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Dear Councillor

HEALTH AND WELLBEING BOARD - WEDNESDAY 9TH SEPTEMBER, 2020

I refer to the agenda for the above meeting and now enclose the following report(s) which were unavailable when the agenda was published.

Agenda No.	**Item**
8	**The Direct and Indirect Impacts of COVID-19 on the Health and Wellbeing of our Local Population** (Pages 3 - 8) Report of the Director of Public Health
11	**NHS Planning 2020/21** (Pages 9 - 34) Report of the Director of Strategy and Outcomes (interim) - NHS South Sefton CCG, and NHS Southport and Formby CC

Yours faithfully,

Democratic Services

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Report to:	Health and Wellbeing Board	**Date of Meeting:**	Wednesday 9 September 2020
Subject:	The Direct and Indirect Impacts of COVID-19 on the Health and Wellbeing of our Local Population		
Report of:	Director of Public Health	**Wards Affected:**	(All Wards);
Portfolio:	Health and Wellbeing		
Is this a Key Decision:	N	**Included in Forward Plan:**	No
Exempt / Confidential Report:	N		

Summary:

The report presents a Liverpool John Moores University and the Champs Public Health Collaborative, which has produced a rapid evidence review identifying what the current evidence tells us about the direct and indirect impacts of COVID-19 on health and wellbeing.

Recommendation(s):

(1) The paper is to be received and noted by the Board.

Reasons for the Recommendation(s):

The purpose of the paper is to aid understanding of the impact of COVID and inform future Health and Wellbeing Board Decisions.

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

Not applicable

What will it cost and how will it be financed?

(A) Revenue Costs

There are no revenue implications identified within this report.

(B) Capital Costs

There are no capital costs associated with this report.

Implications of the Proposals:

Resource Implications (Financial, IT, Staffing and Assets): None identified
Legal Implications:
Equality Implications: The equality Implications have been identified and risk remains, as detailed in the report.

Contribution to the Council's Core Purpose:

Protect the most vulnerable: Information on the impact of COVID to aid future oversight and decision making
Facilitate confident and resilient communities: Information on the impact of COVID to aid future oversight and decision making
Commission, broker and provide core services: Information on the impact of COVID to aid future oversight and decision making
Place – leadership and influencer: Information on the impact of COVID to aid future oversight and decision making
Drivers of change and reform: Information on the impact of COVID to aid future oversight and decision making
Facilitate sustainable economic prosperity: Not applicable
Greater income for social investment: Not applicable
Cleaner Greener Not applicable

What consultations have taken place on the proposals and when?

(A) Internal Consultations

The Executive Director of Corporate Resources and Customer Services (FD6115/20) and the Chief Legal and Democratic Officer (LD4307/20) have been consulted and any comments have been incorporated into the report.

(B) External Consultations

Not applicable

Implementation Date for the Decision

Immediately following the Board meeting.

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Appendices:

There are no appendices to this report

Background Papers:

There are no background papers available for inspection.

1. Background

1.1 Health inequalities already existed in our community before the pandemic. However, COVID-19 has impacted disproportionately on our most vulnerable communities potentially widening the gap in health and wellbeing measures between some groups and the rest of Sefton. There will be implications during our recovery phase with regard to how we best try to tackle this. The recently published review gives some indication as to what some of the impacts have been and can be expected if applied with a Sefton lens

2 Impacts

2.1 Impacts on family, friends and communities

There is evidence of increased civic participation in response to the pandemic and a positive impact on social cohesion. Thousands of new volunteer groups have been established in communities across the country and the majority of adults believe the country will be more united and kinder following the pandemic.

Social isolation and loneliness have impacted on wellbeing for many. There are also serious concerns about how the combination of greater stress and reduced access to services for vulnerable children and their families may increase the risk of family violence and abuse. Compounding this, safeguarding issues have been largely hidden from view during lockdown.

2.2 Impact on money and resources

There has been an increase in people signing up for Universal Credit and Jobseeker's Allowance benefits. Young workers and low earners have been impacted the most and household incomes have fallen particularly among the lowest earners. The predicted economic downturn will have significant health impacts in the short and longer term.

2.3 Impact on education and skills
Children and young people may be hit hardest by the social distancing and lockdown measures. School closures risk exacerbating existing inequalities in

educational attainment. Surveys suggest that the richest households are more likely to be offered active help from school, and that they are spending more hours a day on home learning.

2.4 Impact on our surroundings

People have spent far more time at home during lockdown which may play a role in exacerbating the health impacts of poor-quality housing. Further, an estimated 12% of households in England have had no access to a private or shared garden during lockdown. Although access to public parks is more evenly distributed, inequalities exist in access to good quality and safe public green space. Air was cleaner and healthier in early lockdown, but global emissions have since rebounded to close to 2019 levels.

2.5 Impact on transport

The impact on transport has been mixed. Falls in road journeys during the early period of lockdown have generally been short-lived and there are concerns about the lasting damage that may be done to public transport systems. A positive impact has been seen with more people cycling, but it remains to be seen whether the changes to cycling infrastructure will have a lasting impact.

2.6 Impact on the food we eat

Lockdown has exacerbated food insecurity and food need; particularly among children. The number of adults who are food insecure is estimated to have quadrupled. Food banks have experienced a rapid increase in demand but alongside this have experienced reduced volunteer numbers.

2.7 Access to health and social care

The COVID-19 pandemic has both disrupted and changed the delivery of NHS and social care services. Concerns have been raised about significant drops in A&E use and the health care needs of people with long-term conditions have been significantly impacted.

2.8 Individual health behaviours

The wider determinants of health both shape the distribution of, and trigger stress pathways associated with the adoption of unhealthy behaviours. Lockdown has impacted on these behaviours in different ways. People who were drinking alcohol the most often before lockdown are also the ones who are drinking alcohol more often and in greater quantities on a typical drinking day. People already drinking alcohol the least often have cut down in the greatest number. The impacts on smoking appear to be more positive, with smokers showing an increased motivation to quit and to stay smoke free during the pandemic.

Findings are less clear in relation to diet. Non-UK studies show decreased physical activity and increased eating and snacking during lockdown. In England, physical activity behaviours among children and adults have been disrupted by lockdown. Although some groups have continued to be physically active, groups that were least active before lockdown are finding it harder.

2.9 Health and wellbeing outcomes

It is expected that long-term conditions will have worsened for many people over the course of lockdown and there are particular concerns about the impact of delayed cancer diagnoses and the knock-on effects as NHS services are resumed. There is also increasing evidence that people who experience mild to moderate COVID-19 disease may experience a prolonged illness with frequent relapses.

Experience from previous pandemics and economic shocks suggests that mental ill health will increase widely during the pandemic, although the scale is difficult to predict. A range of factors may be drivers of poor mental health, including those directly related to COVID-19 (e.g. more generally or because of the loss of family and friends to COVID-19) and those indirectly related through the effects of the social distancing and lockdown measures (e.g. through social isolation or because of financial insecurity).

3 Recommendations

The impacts of COVID-19 have not been felt equally – the pandemic has both exposed and exacerbated longstanding inequalities locally. As we move from the response phase into recovery, the direct and wider impacts of the pandemic on individuals, households and communities will influence their capacity to recover. The unequal impacts of the COVID-19 pandemic go further than the direct impacts of the disease itself. The unintended consequences of lockdown, social distancing and other measures designed to control the spread of infection – isolation at home, economic shutdown, school closures and reduced access to services – have had and will continue to have their own unequal impacts on health and wellbeing outcomes.

3.1 We must therefore adopt the principle of “proportionate universalism”, in line with our health and wellbeing strategy for the borough. Targeted support will be required for some groups who have been disproportionately disadvantaged by the pandemic including men, older people, those with existing health conditions, ethnic minority communities, so-called ‘low skilled’ workers and those from poorer areas are all at a greater risk of infection, serious illness and of dying from COVID-19.

3.2 We are returning to a different social landscape in Sefton to what we were operating in before. We need to understand this landscape and adapt to it to better serve the local community. We must not be afraid of working in new and innovative ways and in new partnerships. This will include how best to carry on with our test and trace model in the years to come.

3.3 We have had a bolstering to our sense of community in terms of the vast numbers of volunteers to help with our community response. This is something we can build on in our response to protecting the health of those most vulnerable in our communities.

3.4 Sefton Council should work with the CCGs on combined efforts to promote the usage of local health services to prevent non COVID related conditions from going

unchecked. This should include consideration of how services return to face to face access rather than a solely digital offer.

3.5 Adopting a life course approach, we potentially have a cohort of children in Sefton who have been impacted educationally and socially, with lifelong impacts who may need specialised consideration and a trauma informed approach. This is of particular note to our more disadvantaged children.

3.6 While mental ill health is difficult to predict in terms of how it will manifest post pandemic for Sefton, it is vital we have systems in place to handle this and consider it as another “wave” of impacts from COVID-19. There may be fear associated with getting back outside, interacting with our local economy and becoming less sedentary.

3.7 There is likely to be an increased demand on local healthy weight services and provision due to an increase in local population weight and the associated comorbidities e.g. CVD. For a while there is also likely to be a widening of the BMI difference by socioeconomic position.

3.8 Worsening financial insecurity is likely to lead to an increased demand on local food banks and more pressure on our employment related services. We should prepare for this by ensuring sufficient capacity and resource in the system.

South Sefton Clinical Commissioning Group
Southport and Formby Clinical Commissioning Group

Report to the Health & Well Being Board - September 2020

NHS Planning 2020/21

Introduction
This is a NHS and local borough update on health issues as part of the NHS planning requirements to March 2021.

In July NHS England and NHS Improvement provided guidance on how the NHS needs to restore the NHS to levels experienced prior to the COVID-19 pandemic. This includes across the board NHS services and consideration of health inequalities such as:

- A restoration of cancer services to full operation and reducing diagnostic delays
- Achieving 80% of last year's elective (planned operations) activity and outpatient/ day case procedures in September, rising to 90% in October through utilising independent sector capacity.
- Restoring 90% and 100% of diagnostic capability by September and October respectively.
- Achieving 100% of last year's outpatient activity from September with an interim step of 90% in August
- Restoring GP activity
- Resuming CHC assessments
- Expanding and improving mental health services and learning disability and autism services
- Preparing for winter
- Significantly expanding flu vaccination programmes
- Expanding NHS 111 First.

Many of these aspects are part of Sefton's Health & Wellbeing Strategy and the NHS 5 year plan – Sefton2gether.

Background

- Peak COVID-19 activity in April and May
- Many NHS services paused to meet COVID-19 demands
- Urgent cases and emergencies continued
- All services being restored taking into account social distancing
- Planning underway for winter including potential of COVID-19 waves
- Many good practices introduced to continue

Urgent and emergency care
The overall winter planning focuses on a number of key objectives involving all partners. These include:

- Reducing A/E attendances with patients being appropriately directed to other services including community and voluntary sector
- Avoiding long waiting times in the A/E Department for patients who require a hospital bed, and
- Maintain same day discharge as early in the day as possible

Schemes include:

- expanding reablement and Home First services.
- Social workers operating from A/E Departments to assist alternatives to hospital admission.
- Alternative transport for mental health patients in A/E
- Implementing NHS 111 First so patients do not require to attend A/E as alternatives are in place
- Extended community based services
- Additional weekend staffing at weekends to support avoiding discharge delays

Care Homes

The CCGs have been working collaboratively with Sefton Council and other system partners to put in place a full range of support to care homes to assist them in responding to the significant challenges that the pandemic has posed. As part of the CCGs' incident management arrangements a Care Home Cell was established which, through Director and senior manager input, fed into the system wide Care Home Cell, led by the Director of Adult Social Services. Components of that support established include:

- The commissioning of significant additional care home capacity for COVID-19 positive patients and "step-down" beds, with wrap around clinical and rehabilitation support to meet the specific needs of patients recovering from COVID-19.
- Rapid roll out of technology to care homes to enable GP and community services video consultations, reducing footfall and risk to care home residents.
- Identification of named clinical lead for each care home, a weekly "check-in" for each home and to proactive multidisciplinary team meetings to enable more proactive care in conjunction with NHS community services, local Primary Care Networks (PCNs) and specialist geriatric services.
- The implementation of a wide range of medicines management arrangements to improve supply and ordering of medicines, proactive review of medication use, new protocols and delivery of homely remedies and end of life medication, in addition to the existing named clinical pharmacist to support each home.
- The development of a joint training programme to encompass a wider range of areas such as End of Life Care (including interactive training from local Palliative Care consultants), medicines management, bereavement support and self-care.
- Implementation of a train the trainer model for infection control and personal protective equipment (PPE).
- Support for care homes to becomes established on the capacity tracker and NHS net.
- Joint approach with Sefton Council in relation to reimbursement of COVID-19 related costs.
- Joint work through shared staffing team to ensure daily communications will all care homes and weekly virtual calls.

Many developments will be sustained and further enhanced through on-going strategic work to support our care homes in the longer term.

Mental health care

Supported living services – ongoing engagement with all supported living providers to provide updated guidance on infection control measures to influence and direct how support is delivered (PPE, staffing issues, testing, bubbles of support, prevention of cross infection)

- Re-assessments of need are ongoing to agree additional/alternative support where required with funding available.
- Continued to liaise with providers regarding additional funding requirements to support recovery planning.
- Full building risk assessments have been undertaken in conjunction with Day Care providers in relation to infection control measures (as advised by Public Health England, PHE).
- A full review of clients who previously attended day centres is being undertaken to prioritise vulnerable clients being able to resume attendance based on reduced capacity in day centres going forward, this work is being undertaken as part of a multi-disciplinary approach.
- A full review of transport to identify future requirements, and infection control measures needed to support the recovery planning for day opportunities (as advised by PHE).
- Continued to liaise with providers regarding additional funding requirements to support recovery planning
- A full online PHE training programme is being made available by Mersey Care NHS Foundation Trust to all day care providers.
- Continued to liaise with providers regarding additional funding requirements to support recovery planning.
- Working with respite providers to resume service delivery in a safe and effective way based upon guidance from PHE.
- Council and CCGs have worked with providers to ensure that support to access the community continues to be delivered where appropriate based upon assessed need in a safe and effective manner.

Mental Health Recovery Team

- The Council has developed a new Mental Health Recovery Team. This is a borough wide service providing intensive recovery-based support and reablement interventions to Sefton residents under the care of secondary mental health services. The service will use a strengths-based approach and will be time limited and goal orientated with the aim of improving service users' confidence, independence, social inclusion and mental wellbeing.
- The team consists of three support workers and three Community Care Practitioners (two full time/one part time) based in the Mental Health Teams both North and South of the borough.
- The team's initial focus is on supporting people who are experiencing difficulties following the COVID-19 restrictions and aim at assisting people in re-establishing pre-COVID-19 confidence and routines. Work will be undertaken under a reablement model with support being offered in 3 or 4 sessions a week for a period of up to 6 weeks.

Elective care

There is a continued focus on clinically urgent patients to be treated first, with next

priority given to the longest waiting patients, specifically those waiting longer than 52 weeks. Changes in the use of infection control guidance means reduced capacity so additional independent sector capacity is being utilised as well as weekend working. To improve efficiency in outpatients patient initiated follow ups are being used which frees capacity for seeing more new patients from GPs.

Consideration will need to be given to any future increases in the numbers of COVID-19 patients as priorities will again be transferred to patients requiring emergency treatment.

Waiting lists have reduced over the last few months as there has been a reduction in the numbers of new referrals from GPs as patients have not been attending general practice. This is expected to change over the coming months and it is important for patients to continue to see their GP if they have any health issues.

Hospitals have fully embraced the requirement for digital technologies, with 'Attend anywhere' - video consultation being implemented across a number of specialties.

Cancer services

Cheshire & Merseyside's Cancer Alliance has been asked to co-ordinate the full restoration of cancer and cancer related services. Planned activity assumes a slow decline in COVID-19 cases and the impact of possible future spikes.

Growth of 6% has been built into referral volumes to reflect a general upward trend pre-pandemic and delayed presentations in primary care during the pandemic which may now result in referrals over the next few months. After an initial lull in presentations to primary care, then an increase, there is now a reduction again in referrals compared to pre-COVID-19 activity. The public are continuing to be encouraged to visit their GP if they experience any possible cancer symptoms.

Numbers waiting over 62 days for a diagnosis are split equitably by tumour group and appear to be within manageable volumes. Numbers waiting over 104 days are low and will be reducing. Any patients waiting over 104 days are reviewed to ensure there are no clinical implications of waiting.

The Cancer screening programmes have not yet fully re-established. Whilst the Breast Cancer Screening Programme will not impact on Southport and Ormskirk Hospital, the Cervical and Bowel screening programmes will start to create additional demand for diagnostic and treatment services as the programmes recover to full capacity. Support for diagnostic services are being organised through Liverpool University Hospitals FT (LUHFT) and other hospitals in Liverpool to assist in clearing backlogs.

Primary care

As with other parts of the NHS primary care remains open and facing a number of challenges including maintaining the safety of patients and staff; achieving the speed of change needed whilst maintaining clinical safety and ensuring no patient groups are excluded.

There are also a number of opportunities including the digitalisation of primary care which has been moved forward considerably in the last few months compared to a number of years; opportunity for triage to the appropriate service or clinician and has forced primary care forced to look at the way they do everything.

Over the course of the last few months there have been a number of changes – even though the doors are closed the surgery has remained open. More has been done over the phone with telephone assessments. This has not just been triage as increasing numbers of patients still needing to be seen face to face.

There are several issues for primary care including capacity; ongoing recruitment difficulties which has been compounded by staff sickness and isolation; the demand on primary care services which continues to increase after an initial lull; the confidence of clinicians as they build up experience of telephone assessments with the conversion rate from telephone to face to face varies from one clinician to another with a telephone assessment and then a face to face appointment meaning two appointments; and the need to minimise stress for some clinicians as they manage their clinical practice in a different way.

There continue to be a number of service changes and improvements including the use of SMS messaging services and information and support; use of video consultations; visiting service (own home and nursing home); extra phlebotomy capacity (which is still under pressure); capacity in enhanced access services (not just GP appointments)

It is acknowledged there can be a number of vulnerable groups (patients with long term conditions have been prioritised) where support is still required including those technologically isolated, patients with communication difficulties, mental health patients, patients with learning disabilities and hearing impaired patients who all need continued support.

Children and young people
Attend anywhere appointments via video are in place with the possibility of face to face appointments based on risk.
The performance in services ie waiting times, are moving back to pre-COVID-19 levels and any agreed improvement trajectories revised.

CAMHS 24/7 crisis helpline introduced: The CCGs' long-term investment plan included a provision for this investment over future financial years to 2023/24 and have been in line with the Long Term Plan and acknowledge the commitment within the Phase 3 letter to retain these services whilst transitioning into a digital led service model. The CCG has made an initial offer of additional funding to retain the service.

The CCGs and its providers are continuing to deliver against the Children & Young People's access targets. In 2020/21 there has been an increase in Kooth activity and a further VCF provider.

A number of learning points have been observed including:
- There has been positive feedback and understanding from parents and professionals with a strong commitment to making the changes work.

- Benefits of continuity of contact/support offset some of the challenges of digital delivery especially for children especially on development and those with ND.
- The appointments are more effective with families already known.
- Quiet space for sessions can be a challenge especially SALT.
- Allowing one parent to attend a face to face with their child, while the other parent, could attend via the video link; reducing the need to be absent from work
- More effective use of time for staff, especially those based in Southport, attending other specialist clinics.

Addressing health inequalities
Collaborative working with the CCGs and Council to reduce health inequalities, in a number of working groups and committees,

- Outbreak management board
- Sefton testing cell
- Sefton test and trace cell
- Public health/CCG communications group
- Care homes group

Collaboration with public health, infection prevention control and adult social care has identified:

- Vulnerable groups/communities at higher risk of infection and adverse impact
- Routes of communicating key COVID-19 messages
- Appropriate training to protect vulnerable groups such as care home residents
- Equality impact assessments are being undertaken to consider inclusivity
- Public encouraged to utilise digital offers
- Monitor and catch up of pre-school immunisations
- Full restoration of contacts for 0-5 service
- Prioritisation of home visits for more vulnerable children re safeguarding
- Restoration of school nursing services with more emphasis on mental wellbeing
- Refreshing Joint Strategic Needs Assessment for Children & Young People to account for COVID-19 impact
- Sefton Public Health is exploring partnership with the Dame Kelly Holmes Legacy Trust to increase the support and offer for young people and they have the resources to provide tablets for anyone who is digitally excluded so that barrier would be removed.
- Smoking - active campaigning and targeting of vulnerable and harder-to-reach groups eg via the health improvement group to mental health service users
- Substance misuse - improved access to service via remote and on-line provision. Opportunity to review future on-line provision and ensure adequate balance between on-line / remote and face to face interactions.

Continuing Health Care (CHC)
In response to the requirement to reinstate the CHC Framework from 1 September and the need to review the status of patients discharged between 19 March 2020 and 31 August 2020, a joint approach with neighbouring CCGs is being taken. All health and social care partners have proactively engaged. An agreement between partners defined that Midlands & Lancs CSU would be responsible for the review of discharges from 19 March 2020 and 31 August 2020.

All patients within the backlog period from the partner organisations are being collated into a single working list. The list will then be rated so that cases can be dealt with via pre-approved collaborative arrangements including risk prioritisation. Resourcing arrangements to support clearance of the deferred assessments are still being finalised.

A Multi-Disciplinary Team approach is being developed with additional resources secured to conduct the assessments. Fortnightly panels have been scheduled to discuss both ongoing assessments and the backlog of cases.

Covid-19 testing

Antigen Testing

Both CCGs in conjunction with Sefton Council have ensured that there is extensive access to COVID-19 antigen testing for the local population and also for staff that work locally. In addition to the regional testing centres the CCGs and LA have established local testing sites in both Bootle and Southport and have worked with the Department of Health & Social Care (DHSC) to support a rolling programme of mobile testing units to further improve access.

Antibody testing

The CCGs and LA have worked with DHSC to ensure that all practice and CCG staff have had the opportunity to have an antibody test. This has been extended to include staff working in care homes and other adult social care staff. In total there is circa 16K staff within that cohort which will enable a good understanding of local prevalence and assist with epidemiology studies.

Sustaining COVID-19 safe services

GP practices have implemented the primary care standard operating procedure (SOP) which enables patients to access safe services. This also enables staff to operate in a safe and effective way. Providers are also implementing COVID-19 secure guidelines and ensuring there staff can access appropriate PPE.

Accessing PPE

There are now well established arrangements for providers including GP practices to access sufficient supplies of PPE. There is further access to emergency supplies to practices in the event of any disruption to supply and this is administered by the CCGs and supplies held locally. The LA provides equivalent support to care homes.

Risks

Within all of the above there are a number of risks which organisations are aiming to mitigate. These risks include:

1. Limited finances and the ability to respond to increases in demand and over longer term.
2. Increased community services demand which will need to be considered as part of initiatives to increase community based care.
3. Level of impact on all services when returning to previous levels of activity whilst needing to take into account winter pressures and the possibility of future spikes in COVID-19 occurrences. Providers are working to ensure that clinical review processes are in place to ensure no harm and mitigate risk due to long waits or

frequency in being seen. Quality schedules cover a range of indicators to help inform of patient quality and experience issues including harm reviews.

4. Care home market sustainability bearing in mind the high number of empty beds in CHs although the numbers are reducing.
5. CHC - There will be a backlog of patients to have assessment of ongoing care needs within the community along with a requirement for timely assessment of subsequent discharges from September onwards. The CCGs are working with Sefton Local Authority, Mersey Care FT and Midlands & Lancs CSU to support assessment and review.
6. Workforce – need to take into account ongoing workforce shortfalls in NHS organisations whilst addressing any backlogs as well as taking into account the possibility of further spikes in COVID-19 occurrences.

3 September 2020

Incorporating all Out of Hospital Cell Covid-19 Response questions

QUESTIONS TO BE ANSWERED

Introduction and scene setting:
The Shaping Sefton II "Sefton2gether" plan was developed on behalf of the local NHS as a response to the NHS Long Term Plan between March and November 2019. Following a lengthy period of engagement the plan 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 of 2014.

The Sefton2gether plan is a 'system' based plan for the whole of Sefton and focuses significantly on community based services. 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.

Aims and objectives
The priorities, aims and objectives of the Sefton2gether plan were brought together from a range of different areas. These include; the Cheshire and Mersey Health and Care Partnership Five Year Plan, NHS Long Term Plan and local target areas based on existing Sefton data and feedback from our engagement exercise with both health and care professionals and the public. These are being pursued through the restoration of services and locally utilising the risk reduction framework.

Agreed Sefton2gether Priorities:

- 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 age 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 reduce the level of obesity and to reduce the level of obesity and 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 - discussions to be pursued 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:
  - 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
  - Distributing resources and intervention proportionately to address need so as to achieve more equal outcomes
  - 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

Risks

1. Finances and ability to respond to increases in demand and over longer term. Further discussions across C&M are required to take into account revised NHSE/I financial guidance.
2. Increased community demand with further possible increases with the introduction of NHS111 First diverting patents from A/E.
3. Level of impact on all services significant and returning to previous levels of activity will be challenging with varying timelines for recovery of activity and waiting times. Providers are working to ensure that clinical review processes are in place to ensure no harm and mitigate risk due to long waits or frequency in being seen. Quality schedules cover a range of indicators to help inform of patient quality and experience issues including harm reviews.
4. Care home market sustainability bearing in mind the high number of empty beds.
5. Impact of future COVID-19 outbreaks.

6. CHC - There will be a backlog of patients to have assessment of ongoing care needs within the community along with a requirement for timely assessment of subsequent discharges from September onwards. The CCGs are working with Sefton Local Authority, Mersey Care FT and Midlands & Lancs CSU (MLCSU) to recommence work on an end to end pathway to support assessment and review.
7. Workforce – taking into account ongoing workforce shortfalls in NHS organisations there is the additional possible impact of a further COVID-19 waves.

Mutual Aid - development of MoU between all partners.

C&M collective

1. Liaison with Lancashire & South Cumbria ICS to have a consistent approach to planning
2. Triggers for mutual aid to be refined with the utilisation of the C&M capacity tracker.

Areas to be covered

Service area (ref Planning letter & implementation guidance)	Phase 3 Requirements	
A3 Restore Delivery in primary care and community services		
Primary Care re-start (all disciplines)	• Restore service to usual levels where clinically appropriate • Reach out proactively to clinical vulnerable people • Address backlog of childhood immunisations and cervical screening • Preventative support / long term condition management	Discussions have taken place with LMC regarding restoring services. Our Local Quality Contract with General Practice has been reviewed and care of those with Long Term Conditions prioritised. Screening aspects being pursued via NHS England. By using on line consultations practices have targeted reviews of patients with LTCs.
Primary Care / Care Homes	• Build on enhanced support to care homes including programme of structured medication reviews	Sefton's response to Care Homes has seen an integrated multi-disciplinary offer of support wrapped around Care Homes, this has included End of Life support, Medicines management, Training and Support, Technology, mutual aid support, extensive communication and engagement and a robust financial offer. This has been co-ordinated through the Care Home Cell with representation from all local partners. The Cell is chaired by the Executive Director for Adult Social Care and Health and the Integrated Social care and Health Manager for the Council and Director of Place for NHS South Sefton and Southport and Formby CCGs. The Cell supports the co-ordination of wrap around support to Care Homes through a fully integrated approach and provides a co-ordinated interface for Care Homes. In Sefton the Care Home are supported by a weekly set of virtual provider forums and daily calls with provider leads from senior (DASS) level social care, public health and NHS personnel to operational management level, and an integrated contracts team, which have been very much appreciated by the care home sector. Sefton Local Authority have weekly

Service area (ref Planning letter & implementation guidance)	Phase 3 Requirements	
		Provider led forums which allows the opportunity for Care Homes to directly link with the LA commissioners and raise any concerns they have. The oversight has been very much informed by provider-led insight and data-flows, including levels of PPE, staffing, capacity and confidence. System CCGs has been supporting primary care colleagues to align clinical leads for each homes alongside Primary Care Network configuration with agreement of cover now in place. There is an expectation that PCNs will use their pharmacists to support care homes. A tactical response was developed by community providers to support an enhanced approach to community services support in homes across Liverpool and Sefton and established a dedicated advice and support service from local Geriatricians (based at the Royal Liverpool Hospital) to avoid admission where appropriate. Homes also benefitted from an End of Life Helpline for care home staff and health care professionals, and the Community Medicines Management Team have aligned pharmacist support under this model in order to offer a more rounded approach. Working with local Primary Care Networks (PCNs), community service providers and specialist support from secondary care providers and the CCG Medicines Management team, good progress has been made to establish: • Delivery of a consistent weekly 'check in', to review patients identified as a clinically priority for assessment of care. • Development and delivery of personalised care and support plans for care home residents • Provision of pharmacy and medication support to care homes Community nursing colleagues are playing a key role in facilitating the weekly check-ins and identifying patients who are in need of proactive support such as those who have been discharged from hospital, recent admissions to a care home or those who have a change in condition. Multi-disciplinary Team Meetings (MDTs) involving a range of health and care

Service area (ref Planning letter & implementation guidance)	Phase 3 Requirements	
		professional are established, where clinically appropriate, in some cases involving specialist geriatric services. PCN colleagues are working collaboratively to explore innovative roles and approaches to further enhance care in care homes. A personalised care planning process is already in place and being implemented and our medicines management support is being supplemented to move to deliver standardised medication reviews in all homes on a routine basis. Our wider medicines management support offer includes a lead clinical pharmacy team member for each home, access to our medicines hub, supporting the supply of medicines, assisting in safe hospital discharge, a homely remedies policy, care home training and a package of end of life support. Work led by NHSE will also help enable social care partners to communicate effectively and securely with PCNs using NHS mail and other digital tools such as video consultations. Through the Merseyside resilience forum PPE cell we have ensured a sustainable and adequate supply to PPE for all CHs, working initially with the national supply disruption chain, moving to supporting care homes to sourcing their own sustainable supplies and supporting the roll out of the national PPE Portal. The model is now well established and all homes report a good level of supply which is checked on each call and through the national Capacity Tracker. The Infection Control Grant Payments support provider to manage the additional expenditure. All CHs were issued with smart phones which allows for virtual discussions and assessments of CH residents by a GP and or community services and support virtual GP appointments. All CHs are now signed up to the national NHS Capacity Tracker and reporting functionality will support our oversight of quality and delivery of the market. Continue to envisage and support the roll out of NHS.net mail to all CHs to support the safe sharing of care records and information.

Service area (ref Planning letter & implementation guidance)	Phase 3 Requirements	
		There will be a pilot on the use of EMIS in CHs and will explore and develop a sustainable long term model to roll this out to support dynamic care planning, end of life and discharge processes. Ensure telecare and assistive technology strategy works alongside CHs to ensure the most effective and efficient use in CHs. **Planned actions** Development and roll out an Integrated (health and care) Care Home Strategy encompassing market management, technology, quality, fair cost of care models, engagement a wraparound offers to care homes from community partners. In regards to EHCH Designing and Thinking sessions arranged with care homes, LA, CCG and community service to explore what full integration of services would look like.
GP appointment systems	• Expand range of services to which patients can self-refer • Offer mix of face to face, video, online & telephone appointments • Support for Patient initiated follow ups	Mix of appointments are available and continue. Healthwatch Sefton is working in partnership with Include-ITMersey to share information about how local residents can be supported to learn how to use digital technology. This offer was made to CHs during lockdown but it is open to all residents in Sefton who need support to get online. Include-IT Mersey is a volunteer-led project helping people to get online across the Liverpool City Region. This project is funded by the European Social Fund (ESF) and The National Lottery Community Fund, and aims to improve digital learning and skills across Liverpool, Halton, Knowsley, Sefton, St Helens and Wirral. The Include-IT Mersey project is managed by Sefton Council for Voluntary Service (CVS). Digital Champion volunteers are at the end of the phone to help beginners learn how to use digital technology. They can help you with smartphones, tablets, laptops, PCs, Wifi connection problems, emails, online shopping for food, connecting to skype/ zoom etc, and accessing YouTube for health/ fitness/ cooking videos.

Service area (ref Planning letter & implementation guidance)	Phase 3 Requirements	
		It is acknowledged that help cannot be offered to those that do not have the internet/ equipment at the moment. HealthWatch Sefton is working with IMerseyside and eConsult, the online consultation platform used by NHS GP practices. They will promote access to this service to local residents and there will be an article in the upcoming Autumn printed newsletter, online information and there will be dedicated Healthwatch Community Champion meetings to focus on this in the autumn to encourage patients to use this facility when practical.
Community health services	• Enhance crisis response services in line with LTP • Rehab support to patients post-Covid • Resume home visiting for all vulnerable patients • Expand range of services to which patients can self-refer	**LSCFT** All community services are actively working to restore their service offers in line with national guidance where clinically appropriate, using both digital platform offers and face to face offers, with all appropriate safe social distancing and IPC measures in place. Capacity to restore fully is compromised by social distancing, enhanced IPC requirements, and access to some estates. For these reasons some lower level interventions such as ear syringing has not been reinstated yet as capacity needs to be targeted on high priority interventions such as wound care/critical medications and end of life care. Services which offered drop in appointments e.g. phlebotomy will continue to be offered on an appointment only basis to manage social distancing which will impact on capacity to restore to pre COVID-19 demand. Services such as podiatry are struggling to reinstate all lower priority routine work in order to continue to prioritise high risk interventions and to address backlog. Discussions with ICS Out of Hospital Sub Groups to highlight these issues has taken place. All services are utilising a 'Back To Better' approach using Digital First principles and promoting self-care as appropriate to service user needs. Teams are prioritising patients against a priority tool rating to ensure vulnerable patients are seen as appropriate. Patients being stepped up in line with clinical priority. Clinical triage taking place to inform priorities. Self-management support given– information and emergency contact details given. Emergency face to face clinics in place to manage ad hoc requests. Attend Anywhere being used when possible to reduce any delays to triage or intervention.

Service area (ref Planning letter & implementation guidance)	Phase 3 Requirements	
		Resource developed by psychology (trauma centre) being rolled out as a tool to support ongoing check in. **MCFT** MCFT have provided activity reports throughout 2020/21 but with challenges in how it can now be accurately used to understand service delivery and pressures. As expected there is a significant shift to domiciliary rather than clinic contacts. However, domiciliary is also being used to capture telephone, video and home visits contacts. In terms of restoring activity to usual levels where clinically appropriate MCFT are in process of reviewing each service and the benefits gained during COVID-19 to determine what aspects of care require F2F either as home visit or clinic and what can be supported by telephone or video consultation. The CCG have been assured that clinical care will not be compromised and that the correct medium will be used to meet need e.g. detailed feedback provided in regard to SALT interventions and clinical management processes. Initial triage processes are in place for all new referrals to determine priority. COVID-19 recovery plans are still under development by the Trust and with the exception of known high risk areas e.g. phlebotomy, AHP waiting times, the full extent of risks attached to restoration will not be known until the Trust completes their phase 3 plans. **Planned action:** MCFT are required to provide a COVID-19 recovery update to each Quality Review Meeting and to highlight known risks and service pressures. The next update will be presented to the first SSCCG/LCCG combined quality meeting on 24/9/20 with opportunity to feedback phase 3 submission plans. The CCG will work with the Trust to support COVID-19 recovery as here becomes a greater understanding of issues. Whilst these have been exceptional circumstances there will remain commissioner responsibility to have assurance that resources are being utilised effectively for Sefton residents. The CCG has been working through transformation plans

Service area (ref Planning letter & implementation guidance)	Phase 3 Requirements	
		within South Sefton prior to COVID-19 and consideration needs to be given to how this work continues with benefits in ways of working due to COVID-19 but also recognising recovery pressures on services. Phlebotomy has already emerged as a significant risk with a major work project underway to support recovery and ongoing sustainability across whole Sefton footprint. Collaboration with LCCG and wider provider footprint to progress areas of mutual benefit.
Discharge	• Embed Discharge to Assess (01/09)	**LSCFT** Enhanced discharge planning scheme continues to operate along with recent NHS guidance with the integrated discharge team for the S&O system. Support is in place for integrated care beds in all areas. Review of Winter Plans taking place with system partners and CCGs. **MCFT** In line with COVID-19 guidance the Discharge to Assess Pathway was introduced for both LUHFT and S&O systems with involvement of health and social care partners across acute and community providers. Creation of single point of contact to simplify both systems. The work is supported by tight control of discharge processes with sharing of daily Ready for Discharge (RFD) patient lists and a daily escalation call/daily huddles to support specific complex patients and patient flow. A SharePoint information system has been developed for all partner organisations as part of the LUHFT system to input to create a full picture of patient journey from hospital to community and outcomes. In the meantime a patient tracker exists across both systems. KPIs have been developed to measure both quantitative and qualitative aspects of pathway. RFD daily dashboard has been further refined to identify average length of delays for key discharge support areas providing more detailed information than previous DTOC weekly reports. **Planned actions:** Both LUHFT and S&O systems group have reviewed pathway in anticipation of changes from September. Given that pathway was built on previous processes but with a tightening

Service area (ref Planning letter & implementation guidance)	Phase 3 Requirements	
		around choice policy there will not be major changes with the exception of recommencement of assessment of ongoing needs and determining of funding eligibility.
CHC	• Resume CHC assessments (01/09) • Assess patients discharged 19/03 – 31/08 & move to appropriate care	In response to the requirement to reinstate the CHC Framework from 1.9.20 and to review the status of patients discharged between 19.3.20 and 31.8.20, a North Mersey approach is being taken, reflective of patient flows and commonality of MLCSU as responsible for the delivery of CHC for the North Mersey CCGs. All health and social care partners have proactively engaged. An agreement between partners defined that MLCSU would be responsible for the review of discharges from 19.3.20 to 31.3.20 and this work is supported by the patient tracker work undertaken from the beginning of this process and the fact that MLCSU had undertaken the 14 and 21 day reviews, so the bulk of patients are known to them. **Restoration** Service will resume with effect on 1.9.20 including Discharge to Assess requirements with separate resourcing from that required to deal with COVID-19 period cases in line with the 21.8 CHC guidance. **Backlog** Currently all MLCSU, LSCFT and Sefton MBC lists are in the process of being reconciled into a single working list. The list will then be RAG rated so that cases can be dealt with via pre-approved collaborative arrangements including risk prioritisation. Resourcing arrangements to support clearance of the deferred assessments are still being finalised. A Multi-Disciplinary Team approach is being developed with additional resources secured to conduct the assessments. Fortnightly panels have been scheduled to discuss both ongoing assessments and the backlog of cases.
A4 Expand and improve mental health services and services for people with LD and / or autism		
MH LTP	• Increase investment in MH in line with MHIS	• This is the plan for both Sefton CCGs. Additional mental/LD information

Service area (ref Planning letter & implementation guidance)	Phase 3 Requirements	
		Supported living services – ongoing engagement with all supported living providers to provide updated guidance on infection control measures to influence and direct how support is delivered (PPE, staffing issues, testing, bubbles of support, prevention of cross infection) • Re-assessments of need are ongoing to agree additional/alternative support where required with funding available. • Continued to liaise with providers regarding additional funding requirements to support recovery planning. • Full building risk assessments have been undertaken in conjunction with Day Care providers in relation to infection control measures (as advised by PHE). • A full review of clients who previously attended day centres is being undertaken to prioritise vulnerable clients being able to resume attendance based on reduced capacity in day centres going forward, this work is being undertaken as part of a multi-disciplinary approach and includes CCG, CLDT and MLCSU. • A full review of transport to identify future requirements, and infection control measures needed to support the recovery planning for day opportunities (as advised by PHE). • Continued to liaise with providers regarding additional funding requirements to support recovery planning • A full online PHE training programme is being made available by Mersey Care NHS Foundation Trust to all day care providers. • Continued to liaise with providers regarding additional funding requirements to support recovery planning. • Working with respite providers to resume service delivery in a safe and effective way based upon guidance from PHE. • We have worked with providers to ensure that support to access the community continues to be delivered where appropriate based upon assessed need in a safe and effective manner. Mental Health Recovery Team • The Council has developed a new Mental Health Recovery Team. This is a borough wide service providing intensive recovery-based support and reablement interventions to

Service area (ref Planning letter & implementation guidance)	Phase 3 Requirements	
		Sefton residents under the care of secondary mental health services. The service will use a strengths-based approach and will be time limited and goal orientated with the aim of improving service users' confidence, independence, social inclusion and mental wellbeing. • The team consists of three support workers and three Community Care Practitioners (two full time/one part time) based in the Mental Health Teams both North and South of the borough. • The team's initial focus is on supporting people who are experiencing difficulties following the COVID-19 restrictions and aim at assisting people in re-establishing pre-COVID-19 confidence and routines. Work will be undertaken under a reablement model with support being offered in 3 or 4 sessions a week for a period of up to 6 weeks.
Validate expansion trajectories	• Fully restore IAPT • Maintain 24/7 crisis lines • Maintain growth in children & young people accessing care • Review CMHT caseloads and increase interventions to prevent relapse / escalation of needs • Ensure local access is advertised • Eliminate dormitory wards	• Clinical review and risk assessment to be completed with the Clinical Lead to assess whether alternative remote therapy options are appropriate, prior to the consideration of a face to face appointment being offered, as per the IAPT guidance. The expected numbers of patients requiring face to face is 5-10 per week. If numbers exceed 10 procedures will need to be reviewed between Insight and CWP. • Clinical review to assess the need for F2F over remote therapy options, as per the IAPT guidance. • A booking system to be developed system to be developed • On booking a request that only one patient attend at planned time (not early). CAMHS 24/7 crisis helpline: The CCGs' long-term investment plan included a provision for this investment over future financial years to 2023/24 in line with the Long Term Plan and acknowledge the commitment within the Phase 3 letter to retain these services whilst transitioning into a digital led service model. The CCG has made an initial offer of additional funding to retain the service. • CYP access: the CCG and its providers are continuing to deliver against the CYP access targets. In 20/21 there has been an increase in Kooth activity and a further VCF provider will flow data to MHSDS.
LD/ Autism	• Reduce number of people in inpatient settings	Inpatient bed activity commissioned by the CCGs has been reduced by 40%. The CCGs have a CTR process in place that support the reduction of admission to inpatient .

Service area (ref Planning letter & implementation guidance)	Phase 3 Requirements	
	• Complete LeDeRs by December 2020 • Identify people with LD on GP registers / undertake health checks / ensure access to screening / flu vaccinations	All LeDeRs are on schedule to be completed by December 2020. Through the TCP we have invested in an IST to work with individuals and organisations to give additional clinical input to prevent admission to inpatient beds. Requested CETRs for <18s have been held virtually during COVID-19. Practices can now choose to deliver the DES themselves or access a service provided by a GP Federation. Registers have recently been validated to ensure accuracy of those patients who should receive a health check. Additionally the LD Health Check has been prioritised via the CCG Local Quality Contract to ensure that practice performance is on track, the LMC is engaged and supporting this work. Plans are in place with community providers to support the uptake of health checks by supporting a pre-health check questionnaire and explaining what would be involved to prepare the patients for a full health check.
B1 Preparation for winter alongside Covid resurgence		
Managing outbreaks	• Place role in outbreak management	Organisations will practice in line with PHE guidance where necessary under the guidance and direction of IPC teams. Organisations will continue to follow all National and organisational guidelines
Testing	• Testing staff • Sustaining Covid-safe services • Accessing PPE	**Antigen Testing** Both CCGs in conjunction with Sefton Council have ensured that there is extensive access to COVID-19 antigen testing for the local population and also for staff that work locally. In addition to the regional testing centres the CCGs and LA have established local testing sites in both Bootle and Southport and have worked with the DHSC to support a rolling programme of mobile testing units to further improve access. **Antibody testing** The CCGs and LA have worked with DHSC to ensure that all practice and CCG staff have had the opportunity to have an antibody test. This has been extended to include staff working in care

Service area (ref Planning letter & implementation guidance)	Phase 3 Requirements	
		homes and other adult social care staff. In total there is circa 16K staff within that cohort which will enable a good understanding of local prevalence and assist with epidemiology studies. **Sustaining COVID-19 safe services** GP practices have implemented the primary care SOP which enables patients to access safe services. This also enables staff to operate in a safe and effective way. Providers are also implementing COVID-19 secure guidelines and ensuring there staff can access appropriate PPE. **Accessing PPE** There are now well established arrangements for providers including GP practices to access sufficient supplies of PPE. There is further access to emergency supplies to practices in the event of any disruption to supply and this is administered by the CCGs and supplies held locally. The LA provides equivalent support to care homes.
B2 Prepare for winter: NB this section is covered by the Winter Planning submission so should not be needed. However, please check that your winter submission includes the relevant information requested in this document.		

Capacity	• Ensure adequate capacity is available for both winter **and** more significant Covid surge:
	  • Bed based / non-bed based services
	  • Working with social care / care homes
	  • Rapid mobilisation of surge capacity
	  • Cross boundary support
		• All included in the winter plan

Flu vaccination	• Expanded flu vaccination programme	• Included in the winter plan
Low complexity emergency care	• Services / pathways to support for NHS 111 First / SDEC	• Included in the winter plan

Service area (ref Planning letter & implementation guidance)	Phase 3 Requirements	
	• Managing "displaced" demand (avoidance of acute admission)	
Volunteers	• Use of NHS Volunteer Responder scheme	• Included in the winter plan
Resilient Social care	• Ensure MRFDs are not delayed • Work with LAs on resilient social care services	• Included in the winter plan
C2 Health inequalities and prevention		
How will you ensure that services are restored inclusively / address needs of vulnerable groups? (see section C2 of the Planning Letter and Section 1 of the document *Implementing Phase 3 of the NHS response to the COVID-19 Pandemic*)	• Take urgent action to increase the scale and pace of progress of reducing health inequalities and regularly assess this progress • Protect the most vulnerable from Covid with enhanced analysis and community engagement • Restore NHS services inclusively so that they are used by those in greatest need • Develop digitally enabled care pathways which increase inclusion • Accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes • Particularly support those who suffer mental ill health • Strengthen leadership and accountability with a named executive board member responsible for tackling	Collaborative working to reduce health inequalities, with CCG participating in key Covid working groups and committees, • Outbreak management board • Sefton testing cell • Sefton test and trace cell • Public health/CCG communications group • Care homes group Collaboration with public health, infection prevention control and adult social care has identified • Vulnerable groups/communities at higher risk of infection and adverse impact • Routes of communicating key covid messages • Appropriate training to protect vulnerable groups such as care home residents • Equality impact assessments are being undertaken to consider inclusivity • Public encouraged to utilise digital (as referenced above) • Monitor and catch up of pre-school immunisations • Full restoration of contacts for 0-5 service • Prioritisation of home visits for more vulnerable children re safeguarding • Restoration of school nursing services with more emphasis on mental wellbeing • Refreshing JSNA for CYP to account for COVID-19 impact

Service area (ref Planning letter & implementation guidance)	Phase 3 Requirements	
	inequalities in place in September in every NHS organisation alongside action to increase diversity of senior leaders • Ensure all datasets are complete and timely to underpin an understanding of and response to health inequalities • Collaborate locally in planning and delivering action to address health inequalities including in incorporating in plans for restoring critical services by 21 September.	• Sefton Public Health exploring partnership with the Dame Kelly Holmes Legacy trust to increase the support and offer for the young person and they have the resources to provide tablets for anyone who is digitally excluded so that barrier would be removed. • Smoking - active campaigning and targeting of vulnerable and harder-to-reach groups e.g. via the health improvement group to mental health service users • Substance misuse - improved access to service via remote and on-line provision. Opportunity to review future on-line provision and ensure adequate balance between on-line / remote and face to face interactions. • CCGs' inequalities lead – Tracy Jeffes, Director of Place • Within Sefton Place, system wide support is in place to increase the utilisation of NHS e-referrals within providers to improve access to core NHS service • Within care settings a range of digital first approaches and technologies have been adopted, including E-consult, AccuRx, AttendAnywhere, with significant usage evidenced with positive feedback shared by Sefton People. Enhancements to video based consultations are being progressed to improve inclusion by incorporating consistency in translator service access. Optimising digital first technologies from being a necessity to the preferred method of health and care interaction across Sefton Place is a key digital priority for the next 6 months. Optimisation will build upon existing engagement channels with patient groups to help minimise levels of digital exclusion through solution design • Digitisation of the ability to access flu vaccination to be in place by October 2020 to support PCNs and partners to maximise the uptake of flu vaccination for those at risk. Early focus of the campaign will be to target CH residence and Sefton people considered to have a health inequality, especially for people from BAME communities, those in deprived communities and people with learning disabilities. • Work with Sefton Council to develop plans to support the promotion of adult learning and digital champion is underway through a Digital Task and Finish group. • Through access to Primary Care Digital First funding, an enhanced provision and simplification of digital "front door" access to patient information will be delivered by 31 March 2021

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