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Health and Wellbeing Board

Wednesday, 17th June, 2020 at 5.30 pm

Virtual meeting

This meeting is open to the public

Members

Councillor Fielker

Councillor Paffey

Councillor Savage

Councillor Shields

Councillor Windle

Debbie Chase – Interim Director Of Public Health

Grainne Siggins - Executive Director Wellbeing,

Hilary Brooks - Director of Children & Families,

Rob Kurn – Healthwatch

Dr Shahed Ahmad - Medical Director,Hampshire Thames Valley, NHS England South East Region

Dr Mark Kelsey (Vice Chair) - NHS Southampton Clinical Commissioning Group,

Contacts
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Democratic Support Officer
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BACKGROUND AND RELEVANT INFORMATION

Purpose of the Board

The purpose of the Southampton Health and Wellbeing Board is:

- To bring together Southampton City Council and key NHS commissioners to improve the health and wellbeing of citizens, thereby helping them live their lives to the full, and to reduce health inequalities;
- To ensure that all activity across partner organisations supports positive health outcomes for local people and keeps them safe.
- To hold partner organisations to account for the oversight of related commissioning strategies and plans.
- To have oversight of the environmental factors that impact on health, and to influence the City Council, its partners and Regulators to support a healthy environment for people who live and work in Southampton

Smoking policy – The Council operates a no-smoking policy in all civic buildings.

Mobile Telephones:- Please switch your mobile telephones to silent whilst in the meeting

Fire Procedure – In the event of a fire or other emergency, a continuous alarm will sound and you will be advised, by officers of the Council, of what action to take

Access – Access is available for disabled people. Please contact the Democratic Support Officer who will help to make any necessary arrangements.

Southampton: Corporate Plan 2020-2025 sets out the four key outcomes:

- Communities, culture & homes - Celebrating the diversity of cultures within Southampton; enhancing our cultural and historical offer and using these to help transform our communities.
- Green City - Providing a sustainable, clean, healthy and safe environment for everyone. Nurturing green spaces and embracing our waterfront.
- Place shaping - Delivering a city for future generations. Using data, insight and vision to meet the current and future needs of the city.
- Wellbeing - Start well, live well, age well, die well; working with other partners and other services to make sure that customers get the right help at the right time

Responsibilities

The Board is responsible for developing mechanisms to undertake the duties of the Health and Wellbeing Board, in particular

- Promoting joint commissioning and integrated delivery of services;
- Acting as the lead commissioning vehicle for designated service areas;
- Ensuring an up to date JSNA and other appropriate assessments are in place
- Ensuring the development of a Health and Wellbeing Strategy for Southampton and monitoring its delivery.
- Oversight and assessment of the effectiveness of local public involvement in health, public health and care services
- Ensuring the system for partnership working is working effectively between health and care services and systems, and the work of other partnerships which contribute to health and wellbeing outcomes for local people.
    - Testing the local framework for commissioning for: Health care; Social care; Public health services; and Ensuring safety in improving health and wellbeing outcomes

Use of Social Media:- The Council supports the video or audio recording of meetings open to the public, for either live or subsequent broadcast. However, if, in the Chair's opinion, a person filming or recording a meeting or taking photographs is interrupting proceedings or causing a disturbance, under the Council's Standing Orders the person can be ordered to stop their activity, or to leave the meeting. By entering the meeting room you are consenting to being recorded and to the use of those images and recordings for broadcasting and or/training purposes. The meeting may be recorded by the press or members of the public. Any person or organisation filming, recording or broadcasting any meeting of the Council is responsible for any claims or other liability resulting from them doing so. Details of the Council's Guidance on the recording of meetings is available on the Council's website.

Dates of Meetings: Municipal Year 2020/21

17 June 2020
16 December 2020

CONDUCT OF MEETING

BUSINESS TO BE DISCUSSED
Only those items listed on the attached agenda may be considered at this meeting.

PROCEDURE / PUBLIC REPRESENTATIONS
At the discretion of the Chair, members of the public may address the meeting on any report included on the agenda in which they have a relevant interest. Any member of the public wishing to address the meeting should advise the Democratic Support Officer (DSO) whose contact details are on the front sheet of the agenda.

RULES OF PROCEDURE
The meeting is governed by the Executive Procedure Rules as set out in Part 4 of the Council's Constitution.

QUORUM
The minimum number of appointed Members required to be in attendance to hold the meeting is 3 who will include at least one Elected Member, a member from Health and Healthwatch.

DISCLOSURE OF INTERESTS

Members are required to disclose, in accordance with the Members' Code of Conduct, ***both*** the existence ***and*** nature of any "Disclosable Pecuniary Interest" or "Other Interest" they may have in relation to matters for consideration on this Agenda.

DISCLOSABLE PECUNIARY INTERESTS

A Member must regard himself or herself as having a Disclosable Pecuniary Interest in any matter that they or their spouse, partner, a person they are living with as husband or wife, or a person with whom they are living as if they were a civil partner in relation to:

(i) Any employment, office, trade, profession or vocation carried on for profit or gain.
(ii) Sponsorship:
Any payment or provision of any other financial benefit (other than from Southampton City Council) made or provided within the relevant period in respect of any expense incurred by you in carrying out duties as a member, or towards your election expenses. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
(iii) Any contract which is made between you / your spouse etc (or a body in which the you / your spouse etc has a beneficial interest) and Southampton City Council under which goods or services are to be provided or works are to be executed, and which has not been fully discharged.
(iv) Any beneficial interest in land which is within the area of Southampton.
(v) Any license (held alone or jointly with others) to occupy land in the area of Southampton for a month or longer.
(vi) Any tenancy where (to your knowledge) the landlord is Southampton City Council and the tenant is a body in which you / your spouse etc has a beneficial interests.
(vii) Any beneficial interest in securities of a body where that body (to your knowledge) has a place of business or land in the area of Southampton, and either:

a) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body, or
b) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you / your spouse etc has a beneficial interest that exceeds one hundredth of the total issued share capital of that class

Other Interests

A Member must regard himself or herself as having an, 'Other Interest' in any membership of, or occupation of a position of general control or management in:

Any body to which they have been appointed or nominated by Southampton City Council

Any public authority or body exercising functions of a public nature

Any body directed to charitable purposes

Any body whose principal purpose includes the influence of public opinion or policy

Principles of Decision Making

All decisions of the Council will be made in accordance with the following principles:-

- proportionality (i.e. the action must be proportionate to the desired outcome);
- due consultation and the taking of professional advice from officers;
- respect for human rights;
- a presumption in favour of openness, accountability and transparency;
- setting out what options have been considered;
- setting out reasons for the decision; and
- clarity of aims and desired outcomes.

In exercising discretion, the decision maker must:

- understand the law that regulates the decision making power and gives effect to it. The decision-maker must direct itself properly in law;
- take into account all relevant matters (those matters which the law requires the authority as a matter of legal obligation to take into account);
- leave out of account irrelevant considerations;
- act for a proper purpose, exercising its powers for the public good;
- not reach a decision which no authority acting reasonably could reach, (also known as the "rationality" or "taking leave of your senses" principle);
- comply with the rule that local government finance is to be conducted on an annual basis. Save to the extent authorised by Parliament, 'live now, pay later' and forward funding are unlawful; and
- act with procedural propriety in accordance with the rules of fairness.

AGENDA

1 ELECTION OF CHAIR

To elect a Chair for the 2020-2021 municipal year.

2 ELECTION OF VICE-CHAIR

To elect a Vice-Chair for the 2020-2021 municipal year.

3 APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)

To note any changes in membership of the Board made in accordance with Council Procedure Rule 4.3.

4 STATEMENT FROM THE CHAIR

5 DISCLOSURE OF PERSONAL AND PECUNIARY INTERESTS

In accordance with the Localism Act 2011, and the Council's Code of Conduct, Members to disclose any personal or pecuniary interests in any matter included on the agenda for this meeting.

NOTE: Members are reminded that, where applicable, they must complete the appropriate form recording details of any such interests and hand it to the Democratic Support Officer.

6 MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)

To approve and sign as a correct record the minutes of the meeting held on 22 January 2020 and to deal with any matters arising, attached.

7 COVID-19: OVERVIEW OF HEALTH AND CARE RESPONSE IN SOUTHAMPTON JUNE 2020

Report of the Director of Quality and Integration outlining the health response to Covid-19

8 POTENTIAL IMPACTS OF COVID-19 ON HEALTH INEQUALITIES IN SOUTHAMPTON

Report of the Director of Public Health exploring Health Inequalities and Covid-19 recovery activity.

9 SOUTHAMPTON CITY SUICIDE PREVENTION PLAN

Report of the Director of Public Health seeking approval of the Southampton Suicide Prevention Plan 2020-23.

Tuesday, 9 June 2020 Service Director – Legal and Business Operations

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HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON 22 JANUARY 2020

Present: Councillors Dr Paffey, Shields (Chair), Taggart and Savage
Grainne Siggins, Rob Kurn, Hilary Brooks and Dr Mark Kelsey (Vice-Chair)

Apologies: Councillors Fielker

10. **APOLOGIES AND CHANGES IN MEMBERSHIP (IF ANY)**

The apologies of Councillor Fielker were noted.

The Board noted the resignation of Dr Jason Horsely as Director of Public Health and the appointment of Debbie Chase as Interim Director of Public Health in place thereof; also the appointment of Grainne Siggins as Director of Adult Social Services in accordance with the provisions of Council Procedure Rule 4.3.

11. **STATEMENT FROM THE CHAIR**

The Chair noted that the Director of Public Health had used delegated powers to submit a bid for Health and Wellbeing funding over 3 years. The proposal focused on health inequalities, tackling childhood obesity and food poverty. The proposal included the development of a community pantry and collaboration with planners and other organisations to improve the food environment in Southampton.

The Chair also noted that there was a Scrutiny Inquiry Panel that was looking at Tackling Childhood Obesity and everyone was welcome to attend the meetings.

The Chair also noted that with a strong Integrated Commissioning Unit and Joint Commissioning Board and general changes in the health and care landscape, a review of the role of the Clinical Commissioning Group had commenced, which included discussions about Health and Wellbeing Boards across the area

12. **MINUTES OF THE PREVIOUS MEETING (INCLUDING MATTERS ARISING)**

RESOLVED that the minutes of the meeting held on 19 June 2019 be approved and signed as a correct record.

13. **DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2018/19**

The Board considered the report of the former Director of Public Health for Portsmouth and Southampton which presented the Director of Public Health's Annual Report 2018/19

Dr Jason Horsley, the former Director of Public Health, was present and with the consent of the chair addressed the meeting.

Through discussion of the report with the Board, Dr Jason Horsley highlighted that:

- The topic of the report had been chosen because of a concern about the increase in drug related deaths.
- Drug related deaths had also increased nationally. It was difficult to disassociate this with the economic collapse in 2008. It had been postulated that the increase was due to an aging population of drug users but this did not apply in this area. It was more likely to have been due to reduced funding for health and social services since 2010, an increase in the impacts of homelessness and increased addiction to hard drugs
- As well as considering the direct and indirect harms related to drug use the report also considered the harms to family and to wider society.
- The research for the report included discussions with drug addiction service users and also discussions with parents who had been bereaved by drug use.
- The report examined how to take a strong harm reduction approach to illicit drug use.
- Since 2010 delivery of drug services had merged with all addiction services, including alcohol and the focus had changed to shorter term interventions, also there had been an overall reduction in funding of addiction services. We had good wrap around services in Southampton for homeless people, however there were some services that still did not join up properly such as addiction and mental health services
- Adverse Childhood Experiences (ACE) was the main dominating cause leading to drug addiction. The evidence revealed that the thing which most affected ability to recover from ACE's was regular contact with a trusted adult, increasing the provision of this type of service would be an effective method for addressing the challenges of ACE's
- The report recommended a national review of the criminalisation of illicit drugs as addiction was public health issue. The legal status of chemical substances used was unrelated to their harms. It was noted that society would never win a 'war on drugs' as the profit margin was huge. The more effective the Police became at catching and disrupting drug dealers, the more violent the drug dealers became to keep control of their dealership.
- Another main theme of the report was a recommendation for a review of services, which should be designed around the needs of the service users. The evidence revealed that the chance to spend time with somebody who listened and gave them the time of day was incredibly powerful for drug users.

RESOLVED that the content and the recommendations of the Director of Health's Annual Report would be considered by the Board members within their roles and with their organisations.

DECISION-MAKER:		HEALTH AND WELLBEING BOARD		
SUBJECT:		**COVID-19: OVERVIEW OF HEALTH AND CARE RESPONSE IN SOUTHAMPTON JUNE 2020**		
DATE OF DECISION:		17 June 2020		
REPORT OF:		Director of Quality and Integration Southampton City CCG and Southampton City Council		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Stephanie Ramsey, Director of Quality and Integration**	Tel:	023 8029 6941
	E-mail:	**Stephanie.ramsey1@nhs.net**		
Director	**Name:**	**Grainne Siggins, Executive Director: Health and Adults** **James Rimmer , Managing Director, Southampton City CCG**	Tel:	023 8083 4487 023 80296947
	E-mail:	Grainne.siggins@southampton.gov.uk James.rimmer3@nhs.net		

STATEMENT OF CONFIDENTIALITY		
NONE		
BRIEF SUMMARY		
The attached report outlines the response of health and care services in Southampton to the outbreak of Covid-19.		
RECOMMENDATIONS:		
	(i)	To note the attached report, outlining the health and care services' response to Covid-19 in Southampton.
REASONS FOR REPORT RECOMMENDATIONS		
1.	For the information of the Health and Wellbeing Board.	
2.	To inform future understanding of the current situation and response to date, and inform future decision making	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
3.	No alternative options to present this report have been considered.	
DETAIL (Including consultation carried out)		
4.	Since the outbreak of coronavirus first became public in January, Southampton City Council and NHS Southampton City Clinical Commissioning Group (CCG) have been preparing for the times ahead. The system is now working even more closely together than before. Services have been required to adapt to the most challenging of circumstances, and a number of changes have taken place at a rapid pace. The attached paper gives a brief overview of how the system in Southampton is functioning.	

RESOURCE IMPLICATIONS	
Capital/Revenue	
5.	There are no financial implications of the report, which is an information report only. The capital and revenue implications of Covid-19 are being reviewed and considered by Southampton City Council and Southampton Clinical Commissioning Group within the relevant governance structures.
Property/Other	
6.	This report is an information report only. Resource implications of Covid-19 are being reviewed and considered by Southampton City Council and Southampton Clinical Commissioning Group within the relevant governance structures.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
7.	The Civil Contingencies Act 2004 provides the statutory framework for planning and dealing with emergencies. The Act defines an emergency. The current situation is an emergency because it 'threatens serious damage to human welfare'. The Act provides the power to make emergency regulations.
8.	The Coronavirus Act 2020 also contains some new statutory powers to enable responders to mitigate the impact of the COVID-19 pandemic.
Other Legal Implications:	
9.	Health and Social Care Act 2012 s.199 Supply of information to Health and Wellbeing Boards (1) A Health and Wellbeing Board may, for the purpose of enabling or assisting it to perform its functions, request any of the following persons to supply it with such information as may be specified in the request— (a) the local authority that established the Health and Wellbeing Board; (b) any person who is represented on the Health and Wellbeing Board by virtue of section 194(2)(e) to (g) or (8); (c) any person who is a member of a Health and Wellbeing Board by virtue of section 194(2)(g) or (8) but is not acting as a representative. (2) A person who is requested to supply information under subsection (1) must comply with the request. (3) Information supplied to a Health and Wellbeing Board under this section may be used by the Board only for the purpose of enabling or assisting it to perform its functions.
RISK MANAGEMENT IMPLICATIONS	
10.	This report is an information report only. Risks related to Covid-19 are being monitored and reviewed though the appropriate corporate channels.
POLICY FRAMEWORK IMPLICATIONS	
11.	None.

KEY DECISION?	**No**	
WARDS/COMMUNITIES AFFECTED:	All wards	
SUPPORTING DOCUMENTATION		
Appendices		
1.	**COVID-19: OVERVIEW OF HEALTH AND CARE RESPONSE IN SOUTHAMPTON JUNE 2020**	
2.		

Documents In Members' Rooms

1.		
2.		
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.		**No**
Data Protection Impact Assessment		
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.		**No**
Other Background Documents **Other Background documents available for inspection at:**		
Title of Background Paper(s)	**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**	
1.		
2.		

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COVID-19: OVERVIEW OF HEALTH AND CARE RESPONSE IN SOUTHAMPTON JUNE 2020

1. **Context**

1.1. Since the outbreak of coronavirus first became public in January 2020, Southampton City Council and NHS Southampton City Clinical Commissioning Group (CCG) have been preparing for the times ahead. Over recent months services have been required to adapt to the most challenging of circumstances, and a number of changes have taken place at a rapid pace. This paper gives a brief overview of how the system in Southampton has been functioning.

1.2. There are 19,000 clinical staff in the NHS in Hampshire and the Isle of Wight. At the peak, absence rates increased. Over 430 'Bring Back Staff' (including nurses, medics and allied health professionals) and 770 students have been sent to trusts within Hampshire and the Isle of Wight. Some checks have been completed (for example, DBS) and then the Trust completes the process with uniform, badge, training etc. Most GP returners have been sent to support NHS 111.

1.3. A major incident was declared on 18 March 2020 and remains in place. This allows for systems to be introduced to ensure the right plans are in place, making sure the system is ready and has capacity in the challenging times ahead. Southampton City Council and the CCG are working with the Local Resilience Forum, as a wider multi-agency partnership made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency and others.

1.4. Health and care providers have been required to adapt and make large changes to the way in which they deliver services. In some cases this has required contractual changes. For example, we have put in place a reduction in the need to report and monitor services and shifted to a focus on quality and safeguarding measures, ensuring that where possible providers can put as much of their resources as possible towards frontline care. Southampton City Council has set out changes in payment arrangements for home care, day care, residential/nursing care and supported living providers.

1.5. We are aware that patients may not be presenting for non-COVID-19 conditions due to the emergency period we are in. We are monitoring this situation and working with providers around how we ensure our population

continues to receive the urgent services they require. . This has been a changing situation with attendances increasing over the past month

1.6. Much of the work outlined in this paper has been undertaken by the Integrated Commissioning Unit (ICU). Long established joint commissioning arrangements have enabled Southampton City Council and the CCG to develop and enable, at pace, many of the changes required for the city to meet the challenges caused by the COVID-19 outbreak. The work includes:

- co-ordinating flow across the health and care system and enabling effective integrated pathways to be implemented
- supporting market sustainability (support, quality, financial and contractual)
- building market capacity and resilience in providers and communities
- quality, safeguarding and infection control.

2. Governance arrangements

2.1. We are currently working within a major incident; the Strategic Co-ordination Group (SCG) declared a major incident on 18 March 2020.

2.2. The Civil Contingencies Act 2004 provides the statutory framework for planning and dealing with emergencies. The Act defines an emergency. The current situation is an emergency because it 'threatens serious damage to human welfare'. The Act provides the power to make emergency regulations. The Coronavirus Act 2020 also contains some new statutory powers to enable responders to mitigate the impact of the COVID-19 pandemic.

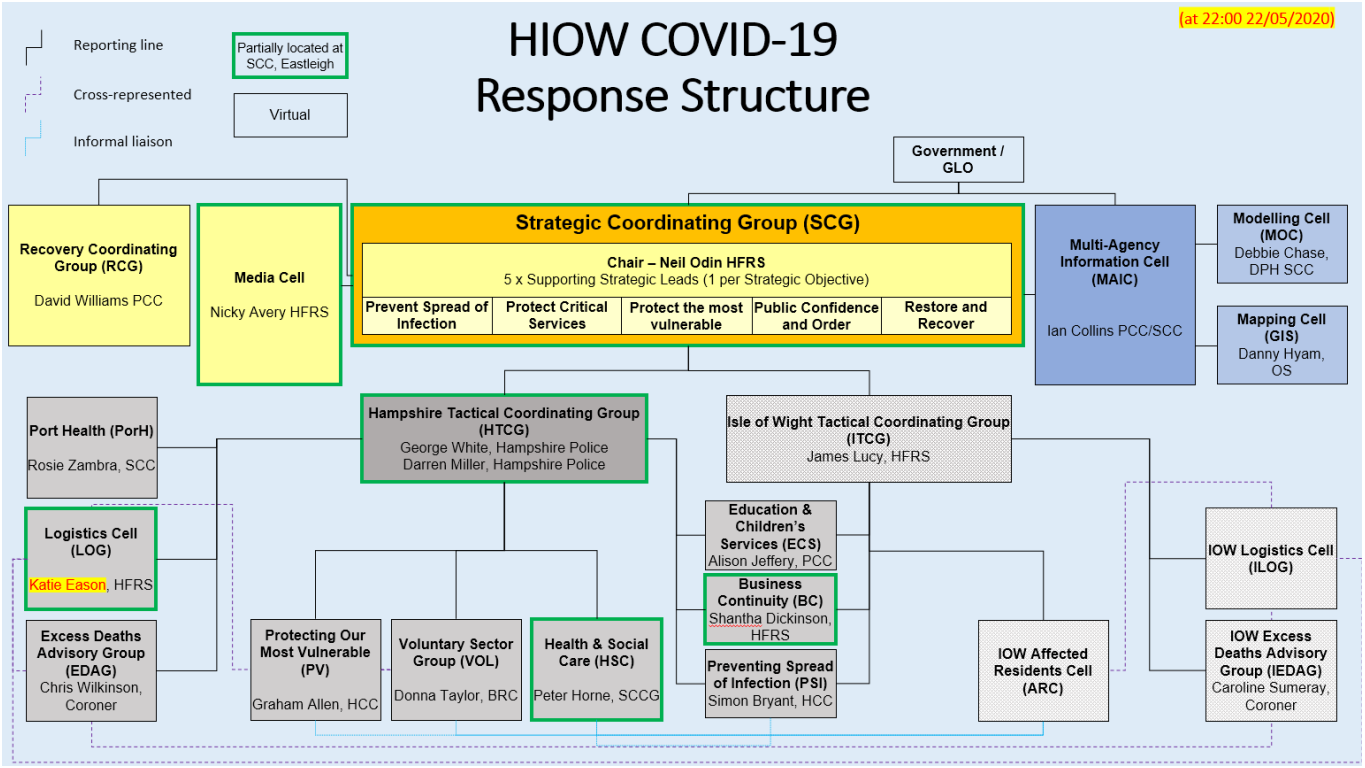
2.3. The Civil Contingencies Act divides local bodies into two categories, with different responsibilities:

- Category 1 responders including local authorities, emergency services and some health bodies. The Act requires Category 1 responders to organise as a Local Resilience Forum in Local Resilience Areas which follow police force boundaries.
- Category 2 responders such as transport providers who must co-operate with Category 1 responders.

2.4. Locally the Hampshire & Isle of Wight Local Resilience Forum (LRF) covers Portsmouth, Isle of Wight, Southampton and the county of Hampshire. The emergency response is based around the concepts of

command, control and cooperation and operates at three levels – operational, tactical and strategic.

2.5. The structure of this arrangement is in the figure below:



2.6. The Strategic Coordinating Group (SCG) is the main command group of this structure. Chaired by Neil Odin the Chief Officer for Hampshire Fire and Rescue Service. This group meets weekly and has the power to escalate issues up to Central Government through the Ministry of Housing, Communities and Local Government – a representative attends SCG. SCG acts under legal authority under the Civil Contingencies Act 2004.

2.7. The agreed Strategic Objectives are as follows with each of the leads having their own support cell and being in attendance at SCG.

- Prevent spread of infection - Strategic Lead: Simon Bryant, HCC Director of Public Health
- Maintain critical services - Strategic Leads: Maggie MacIsaac NHS and Steve Apter Hampshire Fire and Rescue Service
- Protect the most vulnerable - Strategic Lead: Graham Allen, Hampshire County Council

- Maintain public confidence and order - Strategic Lead: Dave Powell and Scott Chilton, Hampshire Constabulary
- Restore and recover to new normal - Strategic Lead: David Williams, Portsmouth City Council

2.8. A number of Council and CCG employees are involved in the supporting cells, for example Debbie Chaise the interim director of public health for SCC leads the modelling cell. Maggie MacIsaac as the local CCGs Chief Executive and Chief Executive of the HIOW Integrated Care System (ICS) leads the health response through the health and care cell to which health and care representatives attend once a week.

2.9. The HIOW LRF produces a Common Operating Picture (COP) each day which is available for all LRF partners which ensures all partners understand the current position of the major incident.

2.10. The Hampshire Tactical Coordinating Group meets twice weekly and takes reports from each of the cells, and will escalate issues up to SCG should they be needed.

2.11. To ensure that Southampton and South West Hampshire health and care provision is optimised to address the COVID-19 threat, a multi-agency group of senior officer and clinical leaders meet regularly. The purpose is to ensure effective demand and capacity modelling, provide system wide oversight, enable mobilisation of additional capacity and resource deployment, monitor risks and impact and put mitigations in place. The group will escalate issues as necessary to the Hampshire and Isle of Wight COVID-19 Health and Social Care cell, within the major incident set up as outlined above. The group will also work on recovery to business as usual.

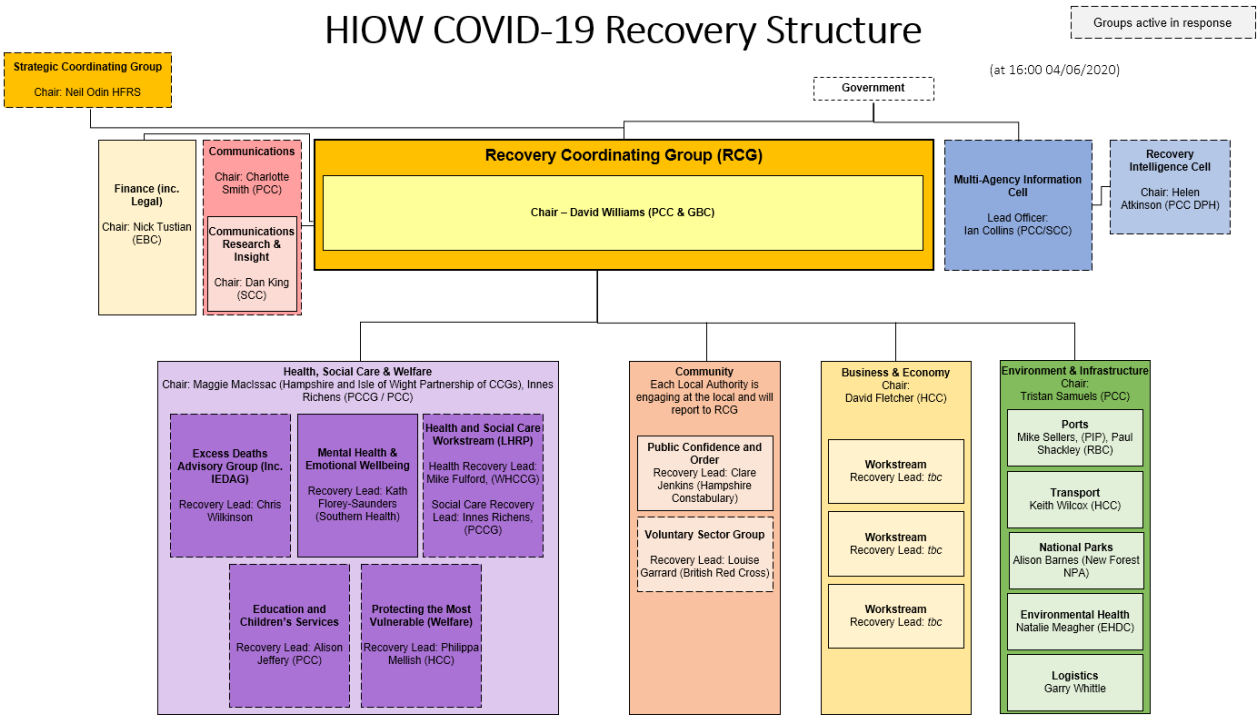
2.12. The HIOW LRF Recovery Structure aim is to restore the social, economic and political well-being of the communities of HIOW.

2.13. The Objectives are

- Help HIOW communities and businesses to recover and move forward as speedily as possible through an effective, collaborative, and well-communicated multi-agency response led by the local authorities
- Develop and maintain an impact assessment for the COVID 19 pandemic in HIOW
- Develop a concise, balanced, and affordable recovery action plan

- Ensure a system is in place for the monitoring and protection of public health and that plans are in place to manage response alongside recovery (second wave or non-COVID-19 incident)
- Critical services including our utilities and transport networks continue to be supported to be supported and maintained
- A pro-active and integrated framework of support to businesses is established
- Help those traumatised by their experience of the impact of COVID 19 on themselves, their families and their loved ones address their trauma (and grieve their loss)
- Reinforce and restore public confidence in the resilience of the machinery of government to protect the public from critical incidents
- Celebrate and commemorate the contributions made to support our communities through the incident and give the public opportunities to express their appreciation
- Collaborate to help re-build those critical services most ravaged by the incident and reflect on future prioritisation
- Co-ordinate environmental protection and recovery issues arising
- Information and media management of the recovery process is co-ordinated
- Establish effective protocols for political involvement and liaison (Parish, District / County / Unitary and Parliamentary)
- Cherish and implement the learning from the incident, including capturing best practice and reflect on future priorities in the light of collective experience.

2.14. Below is the HIOW LRF Recovery Structure, this is Chaired by David Williams CEO of Portsmouth Council. Similar groups exist in this structure to those dealing with the crisis. For Health, Social Care & Welfare this is chaired by Maggie MacIsaac (Hampshire and Isle of Wight CCGs CEO) and Innes Richens Director Of Adult Social Services (DASS) Portsmouth City Council.



3. Prevent Spread of infection

3.1. Preventing the spread of COVID-19 infection is fundamental to tackling the pandemic, and at the core of the national and local response. The focus of the national strategy ("contain, delay, research and mitigate") has been to flatten the epidemic curve and push the first wave into the Spring and Summer months to give the health and social care system (and other critical services) more time to prepare, build capacity, and respond. Alongside this, measures have sought to protect those groups that are more clinically vulnerable to the severe impacts of contracting COVID-19.

3.2. A comprehensive overview of the national measures that have been used to prevent the spread of COVID-19 infection is captured by the Health Foundation's Policy Tracker, see: https://www.health.org.uk/news-and-comment/charts-and-infographics/covid-19-policy-tracker

3.3. *Our Plan to Rebuild: The UK Government's COVID-19 recovery strategy* sets out key preventing the spread of infection measures for phase 2 and 3 of the current recovery, with phase 2 focussing on "smarter controls" and phase 3 on reliable treatment and/or a reliable vaccine. Smarter controls includes making contact safer (by redesigning public and work spaces), those with symptoms and contacts self-isolating, using testing, tracing and

monitoring of infection to better focus restrictions according to risk, and localised outbreak management.

3.4. At the LRF level, a Preventing the Spread of Infection (PSI) Cell is in operation, which supports strategic decision-making and alignment of policy in relation to preventing the spread of infection measures. Going forward it is likely that the scope of the Cell will focus on the following:

- Hampshire and Isle of Wight coordination and oversight of the delivery of national Testing programmes
- Hampshire and Isle of Wight coordination and oversight of the delivery of the national elements of Test and Trace programme
- Alignment of local authority Outbreak Control Plans (as appropriate, it is recognised there will be overlap)
- Identification of the need for coordinated public messaging to help prevent spread of infection with delivery via the LRF Media Cell.

3.5. At the local level a PSI Group, chaired by the Executive Director for Wellbeing and Adult Services (with the Director of Public Health as Lead Officer), has been established with a focus on coordinating delivery and ensuring oversight of key PSI measures by Southampton City Council. This includes delivery in relation to PPE, the national testing programme, messaging on social distancing and good hygiene practice, high risk settings (i.e. care homes, education settings, homeless hostels), and high risk and/or vulnerable groups. This is due to evolve into the COVID-19 Local Health Protection Board, which will be chaired by the Director of Public Health and responsible for the development and operational implementation of a Southampton City outbreak control plan; and hence will be a multi-partnership Board with oversight across the Southampton system.

3.6. To date, key local actions to support the PSI agenda include:

- Contribution to a pilot testing programme in Southampton.
- Rapid mobilisation of an Information Cell (supported by Public Health, strategy, HR and communications) to provide coordinated and robust advice to Southampton City Council services in relation to COVID-19 related queries, a large proportion of which require advice on preventing the spread of infection.
- Establishment of a working group to focus on PSI in relation to care homes (a high risk setting).
- Establishment of a “safe working in the Civic” working group, to ensure the return of some workers to Southampton City Council buildings is as low risk as possible.

- Rapid mobilisation of a Southampton City Council PPE Group to oversee and coordinate the supply of PPE to council services and, where required, providers.
- Southampton City Council recommendations for use of PPE by its staff not in health or social care settings.
- Prioritisation Framework (and supported by a paper on ethical frameworks) for utilisation in the event that there are shortages of PPE.
- Liaison with the LRF PPE Cell and TCG to enable use of the LRF Hampshire and Isle of Wight stockpile for providers where required (strengthening their supply chain options).

3.7. Key areas of focus going forward include:

- Establish a COVID-19 Health Protection Board (as above)
- Develop a Southampton Outbreak Control Plan
- Continue prioritisation of care homes for staff and resident testing
- Support education sector in ensuring schools can open safely and in engaging with PHE when there are suspected or test positive cases in a school community
- Support primary care in developing a sustainable and cost efficient procurement process for PPE in the medium term (aligned with LRF work)

4. Impact of COVID-19

4.1 Overall deaths from COVID-19

4.1.1 Overall there are **4,444** lab-confirmed cases in the Hampshire and Isle of Wight area: **3,336** in Hampshire; **199** in Isle of Wight, **320** in Portsmouth; **589**in Southampton. (At 17:00 01/06/2020).

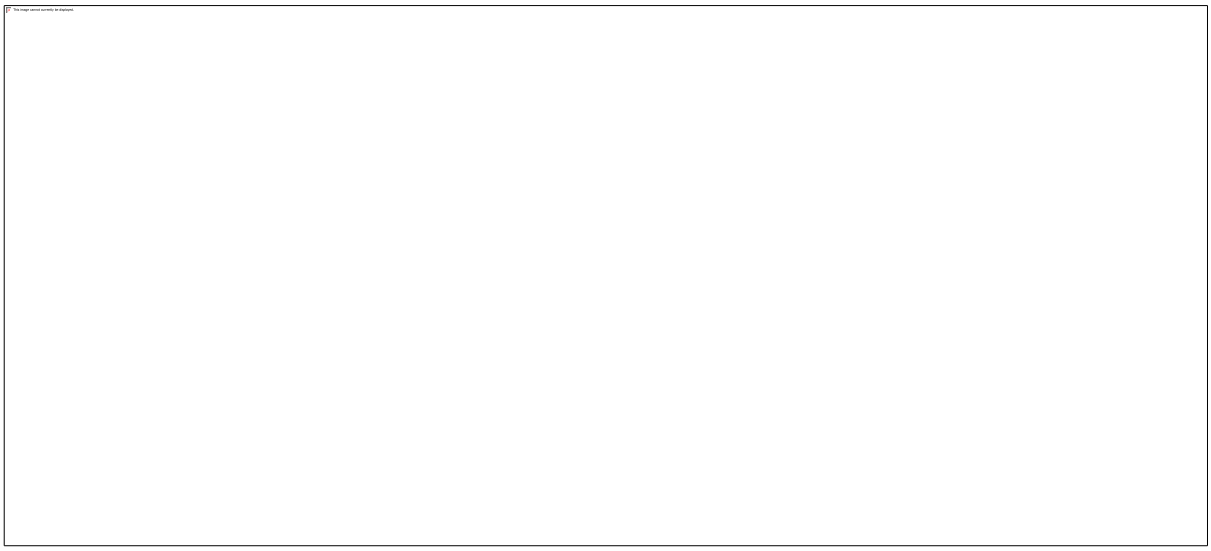
4.2 Outbreaks in Care Homes

4.2.1 The first notification of an outbreak in a care home in Southampton occurred in the week commencing 16 March 2020. There was then a gradual increase in notification of new outbreaks in care homes in Southampton over subsequent weeks, peaking at nine new care home outbreaks in the week beginning 13 April 2020 before beginning to drop over subsequent weeks, as presented below in Figure 1. In total 25 out of 63 care homes (40%) in Southampton experienced outbreaks of COVID-19 up to the 25th May 2020. This is similar to the whole of the South East average at 38.4%. Only the South West (28.1%) and East Midlands (34.0%) have lower proportion of care homes with outbreaks, with other regions ranging from 38.6 to 50.1%.

Figure 1: Number of new care home outbreaks over time in Southampton

4.2.2 The cumulative proportion of care homes with outbreaks in Southampton is also similar to local neighbouring local authorities as presented in Figure 2.

Figure 2: Proportion of care homes with COVID-19 outbreaks across Hampshire and the Isle of Wight.



4.2.3 Due to the evolution of testing it is not possible to be certain about the total number of cases of COVID-19 among care home residents in Southampton. Early on in the response, tests were limited, and many symptomatic residents would not have been tested.

4.3 Southampton Care Homes with deaths

4.3.1 COVID-19 is an acceptable direct or underlying cause of death for completing the Medical Certificate of Cause of Death. Data on deaths in care homes due to COVID-19 is compiled by the Office for National Statistics (ONS) using these certifications. Homes are also required to notify deaths within the care home setting to the Care Quality Commission (CQC).

4.3.2 In addition to CQC/ONS data on COVID-19 deaths, the Southampton IPC team have made careful enquiries about resident deaths during the support calls to care homes with outbreaks. This has been especially important in identifying deaths in care home residents that have occurred following admission to hospital.

4.3.3 To date, there have been 69 deaths in Southampton care home residents due to COVID-19 with 45 of these among nursing home residents and 24 among residential home residents, as presented in Table 1. A higher proportion of nursing home residents died within care home setting compared to residential home residents, more of whom died in hospital. An additional four COVID-19 deaths have occurred in supported living settings (data not shown).

Table 1: Care home resident deaths due to COVID-19 in Southampton

Type of home	Place of death		
	Care Home	Hospital	Totals
Nursing home resident	36	9	45
Residential home resident	10	14	24
Totals	46	23	69

4.3.4 The crude death rate per 1000 care home beds compared across different health geographies is presented in Figure 3 for all care home residents and the rate per 1000 care home residents aged 80 years and older in Figure 4. Southampton care home deaths from all-causes and from COVID-19 are not significantly different from Portsmouth, Hampshire, and the England average. The Isle of Wight has significantly lower deaths from

all-causes and COVID-19 compared to the England average but deaths due to COVID-19 are not significantly different from those in Southampton. However, these data are for deaths within the care home and do not include care home residents that have died in hospital.

Figure 3: Mortality rate per 1000 care home beds

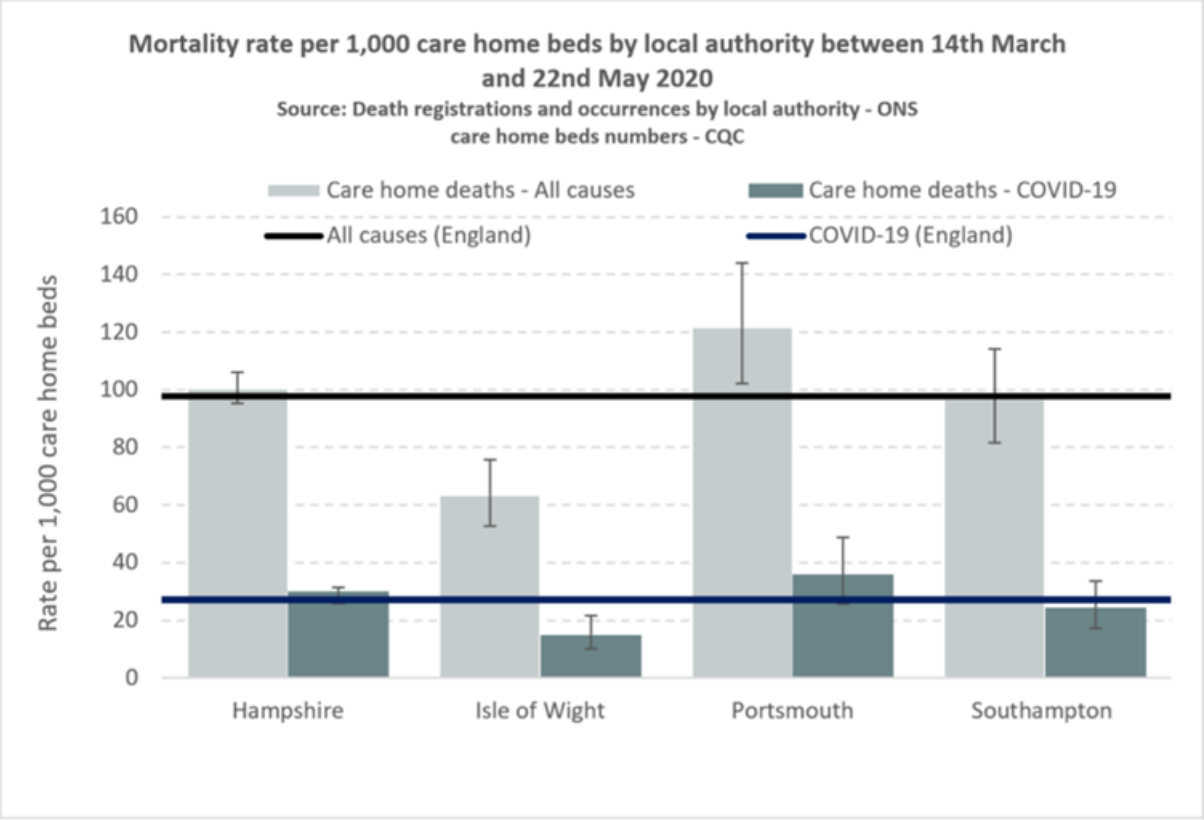
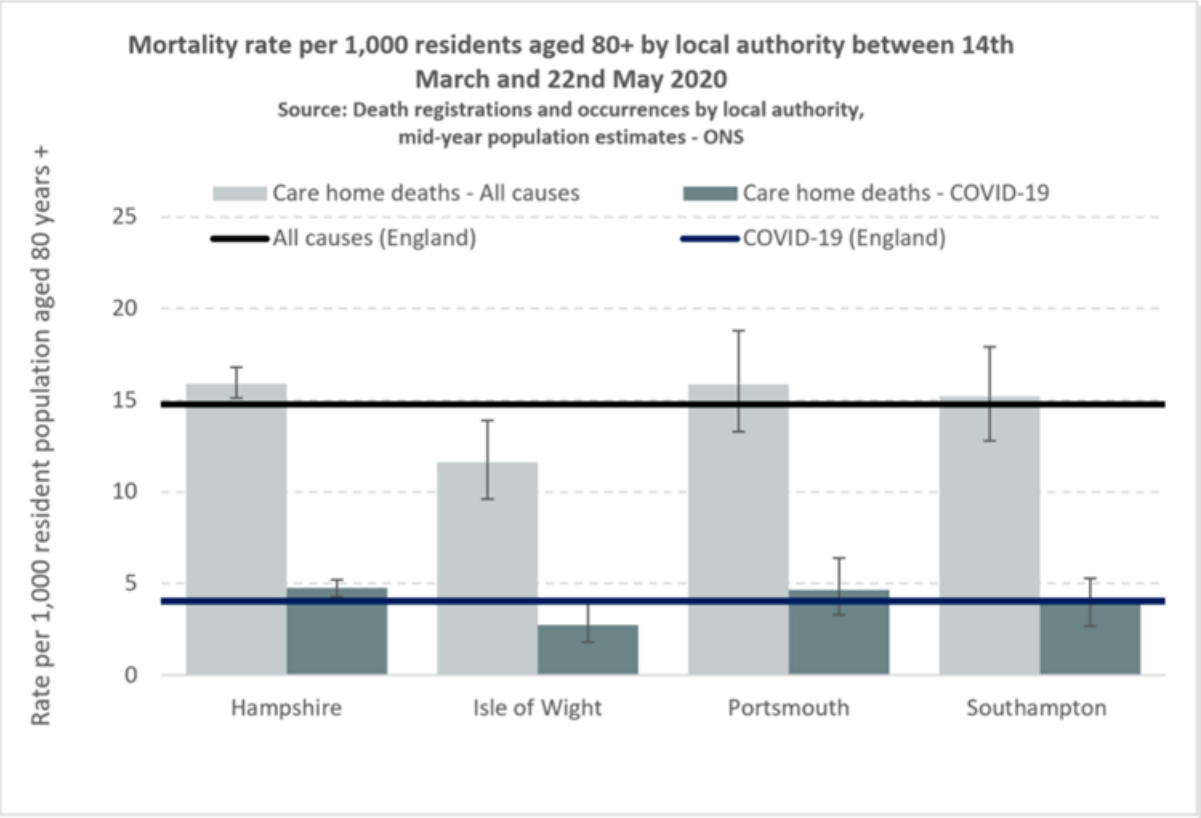


Figure 4: Mortality rate per 1000 care home residents aged 80 years and over



4.3.5 In summary, the cumulative proportion of care homes with outbreaks during the first wave of the virus has been similar in Southampton to elsewhere. The crude (unadjusted) rate of deaths in care homes due to COVID-19 and all-causes is also similar in Southampton to the whole of Hampshire and the Isle of Wight, and to England averages, although do not include those care home residents who have died in hospital. The number of new outbreaks in care homes has now slowed and those with ongoing outbreaks are rapidly coming under control. This will be in part due to good adherence to infection, prevention and control measures, including wider use of PPE, increases in testing capacity, and the lower community prevalence of active infection due to the wider societal measures of stay at home advice and social distancing. As these measures begin to be relaxed it is important that the situation in care homes will be closely monitored and whole-home testing will be extremely helpful in controlling infection.

5. Personal Protective Equipment (PPE)

5.1. NHS Supply Chain, the company owned and operated by the Department of Health and Social Care (DHSC), and the Government are working to provide Personal Protective Equipment (PPE).

5.2. Guidance was published on which PPE should be used where - and this was endorsed by royal colleges and trade unions. This guidance is shared by and discussed with Infection Control experts on a weekly basis.

5.3. Public Health England (PHE) works with other agencies across the UK to ensure health and care staff have the right PPE, while NHS Supply Chain - under the jurisdiction of the DHSC – is responsible for ensuring that PPE is distributed across the NHS and other health settings appropriately, as quickly as possible.

5.4. Steps continue to be taken across Hampshire and the Isle of Wight through a supplies task group to ensure there is enough PPE. Supplies are flowing and steps are in place for organisations to raise urgent issues as they arise. Training, support and advice is being provided to care homes, home care and other providers.

5.5. In Southampton, the Integrated Commissioning Unit (ICU) is working closely with colleagues in the Council to ensure that supplies are managed appropriately in line with government guidance. In order to enable this, the ICU is providing guidance and facilitates urgent deliveries of PPE to providers, primary care, pharmacies and other services. The greatest demand through the ICU Hub is from care homes, home care providers and those employing staff via personal budgets for access to PPE.

5.6. The availability and affordability of PPE to our local providers through normal supply routes has been variable. This has largely been in response to national market fluctuation and changing demand profile to match changes in national policy. This has meant that providers dedicate significant management time to sourcing PPE, pay significantly higher rates and at times are unable to arrange deliveries in time to meet their needs. The hub has been able to support this, in all cases, ensuring that they have supply to tide them over until they receive their next delivery.

5.7. At the end of March 2020 there was a national concern about the availability of PPE, due to increased demand and disrupted supply chains. The council launched an appeal for local businesses to donate PPE and gratefully received a number of donations. Both the Council and Clinical Commissioning increased procurement activity, using existing supply chains and working with new suppliers following appropriate due diligence activity. In addition to this activity, supplies have been made available to the city via the Local Resilience Forum.

5.8. At this time, the Council has sufficient supplies to meet demand in the immediate future, but is continuing activity to ensure that suitable stocks of PPE are procured on an ongoing basis, as well as working with providers to assist them in sourcing PPE supplies as in the current circumstances this remains a concern.

6. Changes to acute services and capacity

6.1. The NHS and local authorities across Hampshire and the Isle of Wight are working with their partners to make sure we are as prepared as possible for any increase in demand for services, and any need to change the way we work as a result of the current COVID-19 national emergency. A huge amount of planning and preparation has taken place to ensure we are as ready as we can be to meet the challenges we are facing. This has involved not just securing extra capacity for patients who have COVID-19, but also finding new ways of looking after patients with other conditions and illnesses who will still need care.

6.2. We are fortunate in Southampton to have a large regional centre in University Hospital Southampton NHS Foundation Trust (UHS). Throughout this period there has been capacity for critical care patients and plans are in place to increase these beds if required. At the peak, Emergency Department (ED) attendance was considerably lower than normal, as was the case across the country as a whole.

6.3. In line with the Government Discharge Guidance, we are working across health and care across Southampton and South West Hampshire to ensure patients that do not need to be in hospital can be cared for in different settings.

6.4. At UHS, a number of services have adapted, such as:

- The paediatric intensive care unit was moved to create additional COVID-19 critical care capacity.
- Testing laboratories increased capacity greatly from the start of the pandemic with the laboratory and pathology teams responsible for processing samples for the South of England.
- Maternity services have established a dedicated support group for pregnant women to keep them updated on changes to guidance and provide reassurance.
- More than 90 outpatient services in UHS have been now set-up to run as video and telephone clinics and a new triage tool has been implemented to ensure patients are treated in the right place and the

right time, such as by telephone, video, face-to-face or a decision to postpone the appointment.

- UHS has installed a results channel which provides nursing staff and infection control teams with live results on inpatients testing positive for COVID-19.
- A number of UHS cancer services have been moved to the Spire Southampton Hospital , which is across the road from the main Southampton General Hospital site.
- A number of other urgent services have been moved to the Southampton Treatment Centre at the Royal South Hants and the Nuffield Hospital in Chandlers Ford
- No visitors are allowed on UHS sites, in line with national guidance, but the Trust's Experience of Care Team is now accepting messages via email which will be printed, laminated and delivered to patients, and offering the chance for people to drop off small gifts and letters which members of the team can pass on.

6.5. A nationwide publicity campaign, 'Help us to help you', is underway to ensure the public is aware that services such as the Emergency Department continue to be open.

6.6. The Urgent Treatment Centre (UTC), provided by CareUK and located at the Royal South Hants Hospital, has worked alongside UHS to change their offer to support the emergency department. This includes moving as much of the adult and children over the age of 5 minor injuries work out of the UHS site and into the UTC for patients without COVID-19 symptoms. To support this, the UTC's opening hours are slightly shorter than normal with the site closing at 8.00pm daily. The UTC and the Emergency Department are also now diverting people attending with minor illnesses to primary care.

6.7. Temporary mortuary provision for Hampshire and Isle of Wight has been set up in a site within Southampton Airport.

7. Adult social care

7.1. Adult Social Care Operations Hub

7.1.1. Critical services across Health & Adults continue to provide a 7-day service with 8am to 8pm cover where there is a need to do so.

7.1.2. Increased manager presence is still being provided in areas where staff anxiety and wellbeing concerns are evident.

7.1.3. Dashboards have been developed and activity is being monitored daily to include demands across the teams as well as the daily resource position. Activity monitoring is specific to each team; however, resource monitoring activity is uniform across the services.

7.1.4. The daily activity and capacity monitoring in place provides the opportunity for managers to raise any critical items, identify pressures, challenges, practice issues, learning that may be helpful to share and circulate across teams, as well as areas of success that we may want or need to communicate to staff.

7.1.5. The demands upon the Hub have significantly reduced as the teams have adapted in their new ways of working. The monitoring, remains critical to ASC functioning and planning moving forward, and is statutorily required by the Care Act Easement Guidance of 31st March 2020.

7.2. Care Act Easements

7.2.1. We remain in the position that the Care Act Easement legislation does not require invoking at this time. This remains under constant review against the guidance criteria previously presented.

7.2.2. A tracker has been developed to build an evidence base should easements be invoked.

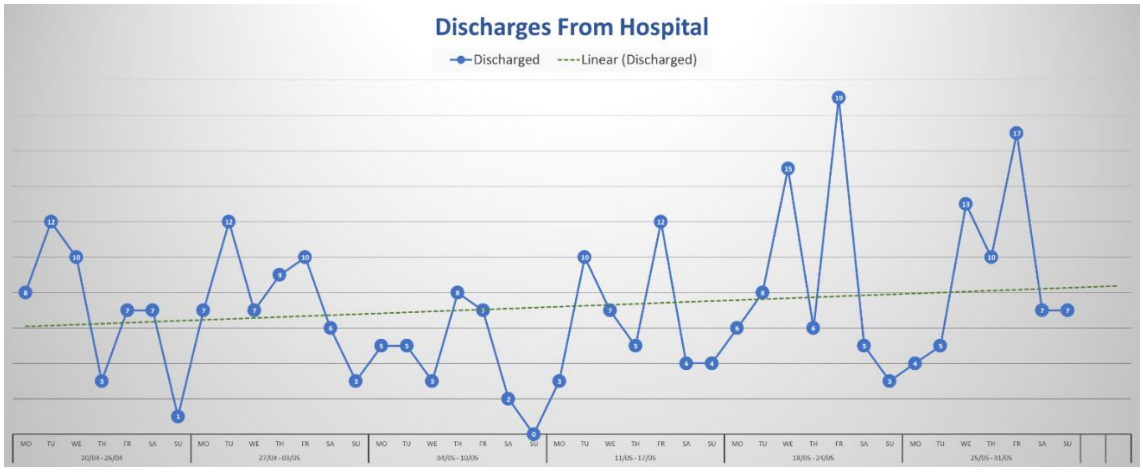
7.3. Adult Social Care Connect and social work teams

7.3.1. The ongoing demand on the service remains constant with no capacity issues at this stage. Safeguarding levels remain consistent. A focus on understanding levels of risk is ongoing especially as lockdown has now reduced slightly.

7.3.2. Face to face visits are still only being carried out where essential.

7.3.3. New activity coming into the Adult Social Care Connect team continues to show a slight downward trend since mid-April. The regular pattern of a peak on Mondays following the weekend dip remains as shown in the graph below:

7.3.4. The number of number and pattern of discharges from hospital has remained consistent from mid-April through to mid-May. However, there is a continued increase in the number of discharges over the last few weeks, which aligns with the slight easement in government lockdown measures and general communication around accessing hospital care for non-COVID-19 issues.



7.3.5. This activity is being monitored daily alongside staffing capacity. Continued monitoring over the coming weeks will identify if the further easement of lockdown by the government and continued opening of hospital services will result in a further increase in activity.

7.4. Holcroft House Residential Home

7.4.1. Currently there are 22 residents at Holcroft House. Four residents have unfortunately died from COVID -19.There is one resident that is currently COVID-19 positive.

7.4.2. The home has ordered home testing kits and all tests have been completed apart from one resident that refused a test, this resident is currently not symptomatic. This will to allow periodic testing of residents and reduce the period of the testing cycle timescale should any residents show symptoms in the future.

7.4.3. We have received 32 staff results of which one was positive, and the staff member is isolating. There have been 17 residents tested we are still awaiting results for four residents and 34 staff.

7.5. **Telecare**

7.5.1. The telecare service has remained fully operational, with some minor changes. The installation process has been adapted to reduce social contact with customers by carrying out telephone assessments/planning alongside the use of simple devices that can be remotely programmed and configured to operate independently using SIM technology.

7.5.2. Call handling has been continuous 24/7 and staff have triaged calls in detail, carrying out COVID-19 risk assessment and limiting the need for a home visit where possible. Call handling activity is currently only possible in an office setting (City Depot plus a small disaster recovery suite at Manston Court). The service is in the process of procuring the necessary software and call handling infrastructure that will enable call handling from any location, which will build in resilience for the future.

7.5.3. The emergency response service has remained operational 24/7, but with strict compliance with social distancing and appropriate use of PPE, following guidance on risk assessment of delivering personal care where social distancing is not possible.

7.5.4. Telecare devices have been supplied to the new ‘step down from hospital’ services. An additional 400 devices were purchased to support this, and as the devices are re-cyclable they will be used for people living in their own homes after the ‘step down’ facilities are no longer needed.

7.5.5. Demand for telecare services initially reduced, but these have more recently increased due to promotional activity amongst professionals and

the better use of the service to support discharges / stepdown from hospital.

7.6. Supported Housing

7.6.1. Support to customers living in supported housing and those receiving support in the general community has continued over recent weeks, mainly in the form of telephone support, but home visits when necessary.

7.6.2. Staff have retained a presence within supported housing complexes but have kept contact with residents to a minimum and have been working in offices with closed doors where possible.

7.6.3. Essential health and safety checks and housing management work has continued, but the letting of properties has been suspended. The biggest challenge has been around IT and the need to have a robust software package and IT infrastructure to support the service going forward. This is particularly important as we continue social distancing and remote working into the foreseeable future.

7.6.4. Social isolation continues to be an issue for elderly people, and the service continues to offer remote support, advice and referral to other services. People who were not previously receiving support have become more socially isolated and are now receiving support for the first time.

7.6.5. In the coming months the service will be supporting people to become less dependent and return to a level of independence that has been recently taken away from them.

7.7. Housing Adaptations

7.7.1. The OT assessment process has been scaled down significantly since the lockdown was announced. A number of staff have volunteered to work in other service areas and have been undertaking the necessary training for this to be possible.

7.7.2. Clients have limited access to some essential facilities and continue to rely on care support and relatives to help manage their existing situation. Many clients fall within the vulnerable groups, and do not want visits to take place.

7.7.3. The service has developed a telephone- based assessment process, which will be used where possible, in conjunction with other technologies such as 'WhatsApp', where a client or family member is able to show the OT the home environment.

7.8. Internal Day Services

7.8.1. National restrictions are in place which prevents day services operating as they did previously. A full risk assessment of each individual and their circumstances was undertaken to ensure that the support continued to be available as it was needed. This has included day opportunities providers supporting individuals with their daily exercise routines and contacting families offering support as needed.

7.9. Kentish Road Respite Centre

7.9.1. Kentish Road respite centre was temporarily closed due to the cancelling of all respite bookings. Officers have been deployed to support other services as needed.

7.9.2. Respite provision is available if needed via external provision and considered in conversations with individuals and families as part of the ongoing contact and assessment of risk.

7.10 Urgent Response Service

7.10.1 Demand on the service has been increasing over the last few weeks. Current levels are manageable within the existing resource envelope. There remains a high level of complex care packages for the service with more double handed care being required following discharge. CQC continue to monitor PPE and COVID-19 positive cases in relation to both staff and clients daily.

8. Financial impact of COVID-19

8.1 Southampton City Council's provider payment terms have been revised to promote cash flow for residential and nursing homes and are being made in advance on an assumed occupancy basis. For home care, payments are now made as soon as possible following receipt of invoices from providers, foregoing the usual contractual timetable. The CCG has also revised its terms of payment to ensure provider's cash flow is sufficient.

8.2 Taking into account pressures providers within the local market are experiencing, including increased staff absences due to COVID-19 or self-isolating and the additional time required for care, the CCG and SCC have implemented a 10% uplift to residential and nursing homes. For the CCG this covers the period 1 April to 30 June. For the Council this covers the period from mid-March until end of June. There is also a similar 10% uplift for home care packages and housing support services, recognising the additional pressures these sectors have faced. These are in addition to the uplifts awarded to placements made at the council's published rate levels for care homes from April 2020 – 5% for residential home placements; 6% for nursing home placements.

8.3 A similar 10% increase for home care, over the same periods, is in addition to changed rates following the re-opening of the local home care framework which enabled providers to re-set their rates from April 2020. The 10% uplift was the amount agreed following analysis of extra costs being faced by providers at the time and projecting likely costs until 30 June 2020.

8.4 Standard rates for new placements have been increased by 15% during this period. Some block booking of beds has been undertaken to provide further security. There is a separate process in place to further support homes, providers of home care and others in the care industry should the additional costs faced be above usual costs and mitigating measures have been exhausted. This process enables providers to request support by detailing the additional costs and impacts. The aim is to ensure that where cash-flow is compromised and costs are causing serious difficulties for providers, financial support with those costs can be provided on a case by case basis.

8.5 The above measures will be reviewed by the 30 June 2020 in order to determine whether uplifts will continue beyond this date. The review will consider whether the measures have been sufficient in the support provided; and any further actions including the possible return to normal contractual arrangements.

8.6 It is the intention to meet the allocation requirements of the Infection Control Fund announced on 14 May 2020. 75% of the allocation (£1,518,953.25) is to be paid direct to care homes and the council based upon the total of CQC registered beds in each home. Payment will be made as a grant to provider organisations. The first payment will include a condition of use of the Capacity Tracker. The second payment will be made only if the provider has made use of the Capacity Tracker and has used the initial payment in full on infection control measures. The final

25% of the allocation (£505,507) will provide the council with greater discretion to direct resources where it, working with partners, considers it will have the greatest positive impact on infection prevention and control measures. The options for this are being considered.

8.7 The longer-term financial impact of COVID-19 on the demand for adult social care and the additional costs that providers will face in the medium and longer terms is being explored. Demand modelling activity has started to ensure that total demand is understood and the impact this might have on the growth forecast. This will be a dynamic process as the impact of COVID-19 materialises and will be used for both in year and future planning purposes. It will be particularly important to understand the impacts the current period may have on demand for services from self-payers who form a majority of users in most homes.

9. Discharge arrangements

9.1. National requirements now in place mean that acute and community hospitals must discharge all patients as soon as they are clinically safe to do so. This includes those who have ongoing health and social care needs and require a package of care of some sort.

9.2. The hospital collates daily a list of those individuals who are medically optimised for discharge which is being shared with a newly formed single Point of Access based at Sembal house. The team there, comprising social workers from the Integrated Discharge Bureau, members of the Continuing Healthcare team, the Integrated Rehab and Reablement team (Urgent Response) and others are following Discharge to Assess processes and identifying interim placements for individuals.

9.3. To achieve quicker discharges locally, additional interim care capacity has been commissioned including hotel beds. Over 200 hotel beds in a number of settings in the city, Eastleigh and the New Forest, were set up at pace through a collaborative arrangement between CCGs, Southampton City Council and Hampshire County Council. The aim has been to provide care places in the community to deliver supported bed spaces, so that hospital beds can be utilised by people with a diagnosis of COVID-19 and for those in the greatest need. The service has operated on a home care style basis with live in carers, co-ordinated by an agency. The level of care that could be provided is up to four daily double-up care visits. Whilst in the interim placement, patients are assessed for a longer term placement, with relevant Care Act requirements fulfilled (but under

COVID-19 Care Act easement some of the current practices may be reduced if implemented). As demand has not been as high as originally predicted, some of these beds have been decommissioned, but a significant amount of capacity still remains to ensure demand can be met in any future wave of the pandemic.

9.4. Additional care home beds have also been commissioned. Residential and care homes are experiencing significant pressures which the CCG and Southampton City Council are mitigating in a number of ways. This includes ensuring providers are paid fully in advance for all commissioned care, providing infection control guidance to prevent and contain infections, and suppling homes with extra PPE equipment when stocks are low.

9.5. To meet the increased health needs for patients during the COVID -19 period there has been a remodelling of health care in the city. The acute hospital will focus on the most ill and community hospitals will change to provide care for those needing oxygen and respiratory care or those ill and potentially requiring symptomatic or palliative care. To support this new community hospital beds have also been developed at Adelaide Health Centre and Lymington hospital.

10. Continuing Healthcare (CHC) and individual funding arrangements

10.1. To speed the discharge process the Government has agreed the NHS will fully fund the cost of new or extended out of-hospital health and social care support packages. Formal CHC assessments, charges to self-funders or client contributions will not be progressed until after the COVID-19 emergency period. As a consequence of this instruction, the CCG has not been undertaking CHC assessments for the majority of individuals.

10.2. The CHC team can receive new applications for CHC funding for individuals from community settings at this time and the CCG will take a pragmatic approach to decision making on these during this period. The CCG is working with care providers and families to exploring undertake community DST's for new community referrals. These will be completed using technology to support both remote evidence gathering and the holding of virtual Multi-Disciplinary Team for meetings to complete the Decision Support Tool (DST). The CHC team will ensure that all DST processes are in line with NHS Framework for CHC requirements and are completed in partnership with individuals, relatives and provider services.

10.3. During the COVID-19 period, the CCG can still receive appeals regarding previous CHC decisions. The timeframe during this period is more flexible, but the CCG will endeavour to respond to appeals in a timely way. The CCG has received two appeals to date during the COVID-19 period as is liaising with the appellants to agree how the appeal will be progressed within the current COVID-19 social distancing restrictions.

10.4. The CCG is also required to track the patients being funded under the COVID-19 arrangements and to prepare to return to usual funding arrangements following the emergency period set out in the Coronavirus Act.

11. Primary care services

11.1. To prepare for the unprecedented clinical challenge in primary care in the city the CCG, with collaboration of Primary Care Network (PCN) leads, has set up a clinical command group. This work links in with Hampshire and Isle of Wight wide work around primary care as part of the overall system response. The role of the command group is to do full time planning to ensure we have adequate preparedness to meet this task. The team comprises of representatives from the CCG (both clinical and managerial), PCN leads and Southampton Primary Care Limited.

11.2. All GP practices remain open and are offering a “remote triage” first model, where patients needs are assessed remotely by a clinician either over the phone, video-call or via an electronic consultation (e-consult). 100% of practices in the city are offering e-consults and video consultations. Additionally, local centralised telephone triage arrangements have been established for patients who are suspected to be COVID19 positive. This service receives transfers from both NHS 111 services and local practices and assesses the needs and arranges suitable responses for patients who are COVID19 positive in a systematized and consistent way. The service is operated by our local GP Federation, Southampton Primary Care Limited (SPCL).

11.3. Hot and cold sites have been set up in the city for patients who require a face to face appointment in primary care.

11.4. One hot site exists which caters for those patients deemed likely to be COVID-19 positive and who require face-to-face assessment. This is presently located in St Mary’s Surgery and the opportunity to open other hot sites is in place, if demand requires this. The hot site is well equipped physically and in terms of trained workforce; it also has some specific

operating procedures. This site is operated by SPCL, which also operates a city wide home visiting service for patients who are COVID-19 positive. During weekdays, local practices contribute to the staffing of the hot site and visiting services. Across England, patients with suspected COVID symptoms are encouraged to call NHS 111. When Southampton patients with COVID-19 positive call NHS 111, if they are deemed to require further assessment they will be transferred to the services of our local GP federation (SPCL) who will provide further clinical assessment over the phone and if necessary see them at the hot site or via a home visit.

11.5. Over April and May 2020 these hot services have expanded in scope to include a remote oxygen saturation monitoring service enabling patients to safely remain at home while being monitored. SPCL have also played a key role in supporting patients who are end of life in collaboration with Solent NHS Trust and other partners.

11.6. Twelve cold sites exist for patients deemed likely to be COVID-19 negative. Patients must have an appointment before approaching any of these sites, which are spread geographically across Southampton. These sites have been set up through local practices collaborating with each other. In May 2020 these cold site arrangements were reviewed and from June 2020 more cold sites have safely re-opened to face-to-face appointments. At present 30 of 39 sites in the city are open for face-to-face appointments

11.7. During April and May 2020 the CCG has worked collaboratively with SPCL to develop their Enhanced Healthcare in Care Homes (EHCH) service. From 22 May 2020 all registered care homes in the city now have a named clinical lead and work continues to develop more enhanced Primary Care support to all residents in care homes across the city.

11.8. From May 2020, both within the city and at a Hampshire and IOW level, work has commenced in earnest around the restoration and recovery of primary care services. The emphasis of this work balances the need to restore services to mitigate the unintended consequences of undiagnosed or unmanaged health issues with the need to maintain a state of readiness for any potential re-escalation of the COVID-19 pandemic. In July 2020 the Primary Care Command Group will take stock and implement any necessary amendments to the configuration of services for the medium term. Alongside maintaining a suitable response to the COVID-19 pandemic this will also accommodate the usual changes in demand associated with an approaching winter and seasonal flu pandemic.

12. Mental health services

12.1. The ICU is in regular contact and is working in partnership with providers to understand the current service provision, understand how business continuity plans are being adapted for the fast paced changes, and to identify and jointly resolve concerns and mitigation plans for emerging risks. This includes all providers that are commissioned by Southampton City Council and the CCG, and is supporting the full range of mental health needs in the city, from mild-moderate common mental illness (depression, stress and anxiety related disorders) to supporting people living with severe and enduring mental illness.

12.2. Mental health services continue to function and have made adaptations to accommodate social distancing rules. Services are preparing for an increase in demand due to COVID-19, both immediate and into the future.

12.3. Southern Health NHS Foundation Trust has continued to provide adult mental health services in the city. Psychological services across the Trust have been moved where possible to video/telephone contact, including older people's mental health, eating disorders, adult mental health, early intervention in psychosis, crisis resolution and home treatment and community mental health teams. The Lighthouse (run in partnership with Solent Mind) is temporarily running as a 'virtual' crisis lounge. During April The Lighthouse supported 202 virtual visits by 63 people across the city who were in crisis or experiencing emotional distress who may have otherwise presented to ED services.

12.4. The Steps to Wellbeing service, provided by Dorset Healthcare NHS Foundation Trust, continues to offer digital treatment options. In addition to the usual therapeutic interventions a series of pre-recorded webinars have been developed by clinician and people with a lived experience to help local residents in coping with COVID-19 anxious thoughts, these are available to ensure that people are able to access the early support when it is convenient to their own individual home, work and family circumstances.

12.5. Solent Mind is offering alternative online, text and telephone provision in place of its usual services recognising the impact that self-isolation can have on peoples mental wellbeing and recovery

12.6. Work is underway to review national developments in mental health response to COVID-19 related anxiety and discussing with local providers. Locally we are acknowledging a potential increase in need for mental

health services over the months ahead, in light of the impact of self-isolation measures.

13. Services for those with Learning Disability

13.1 271 people use learning disabilities day services. All learning disabilities day services in the city are currently closed, including the council's internally run service. It was identified at an early stage that this would create difficulties and added pressures on services users and their carers. Therefore day services were asked to stay in regular contact with the individuals they usually support, this has been done in a variety of ways including via phone call, online and some home visits. This has led to a lot of variety in what individuals have experienced though. In a small number of cases clients have accessed day centre buildings with carers to relieve stress with appropriate social distancing and infection control measures. Rather than day services furloughing staff who weren't needed for the regular contacts, the council matched day services to supported living providers with the aim that they could provide extra capacity where needed for non-direct support tasks like shopping. In practice this support has not been widely needed as supported living services have managed to maintain service provision within their own staffing teams however it is something which could be used in the future if necessary. Work is currently taking place with external day services to establish what each day service can offer and a revised agreement for fair and equitable pricing, during this interim period, where impacts of COVID-19 mean they are unable to deliver their normal service.

13.2 The community health services commissioned by the CCG and provided by Southern Health Foundation Trust have adapted their service offer to include more virtual training for service providers such as sessions on eating and drinking awareness, positive behaviour support and postural awareness. The team continues to work in an integrated manner with the social care team in order to ensure those people that require specialist health interventions have their needs met in an appropriate and timely manner.

13.3 At University Hospital Southampton, the LD acute liaison nurses have promoted the use of Hospital Passports and put in process a place for

these to be recorded on hospital systems as well as accessible by wider health services.

13.4 The adult social care learning disability team have a process in place in which they contact service users and/or their carers to risk assess what level of ongoing communication or direct support that may be needed. This has been completed for every service user known to the team and regularly reviewed. 753 people are open to the Learning Disabilities Team.

13.5 The two externally commissioned respite services, Rose Road and Weston Court have both remained open throughout the pandemic. Most service users and carers have decided not to access their regular respite stays but some families where there are particular challenges or risks have continued to access. In addition the services have taken on a small number of emergency referrals where there is an urgent need for respite. Services are operating within government guidelines to maintain safety of service users and carers.

13.6 To help manage the process of welfare calls (which have been one of the main tasks that day service providers are undertaking) SCC officers have started contacting all individuals and/or carers that receive day care to ask key questions about the quality of the welfare calls, the frequency, and whether there anything else they need from a social worker, but also, is there anything else they would like day services to do/put in place at the current time. This also helps us ascertain, from the latest Government announcement on the easing of some of the lockdown restrictions, whether some carers are needing to return to work and if so, how we are going further develop ways to support them. We will use this intelligence to work in partnerships with individuals and carers on their own plan, but also consider feedback to help shape what a good day services offer can look like in this interim period, whilst they are unable to be fully operational.

14. Community Services

14.1. All commissioned community services have been reviewed with priority given to discharge pathways; and essential support to high-risk individuals and patients cared for at home.

14.2. All Solent NHS Trust community services in the city have completed an assessment of frontline workforce capacity and their ability to safely

operate in the event of a reduction in workforce. Mitigation plans have been put in place for essential services.

14.3. Where changes to services are necessary to ensure patient safety, or as a consequence of re-deployment of staff to priority essential services, a corresponding Quality Impact Assessment (QIA) has been completed to consider necessity of the changes, assessment of risk and proposed mitigation plans. The QIAs are reviewed by the Chief Nurse, Medical Director and relevant Operational Directors within Solent NHS Trust and ratified by its Ethics Group. Commissioners receive updates on any changes to Solent services.

15. Children and young people services

15.1. We are in regular contact with providers, the local authority and commissioning colleagues across the Hampshire and Isle of Wight system to identify, mitigate and jointly resolve any current and emerging risks.

15.2. Child and adolescent mental health services (CAMHS), provided by Solent NHS Trust, are now delivering a community crisis pathway for urgent assessment within 24 hours of young people who are/were at risk of being directed to Southampton General Hospital. This is an extension of the current service and is provided seven days a week. There is a triage system in place for this model to ensure that young people whose needs are best met within the hospital are still able to be supported there. Young people whose needs are not best met within a hospital setting will be contacted by the community CAMHS team who will undertake an initial assessment of need over the phone or through other digital platforms (including video calls) to jointly determine next steps.

15.3. CAMHS recognise that families may need additional contact with the service at this time and have increased duty capacity to respond.

15.4. Any referrals to CAMHS are reviewed daily, based on the information made available by the referrer. Those with urgent or crisis levels of need are contacted on the same, or next working day. Referrals for more routine to moderate levels of need were temporarily paused with families being provided with advice, guidance and evidence based self-help information; however these have now resumed

15.5. At a Hampshire and Isle of Wight level, a CAMHS worker is available for children and young people who call 111 for mental health support. This service can also provide a home visit if required.

15.6. Recognising the potential for increased anxiety amongst young people during the COVID-19 pandemic, 'Think Ninja', an online resource to support 10-18 year olds with their mental health has been made available to all children and young people across Hampshire and the Isle of Wight.

15.7. The 0-5 Public Health Nursing service (health visiting) is continuing to deliver some mandated contacts including the antenatal, new baby and 6 - 8 week reviews. These will either be carried out by telephone, videoconferencing or face to face visits where there is an ascertained need.

15.8. The 5-19 Public Health Nursing service (school nursing) has been largely deployed to support CAMHS, Community Children's Nursing (CCN) and the Community Paediatric Service. The CCN offer has been increased to seven days a week to avoid any hospital visits for children at weekends and looking to support the development of a Hospital@Home service.

16. Residential and home care

16.1. Residential and care homes have been experiencing significant pressures which Southampton City Council and the CCG have been working hard to mitigating in a number of ways. This includes ensuring providers are paid fully in advance for all commissioned care, providing infection control guidance to prevent and contain infections, other clinical nursing advice and supplying homes with extra PPE equipment when stocks are low.

16.2. The ICU is supporting care homes with access to the national NHS.net email service which has teleconferencing facilities through which a range of training sessions relating to COVID-19 are being provided. Additional support has included ensuring all care homes have a named clinical lead, a doctor or advanced nurse practitioner, who can provide active clinical advice, care planning and support for all residents. Care homes have also had access to weekly teleconferences providing a range of training and Q&A sessions. Alongside this a national training programme on the use of PPE, hand washing and testing has been rolled out to all homes who accepted the offer by 29th May, those who were unable to take up the offer in the initial period have been offered access to this training in June. A number of homes have experienced outbreaks of COVID-19 and a number of residents have sadly died during this period.

16.3. As part of the national response to the challenges in the care home sector the council has prepared a letter outlining the support to the sector in Southampton and an action plan is in place. This is being managed by the Care Home Oversight Group. The letter and action plan can be found at https://www.southampton.gov.uk/coronavirus-covid19/supporting-you/

16.4. The home care market comprises of providers delivering care to approximately 1500 of the most vulnerable people living in the city; there are approximately 40 providers in total. The providers cover a range of environments from client's homes, supported living clients for people with a learning disability and extra care courts where care is dedicated to that site and promoting the release of capacity. This is to support hospital discharge and the delivery of care to their existing client group. Commissioners are working with the market to facilitate mutual aid arrangements between providers and wider health and care provision. The home care sector has also had access to training and support provided by the CCG quality team.

17. Supporting the most vulnerable

17.1. Community Support Hub

17.1.1. Southampton City Council has launched a Community Support Hub and a dedicated helpline in response to the COVID-19 crisis, to ensure that the most vulnerable people across the city have access to the support they need. Southampton Community Support Hub brings together support from across the city including the NHS, Southampton City CCG, Southampton Voluntary Services and other voluntary and faith groups across the city. The service prioritises those who have received a letter from NHS England stating they are in a priority group and are unable to rely on family or friends for adequate practical support. The Hub enables the council to respond to requests, using its own resources and the voluntary sector, the community, and faith sector partners to deploy help quickly.

17.1.2. It provides a dedicated telephone helpline, arranges emergency food and social contact, signposting for people to voluntary organisations and community groups in their local area for support, and links residents to an appropriate service, which may be provided by the Council or the Voluntary sector.

17.1.3. The Community Support Hub connects people to the service available from SO:Linked, provided by Southampton Voluntary Services and commissioned by Southampton City Council and the CCG. SO:Linked is navigating people who are affected by the coronavirus situation to practical and emotional support and coordinating the Southampton voluntary sector response. This involves the establishment of a single referral and case allocation system at a cluster level to coordinate support to vulnerable people maximising capacity at a neighbourhood level, working closely with voluntary organisations, neighbourhood and resident groups, faith organisations and individual volunteers. We have also worked with SO:Linked to engage Love Southampton and the Council of Faiths to develop guidance and online training for volunteers to assist them in supporting residents experiencing bereavement.

17.1.4. The CCG is also supporting Communicare in Southampton to establish a daily telephone contact system.

17.2. **Prescription delivery service**

17.2.1. The CCG and Southampton City Council via the ICU have commissioned the Saints Foundation to provide a city-wide Prescription Delivery Scheme.

17.2.2. Saints Foundation staff work with pharmacies across the city to co-ordinate the service, as well as delivering prescriptions to the homes of those who are self-isolating or shielded as a result of the COVID-19 pandemic.

17.3. **End of life care**

17.3.1. A process has been established in conjunction with Mountbatten Hampshire (the provider of hospice services), Southampton Primary Care Limited (the local GP Federation) and Solent NHS Trust to care for those who are dying in the community, with the wishes of the patient adhered to wherever possible. This has proved to be a very successful partnership to ensure effective support is in place for people needing end of life care.

17.3.2. Community hospital beds are available in the Adelaide or Royal South Hants hospital if that is the patient's wishes or care and symptom control is difficult to provide at home. All Quality Impact

Assessments have been reviewed by the Chief Nurse, Medical Director and respective Operational Directors.

17.3.3. As a direct result of the COVID-19 pandemic the following has also been implemented:

- 24/7 advice and support available to stakeholders, including families for those specifically at end of life with COVID-19.
- Bereavement service expanded (ahead of planned time) to provide support to the care home sector.
- Increased telephone consultations with patients and families.
- Extended bereavement support to families affected by COVID-19.

17.4. **Homelessness**

17.4.1. Working with housing colleagues, we are working to ensure all rough sleepers are actively offered accommodation, in doing so ensuring we identify suitable accommodation for those who are the most vulnerable and securing appropriate options for them to self-isolate. We are supporting homeless accommodation providers with regular communication and planning discussions around workforce, supplies (PPE, food) and client support.

17.4.2. Plans are in place to support increased levels of self-isolation, cleaning routines and food deliveries for all other residents unable or unwilling to isolate.

17.5. **Vulnerable adults and young people requiring Housing Related Support (HRS)**

17.5.1. Building on the work with our single adult homeless population, the ICU is in regular contact with providers of HRS to young people, young parents and single adults who require a level of support to assist them to live in the local community. Both telephone and online contact options have been developed at pace.

17.5.2. Residents living in shared accommodation are being advised and supported to adhere to the government guidance for living in shared accommodation.

17.6. **Carers**

17.6.1 There has been close working with Carers in Southampton. A joint letter was sent out to known carers asking them to make contact with either Carers in Southampton or the Council Helpline to identify if support was needed for food, medication or social contact. Support is being provided by redeployed learning disability day centre staff to make contact with all who have not responded to the letter. Carers who need support are being referred to SO:Linked, so they can access support though the Community Coordinators. In addition daily phone calls can be provided by Communicare from their new Hello Southampton service. These are calls made by SCiA dental staff currently and in the future Communicare volunteers.

17.6.2 Work is underway with Southern Health Foundation Trust and Solent NHS Trust to raise the awareness of clinical staff about carers and promoting the need to refer and identify carer's needs.

17.6.3 We have finalised the emergency plan format and Carers in Southampton have commenced implementing this tool to gather and plan with carers.

17.7. **Victims of domestic abuse**

17.7.1. Working with local providers in Southampton and the wider network of providers across Hampshire, we are ensuring an appropriate support and response service offer remains in place through telephone and online systems. Additional resources have been made available to support an increase in demand on the services since the outbreak of COVID-19.

17.7.2. Refuge provision continues to provide a place of safety for those in need.

18. **Pharmacy services**

18.1. As a CCG we are in close contact with the Local Pharmaceutical Committee and NHS England, supporting pharmacies where we can. NHS England remains the commissioner for pharmacy services.

18.2. Locally, pharmacies have seen a significant increase in demand. This is partly due to an increase in prescriptions, higher staff absence rates and issues around patients not complying with social distancing measures within close proximity to pharmacies.

18.3. The CCG has provided guidance to GP surgeries with regards to not extending the duration of supply on repeat prescriptions and to not issue prescriptions too early, to help manage workload and supply. The CCG has communicated with the community pharmacies that provide supervised consumption of methadone and end of life drugs to keep them updated about changes to usual policy due to COVID-19.

18.4. Southampton City Council and the CCG are working with some volunteer groups, with the help of the Saint's Foundation, to help deliver medicines to the most vulnerable patients in the city, as detailed above.

18.5. In line with a nationally agreed standard operating procedure, some pharmacies are now only open between 10am - 12pm and 2pm - 4pm to deal with acute issues. The rest of the time they are working behind closed doors to catch up in a safer working environment.

19. Dentistry services

19.1. These services are also commissioned by NHS England.

19.2. During the COVID-19 pandemic all routine NHS and private dentistry have stopped. Patients who have scheduled appointments in the coming weeks are being contacted by their dental practice. The NHS is continuing to provide urgent and emergency dental care. This will be available to both NHS and private patients.

19.3. If patients have a dental emergency they should call the dental practice they normally attend during their opening hours for further advice. If they do not have a regular NHS dentist they can search for a local dentist on the NHS website at www.nhs.uk. In the evening and at weekends patients can contact NHS 111 who will provide advice and direct patients to an out of hours service if necessary.

19.4. When patients call a practice, a member of the team will carry out a telephone assessment with to assess their dental needs. They will be able to offer advice or prescribe medication to relieve any pain or to treat an infection. Urgent Dental Care hubs will be set up to provide urgent treatment when it is required. The dental workforce in the South East has been contacted to complete a short survey to advise about working in one of these new centres.

20. Quality assurance

20.1. The ICU continues to review the impact of rapid changes to health services and the potential for deterioration in existing health condition or delayed diagnosis of new conditions. Ongoing assurance is continuing for essential service provision to key patient groups, such as cancer, ophthalmology, and stroke care services

20.2. A reduced number of incident / serious incidents were reported in the early stages of the pandemic but this has now returned to normal levels. The reduction noted was caused by the reduction in normal activity. There have been a number of incidents reported relating to the management of people affected by COVID-19 and this includes an increase in pressure ulcers from facemasks, ventilator equipment and prone positioning (laying someone on their front has been found to assist recovery in the ventilated patient).

20.3. We are monitoring arrangements for new service provision, as outlined in this report, to ensure any incidents or learning can be shared at the earliest opportunity. Additionally a fortnightly sharing learning event has been established between health providers which has been welcomed and has allowed learning from events to be shared rapidly

20.4. We are also supporting quality assurance activity across Hampshire and the Isle of Wight to support providers in maintaining standards of care whilst adapting to needs arising from the pandemic. This includes identification and management of existing and newly emerging risks. This activity is continuing and we are currently working with colleagues across the system to establish longer term approaches to this work as it has been welcomed by all health partners.

20.5. The infection prevention and control team continues are working to advise and support primary care and others in the community, with a particular focus on supporting care homes and home care providers. This activity has significantly increased during the pandemic. The support provided to care homes has included daily support calls to care homes with confirmed or suspected cases of COVID-19, access to a weekly information sharing and Q&A session provided by videoconferencing which has proved to be extremely well attended. The sessions cover updates on infection prevention and control practice, use of PPE, testing, handwashing, end of life care and other relevant areas of practice. Each session is recorded and made available to the providers unable to join the live event. Attendance at the live event and views of the recording have resulted in over 100 care home and home care staff accessing this resource each week. Ongoing work with the public health team has supported the

development of an evidence based RAG rating system to allow the early identification of care homes that may be facing problems.

DECISION-MAKER:		Health and Wellbeing Board		
SUBJECT:		Potential impacts of Covid-19 on health inequalities in Southampton		
DATE OF DECISION:		17th June 2020		
REPORT OF:		Interim Director of Public Health		
CONTACT DETAILS				
AUTHOR:	**Name:**	**Kate Lees**	Tel:	
	E-mail:	Locum Consultant in Public Health		
Director	**Name:**	**Debbie Chase**	Tel:	023 80833694
	E-mail:	Interim Director of Public Health		

STATEMENT OF CONFIDENTIALITY

BRIEF SUMMARY

Southampton experienced significant health inequalities before Covid-19. The expectation of the impact of Covid-19 is that health inequalities will be exacerbated. However, the evidence is emerging and future decision-making to reduce health inequalities should be informed by clinical, public health and wellbeing intelligence.

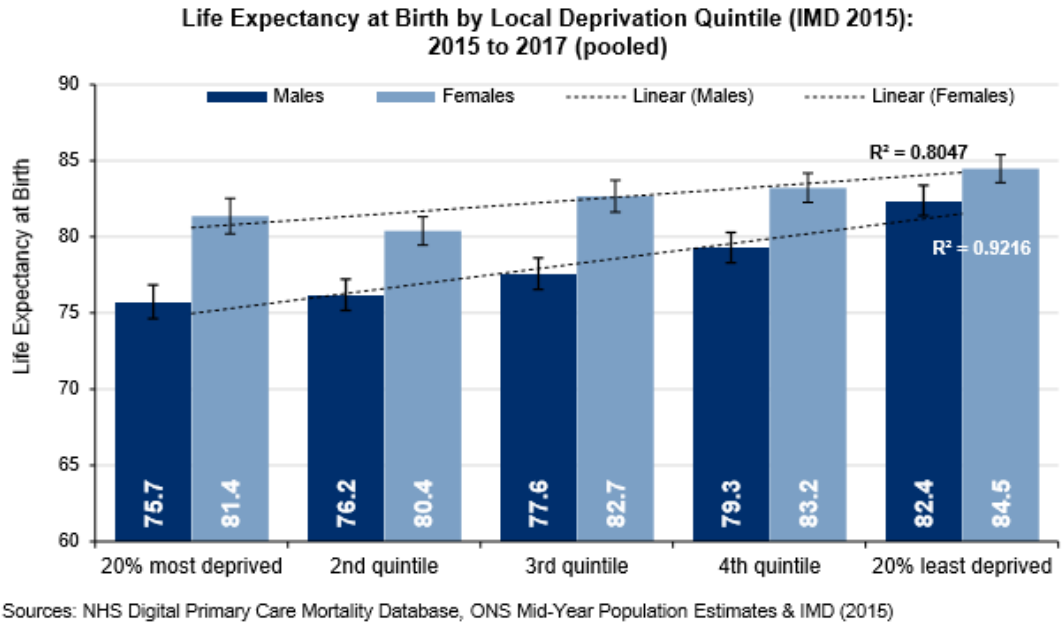
There are a range of evidence-based interventions for reducing health inequalities, which take a lifecourse and place-based approach. A focus on the wider determinants of health will have the maximum population impact. These approaches require a 'whole-system' approach. The Health and Wellbeing Board is well-placed to lead this approach to reduce health inequalities and improve health outcomes for the city.

RECOMMENDATIONS:		
	(i)	That the board notes the content of this report.
	(ii)	That the board agree in principle to consider the impact on health inequalities when developing Covid-19 recovery, or 'rebalancing' plans and consider what they require to enable this.

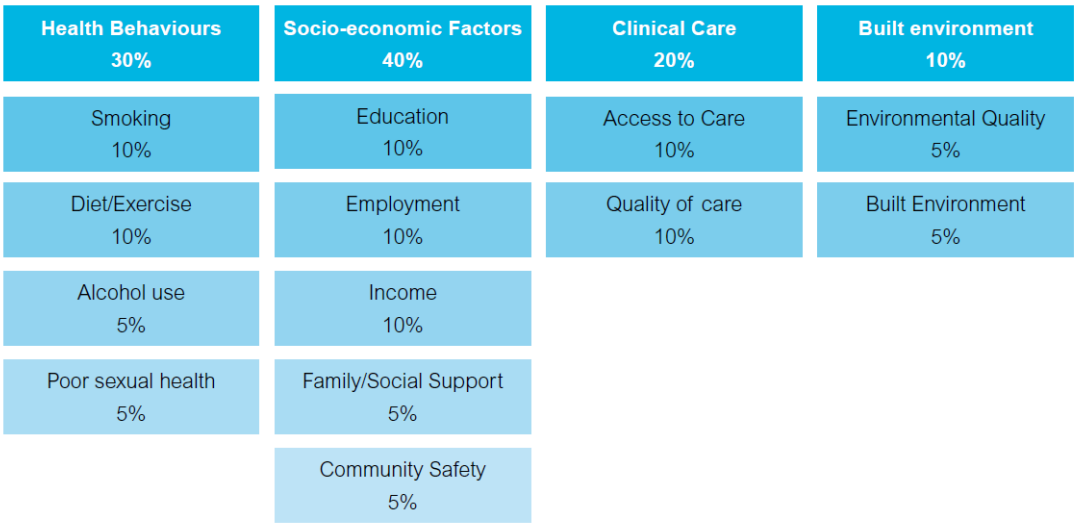
REASONS FOR REPORT RECOMMENDATIONS	
1.	The Health and Wellbeing Board has made a commitment to reduce health inequalities and many of its member organisations have a duty to do so.
2.	Health inequalities are expected to be exacerbated and to affect a greater proportion of our residents following the impact of Covid-19.
3.	The leadership of the Health and Wellbeing Board is essential for the whole system approach required to reduce health inequalities by putting this at the heart of plans to rebalance following Covid-19.

ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
	None

DETAIL (Including consultation carried out)

	Background
1	The Health and Wellbeing Board is a statutory board that aims to; improve the health and wellbeing of the people in their area; reduce health inequalities; and, promote the integration of services. Southampton City Council as a member of the Board has an independent statutory responsibility to improve the health and wellbeing of residents and to reduce health inequalities. The NHS, another statutory member of the Board has also committed to strengthening its' contribution to reducing health inequalities through the NHS Long Term Plan.
2	Health inequalities are defined as "differences between people or groups due to social, geographical, biological or other factors. These differences have a huge impact, because they result in people who are worst off experiencing poorer health and shorter lives." (NICE, 2012)
3	The Health and Wellbeing Strategy prioritises reducing inequalities in health outcomes and is supported by the Health and Care Strategic Plan through the goal to target health inequalities and confront deprivation.
4	A major incident was declared by Hampshire and the Isle of Wight Local Resilience Forum in March 2019, in response to Covid 19, the disease caused by a novel coronavirus spreading in the community. The virus and measures put in pace to control its' spread have had large and far-reaching impacts across society.
5	Given HWBB and partners' responsibilities and commitments to reduce health inequalities, this paper considers the impact of Covid 19 on health inequalities and the implications for recovery planning.
	Health Inequalities in Southampton pre Covid-19
6	Men living in the most deprived quintile in Southampton live on average 6.6 years less than those in the most affluent quintile. For women this difference is 3.1 years. The graph below shows a clear relationship between life expectancy and deprivation.  Sources: NHS Digital Primary Care Mortality Database, ONS Mid-Year Population Estimates & IMD (2015) People living in the most deprived quintiles in Southampton are almost twice as likely to die prematurely (under 75 years old) than those in the most affluent.

7	People living in the most deprived quintile in Southampton are more likely to have long term health conditions compared to those in the most affluent quintile. For example, they are almost three times as likely to have COPD, over one and a half times more likely to have diabetes. Those in the most deprived quintile are 1.78 times more likely to have depression and 2.77 times more likely to have schizophrenia.[1]
8	People living in the most deprived quintile in Southampton are 1.93 times more likely to smoke and 2.6 times more likely to be inactive and children 1.7 times more likely to have excess weight compared to those in the most affluent quintiles.[1]
9	Southampton had significant health inequalities before the major incident in response to covid-19. This difference was seen across a range of different health outcomes, both in mortality and morbidity and across physical and mental health outcomes.[1]
	The determinants of health
10	Our health is affected by a wide range of factors as shown in the figure below. The biggest determinant of health is socio-economic factors, followed by health behaviours, then clinical care and the built environment. The socio-economic and environmental are referred to as the wider determinants of health.
11	The distribution of social, economic and environmental assets impacts differently on health outcomes across society and results in inequalities in health outcomes. This impact starts before birth and builds over the life-course, as the positive and negative impacts of the wider determinants of health accumulate over time.



Source: Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute. Used in US to rank counties by health status

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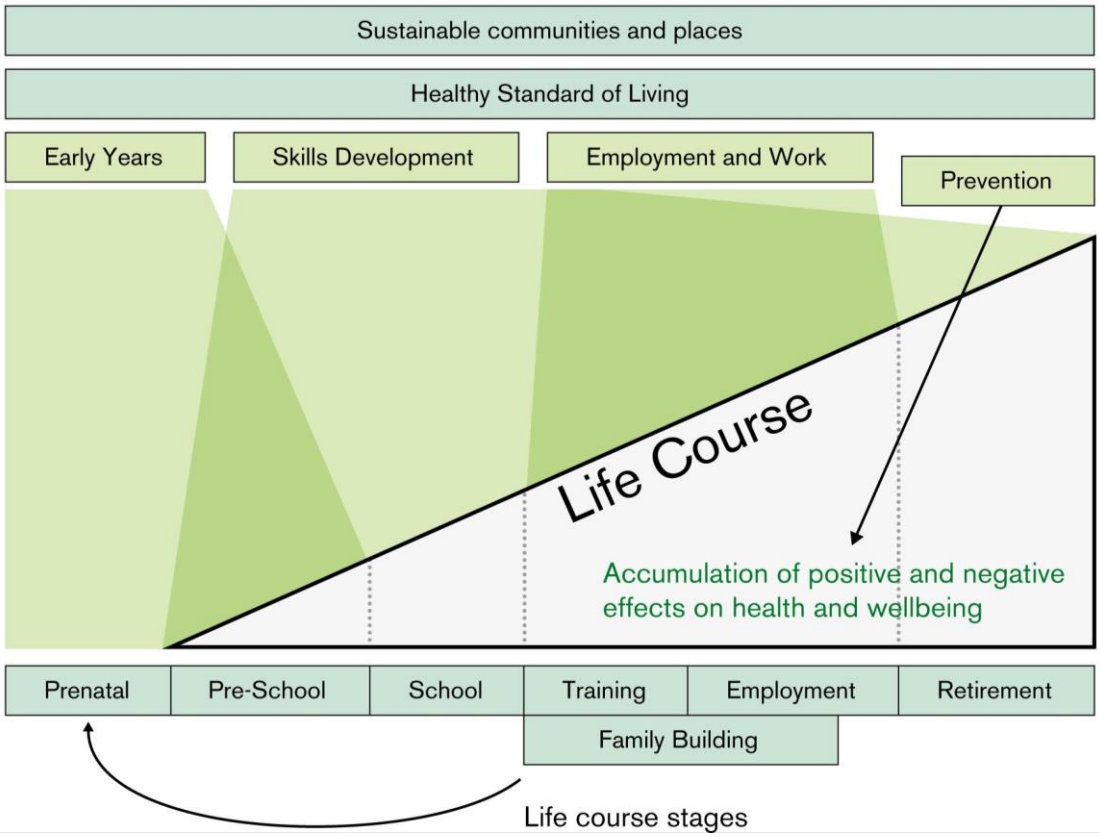


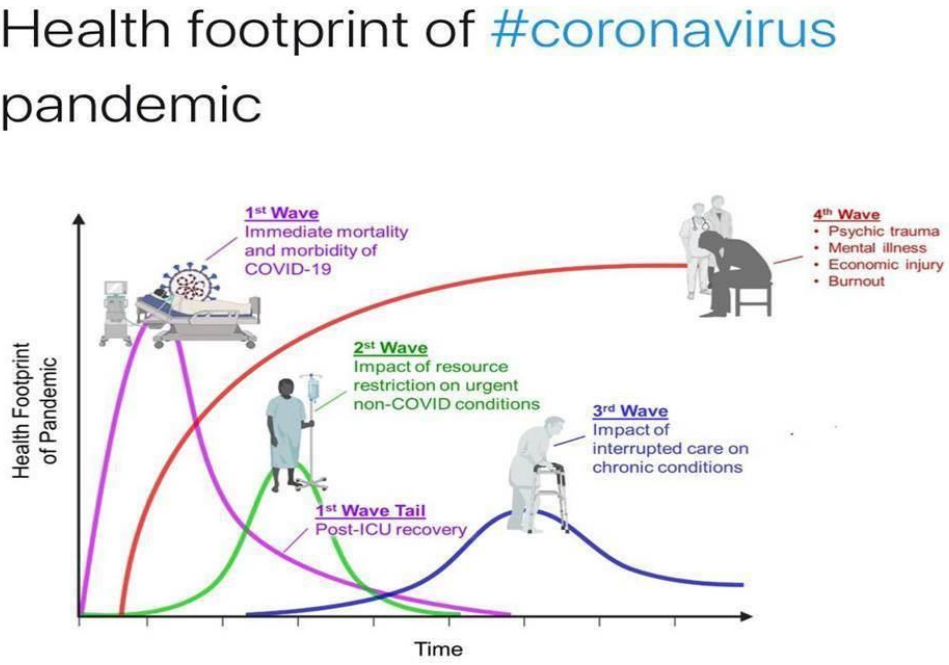
Marmot 'Fair Society, Healthy Lives' 2010.

12 This evidence has informed the life-course approach to reducing health inequalities, which recognises that no one agency can implement any of these objectives on its own. Reducing health inequalities requires collaboration, partnership and collective action in many different spheres of activity.

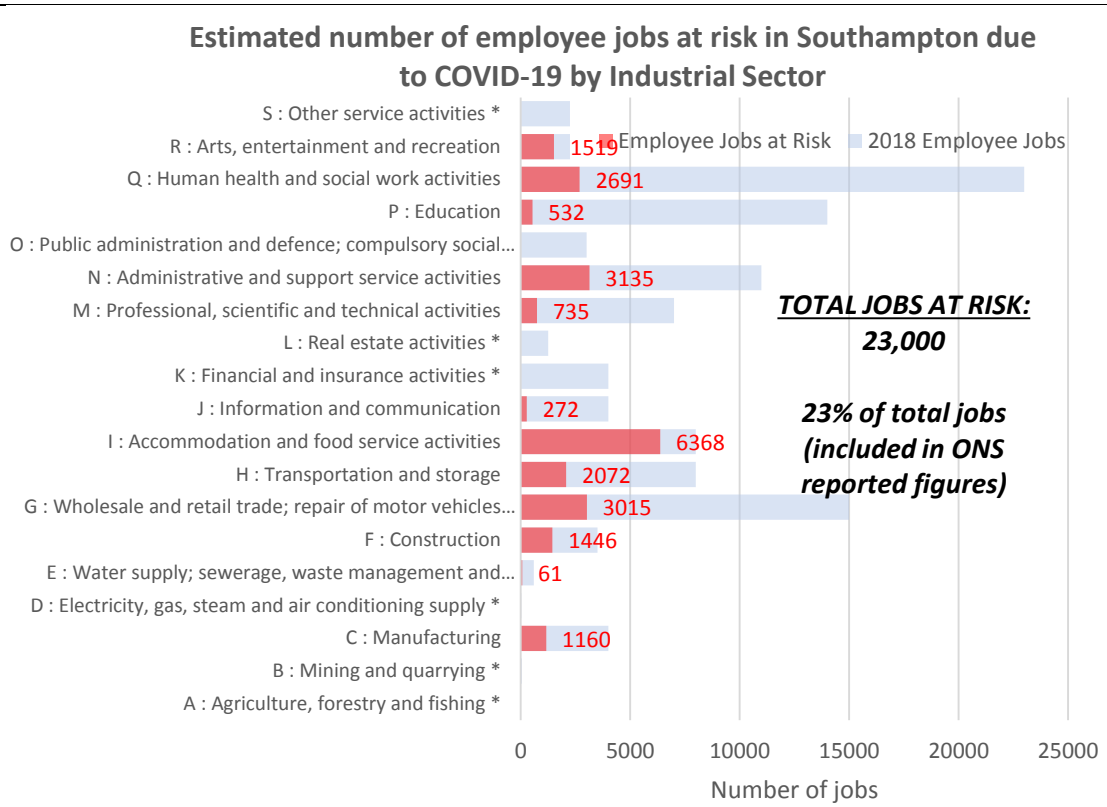
13 The chart below shows the impact of actions taken across the life-course on health outcomes, health inequalities and both the speed of this impact and the strength of evidence for its effectiveness. Action on the best start in life, healthy schools and pupils, jobs and work, access to green space and leisure opportunities and health and spatial planning have the highest impact on health inequalities.

Area	Scale of problem in relation to public health	Strengths of evidence of actions	Impact on health	Speed of impact on health	Contribution to reducing inequalities
Best start in life	Highest	Highest	Highest	Longest	Highest
Healthy schools and pupils	Highest	Highest	Highest	Longer	Highest
Jobs and work	Highest	Highest	Highest	Quicker	Highest
Active and safe travel	High	High	High	Longer	Lower
Warmer and safer homes	Highest	Highest	High	Longer	High
Access to green spaces and leisure services	High	Highest	High	Longer	Highest
Strong communities, wellbeing and resilience	Highest	High	Highest	Longer	High
Public protection	High	High	High	Quicker	High
Health and spatial planning	Highest	High	Highest	Longest	Highest

9 http://www.kingsfund.org.uk/publications/improving-publics-health

	Impact of covid-19 on health inequalities
14	The health impacts of Covid-19 include the impact of mortality and morbidity from Covid-19, followed by the further impacts due to restricted care on both urgent and log-term conditions, and then longer-term impacts on mental health and poor health due to the economic impact of measures to control its spread. 
15	Covid-19 and the measures put in pace to control its spread have been experienced differently across different parts of the community and differentially across the lifecourse. This is expected to increase health inequalities. Disparities in the risk and outcomes of Covid 19 are seen across age, gender, comorbidities, geography, occupation, ethnicity and deprivation[2].
16	There is a clear correlation between exposure to coronavirus and risk of disease. BAME groups are over-represented in those occupations more likely to be exposed to those with Covid-19 whilst doing their job, and over a third of these occupations had a median pay lower than the median UK hourly pay.[3]
17	There is an emerging socio-economic gradient emerging of risk of severe illness from Covid-19. Nationally, 25% of critical care patients are from areas in the most deprived quintile, compared to 15% from those in the most affluent. Mortality rates from Covid-19 also vary within the population. People living in more deprived areas have experienced COVID-19 mortality rates more than double those living in less deprived areas.[2,4]
18	The risk of severe illness with covid-19 is much higher amongst people with existing long-term conditions such as diabetes, respiratory disease and heart disease, as well as an association between obesity and severe Covid-19, potentially exacerbating existing health inequalities[4].
19	The risk of death involving Covid-19 varies significantly with ethnicity. After accounting for the effect of sex, age, deprivation and region, people of Bangladeshi ethnicity had around twice the risk of death when compared to people of White British ethnicity. People of Chinese, Indian, Pakistani, Other Asian, Caribbean and Other Black ethnicity had between 10 and 50% higher risk of death when compared to White British[2].

20	The impacts of Covid-19 have been experienced very differently across the lifecourse. There is a clear link between age and risk of severe illness and mortality from Covid-19. Older people may also be more likely to be shielding so at risk of social isolation.
21	Child poverty is already an issue in the city, and this is expected to be exacerbated by job losses. Those now newly eligible for free school meals may mean more children and families will face food insecurity and digital exclusion is a concern where children and young people are unable to access the equipment and don't have Wi-Fi. There is emerging evidence of the negative impact of Covid-19 on the mental health of young people.
22	BAME communities in the city have expressed concerns with temporary and poorly paid jobs, including zero-hour contracts; children's education and home-schooling; and digital exclusion affecting a range of issues including education, access to welfare and other health and support services.[5]
23	There is evidence of increasing vulnerabilities in the city over the course of lockdown, including an increase in the severity and amount of reported domestic abuse; an increase in child on parent abuse; a reduction in reports to child safeguarding indicating potential 'stored up' neglect and abuse and an increase in demand for mental and emotional support.[5]
24	Covid-19 has had a significant negative impact on incomes in the city. Provisional data suggests that the number of people on Universal Credit increased from around16,500 in March 2020 to 22,200 in April 2020. This represents an increase in the proportion of the working age population claiming UC from 9.5% in March to 12.8% in April and is higher than the proportion in both the South East (8.2%) and England (10.3%).[6] Voluntary services across the city have also reported increased concerns from their service users about debt.[5]
25	Estimates from Business Impact of Coronavirus (COVID-19) Survey (BICS) suggest that 27% of the UK workforce were furloughed at the end of March 2020. The long-term impacts for these jobs is still unknown, however the graph below shows that an estimated 23,000 (23%) of jobs in Southampton are at risk due to Covid-19.

	 *These figures have been estimated based on Wave 2 of the ONS Business Impact of Coronavirus Survey (BICS) which contains data on the furloughing of workers across UK businesses between March 23 to April 5, 2020. These figures have been applied to the local industrial profile to estimate the number and proportion of jobs at risk due to COVID-19.*
26	Evidence suggests that Covid-19 and the measures put in place to reduce its spread have had a disproportionate impact on those already experiencing health inequalities in the city, therefore these health inequalities are likely to be exacerbated.
27	The measures put in place to reduce the spread of Covid-19 have already had an impact on the wider determinants of health. It is likely that the number of people in the city experiencing social and economic hardship will increase, with the risk of an associated negative impact on health outcomes.
	Opportunities
28	Member organisations of the Health and Wellbeing Board will all need to rebalance their services and interventions as they both respond to future waves of Covid-19 and recover. There is an opportunity to reshape the health and care system with reducing health inequalities at its heart as we move into a new normal. This is recognised within the Southampton Health and Care Strategy launched earlier this year.
29	A focus on the wider determinants of health will provide the greatest opportunities to improve health and wellbeing in the city.
30	There is good evidence for the effectiveness of interventions taken across the life-course to have a positive on health outcomes and health inequalities. These approaches utilise a place-based approach, which looks to strongly connect together the components of civic, service and community. This 'whole system response' is particularly important at times of crisis.

31	The Health and Wellbeing Board has a key role to play to harness the leadership of local anchor institutions to develop a whole system response to health inequalities for Southampton.
	Summary
	Southampton experienced significant health inequalities before Covid-19. The expectation of the impact of Covid-19 is that health inequalities will be exacerbated. However, the evidence is emerging and future decision-making to reduce health inequalities should be informed by clinical, public health and wellbeing intelligence. There are a range of evidence-based interventions for reducing health inequalities, which take a lifecourse and place-based approach. A focus on the wider determinants of health will have the maximum population impact. These approaches require a 'whole-system' approach. The Health and Wellbeing Board is well-placed to lead this approach to reduce health inequalities and improve health outcomes for the city.
RESOURCE IMPLICATIONS	
Capital/Revenue	
	None
Property/Other	
	None
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
	The Health and Wellbeing Board is a statutory board that aims to reduce health inequalities.
Other Legal Implications:	
	None
RISK MANAGEMENT IMPLICATIONS	
	None
POLICY FRAMEWORK IMPLICATIONS	
	None

KEY DECISION?	**Yes/No**	
WARDS/COMMUNITIES AFFECTED:		N/A
SUPPORTING DOCUMENTATION		
Appendices		
1.	N/A	
2.		

Documents In Members' Rooms

1.	N/A	
2.		
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.		**Yes/No***
** - ESIAs and DPIAs will be undertaken for any decision arising from actions proposed in the COVID-19 recovery plan as required.*		
Data Protection Impact Assessment		
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.		**Yes/No***
** - ESIAs and DPIAs will be undertaken for any decision arising from actions proposed in the COVID-19 recovery plan as required.*		
Other Background Documents **Other Background documents available for inspection at:** N/A		
Title of Background Paper(s)	**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**	
1.	N/A	
2.		

Data Sources

1. Southampton data observatory. Health Inequalities https://data.southampton.gov.uk/health/health-inequalities/health-inequalities/health-inequalities.aspx
2. Public Health England. Disparities in the risk and outcomes from Covid 19. 2nd June 2020. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/889195/disparities_review.pdf
3. ONS. Coronavirus deaths by ethnic group. 7th May 2020. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020
4. ONS. Deaths involving Covid-19, England and Wales; deaths occurring in April 2020. 15th May 2020. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19englandandwales/deathsoccurringinapril2020
5. HIOW LRF, Protecting our Vulnerable Residents Group. Provisional Intelligence gathering to inform Community Impact Assessment.
6. Department for Work and Pensions (DWP). People on Universal Credit - Southampton, South East and England monthly trend: April 2019 to April 2020.

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DECISION-MAKER:		Health and Wellbeing Board		
SUBJECT:		Southampton City Suicide Prevention Plan		
DATE OF DECISION:		17 June 2020		
REPORT OF:		Debbie Chase, Interim Director of Public Health		
CONTACT DETAILS				
AUTHOR:	**Name:**	Amy McCullough, Consultant in Public Heath Sabine Stanescu, Public Health Practitioner	Tel:	07833 441461
	E-mail:	Amy.McCullough@southampton.gov.uk		
Director	**Name:**	Debbie Chase, Interim Director of Public Heath	Tel:	07773 884020
	E-mail:	Debbie.Chase@southampton.gov.uk		

STATEMENT OF CONFIDENTIALITY		
NONE		
BRIEF SUMMARY		
The attached Plan presents a final draft of the Southampton Suicide Prevention Plan 2020-23. This is Southampton's second suicide prevention plan, which builds on the 2017-19 plan. The Plan has been developed in collaboration with a range of partners including those with lived mental health experience. The Southampton Suicide Prevention Partnership will oversee the implementation of the Plan.		
RECOMMENDATIONS:		
	(i)	The Health and Wellbeing Board is asked to approve the Southampton Suicide Prevention Plan for 2020 - 2023 and support its implementation
	(ii)	The Health is Wellbeing Board is asked to receive an update report on delivery against the Plan and the work of the Southampton Suicide Prevention Partnership once a year and exception reports as appropriate.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The Five Year Forward View for Mental Health (2016) sets an expectation for every local area to "develop a multi-agency suicide prevention plan that demonstrates how they will implement interventions targeting high-risk locations and supporting high-risk groups within their population".	
2.	Local Authorities are well placed to coordinate the development of local suicide prevention plans, given that they are in a very good position to influence key risk factors for suicide, including wider determinants of health.	
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED		
	The option of not developing a second suicide prevention plan was rejected, on the basis that it is critical in ensuring multi-agency action in preventing deaths by suicide.	
DETAIL (Including consultation carried out)		
1	The Five Year Forward View for Mental Health (2016) sets out the ambition to reduce the number of suicides in England by 10% by 2020, and recommends that all local areas have multi-agency suicide prevention plans in place. The NHS Long-	

	term Plan (2019) reaffirms the commitment to make suicide prevention a priority over the next decade.
2	Suicide is often the end point of a complex history of risk factors and distressing events. Suicide affects children, young people and adults – whether by taking their own life or as a person bereaved by suicide. Whilst death by suicide is highest in middle-aged men (i.e. 45-49 years), suicide is a leading cause of death (nationally) for young people aged 15-24 years. In Southampton around 26 people take their own life by suicide each year (based on 2016-18 data). Southampton has a significantly higher rate of suicides (12.7 deaths per 100,000) than the national (9.6 deaths per 100,000) and South East (9.2 deaths per 100,000) average.
3	This Plan is being introduced during an international COVID-19 pandemic. As it is widely acknowledged that the pandemic will have a major impact on people's mental health and wellbeing, the direction that this Suicide Prevention Plan provides is critical to ensuring a coordinated response that will support our residents, families and communities both during the pandemic and in the recovery period. The Plan has been refreshed to ensure that it is COVID-19 sensitive, and addresses the risk factors that are likely to be heightened by the pandemic, and which could exacerbate poor mental health and subsequent suicidality.
4	Suicides are not inevitable. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides. By combining the national and local evidence base, seven key areas for action have been identified to support delivery of our aim to **reduce the number of suicides in Southampton, and ensure provision of support to those bereaved by suicide, focusing on but not limited to groups at high risk of taking their own life:** 1. Achieve city wide leadership for suicide prevention 2. Reduce the risk of suicide in key high-risk groups 3. Tailor approaches to improve mental health in specific groups 4. Reduce access to the means of suicide 5. Provide better information and support to those bereaved or affected by suicide 6. Support the media in delivering sensitive approaches to suicide and suicidal behaviour 7. Support research and data collection
5	As well as suicide being preventable, key messages learned from practice and research are that suicide is everyone's business, and that collaborative working is key to successful suicide prevention. In Southampton a multi-agency partnership group (*Southampton Suicide Prevention Partnership*) has been established for a number of years to oversee the development and implementation of the local Suicide Prevention Plan. The Partnership includes representatives from Southampton City Council, Southampton Clinical Commissioning Group, providers, emergency services, the voluntary and community sector, and other partners (see **Appendix B** of the Southampton Suicide Prevention Plan for a list of partners).
	Development of the Plan
6	A number of forums and networks have been consulted in development of the Plan, including: • Southampton's Suicide Prevention Partnership (responsible for overseeing the development and delivery of the Plan) • Health Overview and Scrutiny Panel (HOSP) • Southampton Drugs and Alcohol Partnership Group • Stakeholders on the MH Partnership Group* • Stakeholders on the Better Care Vulnerable Adults Group*

	• Residents with lived experience through Solent Mind (via two focus groups) and the MH network facilitated by communicare *Via email as these forums have not been meeting during the current pandemic.
7	Key guidance, evidence, and local intelligence (in addition to stakeholder engagement and consultation) that has been utilised to inform the Plan are as follows: • The Public Health England (2019) *Local Suicide Prevention Planning: A Practice Resource',* and its accompanying resources. • HM Government (2019) *Cross government suicide prevention work plan.* • NICE guidelines, including on self-harm and quality standards on preventing suicide and supporting people bereaved by suicide published in September 2019 • Health Committee Enquiry (2017) and Health and Social Care Committee inquiry into Suicide prevention (2019). • Review of the published literature to inform specific actions, and linking with the Centre for Suicide Prevention at the University of Manchester. • A local suicide audit of coroners records, performed in 2019. Suicide audits identify the context in which suicides occur, the local groups potentially most at risk, key risk factors, and how the picture changes over time. • Data on suspected deaths by suicide provided on a monthly basis by Hampshire Constabulary. In addition, as an NHS England "wave 2" suicide prevention site, H&IW receive national quality improvement support, delivered jointly by the National Collaborating Centre for Mental Health (NCCMH) and the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH).
	To note
8	In England and Wales all deaths by suicide are certified by a coroner. In July 2018 the standard of proof used by coroners to determine whether a death was caused by suicide changed. Previously, coroners and juries have applied the *criminal standard* to suspected suicides, meaning they had to be "sure" that someone had taken their own life. However, appeal court judges ruled that the *civil court standard* can be applied and therefore coroners and juries only have to be satisfied that it was "more probable than not" that someone had deliberately killed themselves. This is expected to lead to more deaths being recorded as suicide, which may have an impact on reported rates and trends.
RESOURCE IMPLICATIONS	
Capital/Revenue	
9	In 2019 NHS England awarded the H&IW STP £468k as a "wave 2" site within the national suicide transformation programme. It has since been confirmed that H&IW will receive a further £468k in year 2 (2021), and a reduced amount in year 3 (2022). The STP funding will be utilised to support those areas highlighted as STP Priorities within the Plan, and including work in the following areas: 1. Self-harm 2. Bereavement support 3. Primary care 4. Workplace health, debt and financial anxiety 5. Community resilience 6. Co-occurring conditions

	The funding is for the whole of the STP area. Local resources and expertise remain critical in implementing the Southampton Suicide Prevention Plan, and will be carried out within the existing budgets of the Council and partner organisations.
Property/Other	
10	N/A
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
11	Will seek a view from legal prior to HWB
Other Legal Implications:	
12	There are no specific legal implications of this Plan
RISK MANAGEMENT IMPLICATIONS	
13	Southampton has a significantly higher rate of suicides (12.7 deaths per 100,000) than the national (9.6 deaths per 100,000) and South East (9.2 deaths per 100,000) average. This Plan is crucial in preventing deaths by suicide in the city, and to make progress in reducing the rate over time.
14	Families and communities bereaved by suicide are at higher risk of subsequent suicides than the general population. Postvention (as described in the attached Suicide Prevention Plan) is an important aspect of in suicide prevention work.
POLICY FRAMEWORK IMPLICATIONS	
15	Suicide prevention an important aspect of Council and ICU/CCG policy.

KEY DECISION?	**Yes**
WARDS/COMMUNITIES AFFECTED:	All
SUPPORTING DOCUMENTATION	
Appendices	
1.	Southampton Suicide Prevention Plan 2020-23 (main report)

Documents In Members' Rooms

1.	N/A
2.	N/A
Equality Impact Assessment	
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.	**Yes**
Data Protection Impact Assessment	
Do the implications/subject of the report require a Data Protection Impact Assessment (DPIA) to be carried out.	**No**
Other Background Documents **Other Background documents available for inspection at:**	
Title of Background Paper(s)	**Relevant Paragraph of the Access to Information Procedure Rules /**

		Schedule 12A allowing document to be Exempt/Confidential (if applicable)
1.	N/A	

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SOUTHAMPTON SUICIDE PREVENTION PLAN

2020 - 2023

OWNER: SOUTHAMPTON SUICIDE PREVENTION PARTNERSHIP
BOARD RESPONSIBILITY: SOUTHAMPTON HEALTH AND WELLBEIGN BOARD
COMPILED BY: PUBLIC HEALTH SOUTHAMPTON

SOUTHAMPTON SUICIDE PREVENTION PLAN

Death by suicide is preventable and every one suicide is one too many. It is a deeply personal tragedy, which has a long-standing effect on families, friends and communities. Nationally, there is a call to reduce deaths by suicide. The Five Year Forward View for Mental Health sets out the ambition to reduce the number of suicides in England by 10 per cent by 2020, and the NHS Long-term Plan (2019) reaffirms the commitment to make suicide prevention a priority over the next decade.

AIM

This plan **aims to reduce the number of suicides in Southampton, and ensure provision of support to those bereaved by suicide, focusing on but not limited to groups at high risk of taking their own life.**

PRIOIRTY AREAS

In line with the 2012 (updated in 2017) cross-government strategy on Suicide Prevention, we will focus on the 6 key areas for action to reduce suicide, plus an additional priority in relation to leadership:

1. Achieve city wide leadership for suicide prevention
2. Reduce the risk of suicide in key high-risk groups
3. Tailor approaches to improve mental health in specific groups
4. Reduce access to the means of suicide
5. Provide better information and support to those bereaved or affected by suicide
6. Support the media in delivering sensitive approaches to suicide and suicidal behaviours.
7. Support research, data collection and monitoring.

CONTEXT

This Plan is being introduced during an international COVID-19 pandemic. As it is widely acknowledged that the pandemic will have a major impact on people's mental health and wellbeing, the direction that this Suicide Prevention Plan provides is critical to ensuring a coordinated response that will support our residents, families and communities both during the pandemic and in the recovery period.

Within the published literature there are suggestions that suicide rates will rise, although this is also acknowledged that this is not inevitable. Suicide is likely to become a more pressing concern as the pandemic spreads and has longer-term effects on the general population, the economy, and vulnerable groups. Preventing suicide therefore needs urgent consideration. The response must capitalise on, but extend beyond, general mental health policies and practices[1].

The likely adverse effects of the pandemic on people with mental illness, and on population mental health in general, might be exacerbated by fear, self-isolation, and physical distancing. Those with psychiatric disorders might experience worsening symptoms and others might develop new mental health problems, especially depression, anxiety, and post-traumatic stress (all associated with increased suicide risk). These mental health problems will be experienced by the general population and those

[1] Gunnell D. et al. 2020. *Suicide risk and prevention during the COVID-19 pandemic*. The Lancet. See: https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30171-1/fulltext

with high levels of exposure to illness caused by COVID-19, such as frontline health-care workers and those who develop the illness.[2] Longer term impacts in terms of trauma, grief and distress may exacerbate the burden of mental ill-health in the community long after recovery.

The Plan has therefore been refreshed to ensure that it is COVID-19 sensitive, and addresses the risk factors that are likely to be heightened by the pandemic, and which could exacerbate poor mental health and subsequent suicidality.

NATIONAL PICTURE

Death by suicide refers to a deliberate act that intentionally ends one's life. Suicide is often the end point of a complex history of risk factors and distressing events. Suicide affects people across the life-course, and whilst the highest proportion of deaths are in middle aged men, nationally, suicide is a leading cause of death for young people aged 15–24 years.

According to data from the Office for National Statistics (ONS)[3] in 2018 there were 6,507 deaths by suicide registered[4] in the UK, an age-standardised rate of 11.2 deaths per 100,000 population. The 2018 rate is significantly higher than the rate in 2017 and represents the first increase since 2013. This is accounted for by the increase in the male suicide rate; for females the UK rate of 5 deaths per 100,000 is consistent with rates over the past 10 years. Despite having a low number of deaths overall, rates among the under 25s have generally increased in recent years, particularly 10 to 24-year-old females where the rate has increased significantly since 2012 to its highest level with 3.3 deaths per 100,000 females in 2018. However, when looking at all age suicide rates over the last two decades, there does continue to be a general decrease over time from a rate of 10.3 deaths per 100,000 population in 2001-03 to 9.6 in 2016-18.

Three-quarters of registered deaths by suicide in 2018 were among men (4,903 death), which has been the case since the mid-1990s. Males aged 45 to 49 years have the highest age-specific suicide rate (27.1 deaths per 100,000 males); for females, the age group with the highest rate is also 45 to 49 years, at 9.2 deaths per 100,000.

As seen in previous years, in 2018 the most common method of suicide in the UK was hanging, accounting for 59% of all suicides among males and 45% of all suicides among females.

There is a relationship between suicide and deprivation, with suicide rates being statistically significantly higher in the most deprived areas of England.

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[2] Gunnell D. et al. 2020. *Suicide risk and prevention during the COVID-19 pandemic*. The Lancet. See: https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30171-1/fulltext

[3] ONS. 2019. Suicides in the UK – 2018 registrations. See: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations

[4] In England, Wales and Northern Ireland, when someone dies unexpectedly, a coroner investigates the circumstances to establish the cause of death. The investigation, referred to as an "inquest", is a process that can take months or, in some cases, years. The length of time it takes to hold an inquest creates a gap between the date of death and the date of death registration. For deaths caused by suicide, this generally means that around half of the deaths registered in a given year will have occurred in the previous year or earlier.

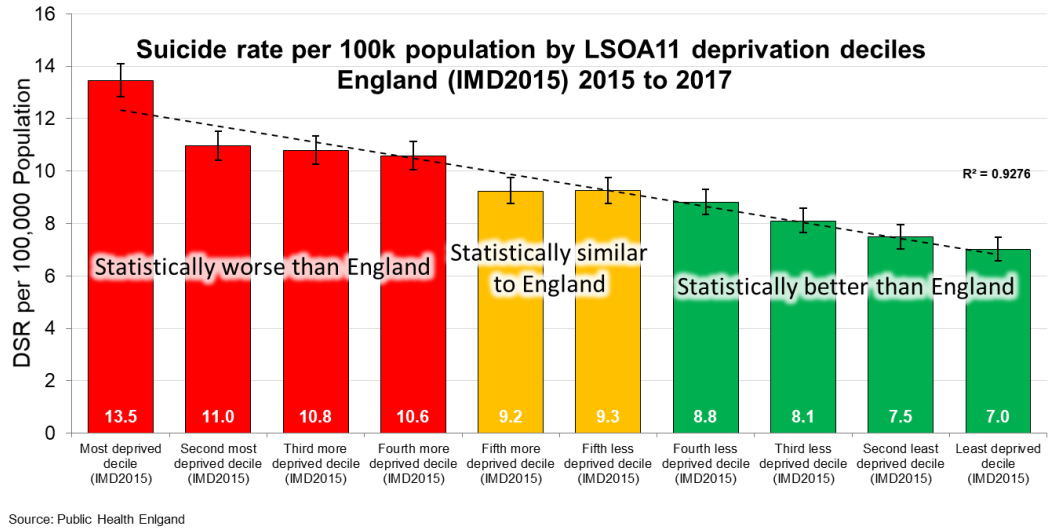


Figure 1. Differences in suicide rate by deprivation deciles in England.

LOCAL PICTURE

In Southampton, the suicide rate has fallen in recent years from 15 deaths per 100,000 in 2012-14 to 12.7 in 2016-18. However, Southampton continues to have a significantly higher rate of suicides than the national (9.6 deaths per 100,000) and South East (9.2 deaths per 100,000) average. Southampton's suicide rate is also the third highest when compared to 15 similar Local Authorities (using the CIPFA nearest neighbour definition)[5]. Translated into numbers of registered deaths by suicide, we know that around 26 residents in Southampton take their own life by suicide each year (based upon 2016-18 data). This number is subject to small year on year variability, and in the period 2001 to 2018 was highest in 2012-14 when there was an average of 29 registered deaths by suicide per year.

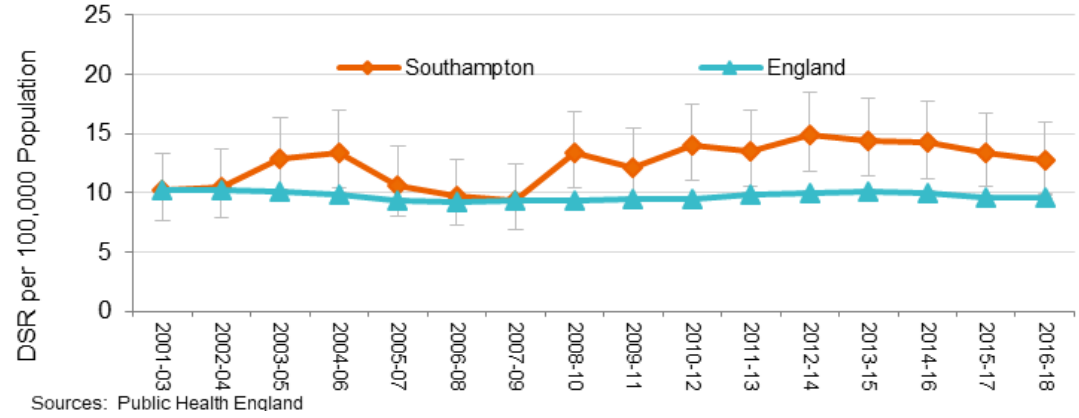
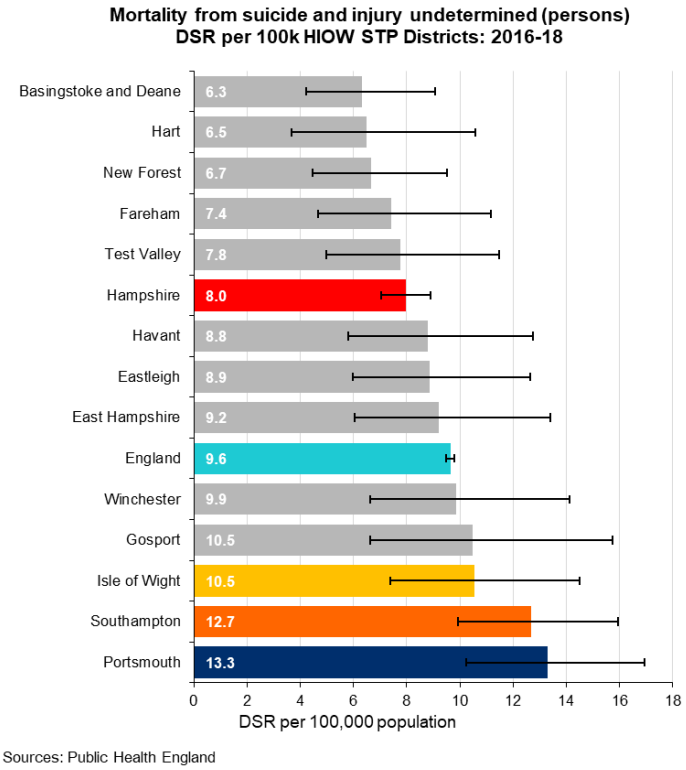


Figure 2. Southampton and England suicide rates per 100,000 from 2001-2003 to 2016-2018

[5] Public Health England suicide prevention profile: https://fingertips.phe.org.uk/profile-group/mental-health/profile/suicide

The figure below shows suicide rates for Southampton, compared to the other Sustainability and Transformation Plan (STP) areas (Hampshire, Portsmouth and the Isle of Wight).



Sources: Public Health England

Figure 3. Suicide rate for the South East region.

SCC Public Health works with the coroner's office to undertake suicide audits to gather intelligence on deaths by suicide. For the two year period 2017-2018, 38 deaths by suicide in Southampton were audited. Of the 38 deaths by suicide:

- 71% (27) were male, and 28% (11) female.
- The highest proportion of deaths took place in men aged 51-60 years.
- 90% were White British (for 5% ethnicity is unknown).
- 52% were known to mental health services (48% were not), and 31% had been in contact with their GP in the 4 weeks prior to taking their life.
- 47% were known to have previously attempted to take their life by suicide, and 23% were known to have a history of self-harm.
- Hanging was the most frequent method of suicide (55%), with most people taking their own life at home. The next most frequent methods are overdose/poisoning (16%), injuries (10%), suffocation (5%), falling from a height (3%) and by being hit by a train/life taken on the tracks (2%).
- 42% of those that died were employed, 29% unemployed, 13% retired, and 13% had a long-term disability which meant they could not work.
- Mental health problems (65%), relationship problems such as separation (52%), physical health problems (52%), job problems (28%), history of contact with the criminal justice system (28%), financial issues (26%), adverse childhood experiences (26%), and being a victim of abuse (21%) were the most common recorded "life event" risk factors.

In relation to risk factors for suicide, according to the Public Health Outcomes Framework (2019), Southampton has a higher than the national average prevalence of recorded depression in those aged 18 years and over, and higher prevalence of patients with schizophrenia, bipolar affective disorder and other psychoses as recorded on practice disease registers for all ages. Southampton also has a higher than national average levels of unemployment, and a higher than average percentage of people living alone. In relation to children and young people, Southampton has higher than national average levels of looked after children, care leavers, and children in the youth justice system.

Unfortunately, many of these known risk factors could be exacerbated by the current COVID-19 pandemic. The diagram below, developed by Hertfordshire County Council in April 2020 demonstrates the mental health impacts of COVID-19 across the life-course, and which will have implications for suicidality.

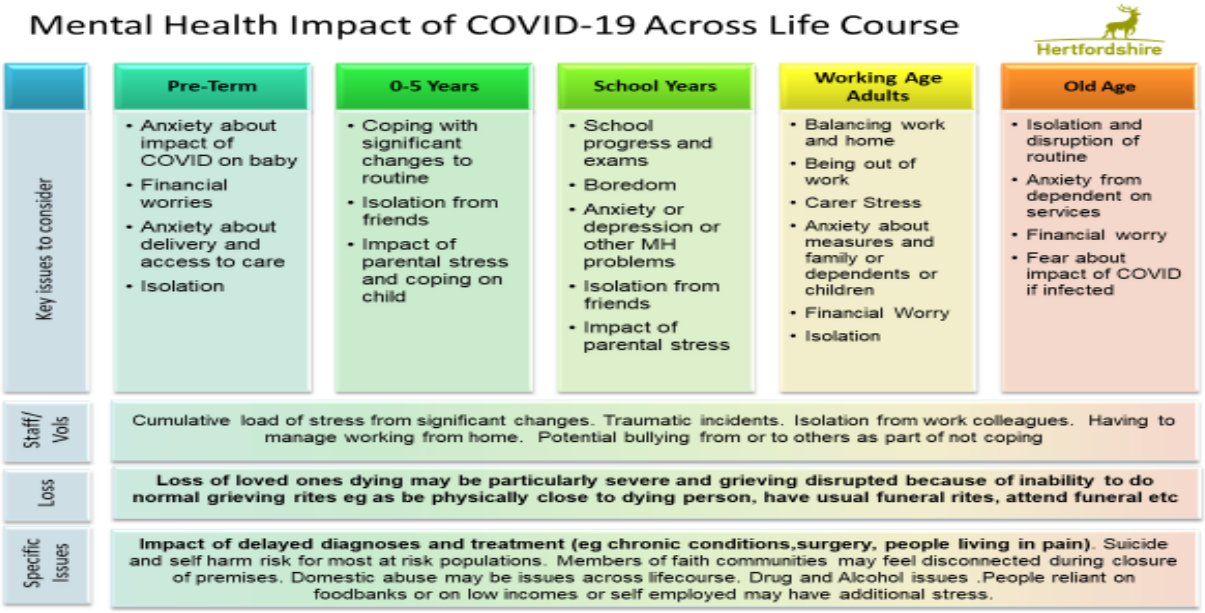


Figure 3. MH impacts of COVID-19, which could be interpreted as risk factors for poor mental health. Source: Hertfordshire County Council, April 2020.

SELF-HARM

Self-harm is a concern in its own right, as well as being a risk factor for completed suicide. Not everyone that self-harms will have suicidal thoughts, whilst not everyone that dies by suicide will have self-harmed. However, we know that previous self-harm is an important predictor for suicide.

As already noted, of those deaths by suicide in Southampton during 2017 and 2018 that were audited, 47% were known to have previously attempted to take their life by suicide, and 23% were known to have a history of self-harm.[6] In line with national guidance, self-harm has been identified for inclusion in this Plan as a priority for further action.

[6] The local audit of Coroner's records will under-estimate the individuals that have self-harmed as it is well documented that many people who self-harm do not seek help from health or other services and so self-harm episodes are not recoded.

National and local Southampton data suggest levels of self-harm are increasing, although only the 'tip of the iceberg' presents to healthcare services. Young people and adolescents (especially females) have disproportionately high rates of self-harm, both nationally and in Southampton. Self-harm in adults of all ages, taken together, also represents a significant health (and healthcare) burden. Local hospital admissions for self-harm in 10-24 year olds are significantly higher in Southampton than the national average.[7]

National risk factors for self-harm include the following:

- Women - rates are two to three times higher in women than men;
- Young people - 10-13% of 15-16-year-olds have self-harmed in their lifetime;
- Mental health disorders including depression and anxiety;
- People who have or are recovering from drug and alcohol problems;
- People who are lesbian, gay, bisexual or gender reassigned;
- Socially deprived people living in urban areas;
- Women of black and South-Asian ethnicity;
- Groups including veterans, prisoners, those with learning disabilities, and those in care settings;
- Individual elements including personality traits, family experiences (being single, divorced or living alone), exposure to trauma (including bullying, abuse or adverse childhood experiences), life events, cultural beliefs, social isolation and income.

OUR APPROACH

Partnership: As a large percentage of suicidal individuals are not in contact with health or social care services, action is required beyond the health and social care system. Partnership is required with community groups, local business and the voluntary and community sector to help identify and support people at risk of suicide and those bereaved by suicide. Key messages learned from practice and research are that suicide is preventable, that it is everyone's business, and that collaborative working is key to successful suicide prevention. This Plan has been developed by a wide range of partners to ensure that is a collaborative effort, and that action to prevent suicide is a shared responsibility across Southampton.

Prevention and early intervention: The Plan supports taking early action to prevent individuals from reaching the point of personal crisis where they feel suicidal. This requires action much earlier and across a range of settings from general practice, to schools, the workplace and community groups.

Life-course: This Plan takes a "life course" approach as advocated by the Marmot Review (2010), and aligned with the national mental health and suicide prevention strategy.

Evidence based: This Plan is informed by the evidence base. It uses national and local evidence to both identify areas of focus and specific need, and to inform the actions that will be taken to address need. This includes national guidance, published literature, and national and local intelligence, including from the local suicide audit of coroner records and real-time surveillance data from Hampshire Constabulary. The Plan has also been informed by stakeholder engagement with partners across the system, including Southampton residents with lived experience of mental health.

[7] See https://fingertips.phe.org.uk.

Agile use of intelligence and resources: As new or additional intelligence on the mental health implications of the current pandemic becomes available, the Plan may need to flex to adapt to a changing situation, with resources potentially needing to be reprioritised to focus on areas of greatest need.

HOW WE WILL MEASURE SUCCESS

Ultimately, we want to see a reduction in Southampton's suicide rate. This will be particularly challenging in the current context of a pandemic, and in the years beyond due to the economic fall-out, which is expected to be far-reaching and be felt for many years. However, aiming to reduce deaths by suicide is the right thing to do, and we should be doing all we can as a system to prevent each and every death.

Due to the low numbers of suicides it is difficult to show a *statistically* significant improvement in suicide rates across a local area and additional (proxy) measures will be used to assess the Plan's success. This includes for example, hospital admissions for self-harm and stigma in the population. See **Appendix A** for a breakdown of monitoring measures that will be used.

DELIVERY AND GOVERNANCE

Southampton Suicide Prevention Partnership (SPP) has responsibility for delivering on and monitoring progress towards the Suicide Prevention Plan. The Suicide Prevention Partnership will report to the Health and Wellbeing Board, which has overall responsibility for suicide prevention.

The Suicide Prevention will review status against actions on a six basis, for which all partners will be expected to submit a short status report.

ACTION PLAN

AREA 1: ACHIEVE CITY-WIDE LEADERSHIP FOR SUICIDE PREVENTION

This plan has been developed by a wide range or partners to ensure this is a collaborative effort and that action to prevent suicide is a shared responsibility between stakeholders in Southampton. The Suicide Prevention Partnership (SPP) in Southampton has been in place for a number of years and will continue to work together to achieve shared outcomes.

Ref	Target Group	Action	Lead Partner	Anticipated Outcome	Timescale
1.1	All groups	Continue with regular meetings by the strategic multi-agency group; Southampton Suicide Prevention Partnership (SPP), reporting to Southampton Health and Wellbeing Board.	SCC Public Health	Clear leadership and governance structure to enable decision-making and coordinate suicide prevention efforts.	Ongoing
1.2	All groups	Members of the SPP advocate suicide and self-harm prevention in their organisations/service areas, disseminate key messages, and take action where they are a "lead partner" in this Plan.	All partners	Co-ordinated advocacy and ownership of suicide prevention across all sectors.	Ongoing
1.3	All groups	SPP maintains and develops strong links with national, South East and Hampshire-wide mental health networks, including: - STP Suicide Prevention programme, including links with the National Collaborating Centre for Mental Health (NCCMH) and the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) - LRF Mental Health Recovery Group (formed from the STP MH Board) - CYP Transformation Board and sub-groups - H&IW CYP Mental Health Steering Group - PHE South East Mental Health Network	All appropriate partners, including SCC PH, STP SP Programme Manager, CCG, Southern Health, CAMHS	Alignment of suicide prevention outcomes, strategic support from other networks, and learning from other areas.	Ongoing Aligned with the COVID-19 response Good representation on all of the networks

1.4	People with lived experience	Refresh the membership of the SPP to ensure that key stakeholders are represented, including people with lived experience.	SCC Public Health Solent Mind	Improved representation of stakeholders on SPP, co-production, and engagement in delivery of actions.	2020-21
1.5	People with lived experience	Establish links with networks representing residents with lived experience to maximise coproduction opportunities.	SCC Public Health ICU Solent Mind	Coproduction with those with lived experience	2020-21

AREA 2: REDUCE THE RISK OF SUICIDE IN KEY HIGH-RISK GROUPS

The following groups are at higher risk of suicide in Southampton. These groups are in line with at risk groups identified by national guidance such as the national strategy report Preventing Suicide in England: Two Years On (2018).

- Men, particularly middle-aged men.
- People experiencing mental health problems, particularly depression and personality disorders – both in the care of mental health services and those not currently receiving treatment. For those in treatment, high risk periods include the first 3 months post-discharge from acute mental health services.
- People experiencing:
    - Relationship difficulties, particularly separation for men (most commonly occurring life event identified by the Southampton Suicide Audit)
    - Unemployment and financial difficulties
    - Physical health problems, particularly disability and chronic pain
    - Housing difficulties and/or social isolation
    - Bereavement, especially bereavement by suicide
- People with history of attempts of suicide or self-harm
- People formerly convicted of a crime
- People with a history of substance misuse (especially co-occurring substance misuse and mental health needs)
- People who have experienced abuse (either as victims or witnesses)

All of the above risk factors could be exacerbated by the COVID-19 pandemic and economic fall-out in years to come. Additional risk factors include those stated in Figure 3.

Ref	Target Group	Action	Lead Partner	Anticipated Outcome	Timescale
2.1	All groups	Provide immediate suicide prevention guidance to key settings within the context of COVID-19, to support them in providing effective advice and support to CYP, adults and families who may be distressed or in crisis. The guidance should include advice on known risk factors, risk factors that the pandemic may exacerbate, free online training for front line staff, details on support available	SCC Public Health	Suicide prevention knowledge better embedded in key settings to for immediate use	2020-21

		locally/nationally, and clarity on what to do in a crisis.			
2.2	All target groups	Map the different services, organisations and support groups (e.g. Citizens Advice, Foodbanks, Gyms, Libraries, Men's Sheds, Relate, Street Pastors, Housing services as well as health services) that each of the at risk groups are likely to have frequent contact with – their "touch points" in order to identify gaps, unmet needs, and opportunities i.e. to target suicide prevention interventions.	Public Health to utilise a Southampton Suicide Prevention Partnership meeting to complete mapping	Identification of opportunities to utilise community organisations and support groups as assets in the prevention of suicide.	2020
2.3	All target groups	Develop and secure an improved training offer to ensure the provision of mental health, self-harm and suicide prevention training to frontline staff and "touch points" (see above) to enable them to better identify those in need of help, provide support, and signpost/refer. Examples would be working with Related and similar organisations that work with recently separated men, and organisations that provide advice on debt and financial difficulties. The above will require mapping what is currently being delivered across the city, and exploring opportunities to collaborate locally and regionally where appropriate.	SCC Public Health to coordinate All partners to support	Improved competence and confidence in suicide prevention in front-line staff and key "touch points" in the community.	Developed and secured in 2020-21
2.4	Men, and especially those that are recently separated, socially isolated,	Deliver public awareness mental health campaigns (including suicide prevention and self-harm messaging) that target at risk groups, reduce stigma, and encourage people to seek support. These should amplify national campaigns as appropriate.	Southampton Anti-Stigma Partnership	Reduce stigma surrounding suicide, and increase help-seeking behaviour with regards to mental and emotional health.	At least one campaign each year Ongoing messaging as part of MH and wellbeing

	have a disability/ pain and/or financial difficulties				communications, and including during the COVID-19 period
2.5	All groups and especially, men, CYP, LGBT and BME groups	Deliver Time to Change events that raise public awareness of mental health, tackle stigma, and encourage people to talk about mental health. Events include Mela, Pride, and sports related events, though should also be delivered via online events and communication channels in the absence of mass gatherings.	Southampton and Portsmouth Time to Change Hub (Solent Mind) Southampton Anti-Stigma Partnership	Reduce stigma surrounding suicide, and increase help-seeking behaviour with regards to mental and emotional health.	At least two events each year for 2020-21 and 2021-22
2.6	All groups	Promote the distribution of Life Cards* to local organisations, services and support groups, including those that are frequent "touch points" for our target and vulnerable groups. *Developed by Southern Health, credit card sized, and with vital information on the back aimed to signpost people to key tools and organisations that can offer support and advice to anyone that needs it.	Southern Health	Improved signposting to service	2020-21 (and ongoing)
2.7	All groups	Promote community resilience in relation to mental health and suicide prevention through the establishment of a H&IW Innovation Fund to fund community projects that will deliver interventions that promote suicide prevention	STP Suicide Prevention Programme SCC ICU and Public Health	Improved community resilience	2020-21 and 2021-22
2.8	All, though targeting of men, and especially recently separated, socially	Gain the commitment of key employers to promote mental health and wellbeing within their organisations through a combination of: - Mental health (including suicide prevention) training; - Signing up to the Time to Change Employer Pledge;	All SPP partners Southampton and Portsmouth Time to Change Hub (Solent Mind)	Improved awareness and identification of mental health need, support, and referral amongst targeted high-risk employers and employee groups.	Ongoing and by end of 2023

	isolated, have a disability/ chronic pain and/or have financial difficulties	- And/or other workplace health policy and procedures that promote good mental health and wellbeing in the workplace and better identify and respond to those in need of support – aligned with the STP Suicide Prevention Programme. Occupations: Low skilled male labourers (three times more likely to take their own lives than the national average); nursing staff and primary teachers also high.	STP Suicide Prevention Programme Align with the work of LRF and STP groups i.e. workforce and Business/economy sub-groups of the LRF MH Recovery Group		
2.9	As above	Engage with Trade Unions and industry/business representatives to develop workplace suicide prevention tools and initiatives in targeted industries.	STP Suicide prevention programme Align with the work of LRF and STP groups i.e. workforce and Business/economy sub-groups of the LRF MH Recovery Group	Improved awareness and identification of mental health need, support, and referral amongst targeted high-risk employers and employee groups.	2020-21 and 2021-22
2.10	Target groups: As above	Strengthen the debt/financial need pathway through the following actions: - Work with LA stakeholders to ensure that Local Authority debt recovery is sensitive the MH and wellbeing needs of residents. - Improve the skills and confidence of those providing debt and financial advice in identifying MH and wellbeing needs and providing proactive support in accessing MH resources and services. - Work with health partners (i.e. Southern Health and primary care) to strengthen the pathway to debt and financial advice.	STP Suicide Prevention Programme SCC PH Align with the work of LRF and STP groups i.e. workforce sub-group of the LRF MH Recovery Group	Improved pathways and access to both debt and financial advice and services, and MH resources and services.	2020-21

		- Embed financial literacy, access to financial advice and support, and active sign-posting to support organisations amongst targeted high-risk employers, and other key organisations.			
2.11	Social isolation	Promote social prescribing as a means of improving mental health and wellbeing, including as a way of reducing social isolation. Ensure existing VCSO's/projects that support life events and address risk factors (e.g. financial advice, relationship advice) are involved.	Southampton CCG	Improved early intervention and access to protective factors.	Ongoing
2.12	All target groups	Improve identification of, and care planning with, patients with low mental health and wellbeing amongst the primary care workforce, with a focus on suicide prevention and self-harm training and making good quality resources easily available.	STP Suicide Prevention Programme Align with the work of LRF and STP groups i.e. primary care education sub-group of the LRF MH Recovery Group	Improved identification of suicide risk and care planning for vulnerable patients in primary care.	2022
2.13	People with a history of self-harm People that could self-harm - primary prevention and early intervention	Better understand the data and pathways in relation to self-harm and identify areas for quality and service improvement, with a focus on identifying and delivering interventions that promote prevention and early intervention in the school and/or family settings (i.e. access to peer support for family/carers), and interventions within the first month post ED admission for self-harm.	STP Suicide Prevention Programme Align with the work of CYP ICS Transformation Board	Improvements in the self-harm pathway and subsequent contribution to reducing self-harm rates	2022
2.14	People in contact with services.	Mental health trusts have robust suicide prevention plans in place, which include:	Solent NHS Trust Southern Health	Improved clinical intervention to reduce suicide rates.	2020-21 and ongoing

	High risk periods; first 3 months post-discharge from MH services and first month after ED	• The undertaking of psychosocial assessments for all people who present at emergency departments for self-harm. • Robust discharge planning processes for vulnerable patients (heeding the House of Common's Health Committee's recommendation that people being discharged from inpatient care should receive follow up support within 3 days of discharge, rather than the current standard of 7 days). • Compliance with NICE guidance.			
2.15	Children and young people	Promote positive mental health and wellbeing in the schools through the work of Mental Health Support Teams*, partnership with the Anna Freud programme, and the work of the CYP Social and Emotional Mental Health Partnership. This should include a focus on key protective factors such as training CYP and parents/carers on safe use of social media (protective in reducing online bullying). *Have a remit to provide evidence-based physiological interventions for those with mild to moderate level MH needs, and promote a whole school approach to MH and wellbeing.	CYP Social and Emotional Mental Health Partnership (chaired by the ICU)	Improved social and emotional health in CYP	Ongoing 2020-2023
2.16	Families	Inform the proposals for locality based teams so that support families in Southampton to raise awareness of suicide prevention support and build community and family resilience.	SCC Public Health ICU	Suicide prevention embedded within Locality Team proposals	2020-21
2.17	Physical health problems, particularly disability	Embed mental health and wellbeing within key physical health pathways and vice versa, including through: - The chronic pain pathway	Southampton CCG UHS Steps 2 Wellbeing	Improved integration of both mental and physical health needs	During both 2020-21 and 2021-22

	and chronic pain	- Through the Persistent Physical Symptoms pilot at UHS - Promotion of physical health through the Steps 2 Wellbeing service. - The roll out of physical health checks for those with severe mental illness (SMI).			
2.18	Housing difficulties	Explore how the mental health needs of those using night shelters could be better met to address unmet need.	Southern Health Society of St James Southampton ICU	Recommendations for meeting the MH needs of those using night shelters	2022-23
2.19	Co-occurring substance misuse and MH	Assess co-occurring conditions policy and services against NICE standards, identify priority areas for action, and develop strategies to manage co-occurring conditions effectively, including integrated care pathways.	Drug and Alcohol Partnership Group Suicide Prevention Programme Supported by all relevant partners	Improved outcomes for those with drug and/or alcohol and mental health needs	By end of 2023
2.20	People in contact with the criminal justice system	Roll out of suicide prevention training within Hampshire Constabulary, and exploration of plans and procedure in relation to the pre and post release period (i.e. “through the gate” services/pathways).	Hampshire Constabulary	Improved awareness and identification of mental health need, support, and referral to MH and wellbeing resources and services.	Training – 2020-21 Pre-and post-release period – 2022-23

AREA 3: TAILOR APPROACHES TO SUPPORT IMPROVEMENTS IN MENTAL HEALTH IN SPECIFIC GROUPS

As identified by national guidance, the following groups may need tailored approaches to support improvements in resilience and contribute to improved mental health and wellbeing:

- Looked after children and/or care leavers;
- Military veterans;
- People who are lesbian, gay, bisexual or gender reassigned;
- Black and Minority Ethnic groups and asylum seekers (men of Eastern European backgrounds were found especially at risk by the Suicide Audit);
- Those with complex (and often multiple) needs;

Ref	Target Group	Action	Lead Partner	Anticipated Outcome	Timescale
3.1	Adults Those with complex needs i.e. MH, substance misuse, rough sleeping	Ensure SPP representation at the Vulnerable Adults Group of Better Care Southampton; to ensure suicide prevention is aligned with other work and embedded as appropriate.	SCC Public Health SSJ	Improved partnership working in relation to vulnerable adults and subsequent work on co-occurring conditions.	2020 and ongoing
3.2	All age groups Target groups: LGBT, BME, Veterans (ex), young offenders, bereavement support services.	Identify individuals/groups/organisations that can help engage with those identified as requiring tailored support (i.e. LGBT, BME groups, those with learning disabilities) and ensure they are aware of the pathways, services and resources in place so that they can best support individuals.	CYP Social and Emotional Mental Health Partnership sub-group (work on pathways, services and resources underway and will be promoted through Wessex Healthier Together)	Improved awareness of pathways, services and resources by professionals and in turn residents. Community groups/organisations identified and included in implementing the Suicide Prevention Action Plan.	2020-21

	Vulnerable CYP	Using the suicide audit, real time surveillance and other available data, complete a "deep dive" on the characteristics (including risk and protective factors) of CYP up to and including 25 year olds that have taken their own life by suicide; to inform the work of the H&IW CYP Mental Health Steering Group, including the following: - Work with Coroner's on the information that they are able to capture and record, including in relation to adverse childhood experiences (ACE's). - Work with the Child Death Overview Panel (CDOP) on joined up learning in relation to deaths of CYP by suicide. - Co-design changes to the Joint Agency Rapid (JAR) information gathering process.	SCC Public Health	Improved knowledge about the characteristics of CYP to inform H&IW CYP Mental Health Steering Group decision-making on unmet needs and interventions; which will seek to improve MH in vulnerable groups, including improvements to the JAR, and CDOP process, and recording of risks by Coroners.	2020-21

AREA 4: REDUCE ACCESS TO THE MEANS OF SUICIDE

This refers to reducing or restricting access to lethal means individuals use to attempt suicide is an important part of a comprehensive approach to suicide prevention.

Ref	Target Group	Action	Lead partner	Anticipated outcome	Timescale
4.1	Adults Those experiencing chronic pain	Promote safe prescribing of painkillers and antidepressants, including through promoting NICE guidelines on the appropriate use of drug treatments for depression, and sharing findings from the suicide audit in relation to deaths by overdose of prescription drugs.	SCC Public Health Southampton CCG	Safer prescribing and reduced fatal suicide attempts	Ongoing Larger push in 2021-22
4.3	All age groups	Include suicide risk in building design considerations for: - SCC major refurbishments and upgrading of social housing stock - SCC corporate assets - Acute MH Trust settings - Custody settings	SCC Housing Southern Health Hampshire Police	Suicide risk embedded in SCC housing stock (where major refurbishments and upgrading), and within MH Trust Suicide Prevention Plans, and Police plans	By 2023
4.4	All age groups	Work with planning and developers to include suicide risk in new building design considerations, especially in relation to multi-storey car parks, bridges and high rise buildings that may offer suicide opportunities.	SCC Planning and other partners as required	Suicide risk embedded in building design of major new infrastructure	2020-21
4.5	All age groups	Review suicide prevention measures at high-frequency locations (for attempted and completed suicides) and make recommendations.	SCC Public Health, Planning and Infrastructure and Transport Hampshire Police, and emergency services	Suicide prevention measures in place at specific high-risk locations	2021-22

4.6	All age groups	Continued commitment to mental health and suicide prevention training for front line staff, and continued assessment of locations for suicide risk and implementation of subsequent actions.	Network Rail	Suicide prevention measures in place in relation to the rail infrastructure and network rail staff (i.e. suicide prevention training).	Ongoing

AREA 5: PROVIDE BETTER INFORMATION AND SUPPORT TO THOSE BEREAVED OR AFFECTED BY SUICIDE

The provision of timely information and support to those bereaved or affected by suicide such as families, friends, colleagues and peers, is important in supporting people through the different stages of bereavement and in preventing future mental ill health. We know that death of a family member or friend by suicide is a risk factor for suicide in the bereaved.

Ref	Target Group	Action	Lead partner	Anticipated outcome	Timescale
The following actions are embedded in the STP Suicide Prevention Programme and so will be led by the STP work-stream on bereavement support and postvention, though the SPP will play an active role in informing the programme and supporting the delivery of solutions in the Southampton system. The work will align with the bereavement sub-group of the LRF MH Recovery Group and the work of the CYP Transformation Board.					
5.1	Families bereaved by suicide or a death of undetermined intent	Strengthen effective referral to bereavement support/services by emergency services that attend the death and those in contact with the families soon after bereavement from suicide occurs (i.e. Coroner's Office), so that referrals are appropriate and timely.	SCC Public Health Hampshire Police NHS South Central Ambulance Service (SCAS) Coroner's Office Bereavement services	Strengthened pathways and referral to bereavement support services. Standardise approach to supporting those bereaved by suicide	2021-22
5.2	Families bereaved by suicide or a death of undetermined intent	Promote the distribution of the "Help is at Hand"* booklet or zcard by local organisations, services and support groups, including the first responders, Coroners, Funeral Directors and education settings. *A national bereavement support resource developed by those with lived experience of bereavement in partnership with Public Health England.	SCC Public Health Hampshire Police Coroner's Office NHS Solent Southern Health Southampton General Southampton CCG (including primary care) British Transport Police Network Rail Voluntary sector partners	Information about bereavement support services more accessible	2020-21
5.3	Families bereaved by suicide or a	Develop and implement a Real-Time Suicide Surveillance System to 1. Enable a timely response by partners to ensure	SCC Public Health Hampshire Police Southern Health	Implementation of real-time suicide surveillance	First phase: 2020-21, and second phase 2021-22

	death of undetermined intent	family/carers/friends are appropriately supported after a death by suicide (i.e. within 48 hours), 2. Enable system learning by partners to inform future prevention work and 3. Enable early identification of any 'clustering' to inform prevention work.	NHS Solent Education settings		
5.4	Families bereaved by suicide or a death of undetermined intent	Review the current bereavement support offer to families in Southampton, determine how best needs can be met, and work with services to strengthen the provision of suicide-specific bereavement support.	SCC Public Health Bereavement support services	Strengthened suicide specific bereavement support	By end of 2021-22
5.5	Families bereaved by suicide or a death of undetermined intent	Build awareness raising on suicide-specific bereavement into core mental health and suicide prevention training for front line staff.	Southampton CCG (primary care)	More informed and competent workforce	2023
Out of scope of the STP programme					
5.6	Families bereaved by suicide or a death of undetermined intent	Develop a prevention and postvention protocol with Southampton schools and colleges; to ensure they can provide a supportive and robust response in the event of a suicide.	SCC Public Health SCC Education Education settings	More informed and robust response to deaths by suicide by education settings – reducing the risk of further suicidality.	2020-21
5.7	All groups Families affected by a suicide attempt	Ensure those affected by an attempted suicide are signposted to resources, tools and organisations where they can seek further support.	Southern Health Solent NHS Trust UHS	Strengthen support, reduce risk of future attempts Learn from attempted suicides	Ongoing

AREA 6: SUPPORT THE MEDIA IN DELIVERING SENSITIVE APPROACHES TO SUICIDE AND SUICIDAL BEHAVIOURS

There is a proven link between certain types of media reporting of suicide and increases in suicide rates. This objective aims to promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media and reduce the risk of additional suicides

Ref	Target Group	Action	Lead partner	Anticipated outcome	Timescale
6.1	All age groups	Promote the responsible reporting and portrayal of suicide and suicidal behaviour in the media, including by encouraging use of the Samaritans guidance on responsible reporting, and challenging the publication of harmful or inappropriate material with reference to the updated laws on promoting suicide.	Anti-stigma partnership SCC comms	Reduce stigma around suicide	Ongoing (recirculate guidance when new reporters and when timely to do so i.e. when a death by suicide in a public place)
6.2	All age groups	Work with local media to encourage inclusion of positive stories (i.e. hope and recovery) and signposting of national helplines and local services for people that are affected by local campaigns and coverage of deaths by suicide or undetermined intent.	All partners, including SCC comms, CCG comms, Samaritans, Solent Mind	Establish a direct approach/contact with local media Increase in help-seeking behaviour	Ongoing

AREA 7: SUPPORT RESEARCH, DATA COLLECTION AND MONITORING

It is important to build on the existing research evidence and other relevant sources of data on suicide and suicide prevention.

Ref	Target Group	Action	Lead partner	Anticipated outcome	Timescale
7.1	All age groups	In relation to the Suicide Audit: - Ensure suicide data is recorded consistency across the STP so that it can be better analysed at the STP footprint. - Explore what further risk and protective factors can be included in relation to CYP and families, in discussion with the H&IW CYP MH Steering Group. - Continue to include findings of all serious incident reviews.	SCC Public Health, Coroner's Office	Audit to inform Suicide Prevention Plan refresh.	2021-22
7.2	All age groups	Circulate the key findings of the suicide audit to Partners to encourage learning from suicides locally.	Public Health CCG SPP	Learning from suicide audit inform practice.	2020-21 and ongoing
7.6	Children and young people	Include a section in the Year 7 Survey (with schools) or Youth Forum Survey, which will collect information on the status and views of children and young people in relation to mental health, social and emotional wellbeing – to support identification of need and preventative activities.	Public Health SCC	Identification of need and preventative activities.	2021-22
7.7	All age groups	Establish links with regional and leading universities on suicide and self-harm prevention to strengthen research links and academic input to the Partnership.	SCC Public Health, Academic partners	Strengthen academic and research links.	Ongoing
7.8	All age groups	Conduct "deep dives" where there is an opportunity to inform strategic and commissioning decision-making (could be in relation to self-harm, attempted suicides and/or completed suicides).	SCC Public Health, Academic partners Samaritans	Learning on suicidal thoughts and risk factors can help inform suicide prevention	Ongoing

APPENDIX A: MONITORING MEASURES AND OUTCOMES

No	Quantitative indicators
1	Suspected deaths by suicide as reported by first responders through real time surveillance data
2	Confirmed deaths by suicide as reported by Coroner's and captured through the Suicide Audit (biannual)
3	Recorded deaths by suicide as reported by ONS (annually)
4	3 year suicide rate as captured by the Public Health Outcomes Framework (PHOF)
5	Crude suicide rate by age group (10-34 years, 35-64 years, 65 years plus) as captured by PHOF (5 year average)
6	Years of life lost due to suicide, age standardised rate 15-74 years (3 year average, and for all persons, males and females) as captured by PHOF
7	Hospital admissions as a result of self harm by age group (10-14 years, 15-19 years, 20-24 years) as captured by PHOF
8	*Will explore how improve intelligence in relation to attempted suicides*
No	**Cross sectional and qualitative intelligence**
1	SCC PH snap shot survey of residents repeated periodically to monitor MH stigma in the community setting
2	People's Panel/Residents survey (MH and wellbeing questions embedded in the COVID-19 surveys)
3	No Limits survey
4	MRC University of Southampton study to understand the impacts of COVID-19 restrictions on young people, engaging young people in Southampton and surrounding areas about their experiences and concerns under lock down measures, to identify and develop solutions that support their wellbeing, mental and physical health. SCC PH informing.
5	Feedback through SMILE (network of Southampton residents with lived mental health experienced)

APPENDIX B: SOUTHAMPTON SUICIDE PREVENTION PARTNERSHIP MEMBERSHIP

Public Health, SCC
GP clinical lead for Southampton CCG
Mental health commissioner, ICU
Community engagement officer, ICU
Southern Health
Steps 2 Well-being
Southampton Solent University
University of Southampton
Solent Mind
Samaritans
British Transport Police
Hampshire Police
Society of Saint James
Survivors of Bereavement by Suicide (SOBS)

With thanks to the Southampton Suicide Partnership for overseeing the development of this Plan. Thanks also to Solent Mind and the Southampton residents with lived experience of mental health whom generously shared their experiences, expert knowledge and views to inform this Plan.

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