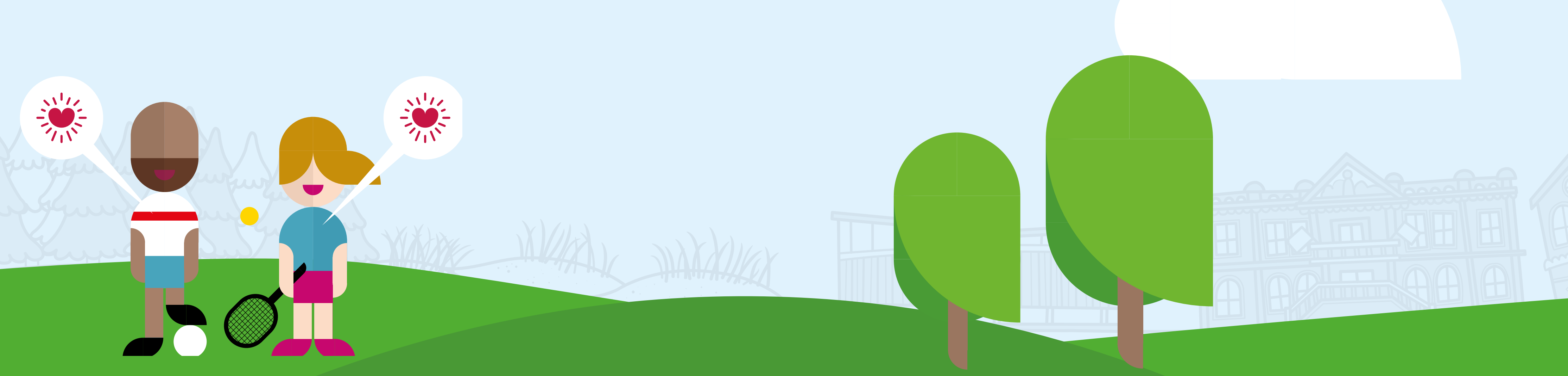
This includes looking at “social value”; which describes the social benefits achieved from public services. It considers more than just people’s wages and income and includes things like wellbeing, health, inclusion and many other benefits of being employed and active in the community.

Our main areas of focus are outlined in the plan and you will see they are ambitious. There are though some stark health and care issues in Sefton which need to be addressed for the benefit of everyone.

We need to prevent and reduce existing conditions like diabetes, heart disease, cancer and mental health conditions across all ages; reduce the time you wait for surgery and urgent care and provide value for money to you, as a taxpayer. We can do this by thinking more strategically about our future commissioning arrangements with all providers, including the VCF sector.

How we developed this plan

We have developed this plan in discussion with our partners both across the NHS and Sefton Council. The plan also includes feedback from a number of engagement events with organisations and partners in Sefton, including those providing services to Sefton residents, people who use such services and the VCF sector.



Alongside this activity there have been numerous other engagements with existing committees, meetings and other groups and forums, listed in Appendix 1. A broader public engagement exercise has also taken place to help guide the planning process, which included an online survey around our ambitions.

As part of this 'system' based approach, a key element of the plan will be to incorporate and support delivery of Sefton Health and Wellbeing Strategy, currently being refreshed by the Health and Wellbeing Board for publication in early 2020. We are all committed to delivering the key aims of this strategy for Sefton and helping people start well, live well, age well, die well.

We want to ensure that health and care across Sefton considers your entire life-cycle so that we can help and support whether you are a new born baby or coming towards the end of life.

There will be one implementation plan combining the joint actions of the NHS and Council from the Sefton Health and Wellbeing Strategy, the Children's and Young People Plan and this Plan to ensure consistent messaging around local strategic aims and priorities.

Working with partners across the region

This plan also contributes to the Cheshire and Mersey Health & Care Partnership's NHS Five Year Plan.. There are now four agreed priorities within the Cheshire and Merseyside Programme, these are:

1. **CVD Disease: Zero Stroke** – reinforcing the importance of prevention, given that diseases of the circulatory system are the second biggest killer in Sefton
2. **Mental Health and Wellbeing: Zero Suicide** – mental health is a priority across the life-course in Sefton. The suicide rate exceeds the national average (and doubled in the period to 2016/17). Hospital admissions for self-harm are also rising
3. **No more harm from alcohol** – Sefton is an outlier for alcohol admissions and mortality. Drinking too much can have numerous impacts on health as well as raising the chances of other related health issues, such as violence, or increased risk of having an accident
4. **No more harm from violence** – this work will focus on reducing violence from a Public Health and behavioural science perspective. Building on work from the UK and abroad, it is anticipated that a big difference can be made to people's quality of life if violence can be reduced. It will also have an impact on hospital admissions and the other burdens on public services

NHS Long Term Plan

The foundations of the *NHS Long Term Plan (National Health Service England, 2019) are already being implemented in Sefton including:

- Fully integrated community-based care to support general practice and bring a blend of local services closer to home to improve care and reduce the burden on GPs
- Reducing pressure on emergency hospital services
- Giving people more control over their own health
- Digitally enabling primary care and outpatients
- Improving cancer outcomes
- Expanding mental health services
- Shorter waits for planned care

The following services and care group areas are being considered both in Sefton and within the NHS Long Term Plan:

- **Mental Health –** helping more people get therapy for depression and anxiety and delivering community based physical and mental care for those with severe mental illness
- **Maternity and neonatal services –** reducing stillbirths and mother and child deaths during birth by 50 %, enabling women to benefit from continuity of carer through and beyond pregnancy and providing extra support for perinatal mental health conditions and new mothers at risk of premature birth
- **Services for children and young people –** increasing funding for children and young people's mental health, taking further action on childhood obesity and delivering the best treatments for children with cancer

- **Learning disabilities and autism –** bringing down waiting times for autism assessments and providing the right care for children and young people with a learning disability, autism or both. Our work to improve GP medication reviews will also encompass the STOMP (stopping over medication of people with a learning disability, autism or both and STAMP (supporting treatment and appropriate medication in paediatrics) agendas so that only the right medication is prescribed, at the right time and for the right reason
- **Transforming care –** increased funding for primary and community care, bringing together different professionals to coordinate care better, helping more people to live independently at home for longer and giving more people a say about the care they receive and where they receive it
- **Cardiovascular diseases, stroke and dementia care –** preventing a significant number of heart attacks and stroke cases. This will include providing education and exercise programmes to those with heart problems and making further progress on the care provided to people with dementia
- **Cancer –** 250 fewer deaths from cancer each year achieved by diagnosing cancer earlier
- **Severe ill health –** increasing the contribution to tackling some of the most significant causes of ill health, including new actions to help people stop smoking, overcome drinking problems and avoid type 2 diabetes
- **Respiratory disease –** investing in spotting and treating long term conditions like asthma and COPD early to prevent stays in hospital and vaccine preventable causes of pneumonia
- **Financial tests –** continuing the work with doctors and other health professionals to identify ways to reduce duplication in how clinical services are delivered and reduce spend on administration
- **Workforce –** requirements for the future workforce are being considered and will take into account current shortfalls; the need to flex and adapt the current workforce to new ways of working; maximising the potential of digital; the need to build in capacity to deliver the long term plan requirements; and to support the ongoing development of the workforce

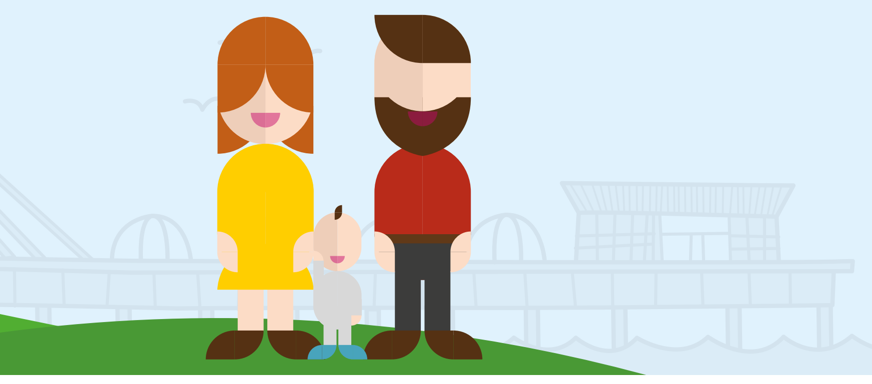
- **Digital**
  Being able to access services and information online and through digital technology is now an expectation for you. Digital transformation is key to delivering integrated care for the people of Sefton. From sharing information and enabling people to contribute to their own care, maximising opportunities for prevention, supporting the delivery of care and treatment, and helping clinicians use the full range of their skills, we can reduce out-dated bureaucracy and drive research and transformation. Our partners across Sefton already have good working relationships to build on and they will collaborate even more to make the most of digital opportunities for the people of Sefton in the future

- **Estates –** an estates strategy is currently being prepared for Sefton including One Public Estate. Work to reshape care in community settings is already underway – integrated health and social care is an emerging reality. Plans include improvements in primary care, greater access to GPs, more support for people to manage their own care, better illness prevention and more services moving from hospitals into the community

  Our primary and community estate will be better utilised and enhanced to deliver these new models of care. The estates strategy is informed by the principles of enabling more are to be delivered outside of hospital by integrated health and social care teams. It is a living strategy, which over time will incorporate our plans for reconfiguring hospital estate and, working with other partners, to make best use of all public estate in Sefton

Additional indicative funding has been made available to Sefton CCGs to support the implementation of the NHS Long Term Plan. These are detailed in Appendix 2

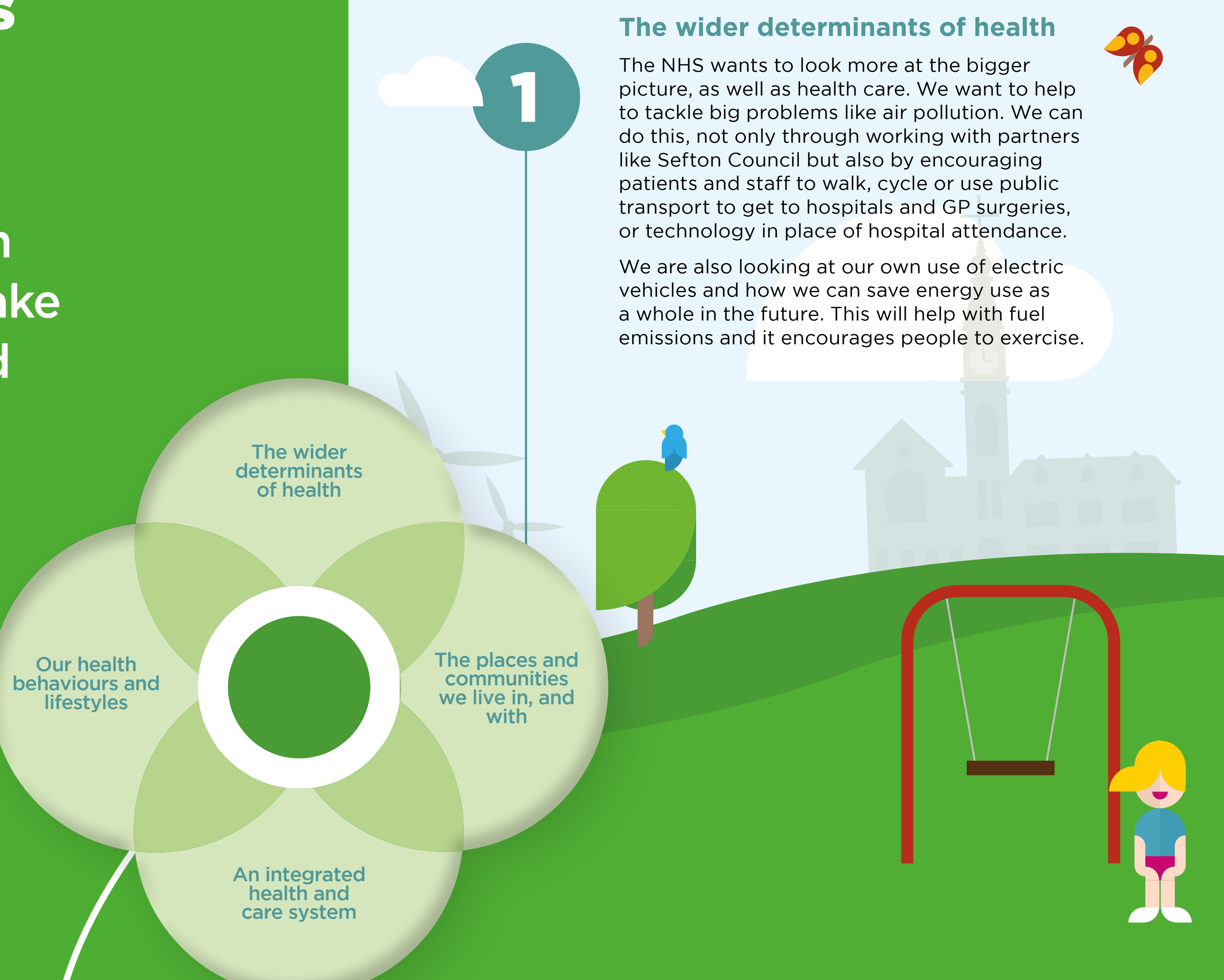
National Health Service England (NHSE) published its Long Term Plan on January 7, 2019. It sets out the plan for the future of the NHS, including ambitions for improvement over the next decade, and plans to meet them over the five years of the funding settlement



The Four Pillars

These four pillars work together to address population health issues to make sure the health and care system is the best it can be.

They were developed by Public Health England.



The wider determinants of health

The NHS wants to look more at the bigger picture, as well as health care. We want to help to tackle big problems like air pollution. We can do this, not only through working with partners like Sefton Council but also by encouraging patients and staff to walk, cycle or use public transport to get to hospitals and GP surgeries, or technology in place of hospital attendance.

We are also looking at our own use of electric vehicles and how we can save energy use as a whole in the future. This will help with fuel emissions and it encourages people to exercise.

2 Our health behaviours and lifestyles

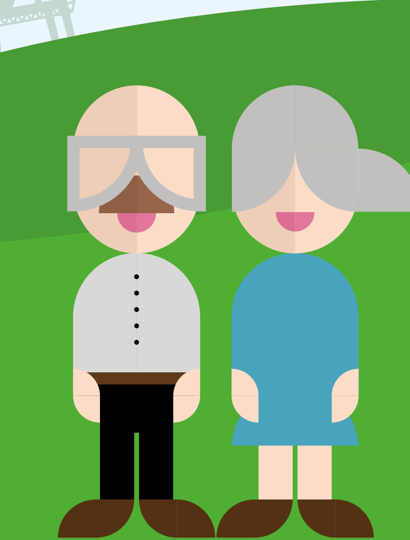
One of our goals is to help you live the healthiest and happiest life possible. This means we encourage and help people to stop smoking, avoid drinking in excess and improve their diet and exercise.

3 The places and communities we live in, and with

We want to make sure people have the best possible health care and to encourage you to have great relationships with friends, neighbours and the rest of your community. Being more sociable can help people to have a more positive outlook on life, reducing mental health issues and encouraging a greater feeling of wellbeing.

4 An integrated health and care system

We understand people often have more than one health care need. This is why it is important that services across health and care work together to ensure your needs are met in the most appropriate way.



Additional Public Health Goals

Adverse childhood experiences (ACEs) – evidence suggests that these have a significant negative impact on the health and wellbeing of the population and so the aim will be to consider how these can be reduced, and also responded to effectively.

Carers – To work alongside the priorities of the Sefton Carers strategy to support joined-up working for individual organisations, develop support for carers across the whole life-course, including young carers and ensuring that carers are involved in all of the planning for all services and proposals for the person they care for.

Transport – We will look at how improvements can be made to ensure sustainable and environmentally sound transport for patients and the public. This includes:

- Working with local transport providers and Sefton Council to identify potential changes to routes to improve access to services
- Working with the VCF sector to encourage more volunteer community drivers
- Working with patient transport services (including North West Ambulance Service (NWAS)) to improve access to services and encourage appropriate use

Education – we are also looking to increase collaboration between the NHS and education. This includes:

- Being school and child ready including the transition to secondary school
- Supporting mental health and wellbeing
- Increasing physical activity
- Ready for employment
- Importance of life skills
- How to provide educational information and materials to help encourage healthy lifestyles at an early age
- What can be provided by healthcare providers to reduce demand

Where there's a will...

As part of our responsibilities it is for us to encourage the people of Sefton to assist themselves and for services to be provided in the right way. The statements below describe what is hoped of all of us on this journey. We have developed the statements below in conjunction with Healthwatch Sefton, based on public surveys of the NHS Long Term Plan.

I will, while also encouraging my friends and family, try to:

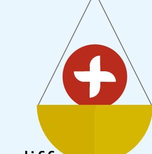
- **Ask for help** from health care professionals on how best to look after myself and I will take on board their advice
- **Find time** to take regular exercise
- **Eat** a more balanced and healthy diet
- **Get help** to stop smoking, or not start in the first place
- **Take** my medication as advised by my doctor or other professional
- **Attend** my appointments, or cancel them in advance if they are not needed any more, or I cannot make them
- **Socialise** with more people in my community where possible
- **Use** digital technology to make appointments and seek health and care advice when I need help
- **Make sure** I attend invitations for cancer screening where I am eligible for cervical, breast and bowel cancer screening programmes

In the future I would like to be able to:

- **Access** the right health and treatment when I need it most
- **Easily** get advice on how to lead a healthy life and to access the resources I need
- **Learn** more about staying independent and healthy while getting older
- **See** more support in my local community
- **Choose** the right treatment for me and be offered alternatives if I can't be seen quickly
- **Talk** to an appropriate health professional about my care and be confident that my personal data is secure
- **Use** technology where possible and be offered alternatives where not
- **Have** better access to general practice which can include a GP, other health professional or another person who is best able to meet my needs
- **See** the person who knows the most about my health and treatment even if I wait a bit longer
- **Access** services closer to my home which are focussed on my community

You can find more information about a range of health and care support services at: **www.seftondirectory.com**

Our Ambitions



1
A healthy balance

Did you know that there is a 12-year difference between the life expectancy in the poorest parts of Sefton compared to the richest parts? Our goal is to reduce that gap through targeted advice, information and support with health care when it is needed, helping you to live longer.

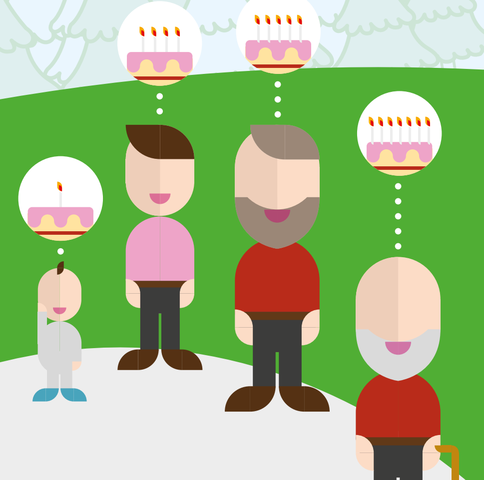
3
Early intervention

If you need help, the sooner we step in the better it is. That's why we are promoting early intervention through our health care system, making sure that any worries that you have are seen to as quickly as possible before they turn into major problems.

5
Empowering self-care

Helping you to care for yourself is very important to us. Self-care and lifestyle changes; such as not smoking, doing more exercise and eating and drinking healthily can make a big difference to you – from weight loss to managing mental existing conditions.

This also includes helping those people with long term conditions, eg. diabetes, or recovering from cancer to maintain as healthy a life as possible. After all, real change can only come from within.



2
Great expectations

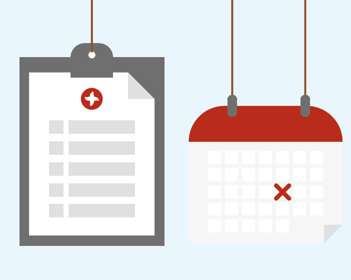
We want to make sure that you are able to live your best life by helping you choose to live longer, healthier. We want to help you increase the amount of years you live free from any major health conditions.

4
Prevention

Prevention and intervention go hand in hand. This is why we are encouraging people to stay healthy and active to prevent health and wellbeing problems later on in life.

6
Access to high quality services

We want to make sure that your health and care systems are the best that they can be, meet required quality standards and are located where you need them most. We are constantly looking for new ways to improve and meet your needs efficiently and effectively.



7

Planning ahead

There are long-term NHS goals that we have to meet to make sure that you are well looked after. These goals include; reducing your waiting times, supporting maternity services, reducing health inequalities and tackling diabetes, improving outcomes from cancer and supporting people with mental health problems at a local and national level.

8

Sustainability

We currently spend more money than we get. We want our health and care system to be financially sound. We have to understand how we can manage our money in a way that meets all of your needs. We also want to be able to maintain the high quality of care available, no matter what happens politically and economically.

Because of this we have to make sure that we are prepared for all circumstances and have the services in place when and where they are most effective.

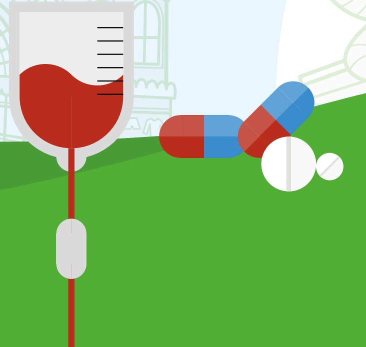
9

Social value

We want the NHS and other public sectors to be of value to you. We want to create a service that you love and trust, an employer who is fair and loyal and a pillar that the community can depend on. We aim to do this through constant communication and transparency about what we are doing and why.

This includes the five main things which make the NHS an “Anchor Institution”:

- Purchasing more locally and for social benefit
- Using buildings and spaces to support communities
- Widening access to quality work
- Working more closely with local partners
- Reducing its environmental impact



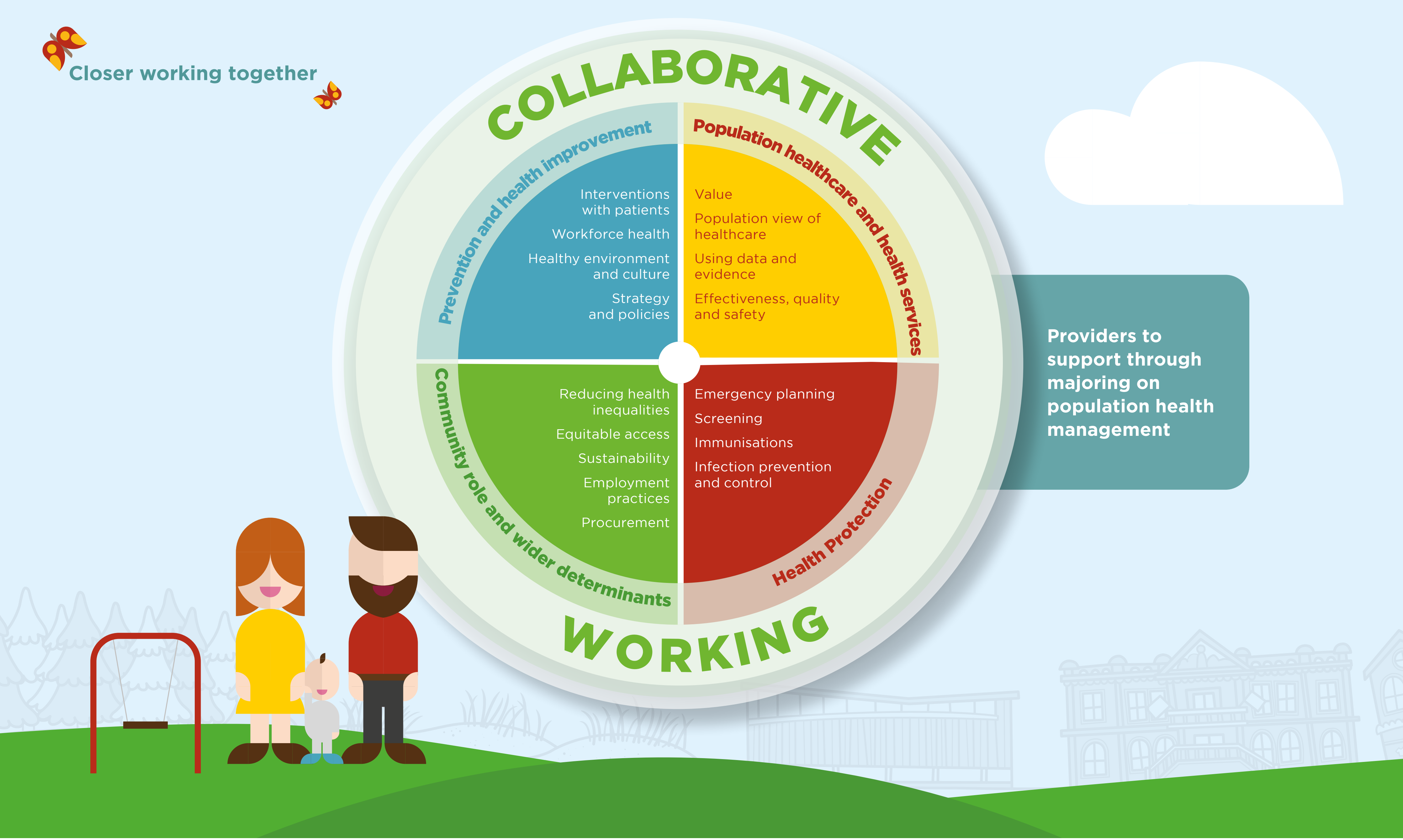
10

Working together

We aim to make the most of the resources we have available, both within the NHS and across our partners.

We want to ensure we all focus on “whole system delivery” through working together and being as efficient as possible.

The overall approach is guided by the need to address the health issues within Sefton, which mean that people are not living as long or as healthily as they could.


Closer working together
COLLABORATIVE WORKING
Prevention and health improvement
Interventions with patients
Workforce health
Healthy environment and culture
Strategy and policies
Population healthcare and health services
Value
Population view of healthcare
Using data and evidence
Effectiveness, quality and safety
Community role and wider determinants
Reducing health inequalities
Equitable access
Sustainability
Employment practices
Procurement
Health Protection
Emergency planning
Screening
Immunisations
Infection prevention and control
Providers to support through majoring on population health management

Rooted in your community

Information published by Public Health England (PHE) shows that many of the priority areas we are focussing on, such as; obesity, alcohol consumption, smoking and lack of regular exercise have a strong effect on both the length of life and healthy life for the people of Sefton.

We in the NHS are focussing much more on our contribution to health management and the improvement of wellbeing across the population. **This includes making the most of social value and leading on the 5 principles of anchor institutions.**

WHAT MAKES THE NHS AN ANCHOR INSTITUTION?

NHS organisations are rooted in their communities. Through its size and scale, the NHS can positively contribute to local areas in many ways beyond providing health care. The NHS can make a difference to local people by:

Purchasing more locally and for social benefit. In England alone, the NHS spends £27bn every year on goods and services.

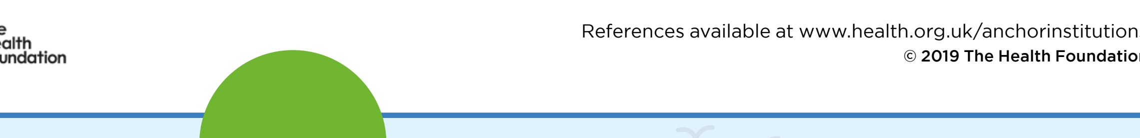
Using buildings and spaces to support communities. The NHS occupies 8,253 sites across England on 6,500 hectares of land.

Working more closely with local partners. The NHS can learn from others, spread good ideas and model civic responsibility.

Widening access to quality work. The NHS is the UK's biggest employer, with 1.5 million staff.

Reducing its environmental impact. The NHS is responsible for 40% of the public sector's carbon footprint.

As an anchor institution, the NHS influences the health and wellbeing of communities simply by being there. But by choosing to invest in and work with others locally and responsibly, the NHS can have an even greater impact on the wider factors that make us healthy.



Our future landscape

There is a national requirement for all health and either care systems or economies to become integrated care systems (ICSs) by April 2021, including setting out "how they see the provider and commissioner landscape developing".

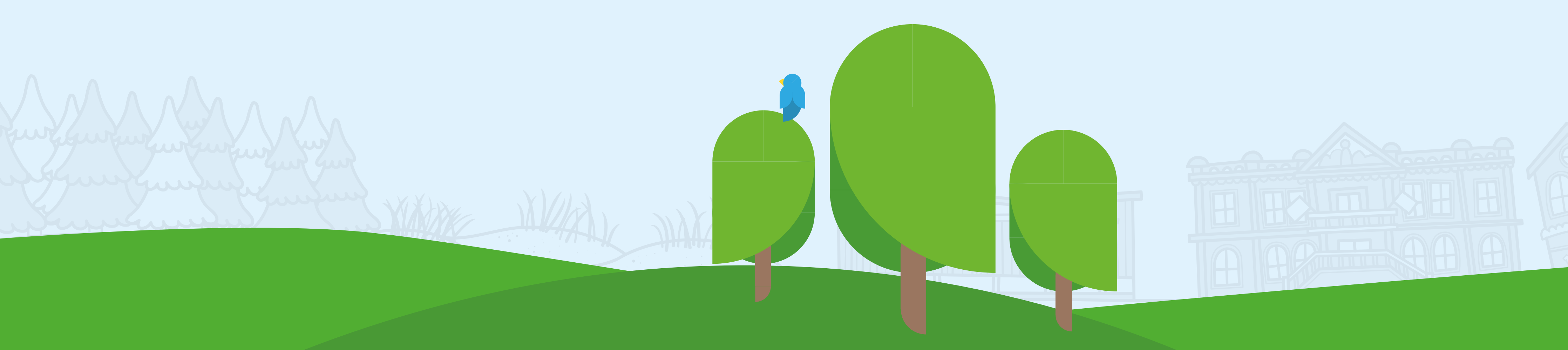
In an integrated care system, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve.

For Sefton this means being part of an ICS incorporating Cheshire & Merseyside; working as a strategic commissioner with NHS Southport and Formby CCG, NHS South Sefton CCG and Sefton Council; and developing Sefton's Provider Alliance (this means all health, care and VCF service providers working together).

Transformed community based care

The "future state" for Sefton includes integrated community-based provision. This includes community and general practice services along with those from our much valued and extensive VCF providers in Sefton, of which there are around 1,200 in the borough.

This will see partners from the NHS, local authority and VCF working together with the aim of providing a seamless service for the people of Sefton.



Sefton healthy future

Together a stronger community | A borough for everyone | A clean, green and beautiful borough

A confident and connected borough – future health, care and wellbeing in Sefton

Health, care and wellbeing services are joined-up, with many provided in local communities. Empowered people make positive changes to their lives and it is easy to get the right support in the right place first time and they live longer, healthier and happier lives as a result. There has been a reduction in health inequalities and key identified needs have been addressed.

Living, working and having fun

Integrated Care Partnership

Integrated Care System

Healthy behaviours and lifestyles

Early Intervention, Self-Care and Prevention: coordinated and seamless healthy living.

Health, care and well-being services offer prevention and early intervention services in partnership with voluntary, community and faith sector services.

Mobilised communities are empowered to actively engage in self-care and wellbeing for all ages. Integrated intelligence systems support self care and prevention; 'make every contact count' is embedded and enables risk stratification for targeted and personalised services.

Integrated health and care

Primary Care Networks are part of a multi-disciplinary and multi-agency integrated care team across all health, care and wellbeing providers with a digitally enabled single point of access and targeted care coordination supporting geographies of 30-50k population, with GPs as the senior clinical leader and an overseer of patient care.

People know what local services are available to access for any urgent needs and will have access to care navigators to help them access services. People will experience seamless care between the hospital, community and primary care with integrated services making sure they are home and accessing community care as quickly and as safely as possible. Services are available closer to home and outside of the hospital setting wherever possible with Integrated Specialist Teams.

Optimised acute care

Urgent & Emergency Care and Planned Care are focussed on whole pathway optimisation for physical and mental health and people only attend hospital when they need inpatient or specialist outpatient care.

People can access to acute services which will provide quality services that meet national standards, achieve best practice and deliver the best possible clinical outcomes. This, in most cases, will be delivered locally, but for some areas this may be further away to ensure the best possible expertise, facilities and care are available.

Starting well... living well... ageing well... dying well...

21st Century digital and technological solutions

An integrated trained flexible workforce supports care delivery; system leadership enables empowered teams to work 'without walls'

Financially sustainable and working to a capitated budget maximising the Sefton £

Whole system optimised estates across Sefton

System level coordinated communication and engagement

Strategic commissioning

Primary care networks

On the move

Visit, explore and enjoy | Ready for the future | Open for business

Taking a Clinical Lead

The work we do within both of Sefton's clinical commissioning groups is led by clinicians. They have helped to develop our plan from the beginning; while looking at the needs of the population using their own experience and knowledge alongside detailed facts and findings from the recently refreshed Joint Strategic Needs Assessment (JSNA) for Sefton.

A number of GPs have also been involved in the development of the plan and have had the opportunity to contribute content and ambitions we are hoping to achieve.

Your health and wellbeing is at the top of our priority list; and the people who know about your needs as individuals, and as a population, are helping us to focus on how we can improve your quality and expectations for a healthy life. We will continue to engage with other clinicians in order to ensure all clinical views are considered.

Each of our priority areas of work has involvement from professional clinical staff, colleagues from Sefton Council's Public Health Team, PHE and other organisations. They will continue to be involved in the development of the plan as we move forward from this plan to implementation. There is further work to be undertaken on the clinical aspects of the priorities we have described and this will be led through the CCGs' Clinical Advisory Group, Governing Bodies and other clinical expertise from across Sefton.

How do we balance the books in Sefton?

We are encouraging health and care partners across Sefton to stop thinking about how we fund things as individual organisations and look at where we all spend money on similar outcomes. This "system approach" to managing the financial position of Sefton is being discussed and will require a different approach to help all parts of the system to become financially stable and sustainable. There is a requirement of the regulators to deliver financial plans and this cannot be done in isolation.

It should also mean we become more efficient and target our spend to where it is most effective and in a timely fashion. This will include considering the benefits of investing in schemes that tackle the root causes of ill health.

As we work towards our new way of collaborative working we must also be aware of the need to not only be as efficient and effective as possible, but also balance the books.

The financial position across the system is currently in deficit and the CCGs have challenges to ensure savings are made to meet their obligations and those of other NHS and local authority organisations to ensure we spend only the money allocated to us.

There is an ongoing approach within the CCGs alongside other work to ensure we get the best value of taxpayers' money for you which is a key aspect of the NHS Long Term Plan. This will include considering out of hospital treatment being more cost effective.

While there are indicative funds (Appendix 2) allocated to the CCGs to support the delivery of NHS Long Term Plan requirements there is a need to contain increased healthcare activity especially in hospitals which supports the plan's aims and reduces the financial pressures on the local NHS. This will also need to take into account the demands of an ageing population with more complex (and expensive) care needs and with limited funding we need to get more from the resources we have.

The CCGs will continue to work with all NHS organisations to ensure our financial obligations are met and this is going to be a challenging position especially for the first two years of the planning period. Many of our partners are in a similar position, NHS, Local Authority, and the VCF sector, so we will make great efforts to ensure we work together to provide the best possible outcomes in the future with the money available so maximising the Sefton pound.

To assist with this we will be looking at how budgets can be combined (pooled) to maximise their value and over time if a defined budget can be held by the Provider Alliance to increase the flexibility of budgets with providers working together. This will be supported through the integrated commissioning approach of Sefton Council and the Sefton CCGs working in an aligned fashion on areas of mutual benefit and be supported by appropriate governance.

A more collaborative approach

Through the development of the Sefton Health and Care Partnership's approach there is a greater emphasis on working together. If we work and think more as a "system" then there is a reduced need for continual procurement as more providers work collaboratively together.

This does not necessarily mean organisations have to join together but just work more effectively together, think as one and focus more clearly on joined-up outcomes for the public. We must ensure all services provide value for money and all of our providers, existing and new, are able to work collaboratively.

Showing we care in every locality

We are developing integrated care in Sefton to include community service providers, locality based mental health provision, PCNs and the VCF sector. This integrated approach will encourage a greater mental and physical health collaboration as well as making the most of local assets such as community buildings, workforce, volunteers and services and promoting social prescribing; which encourages health professionals, volunteers and other prescribers to guide people towards activities and community services rather than just considering traditional medical treatments.

Different localities may have different integrated approaches depending on the equality and diversity issues as well as their health issues. This approach will be encouraged through the PCNs working with local populations, the Council and local VCF organisations.

In your community

We aim to ensure all our communities will be covered by the integrated community and PCN arrangements, including the provision of more hospital services in the community. In addition localities will have population profiles to identify the specific health issues which require a targeted response, and may differ between localities.

We will also be considering changes to contracts with the VCF sector to give organisations more certainty and longevity and help them to plan and deliver strategically.

Reducing clinical variation across the system

In Sefton there are a few different examples of how people can receive a differing level of service depending on where they live. These can include different waiting times for certain services or differing opening hours of general practice or primary health care services. There are several approaches to addressing clinical variation, including:

- Using of national and regional benchmarking information
- Implementing the outcomes from GIRFT (Get It Right First Time), a national programme for reviewing healthcare services
- Practice variation reviews for prescribing, screening and vaccination rates

The data from these activities will be used by the PCNs to consider how best to address variation between practices. The Local Quality Contract, helps to improve the quality of services in GP practices and as part of that audits are carried out to identify variations between practices.

Reduce growth in demand for care – through better integration and prevention

In Sefton we are working hard as partners within a system to deliver our services in a joined up way. Part of that work is to strengthen and develop how our service providers can work together more closely in the future. Through the development of a "Provider Alliance" there are now regular meetings of the main health and care providers in Sefton. These include senior representatives who are looking to develop more strategic planning to ensure the services are more joined up and we are focused on where we have the chance to make things better.

There are a range of approaches under consideration which will help with reducing demand and achieving financial sustainability. These include:

- Undertaking risk stratification – to identify those most at risk of serious illness or ongoing conditions and provide them with support to reduce the need for medical intervention
- Supporting a range of alternatives to A&E departments including greater use of primary care extended hours; working with community pharmacists to offer urgent care related treatments; and increasing the profile of social prescribers as additional alternatives to accessing traditional healthcare services
- Promoting the revised integrated community and PCN offer to each locality providing universal services and directions to a range of alternatives to urgent care facilities
- Focusing the Provider Alliance on collective actions associated with people with complex lives to reduce the demand on health and care providers

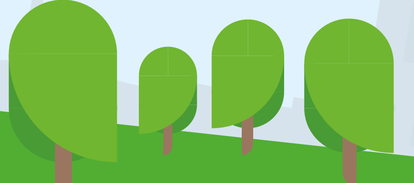
Integration is about improving the outcomes and experiences of individuals who receive support and care, and less so about organisational arrangements. Integrated commissioning is about aligning budgets, whether pooled or not, and increasing investment in services that build independence. Integrated provision is about providers from different sectors, including community services, and VCF colleagues working together to create new ways of delivering services as close to home as possible. (Adapted from LGA, 2019).

Service delivery will be complemented by integrated care, which is joined up, co-ordinated care that is planned and organised around the needs and preferences of the individual, their carer and family. It means that a host of different services, treatments or equipment can be discussed for an individual person's needs and tailored to help them in the best way possible (LGA 2018).

Our Priorities

Having assessed the requirements of the NHS Long Term Plan, alongside other evidence around the health and care needs of the people of Sefton, such as the Joint Strategic Needs Assessment, and the feedback and evidence we have gathered throughout the engagement and development of this plan, we intend to focus on a number of priorities. Many of the priorities outlined below are for the Sefton Health and Care "system" to deliver and will be the subject of further, more detailed development, throughout the lifetime of this plan:

- Child development – ensure all children are ready for school
- Supporting the transition of children and young people to adults
- Parenting and early years – supporting families in the early years of a child's life
- People with learning disabilities – more accessible health, support and advice
- Looked after children – to assist in reducing the number of looked after children and to ensure the health of looked after children is improved
- Immunisation – to signpost and encourage greater uptake
- Improving the uptake of regular exercise
- Substance use including alcohol and prescribed medicines use – encouraging access to appropriate services and reducing the incidence and effects
- Frailty – reducing the incidence of falls and supporting the management of long term conditions such as diabetes and cardiovascular disease
- Social isolation – acknowledging this is a significant issue for older people we will work with the VCF sector to provide support for our residents to reduce the impact
- Supporting older people – through age friendly initiatives with our partners and Sefton Partnership for Older Citizens, we want to enable our older citizens to enjoy Sefton as a place with the freedom to be and do what they value most in good health for as long as possible
- Care homes – working to support the provision of care homes for the benefit of our residents who live in them
- Dementia – supporting patients throughout onset and provide support for patients and their families



- Cancer – this is the biggest killer in Sefton and must be addressed through four key aspects –
    - Prevention through a healthier lifestyle
    - Increasing the numbers of people who participate in cancer screening programmes
    - Ensuring earlier intervention when treatment is required
    - Personalised support for everyone living with cancer
- Mental health (all age) – ensure timely access to mental health services and support reductions in incidence. Support to be offered across all ages with a specific focus on children and young people
- Prevention and early intervention (all age) – increase the vaccination rates and reduce variation across Sefton
- Obesity (all age) – reducing levels across all ages with a specific focus on children and young people e.g. to turnaround the current increase at age 11
- Smoking – to continue to reduce the incidence especially within most deprived areas of Sefton and when pregnant
- Dental – work with dental commissioners to consider how access to services for children and adults can be encouraged to increase access and promote healthy oral care
- Help and support – where it is most needed. This includes:
    1. Removing barriers to access e.g. supporting people to look after themselves, assist with fuel poverty, guiding people to use VCF services and other support services
    2. Distributing resources and intervention proportionately to address need so as to achieve more equal outcomes
    3. Recognising the earlier onset of conditions in deprived areas compared to the least deprived areas
- Funding – Increasing the amount of funding for prevention and maximise the use of the VCF sector
- Primary Care Networks – Supporting the development and maturity of PCNs and embedding the locality model with the VCF sector services, so that a ‘left shift’ in how and where services are provided can take place

We will aim to reduce the number of follow-up appointments and new outpatient appointments at hospital through:

- Appropriate use of technology
- Following best clinical practice to ensure patients are followed up in hospital only when clinically required
- Seeing patients in the community

As well as making better use of hospital based resources it means less travel so helping to reduce air pollution.

The plan also looks to support a number of environmental factors including climate change impacting on health, including:

- Reducing the use of car journeys through less hospital visits
- Encouraging more walking, cycling and use of public transport
- Encouraging NHS vehicles to be carbon neutral
- Support from the VCF sector - including aiding health and wellbeing, encouraging young children's learning, planting more trees within green places in Sefton

These priorities will need to be addressed on a phased basis as some will have an increased profile e.g. mental health, cancer and obesity.

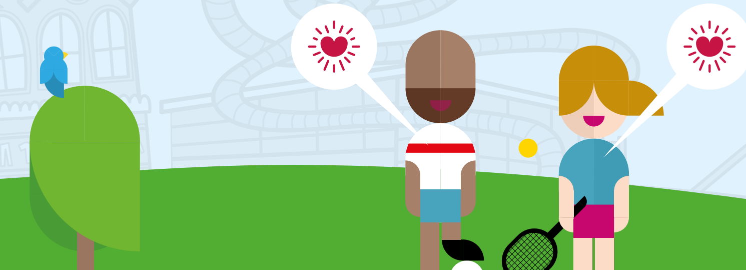
The CCG will look to address health inequalities

(Source: Public Health England – July 2019):

- Ensuring commissioning plans have a specific focus on improving the health of people with the poorest health outcomes fastest
- Identifying and closing the gaps in care which have the most impact on health inequalities
- Ensuring all screening and vaccination programmes are designed to support a narrowing of health inequalities in access, uptake and outcomes, acknowledging there is significant variation in uptake across Sefton
- Ensuring commissioning processes formally assess impact on health inequalities
- Considering the potential of service models to inadvertently increase health inequalities (for example are psychosocial factors likely to impact on accessing services for some groups)
- Undertaking and acting upon Health Equity Impact Assessments

Assessment of plans and services by:

- Using formal mechanisms to proactively identify people who are most likely to benefit from earlier intervention – based on the identification of risk, and early diagnosis
- Targeting resources to support and transform care models and pathways to improve access, experience and outcomes
- Employing targeted use of personal budgets and personalisation, to empower individuals and communities including those in positions of disadvantage
- Supporting healthy workforce initiatives across the partnership
- Funding to support low-cost exercise inclusion activities and other methods to increase the amount of physical exercise
- Ensuring representation of our diverse patient population now and into the future
- Removing significant barriers to employment and financial independence through our local support programmes, including for those with mental health issues or learning disabilities
- Supporting community-centred or independent sector enterprise, to take on and maintain green or open spaces, and harness for community use including activity initiatives and events
- Working across public sector workforce as exemplars to improve physical activity
- Identifying high hospital emergency admissions in priority wards with high deprivation scores and also outliers for excess admissions
- Addressing unwarranted variation in covering primary care, and community-based issues in effective connection to services
- Setting targets to bring emergency admission rates in outlying 'priority' wards down to the average for those with similar deprivation scores, within two years
- Embedding "social value" (see p33) across the commissioning process



Primary Care Networks

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

This includes making the social prescribing of community services and other activities more widely available and accessible. In line with the latest guidance from NHS England and Improvement, we will ensure these networks are supported by the CCGs by enabling advice and support in all areas of business including medicines management, finance, business intelligence, governance and communications and engagement.

The four characteristics of our Primary Care Networks (PCNs) are:

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

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

The organisations across the partnership realise the importance of working towards a common purpose. How we do that together is fundamental to the success of implementing this plan. A charter has been developed which signifies the collective approach.

Population Health Management is an approach which aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across the whole population.

The driver for our ambitions and priorities from the NHS Long Term Plan can be seen at Appendix 3.

Other actions to be considered by PCNs include:

- Recognising the impact of people's understanding of the health system, their thoughts and behaviours on the demand, need and uptake of primary care services
- Systematically targeting and adapting services to the needs of people most likely to experience health inequalities
- Improving access to digital networks and patient records, particularly remotely in ambulances and while out in the community
- Working closely and systematically with other front-line delivery partners to co-ordinate person and family-based approaches to addressing complex needs
- Embedding community-centred approaches in their work with communities as part of developing social prescribing systems
- Ensuring community services for all ages are sustainable and continue to provide the right care at the right time, in the right environment in order to increase people's ability to remain in the community
- Using community-centred approaches to improve health and wellbeing, building social capital to help communities to reduce inequalities
- Increasing Annual Health Checks and screening to improve the physical health and wellbeing of people with a Learning Disability or Autism and increase their opportunities to live well for longer
- Delivering more care through re-designed community-based and home-based services, in partnership with social care and the VCF sector
- Introducing an emergency response car, staffed with a paramedic and a therapist linked to ICRAS, with a prescribing function, to reduce reliance on urgent input from General Practice
- Utilising staff across frontline services to actively make every contact count in identifying physical inactivity and overweight in users, and link in to social prescribing resources
- Developing multidisciplinary integrated teams of professionals with GPs becoming clinical and team leaders, so people with multiple and complex conditions are seen by the right person, first time and without delay

Health care service providers will consider the following to support delivery of the NHS Long Term Plan and population health management:

- Targeting services to the needs of individuals, families and communities most likely to experience health inequalities (including through utilising available data, for example demographic, equality and diversity or wider determinants data)
- Using evidence-based risk stratification tools to offer different levels of wellbeing support depending on individuals' health literacy as part of targeted self-care
- Implementing structures that engage community members, especially the most marginalised groups, in decision-making about service needs, priorities and appropriate delivery methods with demonstrable resulting changes
- Implementing an enhanced and targeted continuity of carer models, in particular, to help improve outcomes for the most vulnerable mothers and babies
- Improving liaison between health and care providers to increase the co-ordination of care to assist schools for children with complex needs
- Ensuring by 2023 and 2024, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services
- Using their role as an anchor institution to improve health outcomes through co-ordinated action on the wider determinants of health, including air pollution and employment. For example, through 'green' transport provision and targeted recruitment of people from deprived communities and offer apprenticeships
- Using community-centred approaches to improving health and wellbeing
- Continuing to create healthy NHS premises
- Ensuring as much of the healthcare spend is retained locally e.g. through procurement supply chains
- Supporting healthy workforce initiatives
- Utilising staff across frontline services to actively make every contact count in identifying physical inactivity and overweight in users, and link in to social prescribing resources

Social Value

We will develop an approach based on generating more social value which better understands and enables you and the wider community. We want our partners and everyone in the borough to see that investing in health, like in education, is indeed an *investment* rather than a cost. By having healthier, happier communities we will also create a wealthier and more prosperous borough – such as creating employment opportunities for local people.

Health, care and wellbeing partners across Sefton can help create social value when they engage with and involve their local communities. We will enable people to be better connected with their local services and resources.

As part of this work we, and our partners, have signed up to the Cheshire and Merseyside Health Care Partnership Social Value Charter.

The model below illustrates how the benefits of social value can be built into the local system of commissioning (or buying) services for the people of Sefton.

Embedding Social Value across the whole commissioning cycle

ANALYSE

1. What is the question?
Start to think about Social Value from the beginning when developing the commissioning question. What is the high level outcome and how does it relate to Social Value?

2. Know your customers
Understanding your customers should also include a review of the needs / assets linked to Social Value (avoidable inequalities)

PLAN

3. Define the Outcomes
Co-design of Social Value Outcomes and how they will be measured. Early engagement and co-production with stakeholders is key.

4. What will it look like?
Thinking about Social Value early can help to stimulate innovation and can shape the service design / model. Market and service User engagement will help you to understand the potential for social value.

DO

5. How will you get there?
Social Value should be a key component of the Procurement Strategy and Contract clauses and schedules e.g Performance Monitoring Framework (PMF). Social Value should be evaluated and weighted as part of the selection and award process. Ensure that Social Value commitments and contractual and measurable. Identify the financial benefits of the social value you are trying to achieve.

REVIEW

6. Measuring the impact
Social Value outcomes and KPI's will be actively measured throughout the life of the contract via the Performance Management Framework (PMF). Social Value impacts can be measured at an individual contract level, and corporately across all contracts collectively. Apply the same contract management approach to social value as you would to quality, performance and finance.

Celebrate success. Identify the shared benefits.

Embedding Social Value across the whole commissioning cycle

This model is based on the principles of good commissioning identified within the LGA integrated Commissioning for Better Outcomes Framework 1, which is a practical tool for council and NHS commissioners to support improving outcomes through integrated commissioning.

Conclusion

The plan has been developed with significant contributions from many people who are enthusiastic to make a positive contribution to the health and wellbeing of people in Sefton. This is a partnership commitment towards improving health care and make a contribution to the wider health determinants and will take a number of years to fully take effect.

Joint implementation will need to be phased over the lifetime of the plan with ongoing engagement taking into account the annual priorities based on available evidence and best practice.

APPENDIX 1 –Engagement

In developing our plan we have gathered views and contributions from a wide range of partners and public including:

Aintree University Hospital NHS Foundation Trust

Alder Hey Children's NHS Foundation Trust

CCGs' Patient Engagement Group (EPEG)

Cheshire and Wirral Partnership NHS Foundation Trust

Health & Care Forum

Healthwatch Sefton

Health & Wellbeing Board

Lancashire and South Cumbria NHS Foundation Trust

Liverpool Women's NHS Foundation Trust

Mersey Care NHS Foundation Trust

NHS Southport and Formby CCG Governing Body, QIPP Committee and Clinical Advisory Group

NHS South Sefton CCG Governing Body, QIPP Committee and Clinical Advisory Group

NHS West Lancashire CCG

North West Ambulance Service

North West Boroughs NHS Foundation Trust

Older Persons Forum Ainsdale

Older Persons Forum Bootle

Older Persons Forum Crosby

Older Persons Forum Formby

Older Persons Forum Maghull

Older Persons Forum Southport

Partnership Stakeholder events in April, July and October

Sefton Association of Primary Headteachers

Sefton Association of Secondary Headteachers

Sefton Council's Consultation and Engagement Panel

Sefton Council for Voluntary Services

Sefton Health and Social Care Forum

Sefton Metropolitan Borough Council

Sefton Overview and Scrutiny Committee – Adults

Sefton Overview and Scrutiny Committee – Children's

Sefton Provider Alliance

Sefton Public Health Team

NHS Southport and Formby CCG Big Chat

NHS Southport and Formby CCG Wider Group of GP practices

Southport and Ormskirk Hospital NHS Trust

NHS South Sefton CCG Big Chat

NHS South Sefton CCG Wider Group of GP practices

South Sefton Primary Healthcare Ltd

APPENDIX 2

This section outline the indicative financial allocations made to both Sefton CCGs based on "Fair Share" funding for some of the priorities in the Sefton2gether Plan.

NHS Long Term Plan

Indicative Allocations based on fair shares

Table 1 – Additional indicative Funding allocations

England Total	2019/20	2020/21	2021/22	2022/23	2023/24
	£m	£m	£m	£m	£m
Total	538	560	814	1,219	1,779
Of which:					
1. Mental Health	60	65	220	441	592
2. Primary Medical and Community Services					
(a) Primary Care	321	335	359	369	364
(b) Ageing Well	0	30	70	204	343
3. Cancer	118	89	71	68	68
4. Other	39	41	94	137	412
Sefton Total	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
0.57%	**£m**	**£m**	**£m**	**£m**	**£m**
Total	3.078	3.204	4.657	6.973	10.177
Of which:					
1. Mental Health	0.343	0.372	1.259	2.523	3.387
2. Primary Medical and Community Services					
(a) Primary Care	1.836	1.916	2.054	2.111	2.082
(b) Ageing Well	0.000	0.172	0.400	1.167	1.962
3. Cancer	0.675	0.509	0.406	0.389	0.389
4. Other	0.223	0.235	0.538	0.784	2.357
South Sefton CCG	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
0.33%	**£m**	**£m**	**£m**	**£m**	**£m**
Total	1.753	1.825	2.652	3.972	5.797
Of which:					
1. Mental Health	0.196	0.212	0.717	1.437	1.929
2. Primary Medical and Community Services					
(a) Primary Care	1.046	1.092	1.170	1.202	1.186
(b) Ageing Well	0.000	0.098	0.228	0.665	1.118
3. Cancer	0.384	0.290	0.231	0.222	0.222
4. Other	0.127	0.134	0.306	0.446	1.342
Southport & Formby CCG	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
0.25%	**£m**	**£m**	**£m**	**£m**	**£m**
Total	1.325	1.379	2.004	3.001	4.380
Of which:					
1. Mental Health	0.148	0.160	0.542	1.086	1.458
2. Primary Medical and Community Services					
(a) Primary Care	0.790	0.825	0.884	0.909	0.896
(b) Ageing Well	0.000	0.074	0.172	0.502	0.845
3. Cancer	0.291	0.219	0.175	0.167	0.167
4. Other	0.096	0.101	0.231	0.337	1.014

Table 2. Commitments to be delivered through system funding allocations

Mental Health	The expansion of community mental health services for Children and Young People aged 0-25; funding for new models of integrated primary and community care for people with SMI from 2021/22 onwards; and specific elements of developments of the mental health crisis pathways. See 2.27.
Primary Care	This funding includes the continuation of funding already available non-recurrently to support Extended Access and GP Forward View funding streams, (eg practice resilience programme), and associated commitments must be met. Additional funding is also included to support the development of Primary Care Networks.
Ageing Well	Deployment of home-based and bed-based elements of the Urgent Community Response model, Community Teams, and Enhanced Health in Care Homes.
Cancer	Rapid Diagnostic Centres funding in 2019/20 only; Cancer Alliance funding to support screening uptake delivery of the Faster Diagnosis Standard and timed pathways, implementation of personalised care interventions, including personalised follow up pathways and Cancer Alliance core teams.
CVD, Stroke and Respiratory	Increased prescribing of statins, warfarin and antihypertensive drugs;
	Increased rates of cardiac, stroke and pulmonary rehabilitation services; increased thrombolysis rates; and early detection of heart failure and valve disease.
CYP & Maternity	Local Maternity Systems funding; Saving Babies Lives Care Bundle funding from 2021/22; postnatal physio funding from 2023/24; funding for integrated CYP services from 2023/24.
LD Autism	Funding for rollout of community services for adults and children and keyworkers from 2023/24.
Prevention	Tobacco addiction - inpatient, outpatient/day case and Smoke Free pregnancy smoking cessation interventions.

NHS Long Term Plan

Indicative Allocations based on fair shares

Table 3 – Targeted Funding available to systems

England Total	2019/20	2020/21	2021/22	2022/23	2023/24
	£m	£m	£m	£m	£m
Total	418	939	1101	1,249	1,481
Of which:					
1. Mental Health	182	251	190	234	292
2. Primary Medical and Community Services					
(a) Primary Care	100	208	303	381	475
(b) Ageing Well	6	40	40	24	24
3. Cancer	46	121	198	186	398
4. Technology	26	238	199	192	179
5. Other	58	82	172	231	114
Sefton Total	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
0.57%	£m	£m	£m	£m	£m
Total	2.391	5.372	6.298	7.145	8.472
Of which:					
1. Mental Health	1.041	1.436	1.087	1.339	1.670
2. Primary Medical and Community Services					
(a) Primary Care	0.572	1.190	1.733	2.180	2.717
(b) Ageing Well	0.034	0.229	0.229	0.137	0.137
3. Cancer	0.263	0.692	1.133	1.064	2.277
4. Technology	0.149	1.362	1.138	1.098	1.024
5. Other	0.332	0.469	0.984	1.321	0.652
South Sefton CCG	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
0.33%	£m	£m	£m	£m	£m
Total	1.362	3.060	3.588	4.070	4.826
Of which:					
1. Mental Health	0.593	0.818	0.619	0.762	0.951
2. Primary Medical and Community Services					
(a) Primary Care	0.326	0.678	0.987	1.241	1.548
(b) Ageing Well	0.020	0.130	0.130	0.078	0.078
3. Cancer	0.150	0.394	0.645	0.606	1.297
4. Technology	0.085	0.776	0.648	0.626	0.583
5. Other	0.189	0.267	0.560	0.753	0.371
Southport & Formby CCG	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
0.25%	£m	£m	£m	£m	£m
Total	1.029	2.312	2.711	3.075	3.646
Of which:					
1. Mental Health	0.448	0.618	0.468	0.576	0.719
2. Primary Medical and Community Services					
(a) Primary Care	0.246	0.512	0.746	0.938	1.170
(b) Ageing Well	0.015	0.098	0.098	0.059	0.059
3. Cancer	0.113	0.298	0.488	0.458	0.980
4. Technology	0.064	0.586	0.490	0.473	0.441
5. Other	0.143	0.202	0.423	0.569	0.281

Table 4. Commitments to be delivered through targeted funding allocations

Mental Health	Includes: - funding for continuation of previous waves such as mental health liaison or Individual placement support funding; pilots as part of the clinical review of standards, and other pilots such as rough sleeping. funding to be distributed in phases in consultation with regional teams including: funding for testing new models of integrated primary and community care for adults and older adults with severe mental illness, community based integrated care, rolling out mental health teams in schools and salary support for IAPT trainees. See2.28.
Primary Care	Digital First Primary Care support funding; the Investment and Impact Fund; and Estates and Technology Transformation Programme.
Ageing Well	Targeted funding to accelerator STPs to rollout the Ageing Well models.
Cancer	Development and roll out of innovative models of early identification of cancer (starting with lung health checks); funding for the development of Rapid Diagnostic Centres from 2020/21 onwards; support for further innovations to support early diagnosis.
Technology	Revenue funding for Provider Digitisation and Local Health and Care Records.
Cardiovascular Disease, Stroke and Respiratory	Pilots for improving access to cardiac, stroke and pulmonary rehabilitation services and early detection of heart failure and valve disease.
Maternity and Neonates	Continuity of carer for BME and disadvantaged women from 2021/22; funding to support the UNICEF Baby Friendly Initiative; funding to support the expansion and improvement of neonatal critical care services from 2021/22; funding from 2020/21 for Family Integrated Care; funding to support the rollout of postnatal physiotherapy and multidisciplinary pelvic health clinics from 2021/22 to 2022/23.
Diabetes	Funding to pilot the use of low calorie diets from 2019/20 until 2022/23; funding to support delivery of recommended treatment targets; funding for multi-disciplinary footcare teams and diabetes inpatient specialist nurses (see 4.31).
Learning Disabilities and Autism	Funding to pilot and develop community services for adults and children and keyworkers from 2020/21 to 2022/23; piloting of models to expand Stopping Treatment and Appropriate Medication in Paediatrics (STOMP-STAMP) programmes from 2020/21 to 2023/24; testing the model for ophthalmology, hearing and dental services to children and young people in residential schools from 2021/22; funding to reduce the backlog of the Learning Disabilities Mortality Review Programme (LeDeR).
Personalised Care	Targeted transformation funding to deliver the NHS Comprehensive Model for Personalised Care from 2019/20–2021/22.
Prevention	Alcohol Care Teams from 2020/21 to 2023/24; Tobacco addiction services early implementer sites from 2020/21; targeted support for weight management service improvements from 2020/21.

APPENDIX 3

Evidence Base – This is drawn from the documents and engagement used to develop the priorities outlined in the Sefton2gether Plan

Stages	Priorities	Reasoning
Starting and Learning Well	Child Development	The percentage of pupils attaining a good level of development is below the England rate, but the Sefton rate is above the England rate for pupils known to be eligible for free school meals. The difference between the two is 13%. The percentage of pupils attaining Level 4 or above and the expected standard in reading, writing and maths in Sefton are above the English rate. However the percentage of pupils attaining Level 4 or above in reading, writing and maths is below the England rate for those pupils known to be eligible for free school meals. The same pupils are above the English rate for meeting the expected standard. The percentage of pupils known to be eligible for free school meals attaining Level A*-C in English and Maths GCSE is well below the English rate and is widening.
	Mental Health	The number of hospital admissions for mental health conditions (crude rate per 100,000 0-17 Year Olds) in Sefton is above the England rate although the gap is less wide now than in 2014/15 or 2015/16. The number of hospital admissions as a result of self-harm aged 10-24 (directly standardised rate per 100,000 10-24 year olds) has increased each year from 2013/14 to 2016/17 from below the England rate to well above.
	Parenting & Early Years	Smoking at time of delivery (rate per 100 maternities) was above the England rate in Sefton. The percentage of mothers who give their baby breast milk in the first 48 hours after delivery is also significantly lower in Sefton. The rate is also lower after 6-8 weeks. Despite year on year variation, Sefton's percentage of low birth weight babies tends to remain around 7%. Sefton's overall rate for 2016 is 6.6%, lower than the England average (7.3%).
	Prevention and early intervention	The percentage of children with excess weight in reception is above the England rate. The percentage of children with excess weight in Year 6 is similar to England.
	Looked after children	The children looked after rate per 10,000 is 85.0 in Sefton compared to 61.7 across England. The percentage of children looked after who had a missing incident during the year (April to March) has increased since 2015 and is above the England rate. The percentage of children in care with up to date immunisations is in line with the England average after having been below in 2015 and 2016.
Living and Working Well	Prevention and early intervention for long term conditions e.g. heart disease, diabetes	The percentage of adults classified as active and those classified as inactive is similar to the England rate. Sports club membership is also similar. Sefton leisure centres have seen an increase in attendance. For long term conditions Sefton is above the England rate for AF, CHD, HF, Hypertension, PAD, Stroke, Diabetes, CKD and Dementia. The percentage of the eligible population aged 40 – 74 receiving a NHS Health Check is much lower in Sefton than England.
	Obesity	There is little difference in the percentage of adults classified as overweight or obese in Sefton compared to England. However in Sefton the percentage of adults classified as Overweight or Obese has fallen by almost seven points between 2015/16 and 2016/17. Obesity rates in both age groups were higher for Sefton's most deprived communities than for Sefton as a whole.
	Smoking	The smoking prevalence in adults (% weighted number of self-reported smokers aged 18+ by total number of respondents with a valid smoking status aged 18 in APS) is lower in Sefton than England. However the number of smoking related deaths is slightly higher.

Stages	Priorities	Reasoning
Living and Working Well	Alcohol	The number of hospital admissions for alcohol-related conditions (directly standardised rate per 100,000) is above the English rate for Sefton. Furthermore the percentage of alcohol users that left alcohol treatment successfully who do not re-present to treatment within 6 months has fallen from above the England rate in 2015 to below in 2016. There is also many more hospitals admission for mental and behavioural disorders due to alcohol and alcohol related mortality in Sefton. The rate for alcohol related mortality for females is not significantly different to the England average; however the rate is significantly worse for males.
	Mental Health	The percentage of people with low life satisfaction score (self-reported wellbeing) is higher in Sefton. The percentage of self-reported wellbeing – people with a high anxiety score was about in line with England in 2016/17 having been above since 2012/13. The suicide rate in Sefton is above the England rate. In most mental health prevalence indicators Sefton is above the England rate. The employment rate for working age people receiving secondary mental health services is below the English rate.
	Cancer	Under 75 mortality from cancer (directly standardised rate per 100,000 0-74) is higher in Sefton than England.
	Substance Misuse	The percentage of Opiate drug users that left drug treatment successfully and did not re-present to treatment within 6 months is lower in Sefton than England overall. For non-opiate drug users the number was similar to the England rate; however the Sefton rate has fallen from 63.4% in 2012 to 35.2% in 2016, which the England rate has remained stable around 37%. The rate of deaths from Drugs misuse is above the England average in Sefton.
Ageing and Dying Well	Obesity	There is little difference in the percentage of adults classified as overweight or obese in Sefton compared to England. However in Sefton the percentage of adults classified as Overweight or Obese has fallen by almost seven points between 2015/16 and 2016/17. Obesity rates in both age groups were higher for Sefton's most deprived communities than for Sefton as a whole.
	Smoking	The smoking prevalence in adults (% weighted number of self-reported smokers aged 18+ by total number of respondents with a valid smoking status aged 18 in APS) is lower in Sefton than England. However the number of smoking related deaths is slightly higher.
	Alcohol	The number of hospital admissions for alcohol-related conditions (directly standardised rate per 100,000) is above the English rate for Sefton. Furthermore the percentage of alcohol users that left alcohol treatment successfully who do not re-present to treatment within 6 months has fallen from above the England rate in 2015 to below in 2016. There is also many more hospitals admission for mental and behavioural disorders due to alcohol and alcohol related mortality in Sefton. The rate for alcohol related mortality for females is not significantly different to the England average; however the rate is significantly worse for males.

Stages	Priorities	Reasoning
Ageing and Dying Well	Long Term Conditions	The percentage of adults classified as active and those classified as inactive is similar to the England rate. Sports club membership is also similar. Sefton leisure centres have seen an increase in attendance. For long term conditions Sefton is above the England rate for AF, CHD, HF, Hypertension, PAD, Stroke, Diabetes, CKD and Dementia. The percentage of the eligible population aged 40 – 74 receiving a NHS Health Check is much lower in Sefton than England.
	Mental Health	The percentage of people with low life satisfaction score (self-reported wellbeing) is higher in Sefton. The percentage of self-reported wellbeing – people with a high anxiety score was about in line with England in 2016/17 having been above since 2012/13. The suicide rate in Sefton is above the England rate. In most mental health prevalence indicators Sefton is above the England rate. The employment rate for working age people receiving secondary mental health services is below the English rate.
	Social isolation	Permanent admission to residential and nursing care homes for adults aged 65 and over (rate per 100,000 population) is 250 points above in Sefton than England. The percentage of adult social care users who have “as much social contact as they would like” according to the Adult Social Care Client Survey shows the Sefton rate has been consistently above the England rate.
	Dementia	The percentage with dementia recorded prevalence aged 65+ (of those on practice register) has been above the England rate from September 2015 to September 2017. There is no significant difference between Sefton and England rates for emergency hospital admission for dementia in those Aged65+. Inpatient admissions for Alzheimer’s Disease and vascular dementia Aged 65+ (directly standardised rate per 100,000) is above the England rate.
	Frailty	The number of emergency hospital admissions due to falls and the number of hip fractures in people Aged 65 and over is higher in Sefton than England. As recently as 2013/14 the rate was below the England average.
	Dying Well	The ratio of excess winter deaths is higher in Sefton than England.

Ambitions	Long Term Plan
Make a full contribution to Sefton's Health & Wellbeing Strategy e.g. wider determinants like air pollution	"reduced respiratory hospitalisations from lower air pollution." "Air pollution and lack of exercise are also significant." "Specifically, we will cut business mileages and fleet air pollutant emissions by 20% by 2023/24." "In 2017, 3.5% (9.5 billion miles) of all road travel in England was related to patients, visitors, staff and suppliers to the NHS. At least 90% of the NHS fleet will use low-emissions engines (including 25% Ultra Low Emissions) by 2028, and primary heating from coal and oil fuel in NHS sites will be fully phased out. Redesigned care and greater use of 'virtual' appointments as set out in Chapter One will also reduce the need for patient and staff travel." "The NHS will continue to commission, partner with and champion local charities, social enterprises and community interest companies providing services and support to vulnerable and at-risk groups. These organisations are often leading innovators in their field. Many provide a range of essential health, care and wellbeing services to groups that mainstream services struggle to reach. Of 100,000 social enterprises in the UK, 31% work in the 20% most deprived communities58, creating jobs and filling gaps in support as well as addressing wider determinants of health and wellbeing such as debt and housing."
Reduce health inequalities	"The burden of obesity isn't experienced equally across society. The NHS will therefore provide a targeted support offer and access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+ (adjusted appropriately for ethnicity), where we know we can have a significant impact on improving health, reducing health inequalities and reducing costs." "Expanding the Diabetes Prevention Programme is a key vehicle for tackling health inequalities, with a significantly higher take up from BAME groups than the general population." "Over the next five years, those hospitals with the highest rate of alcohol dependence-related admissions will be supported to fully establish ACTs using funding from their clinical commissioning groups (CCGs) health inequalities funding supplement, working in partnership with local authority commissioners of drug and alcohol services." "NHS England will continue to target a higher share of funding towards geographies with high health inequalities" "To support local planning and ensure national programmes are focused on health inequality reduction, the NHS will set out specific, measurable goals for narrowing inequalities, including those relating to poverty, through the service improvements set out in this Long Term Plan" "While we cannot treat our way out of inequalities, the NHS can ensure that action to drive down health inequalities is central to everything we do." "Over 1.2 million people in England have a learning disability and face significant health inequalities compared with the rest of the population"
Increase healthy life expectancy	"People are now living far longer, but extra years of life are not always spent in good health… They are more likely to live with multiple long-term conditions, or live into old age with frailty or dementia, so that on average older men now spend 2.4 years and women spend three years with 'substantial' care needs." "Every 24 hours, the NHS comes into contact with over a million people at moments in their lives that bring home the personal impact of ill health. This Long Term Plan sets out practical action to do more to use these contacts as positive opportunities to help people improve their health. This will contribute to the government's ambition of five years of extra healthy life expectancy by 2035."
Embed early intervention	"Over the next five years the NHS will fund new Mental Health Support Teams working in schools and colleges, building on the support already available, which will be rolled out to between one-fifth and a quarter of the country by the end of 2023. These school and college-based services will be supervised by NHS children and young people mental health staff and will provide specific extra capacity for early intervention and ongoing help." "The Five Year Forward View for Mental Health also set new waiting time standards covering the NHS' IAPT services, early intervention in psychosis and children and young people's eating disorders. All of these standards are being achieved or on track for delivery in 2020/21."

Ambitions	Long Term Plan
NHS majoring on the prevention agenda	"Falls prevention schemes, including exercise classes and strength and balance training, can significantly reduce the likelihood of falls and are cost effective in reducing admissions to hospital" "As part of wider move to what The King's Fund has called 'shared responsibility for health', over the next five years the NHS will ramp up support for people to manage their own health. This will start with diabetes prevention and management, asthma and respiratory conditions, maternity and parenting support, and online therapies for common mental health problems." "Improving upstream prevention of avoidable illness and its exacerbations. So for example, smoking cessation, diabetes prevention through obesity reduction, and reduced respiratory hospitalisations from lower air pollution. This can also be achieved through better support for patients, carers and volunteers to enhance 'supported self-management' particularly of long-term health conditions." "This Long Term Plan sets out new commitments for action that the NHS itself will take to improve prevention. It does so while recognising that a comprehensive approach to preventing ill-health also depends on action that only individuals, companies, communities and national government can take to tackle wider threats to health, and ensure health is hardwired into social and economic policy." "The role of the NHS includes secondary prevention, by detecting disease early, preventing deterioration of health and reducing symptoms to improve quality of life." "The creation of a national CVD prevention audit for primary care will also support continuous clinical improvement." "We will design a new Mental Health Safety Improvement Programme, which will have a focus on suicide prevention and reduction for mental health inpatients." "We will work on falls and fracture prevention, where we know that a 50% improvement in the delivery of evidence-based care could deliver £100 million in savings."
Supporting self – care	"Research shows as many as 50% of patients do not take their medicines as intended and pharmacists will support patients to take their medicines to get the best from them, reduce waste and promote self-care." "From 2019, NHS 111 will start direct booking into GP practices across the country, as well as refer on to community pharmacies who support urgent care and promote patient self-care and self-management." "Improving upstream prevention of avoidable illness and its exacerbations. So for example, smoking cessation, diabetes prevention through obesity reduction, and reduced respiratory hospitalisations from lower air pollution. This can also be achieved through better support for patients, carers and volunteers to enhance 'supported self-management' particularly of long-term health conditions." "We will support people who are newly diagnosed to manage their own health by further expanding provision of structured education and digital self-management support tools, including expanding access to HeLP Diabetes an online self-management tool for those with type 2 diabetes." "New models of providing rehabilitation to those with mild COPD, including digital tools, will be offered to provide support to a wider group of patients with rehabilitation and self-management support." "We will also expand access to support such as the online version of ESCAPE-pain (Enabling Self-management and Coping with Arthritic Pain through Exercise), a digital version of the well-established, face-to-face group programme"
Meeting quality standards (in health and care)	National requirement in acute, mental health, community and general practice, care homes, social care and in specific areas e.g. learning disabilities will continue to improve care for those with Learning Disabilities by learning from lived experience as well as from Learning Disability Mortality Reviews (LeDeR). These reviews will always be undertaken within six months of the notification of death and all reviews will be analysed to address the themes identified with recommendations being reported through a local LeDeR report.
Meet NHS Long Term Plan (LTP) requirements	These are referenced throughout the document

Ambitions	Long Term Plan
A sustainable health and care system	"Our aim is to ensure a sustainable overall balance between supply and demand across all staff groups. For doctors, we will focus on reducing geographical and specialty imbalances. For the wider workforce, we aim to ensure sufficient supply of nurses and to address specific shortages for AHPs and other key groups." "Putting the NHS back onto a sustainable financial path is a key priority in the Long Term Plan and is essential to allowing the NHS to deliver the service improvements in this Plan. This means: • the NHS (including providers) will return to financial balance; • the NHS will achieve cash-releasing productivity growth of at least 1.1% a year, with all savings reinvested in frontline care; • the NHS will reduce the growth in demand for care through better integration and prevention; • the NHS will reduce variation across the health system, improving providers' financial and operational performance; • the NHS will make better use of capital investment and its existing assets to drive transformation." "We will also create a new Financial Recovery Fund (FRF) to support systems' and organisations' efforts to make all NHS services sustainable." "The NHS is leading by example in sustainable development and reducing use of natural resource in line with government commitments."
Maximise social value (e.g. NHS as anchor institutions)	"As an employer of 1.4 million people, with an annual budget of £114 billion in 2018/19, the health service creates social value in local communities. Some NHS organisations are the largest local employer or procurer of services. For example, nearly one in five people employed in Blackpool work for the NHS and the Gross Value Added (GVA) from health spending is significantly higher than in areas in the south (over 17% vs 4% in London). Sandwell and West Birmingham Hospitals NHS Trust has committed to deploying 2% of its future annual budget with local suppliers, estimating it will add £5-8 million to the local economy. Leeds Teaching Hospitals NHS Trust is supporting the city's inclusive growth strategy by targeting its employability and schools outreach offer at neighbourhoods in the most deprived 1% nationally and is increasing its apprenticeship programmes by 51% year-on-year. In partnership with the Health Foundation, we will work with sites across the country to identify more of this good practice that can be adopted across England."

Sefton2gether Shaping Sefton II

Sefton's response to the NHS long term plan

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