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