Public Document Pack

NHS
Southampton City
Clinical Commissioning Group

Joint Commissioning Board

Thursday, 18th June, 2020
at 9.30 am – Virtual Meeting

PLEASE NOTE TIME OF MEETING

This meeting is open to the public

Members

Dr Kelsey (Chair)
Councillor Hammond (Vice-Chair)
Councillor Fielker
Councillor Shields
Maggie MacIsaac
Matt Stevens

Please send apologies to:

Emily Chapman, Board Administrator,

Email: emilychapman1@nhs.net

PUBLIC INFORMATION

Role of the Joint Commissioning Board

The Board has been established by the City Council and Clinical Commissioning Group to commission health and social care in the City of Southampton. It will encourage collaborative planning, ensure achievement of strategic objectives and provide assurance to the governing bodies of the partners of the integrated commissioning fund on the progress and outcomes of the work of the integrated commissioning function

Public Representations

Save where an Item has been resolved to be confidential in accordance with the Council's Constitution or the Freedom of Information Act 2000, at the discretion of the Chair, members of the public may address the meeting about any report on the agenda for the meeting in which they have a relevant interest.

Benefits from Integrated Commissioning

- Using integrated commissioning to drive provider integration and service innovation.
- Improving the efficiency of commissioned services
- Increasing the effectiveness of commissioning – across the whole of the commissioning cycle.

Smoking policy – the Council and Clinical Commissioning Group operates a no-smoking policy in all of its buildings.

Mobile Telephones – please turn off your mobile telephone whilst in the meeting.

Fire Procedure – in the event of a fire or other emergency an alarm will sound and you will be advised by officers what action to take.

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

CONDUCT OF MEETING

Terms of Reference

The terms of reference of the Board are contained in the Council's Constitution and the Clinical Commissioning Group Governance Arrangements.

Business to be discussed

Only those items listed on the attached agenda may be considered at this meeting.

Rules of Procedure

The meeting is governed by the Council Procedure Rules as set out in Part 4 of the Constitution.

Quorum

The minimum number of appointed Members required to be in attendance to hold the meeting is 4 with a minimum of 2 from the City Council and the Clinical Commissioning Group.

Disclosure of Interests

A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship

AGENDA

Agendas and papers are now available online at
www.southampton.gov.uk/council/meeting-papers

1 WELCOME AND APOLOGIES

Lead	**Item For: Discussion Decision Information**	**Attachment**
Dr Mark Kelsey		

2 DECLARATIONS OF INTEREST

A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship

Lead	**Item For: Discussion Decision Information**	**Attachment**

Dr Mark Kelsey		

3 **MINUTES OF THE PREVIOUS MEETING/ ACTION TRACKER** (Pages 1 - 6)

Lead	**Item For: Discussion Decision Information**	**Attachment**
Dr Mark Kelsey	Decision	Attached

4 **FIVE YEAR STRATEGY PRIORITIES - NEXT STEPS** (Pages 7 - 122)

Report of the Director of Quality and Integration Southampton City CCG and Southampton City Council detailing the Five Year Strategy Priorities – Next Steps, attached.

5 **COVID-19 OVERVIEW OF HEALTH AND CARE RESPONSE IN SOUTHAMPTON** (Pages 123 - 164)

Report of Director of Quality and Integration Southampton City CCG and Southampton City Council detailing the Covid-19 Overview of Health and Care Response in Southampton, attached.

6 **BETTER CARE STEERING BOARD MINUTES** (Pages 165 - 180)

Lead	**Item For: Discussion Decision Information**	**Attachment**
Dr Mark Kelsey	Information	Attached

Wednesday, 10 June 2020

SOUTHAMPTON CITY COUNCIL ®

NHS
Southampton City
Clinical Commissioning Group

Meeting Minutes

Joint Commissioning Board - Public

The meeting was held on 20th February 2020, 09:30 – 10:30
CCG Conference Room, NHS Southampton HQ, Oakley Road, SO16 4GX

	NAME	INITIAL	TITLE	ORG
Present:	Matt Stevens	MS	Lay Member for Patient and Public Involvement	SCCCG
	Councillor Dave Shields	Cllr Shields	Cabinet Member - Health and Sustainable Living	SCC
	Councillor Lorna Fielker	Cllr Fielker	Cabinet Member – Adult Social Care	SCC
In attendance:	Stephanie Ramsey	SR	Director of Quality & Integration	SCCCG / SCC
	James Rimmer	JR	Managing Director	SCCCG
	Grainne Siggins	GS	Executive Director Wellbeing (Health & Adults)	SCC
	Matthew Waters	MW	Senior Commissioner	SCCCG/ SCC
	Chris Pelletier	CP	Associate Director	SCCCG/ SCC
	Paula Hunter	PH	Finance Business Partner	SCC
	Judy Cordell	JC	Democratic Support Officer	SCC
	Emily Chapman (minutes)	EC	Business Manager	SCCCG
Apologies:	Maggie MacIsaac	MM	Chief Executive Officer	SCCCG
	Councillor Chris Hammond	Cllr Hammond	Leader of the Council	SCC
	Dr Mark Kelsey	MK	CCG Chair	SCCCG
	Sandy Hopkins	SH	Chief Executive	SCC
	Claire Heather	CH	Senior Democratic Support Officer	SCC
	Keith Petty	KP	Finance Business Partner	SCC
	Beccy Willis	BW	Head of Governance	SCCCG

		Action:
1.	**Welcome and Apologies**	
	Members were welcomed to the meeting. Apologies were noted and accepted.	

2.	**Declarations of Interest**	
	A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship No declarations were made above those already on the Conflict of Interest register.	
3.	**Previous Minutes/Matters Arising & Action Tracker**	
	The minutes from the previous meeting dated 19th December 2019 were agreed as an accurate reflection of the meeting. **Matters Arising** There were no matters arising. **Action Tracker** The action tracker was reviewed and updated. **ACTION: Briefing to be provided on the results of the Primary Care East Estates review** **ACTION: Update on DToC to be provided to a future JCB**	**MS** **SR**
4.	**Residential and Nursing Homes – Market Management Update and Commissioning Strategy**	
	MW/CP attended the meeting to present the Residential and Nursing Homes – Market Management Update and Commissioning Strategy to the Board. MW outlined the highlights of the papers to the Board. GS raised any decision today is a recommendation, as the budget hasn't gone through for full decision yet. GS queried the high percentage of packages paid that are above the current published rates. GS queried the cost pressures for 2020/21. MW responded we have increased published rate levels over the years and the budget for adult social care has increased to meet that. This is the first year that an increase has been suggested to put in the adult social care budget to take both the published rate increase and the rise in national living wage into account. MW clarified there is no cost pressure for 2020/21 that hasn't been built in. Cllr Fielker raised having the right skills for people working within the sector, particularly around the challenges we face in recruitment. MW responded discussions are taking place on how to make this sector more attractive to work in. JR raised the homes outside of the city being used and nursing home capacity. MW responded the complexity levels of patients cause	

	challenges meaning homes outside of Southampton need to be used as there is insufficient provision of the correct type meet this need in the city GS raised the high level of residential dementia patients within Southampton; this may be needed to be reviewed in terms of support. **ACTION: MW to bring briefing back to JCB on the Market Position Statement alongside progress of the RSH development** Cllr Shields raised concerns around the city supplying a lot of the care workforce outside of the city, which adds challenge to our recruitment. Cllr Shields also raised the Hampshire and Isle of Wight (HIOW) context we have two levels of cost, one in the north east of the county and then Southampton, why is there no intermediate level. CP raised the issue regarding workforce is about how we compete with Southampton's retail market. MW raised that differential between Southampton and Hampshire rates .There is one published rate level across the county and isn't planned to change. Joint Commissioning Board agreed the following (subject to budget approvals): (i) The increase in the current published rate levels of care homes costs from April 2020 based on the likely impacts of the National Minimum Wage increases and the current inflation rate. The recommended increases are Residential care – 5% increase; Nursing homes – 6% increase. (ii) The strategy for responding to uplift requests from homes providing care at costs above the published rate levels. (iii) The further reviews of the published rates to stratify these based on complexity of care. MS suggested at a future meeting we bring back: opportunities of development, what the barriers are and how we build into planning, how we can build and improve the trusted assessors. CP/MW/JC left the meeting.	**MW**
5.	**Performance Report**	
	The Board received the performance report for noting. At the March meeting there will be a deep dive in the performance report reviewing each level in more detail. MS queried why Continuing Healthcare (CHC) assessments are not being completed within 28 days. SR responded that some of this is due to staffing issues, including it taking longer to achieve the correct composition of Multi-Disciplinary Team meetings. Some of the assessments taking place slightly later are due to ensuring we have all	

	information together to complete a good quality assessment. There is a trajectory in place to improve this with a detailed work plan in place. SR raised the Joint Equipment Store (JES) standstill period has now completed and the provider has moved the Nottingham Rehab (no longer Millbrook Healthcare). Cllr Fielker raised people who work within the current service will continue to work there and are local to the city. Cllr Shields left the meeting.	
6.	**Better Care Highlights Report**	
	The Board received the Better Care Highlights report and SR outlined the key points within the paper. The paper also contained detailed briefing around Delayed Transfers of Care (DTOC) and Improved Better Care Fund (iBCF) expenditure. Cllr Fielker raised all the work that's been done with regards DTOC, we focus on discharge however there is a broader picture to stop people going into hospital. SR responded that part of the frailty work stream is to shift focus on to admission avoidance. SR confirmed the iBCF spend is the same as the previous year, a detailed breakdown will be produced to clarify the spend. GS/SR to discuss outside of the meeting. The Board discussed DTOC and the challenges around this area of work. It was agreed the external support being provided by the LGA and NHS England will be useful. The Board: (i) Noted 2019/20 performance against Southampton's Better Care programme and spend against the pooled budget, including the iBCF. (ii) Noted the priorities going forward for 2020/21. (iii) Noted the iBCF programme of spend for 2020/21.	
7.	**Better Care Steering Board Minutes**	
	The Board received the Better Care Steering Board (BCSB) meeting minutes from the 27th November 2019 for information.	
8.	**Any Other Business**	
	SR highlighted that a member of staff is currently undertaking a piece for research looking at relationships between commissioners and providers, the learning from this will be reviewed.	

Joint Commisioning Board - Action Tracker (Public)					
Date of meeting	**Subject**	**Action**	**Lead**	**Deadline**	**Progress**
17/10/2019	Quality Report	SR to provide a briefing at a future meeting on staffing / workforce within Mental Health / SHFT	Stephanie Ramsey	Apr-20	was scheduled for March, however Meeting was cancelled due to Covid19 response, all items to be reviewed and rescheduled
17/10/2019	Quality Report	Deep dive session to take place on Mental Health.	Stephanie Ramsey	Apr-20	was scheduled for March, however Meeting was cancelled due to Covid19 response, all items to be reviewed and rescheduled
17/10/2019	Performance Report	Deep dive session to take place at a future meeting for the Associate Directors to talk through each of their areas	Stephanie Ramsey	Apr-20	was scheduled for March, however Meeting was cancelled due to Covid19 response, all items to be reviewed and rescheduled
20/02/2020	Action tracker	Briefing to be provided on the results of the Primary Care East Estates review	Matt Stevens	Apr-20	Date to be determined
20/02/2020	Action tracker	Update on DToC to be provided to a future JCB	Stephanie Ramsey	Apr-20	Date to be determined
20/02/2020	Residential and Nursing Homes – Market Management Update and Commissioning Strategy	MW to bring briefing back to JCB on the Market Position Statement alongside progress of the RSH development	Matthew Waters	TBC	Date to be determined

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DECISION-MAKER:		Joint Commissioning Board		
SUBJECT:		Southampton Five Year Health and Care Strategy 2020-2025 – review due to impact of COVID-19		
DATE OF DECISION:		18th June 2020		
REPORT OF:		Director of Quality and Integration Southampton City CCG and Southampton City Council		
CONTACT DETAILS				
AUTHOR:	Name:	Donna Chapman/Clare Young	Tel:	023 8029 6904
	E-mail:	clare.young4@nhs.net		
Director	Name:	Stephanie Ramsey	Tel:	023 8029 6904
	E-mail:	Stephanie.ramsey1@nhs.net		

STATEMENT OF CONFIDENTIALITY
Not applicable

BRIEF SUMMARY
The Council and CCG, along with other health, care and other partners in the city, agreed the Southampton Five Year Health and Care Strategy (2020-2025) in March 2020. The strategy reflects our 'one city place-based' approach to working together to improve health and care outcomes for the population of Southampton that we serve. The strategy has been coproduced and sets out a plan to deliver our vision, 'a healthy Southampton where everyone thrives', and guide the activities of all partners over the next five years. COVID-19 has had a significant impact on all health and care provision and on outcomes for the population and this has altered the health and care needs within city. An impact assessment has therefore been undertaken by the Better Care Southampton Steering Board to develop revised short and medium term priorities.

RECOMMENDATIONS:		
	(i)	The Board is asked to support the revised priorities for the Southampton Five Year Health and Care Strategy (2020-2025).
	(ii)	The Board requests the Better Care Southampton Steering Board to ensure implementation of the strategy with the revised priorities and to provide regular updates on progress to both this and the Health and Wellbeing Board

REASONS FOR REPORT RECOMMENDATIONS	
1.	The Southampton City Health and Care Strategy reflects a whole system approach to improving health and care outcomes for our population, and sets out a plan to guide the activities of all partners over the next five years. The impact of COVID-19 has been significant and so a review of priorities had been required to ensure outcomes can still be achieved.
2.	There are elements of learning and change from actions taken as a result of

	COVID-19 that would be beneficial to maintain and to incorporate into the strategy. New actions need to be included to meet new demands such as the ongoing shielding od some people or the impact of increased levels of deprivation and inequalities.
ALTERNATIVE OPTIONS CONSIDERED AND REJECTED	
3	The original strategy could have used but the COVID-19 virus and measures put in pace to control its' spread have had large and far-reaching impacts across society.
DETAIL (Including consultation carried out)	
4	The Southampton Health and Care Strategy has been developed in response to in-depth analysis into the city's current and future health and care challenges. The strategy is a collective response across NHS organisations, the Local Authority and voluntary organisations to tackle the city's current and future health and care challenges together.
5	The strategy is based on making continuous improvement over a number of years to meet our shared vision, 'a healthy Southampton where everyone thrives'. The vision we share is about enabling everyone to live long, healthy and happy lives, with the greatest possible independence.
6	We want to improve outcomes for the whole population, right across the main life stages, from birth to death. Our strategy will therefore take a life course approach, focusing on the following priorities: • Start Well - Children and young people get the best start in life, are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives • Live Well - People enjoy and are able to maintain a sense of wellbeing and good health, supported by resilient communities • Age Well - People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks • Die Well - People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people
7	The impact of COVID-19 has been significant and so an impact assessment has been undertaken for each of the programmes by the relevant sub group of the Better Care Southampton Steering Board. A review has been undertaken in May 2020 to consider: • Where are we now? What has changed in response to COVID-19? • Assessing the impact of the COVID-19 response, which has included a review of what has worked well and that we should keep as well as the concerns/unintended consequences we now need to address? This has then informed the development of short, medium term and long term Priorities
8	The oversight of implementation of the Strategy is the role of Better Care Southampton Steering Board that reports to Joint Commissioning Board and Health and wellbeing Board

RESOURCE IMPLICATIONS	
Capital/Revenue	
9	Not applicable
Property/Other	
10	Not applicable
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
11	S. 1 Localism Act 2011 (the general power of competence) permits the Council to work in partnership with other public and private bodies to secure the delivery of functions, services and facilities that are for the benefit or improvement of the Southampton and wider regional area.
Other Legal Implications:	
12	The Health & Care Strategy relates to the proposed delivery of public services and as such those services must be delivered in accordance with the provisions of the Equalities Act 2010, the Crime & Disorder Act 1998 and the Human Rights Act 1998. In particular all functions and services delivered under the proposed strategy must be designed and delivered having regard to s.149 Equalities Act 2010, the Public Sector Equalities Duty, which requires that a public authority must, in the exercise of its functions, have due regard to the need to— a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act; b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it; c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it. Members must be satisfied that the Strategy, as proposed, is wholly in accordance with this duty.
CONFLICT OF INTEREST IMPLICATIOINS	
13	Not applicable
RISK MANAGEMENT IMPLICATIONS	
14	Risks to the delivery of the Strategy are overseen by the Better Care Southampton Steering Group. Risks include increasing inequalities, availability of sufficient workforce to meet demand and the sustainability of the voluntary and social care markets.
POLICY FRAMEWORK IMPLICATIONS	
15	The Five Year Health and Care Strategy is directly aligned to and supports the delivery of the Southampton Health and Wellbeing Strategy 2017-2025 (S.116A Local Government and Public Involvement in Health Act 2007), as included in the council's Policy Framework (Article 4.01).

KEY DECISION?	No
WARDS/COMMUNITIES AFFECTED:	**All**

SUPPORTING DOCUMENTATION		
Appendices		
1.	Summary and impact assessments	

Documents In Members' Rooms

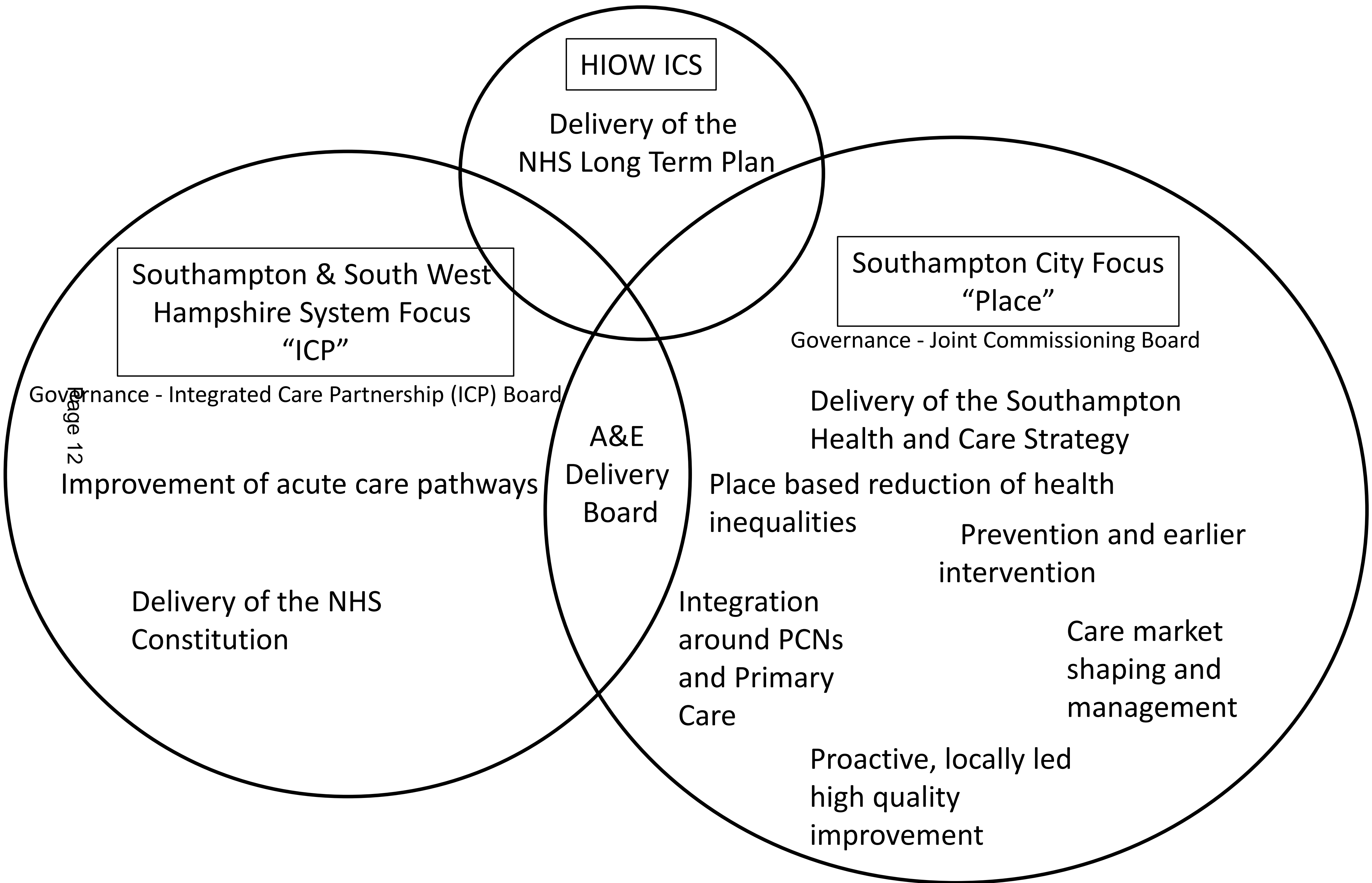
1.	None	
Equality Impact Assessment		
Do the implications/subject of the report require an Equality and Safety Impact Assessment (ESIA) to be carried out.		**No These will be developed as part of the five year plans**
Privacy Impact Assessment		
Do the implications/subject of the report require a Privacy Impact Assessment (PIA) to be carried out.		**No**
Other Background Documents **Other Background documents available for inspection at:**		
Title of Background Paper(s) **None**		**Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)**
1.	N/A	

Southampton City Health and Care Strategy

2020-2025

COVID Impact Assessment

Summary of Short and Medium Term Priorities


HIOW ICS
Delivery of the NHS Long Term Plan
Southampton & South West Hampshire System Focus "ICP"
Governance - Integrated Care Partnership (ICP) Board
Improvement of acute care pathways
Delivery of the NHS Constitution
A&E Delivery Board
Southampton City Focus "Place"
Governance - Joint Commissioning Board
Delivery of the Southampton Health and Care Strategy
Place based reduction of health inequalities
Prevention and earlier intervention
Integration around PCNs and Primary Care
Care market shaping and management
Proactive, locally led high quality improvement

Start Well

Priorities	Place based	ICP	ICS
Short Term Next 8 wks (June – July)	• Mobilise increased emotional and mental health support offer • Promote and support re-integration to school • Identification of "hidden" safeguarding risk /vulnerable families	• Embed CAMHS Crisis Pathway	• Suicide prevention plan – YP – designed at ICS level but implemented at place
Medium Term 3-5 months (Aug – Oct)	• Extended locality model • Healthy Child Programme catch up, incl flu Vac • Review of Disabled Children's Health and Care offer • Implementation of Phoenix • Specialist Resource hub for YP with complex SEMH		

Live Well

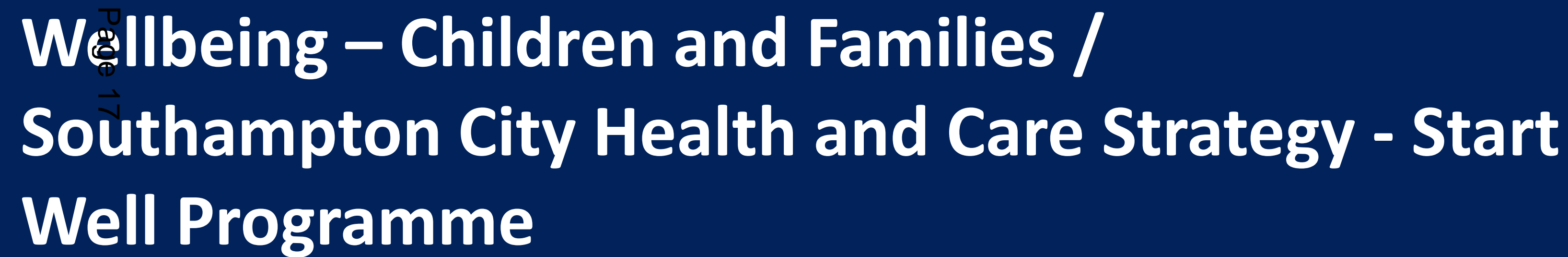
Priorities	Place based	ICP	ICS
Short Term Next 8 weeks (June – July)	• ICT development – focus on shielded • Specialist Smoking cessation service • COPD/Asthma Pharmacist in primary care to review patients at medium/high risk • Promote sign up to the Diabetes LIS and actively improve the 3TT. • Risk stratification of diabetes patients & referral to reduce risk of COVID • Remote initiation of injectables- support from Community Diabetes Team. • Mobilise increased IAPT offer • New processes for LD Annual Health Checks • Reinstate new LD “day activities” offer • Expand Domestic and Sexual Abuse services to meet increased demand	• Restore cancer surgery/ treatment/ screening • Restore cardiology and stroke services	• Assess/plan for MH surge – undertaken at ICS level but delivered at place • Suicide prevention/ bereavement support – designed with ICS but delivered locally
Medium Term 3-5 months (Aug – Oct)	• Broader Smoking cessation services, incl E-cigarette pilot • Continue working towards an Integrated Diabetes Service • Explore opportunities/models for accelerated integration of Adult SMI community care with PCNs • Review/build on social prescribing and support to carers • SMI physical annual health checks in primary care	• Continue work on Wessex Cancer Surgical Hub • Restart Lung Function Testing • Develop and embed a “new normal” for Cardio-Pulmonary Rehabilitation • Further integration of IAPT within Cardio-respiratory services	• Roll out of CVD prevent by NHS E • Crisis resolution and home treatment (CRHT) service development

Age Well

Priorities	Place based	ICP	ICS
Short Term Next 8 wks (June – July)	• Integrated Care Team focusing on Shielded Patient list • EHCH expansion • Pathway 3 Discharge to Assess Step down provision • Further develop community hub VCS offer • Build community navigation/ social prescribing offer		• Information/ Communication about COVID
Medium Term 3-5 months (Aug – Oct)	• Embed support to social care market, inc trusted assessment • Develop Home improvement model / DFG review	• Frailty model – integrated reactive care/urgent response – with elements delivered at place • Build on/embed new discharge model/D2A/ community hub – deliver at place	

Die Well

Priorities	Place based	ICP	ICS
Short Term Next 8 wks (June – July)	• Expand bereavement offer to care homes		
Medium Term 3-5 months (Aug – Oct)	• EOL education training programme for care homes • Development of 24/7 Care Coordination centre • Development of nurse-led beds • Expanding bereavement service provision including development of volunteers		



Wellbeing – Children and Families / Southampton City Health and Care Strategy - Start Well Programme

COVID Impact Assessment

A city of opportunity where everyone thrives

NHS Southampton City Clinical Commissioning Group
SOUTHAMPTON CITY COUNCIL

Content

- Recap of the Start Well Programme prior to COVID-19
- Where are we now? – what has changed in response to COVID-19?
- Assessing the impact of the COVID-19 response
- Summary and key priorities:
  - Short term
  - Medium term
  - Long term

Southampton City 5 Year Health & Care Strategy 2020-2025

6 Key Goals:

- Reducing inequalities and confronting deprivation
- Tackling the city's biggest killers
- Working with people to build resilient communities and live independently
- Improving mental and emotional wellbeing
- Improving earlier help, care and support
- Improving joined-up, whole-person care

A Life Course Approach:

Start Well
Children and young people get the best start in life, are able to achieve the best opportunities and keep as healthy and well as possible throughout their lives

Live Well
People enjoy and are able to maintain a sense of wellbeing and good health, supported by resilient communities

Age Well
People are able to live independently in their own homes with appropriate care and support to maintain and develop their social and community networks

Die Well
People are supported to ensure the last stages of their life happen in the best possible circumstances, receiving the right help at the right time from the right people

A city of opportunity where everyone thrives

NHS Southampton City Clinical Commissioning Group

SOUTHAMPTON CITY COUNCIL

Southampton City Five Year Health & Care Strategy

Start Well Programme

Draft Five Year Plan

2020-2025

Key Ambitions

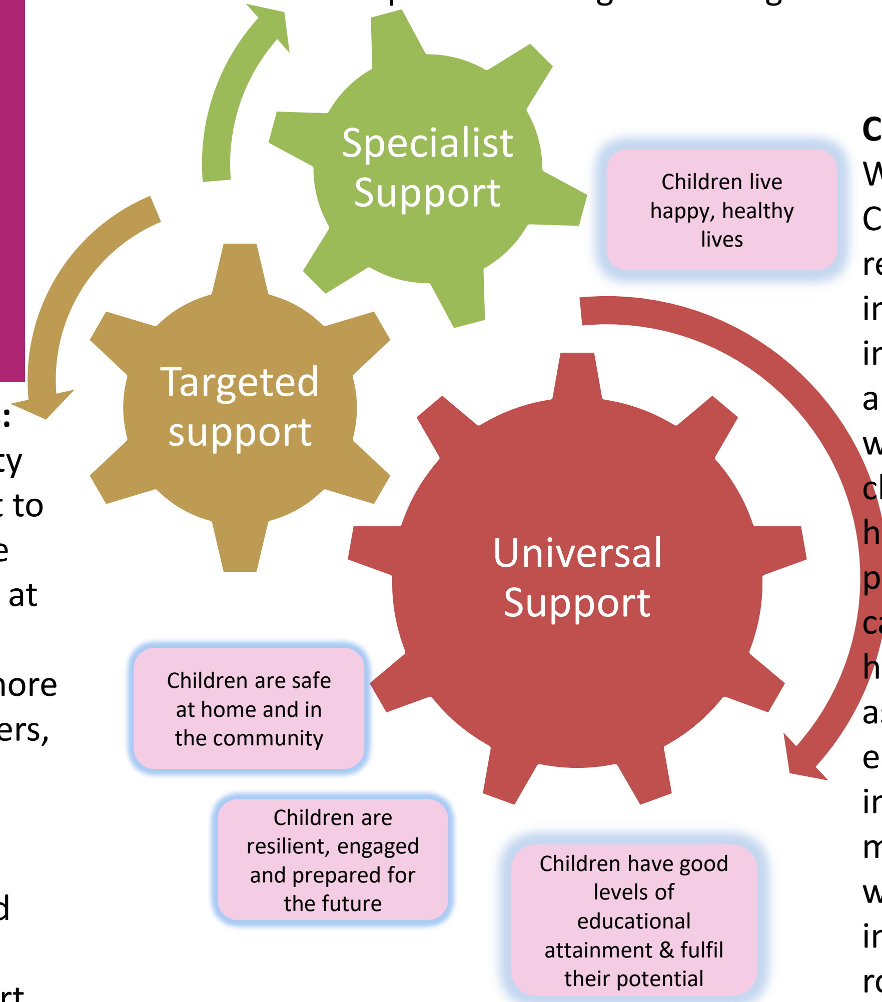
- Reduce the percentage of **mothers smoking during pregnancy**
- Reduce the rate of **teenage pregnancies**
- Increase the percentage of mother's **breastfeeding** 6-8 weeks post birth
- Reduce the rate of **looked after children**
- Increase the percentage of **care leavers in suitable accommodation**
- Reduce the percentage of children in Year R and Year 6 with **excess weight**
- Increase the percentage uptake of healthy child mandated **immunisations and health checks**
- Increase the percentage of **children achieving a good level of development at the end of reception**
- Increase the percentage of **children reporting positive mental health at Year 7**
- Reduce the rate of **first time entrants to the youth justice system**
- Reduce the percentage of **16-17 year olds not in education, employment or training** (NEET)

Start Well Programme Service Model

We will work in partnership across LA, NHS and Voluntary/ Community Sectors to build a strong, joined up service offer based on restorative principles and a whole family approach, to give every child a good start in life.

This will be based around 3 levels of support.

City wide integrated specialist services: We will continue to join up and strengthen Specialist Services across health, education and social care through the development of a more integrated model of provision to better meet the specific needs of the most complex children and families in our city, providing effective and timely support to the locality Early Help teams, as well as specialist assessment and intensive therapeutic intervention where required in a range of settings.



Extended Early Help Locality Teams: We will further build on our 3 locality teams to provide additional support to children and families, enabling more families to receive the right support at the right time in their communities. This will include the devolution of more specialist resource, e.g. Social Workers, CAMHS professionals, DVA and CSE expertise, Adult MH and Substance misuse, into the locality teams to support Early Help staff identify and effectively manage children and families in need of additional support locally, without the need to refer into specialist services

Child Friendly Southampton: We will continue to build a Child Friendly city, based on restorative practice and inclusive principles. This will involve developing the skills and confidence of everyone who comes into contact with children and families (be it health, education, social care professionals, parents or carers) to promote positive health and wellbeing and high aspirations, recognise the early signs of difficulties, intervene early and seek the most appropriate support when needed. This will involve the development and roll out of multiagency training .

Children's Five Year Strategy 2020-2025 – Key Building Blocks

Universal Locality Teams

- Promoting Community resilience
- Universal offer
- Increased use of digital

Extended Early Help Locality Teams

- Comprehen-sive Early help offer
- Targeted interventions to identify children and young people at risk of care
- Earlier intervention to reduce care
- Courageous risk taking
- Maximum caseload of 18 (30 currently)

Specialist Resource Hub

- Prevent need for care
- Intensive support - Step up and Step-down
- Building resilience – children and young people and families
- Offering support to foster carers
- Offering support to extended early help locality teams
- Peripatetic

In House Fostering

- Growth by 10% a year
- A greater mix of foster care placements which reflect need and demographics - including Mother and baby placements
- Well-supported foster carers

Independent Fostering Agencies (IFA)

- Reduce use from current 147 children and young people
- Ensure when IFA is necessary, there is greater availability locally

Tier 4 Fostering (SCC)

- Long term and short term
- Step up in crisis, step down from residential
- Emergency (social care and mental health)
- Constant refresh of carers

Residential

- Long term or short term to stabilise
- 75% within a 20 mile radius

Tier 4 Secure

- For children with complex mental health/ own protection/on edge criminality

Start Well Programme

Key Workstreams

What will be the main workstreams over the next 5 years, and what will they do?

Improving mental and emotional wellbeing		Reducing inequalities and confronting deprivation	
	• Develop Southampton **Whole School offer** • Implement **Mental Health Support Teams in Schools** • Implement the **Specialist Resource Hub for Young People with complex social, emotional and behavioural needs** Develop a robust **crisis pathway** for children in mental health crisis, and improve access in general to specialist CAMHS treatment/support (including meeting the national targets for Eating Disorders and Early Intervention for Psychosis) • Inform and support and the implementation of the Southampton **Suicide Prevention Plan** • Improve access to treatment services – 'no wrong door'		• Develop the **inclusive educational** offer, and reconfigure **specialist educational provisions** to meet local need • Expand the options and support available to YP with SEND for further **education & training, employment, independent living and social inclusion** • Implement the **Youth Justice Plan** with a specific focus on reducing numbers of first time entrants • Implement the **LAC Service Delivery Plan** and **Leaving care policy to** improve outcomes for children in care and care leavers • Implement the **Phoenix project** to reduce the number of babies taken into care • Increase the availability of **in house foster carers** and ensure a greater mix of foster care placements . Develop an in house **Tier 4 specialist foster carer service** able to offer a mix of short term, long term and emergency placements. • Expand availability of local **residential provision**

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Start Well Programme

Key Workstreams

What will be the main workstreams over the next 5 years, and what will they do?

Workstream	Actions	Workstream	Actions
Improving joined up whole person care	• Continue to work in partnership across the Local Authority, NHS and Voluntary/ Community sectors to **build a strong, joined-up service offer** • Develop and implement a whole **interagency workforce development plan** based on restorative, family centred and inclusive principles • Improve **transition** for young people with additional needs into adulthood	Improving Earlier Help Care and Support	• Implement the **extended Early Help Locality Model,** including **Social Workers in Schools** • Continue to develop the **Early Help hub** as a single route into Early Help and expand the community/voluntary sector offer • Embed an **Early Help offer for children with SEND** and their families • Strengthen **Parenting support** • Improve uptake of **early years education offer** • Expand **LARC** offer in maternity and primary care
Working with people to build resilient com-munities	• Delivery of the **Year of the Child 2020**: bringing together the city's businesses, arts and cultural venues, voluntary and community organisations, and practitioners who work with children to provide a year-long programme of consultative and celebratory events. • Increase **play, phys. activity & positive youth opportunities** • Develop an **Employment, Skills and Learning Partnership** Action plan that raises awareness of opportunities for YP	Tackling the city's biggest killers	• Continue to improve birth outcomes through **promoting healthy pregnancies**, e.g. smoking cessation support, continuity of carer and breast feeding support • Reduce **risky behaviours** through city's Sexual health improvement Plan, Alcohol Strategy and Healthy Weight Strategy • Improve coverage and uptake of **HCP** • Improve uptake of **Healthy Early Years Award & Healthy High 5 Award** in schools • Improve information and support in the community for families on **management of common childhood illness** • Improve the quality of care for children with **long term conditions** e.g. asthma, epilepsy & diabetes and their transition to adulthood

Current Position: What has changed in response to COVID-19?

Special Educational Needs and Disabilities Services

What has stopped?	What has continued?	What has changed?
Schools/special schools	EHCPs Tribunals Therapies – virtual	Risk assessment of EHCP actions How we enable vulnerable children to return to school? E.g. PPE, social distancing, parental support

Current Position: What has changed in response to COVID-19?

Emotional and Mental Health Services

What has stopped?	What has continued?	What has changed?
Routine referrals to CAMHS – stepped approach planned for restart (initial focus anxiety and depression) Face to face contacts at No Limits – using Zoom and telephone instead	Urgent referrals to CAMHS – seven day service -face to face where required – Eating Disorders and Self harm referrals Duty and SPA open to discuss referrals Telephone/Zoom support at No Limits ED support from No Limits for YP in MH crisis/assoc with violent crime	New CYP mental health crisis pathway – about 7 YP a week Weekly Zoom sessions with Reminds parents plus Planned zoom session with Education and parents – for reintegration into school No Limits move from ED Moved from face to face to telephone plus Use of visionable and other online platforms

Current Position: What has changed in response to COVID-19?

Safeguarding and Social Care

What has stopped?	What has continued?	What has changed?
Opportunities for face to face "eyes on" contact – schools, nurseries, social care, public health nursing, access to medical appointments Contact service for children who are looked after	Telephone/video conferencing of known vulnerable families, face to face where risk has been identified – now starting to see more families face to face Small number of vulnerable children attending school	Reported increase in non-accidental injuries (NAI) in children not known to social care Reduction of number of contacts to MASH Increase in complexity of contacts to MASH Particular challenges around NAIs to infants and young people assoc with youth offending Adoption journeys impacted

Current Position: What has changed in response to COVID-19?

0-19 Prevention and Early Help

What has stopped?	What has continued?	What has changed?
School nursing 0-5 Public health nursing (health visiting) routine face to face/home visits	HR1 and HR2 reviews. 3 childrens centre hubs still open. Face to face activities. Telephone/Visionable contacts for mandated contacts plus face to face/home visits for those identified as higher risk families – beginning to bring back more regular face to face visits	Increased use of technology Increased concern around 'hidden children' – children who have not previously had contact with CSC

Current Position: What has changed in response to COVID-19?

Child Health Services (Solent community only)

What has stopped?	What has continued?	What has changed?
Naomi House closed Special School nursing (SSN) - Cedar School largely closed, nurses still in situ where schools are open, e.g. Rosewood	Child protection and LAC medical assessments CPMS health reviews/appointments by telephone Therapies: prioritised safeguarding, dysphagia and postural control SSN at Rosewood School	Videoconferencing for LAC health reviews where possible – going forward. Trialling visionable and digital platforms MDT meetings set up with schools for support for children at home. Team around child. Flexing resource to meet need, e.g. use of ECHSA for respite Increased children's community nursing service to seven days/week – able to provide Home IVs now at weekends

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Assessing the Impact – Possible Metrics?

1. Childrens Social Care and Safeguarding	2. Police and Crime	3. Prevention and Early Intervention	4. CAMHS
• Child Protection Medicals • New Looked after Children (episodes) • New referrals of Children In Need (CiN) • ED paediatric attendance / ED liaison • MASH referrals (based on wkly figures starting on 6 Jan) • No. of new referrals of children aged 13+ where child sexual exploitation (CSE) was a factor • Children's Social Care - Number of contacts received (includes contacts that become referrals)	• Children taken into Police Protection • Neglect crimes reported • New reported incidents of CSE (off line) • New reported crimes of CSE (online) • U18 victims of crime • Children linked to high risk domestic crimes • Missing episodes of persons under 18 • Real time surveillance data on deaths by suicide in CYP	• Early Help Referrals (from MASH) (based on wkly figures starting on 6 Jan) • Number of Single Assessments (SA) completed • Number of Early Help Assessment (EHA) started in the month • Take-up of childhood immunisation • ?any socio-economic data, e.g. new homeless families with children, households with children claiming universal credit	• Number of referrals • Number of contacts • Number awaiting first contact • CYP seen in CAMHs Crisis Care Pathway (during covid only) • Number on waiting list for ADHD assessment • Number on waiting list for ASD assessment

Assessing the Impact – Possible Metrics?

5. Therapies and CCN	6. Emergency Paediatrics	7. Elective Care	8. Vulnerable & Complex Needs
• CCN - Number of Contacts • Paediatric Therapies - Number of Contacts • Paediatric Therapies - Number of Referrals	• Number of Main ED attendances aged <5 yrs and 5-17 yrs • Number of Main ED attendances for mental health aged 11-17yrs • Paediatric medicine non-elective admissions • Number of ED admissions for self harm	• E-referrals children & adolescent services (number of booked appointments) • Outpatient attendances aged 0-17 years old - UHS • Elective episodes 0-17 years old	• Take up of school places • Take up of Respite Rose Rd usage • ?Data on children that do not attend school when lockdown lifts because they or parents are shielding/vulnerable?

Cross-sectional and qualitative research that will be used to assess impact

- SCC People's Panel – gathers intelligence on the opinions and behaviours of Southampton residents (including young people) in relation to covid-19 and to use this intelligence to inform the local response.
- Other Southampton surveys i.e. No Limits CYP survey (currently live)
- University of Southampton MRC study engaging young people in Southampton and the surrounding areas to better understand their experiences and concerns under lock down measures, to identify and develop solutions that support their wellbeing, mental and physical health (PH informing).
- National research

 - University of Bristol - analysing google trends to map mental health concerns related to COVID-19 and the consequences of physical distancing

 -The International COVID-19 Suicide Prevention Research Collaboration and links with the Centre for Suicide Prevention (University of Manchester); the latter providing support to Southampton through the STP Suicide Prevention Programme

 - Young Minds survey

 - MQ/Ipsos MORI surveys

Exacerbation of existing needs and new needs

- Those that already have a MH diagnosis - worsening of symptoms
- Those that are already vulnerable i.e. safeguarding concerns
- Impact of lockdown and social isolation; coping with significant changes to routine, separation from friends, potentially higher use of social media (and implications)
- Bereavement and associated trauma
- Children that are in the “extremely vulnerable” (shielding) or vulnerable group because of underlying health conditions
- Widening educational inequalities
- Those that find transition difficult i.e. For children with disrupted attachment, neuro-diverse children, those with OCD, transition to return to school could be problematic
- Impact of parental stress, behaviours and needs:
  - i.e. parental MH need, drug and alcohol use, domestic violence
  - Impact of loss of parental job and/or income – implications for family stress, unstable housing, child poverty and exacerbation of inequalities

Young Minds survey with 2,111 young people to understand the impact of the pandemic on their mental health and on their ability to access support

32% agreed that it had made their mental health much worse
51% agreed that it had made their mental health a bit worse
9% agreed that it made no difference to their mental health
6% said that their mental health had become a bit better

.

CONCERNS ABOUT FAMILY HEALTH

"I'm constantly worried about my family becoming sick as my mum's high risk."

"It has made my OCD so much worse. I am now washing my hands every five minutes or using hand sanitizer."

"I work in a supermarket so I'm kind of on the front line, I worry about catching it and passing it on to vulnerable family members."

CONCERNS ABOUT SCHOOL AND UNIVERSITY CLOSURES

- Potential loss of contact with friends
- Concerns about how their grades affected and impact on university or career prospects
- Concerns about home learning, both for practical reasons and because of stress related to the pandemic
- Loss of structure
- Loss of formal or informal pastoral support
- Loss of their 'safe' place away from difficult or dangerous home environments

LOSS OF ROUTINE

"I have an eating disorder, and it has brought up so many urges to relapse to take control. I also can't socialise or play sports so it's really hard to stay well."

"All my plans are cancelled, which means I have nothing to look ahead to and you find yourself trapped in a void of your own thoughts."

LOSS OF SOCIAL CONNECTION

"My friends are my lifeline, they help me through so much. Now I can't see them and I don't know who I can go to comfortably to talk to. It's not the same talking on the phone at home with my family around. I'm afraid they'll hear."

"Social distancing is causing me to isolate myself which is bringing back old emotions but there's no way around it as I'm no longer choosing to isolate myself, I have to."

OTHER THEMES FREQUENTLY CITED

- Concern about dangerous or crowded home environment
- Concern about family's finances or about losing their own job
- Anxiety about not being able to buy food, or about no longer getting meals at school
- Young people with ADHD concerned about not being able to go outside as much
- Experiencing racism as a result of the pandemic

Evidence from previous pandemics/epidemics

- Cases of infection in children during the outbreaks of SARS-CoV in 2003 and MERS-CoV in 2012 were characterized by low rates of infection, mild symptoms, and good prognosis.

- Data from the SARS outbreak in mainland China, Hong Kong, and Singapore suggest that school closures did not contribute to the control of the epidemic.

- Past studies of the impact of SARS, MERS, influenza, and Ebola epidemics showed short and long term cognitive and mental health effects on the population.
  - Start new psychiatric symptoms in people without mental illness
  - Aggravate the condition of those with pre-existing mental illness
  - Cause distress to the caregivers of affected individuals
  - Traumatic and sudden loss of loved ones (and without being able to visit at hospital, have funerals in the usual way)
  - Potential increased risk of suicide

- Impact on workforce – mental health and wellbeing

Summary

What has worked well and we should keep?	What are the Concerns/Unintended Consequences we now need to address?
CYP Mental health Crisis Pathway ED – model may need modifying Use of technology for some appointments and contacts – building standards and governance around these Parent training via video learning Flexibility and creative ways of working, agility of staff, rapid mobilisation	Support for CYP and families to return to 'new normal' Staff fatigue Backlog - legacy work - immunisation, therapies, Extended waiting lists across the system Increased levels of anxiety, low mood, bereavement/grief, school refusal in children and young people and their families – exacerbated in CYP with neurodiversity Increase in reported non-accidental injuries in families not currently open to CSC – 'hidden children' Increased malnutrition and rates of obesity Increased health inequalities (due to social, educational, financial inequalities)

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Priorities and Next Steps – for discussion

Short Term (Next 4 -6 weeks)

- Restoration of key services
- Mobilise increased emotional and mental health support offer - anxiety, low mood, bereavement/grief
- Promote and support re-integration to school after lockdown – particularly social, emotional & mental health support but also support to children with SEND/Vulnerabilities
- Identification of "hidden" Safeguarding Risk/vulnerable families
- Mobilise support offer for children in families who are "shielding"
- Suicide prevention plan – YP

Priorities and Next Steps – for discussion

Medium Term (Next 3 -5 months)

- Begin to pick up again key priorities prior to COVID-19:
    - Extended locality model
    - Jigsaw review
    - Phoenix
    - Specialist Resource hub for YP with complex SEMH
    - Youth Justice plan
- Ensure CAMHS crisis pathway can be sustained as other services come back on line
- Year of the Child
- Healthy Child Programme catch up - immunisation

Longer Term (6-12 months)

- Continue to progress key priority areas as identified above

Southampton City Health and Care Strategy

2020-2025

COVID Impact Assessment

Live Well Programme

Content

- Recap of the Live Well Programme prior to COVID-19
- Where are we now? – what has changed in response to COVID-19?
- Assessing the impact of the COVID-19 response
- Summary and key priorities:
  - Short term
  - Medium term
  - Long term

Recap: Live Well Programme

Key Ambitions

(taken directly from the strategy document)

- Increase healthy life expectancy
- Reduce the gap in life expectancy between the most and least deprived areas of the city
- Reduce smoking prevalence in adults
- Reduce the percentage of adults who are physically inactive
- Reduce alcohol-related mortality
- Eliminate all inappropriate out of area mental health placements
- Reduce the rate of suicides
- Increase the percentage of adults with a learning disability living in settled accommodation
- Increase the percentage of cancers being diagnosed at an earlier stage
- Reduce early deaths from cardiovascular disease and respiratory disease
- Increase the number of social prescribing referrals
- Increase the number of people being referred to the national diabetes prevention programme

Original Plan

What we said we were going to do (taken from the strategy):

Reducing inequalities and confronting deprivation

- **Population health management systems** will enable health and care staff to identify people most at risk of ill health and identify areas of the city where health inequalities are greatest – this will ensure that resources can be targeted at people with the greatest need.
- Improve **access to appointments in general practice**, such as evening and weekend appointments, and longer appointments for people with multiple long term health conditions.
- Improve **uptake of cancer screening** in areas of the city with the lowest uptake rates, and focus on vulnerable groups. Undertake community engagement to raise the profile of cancer screening.
- Improve **uptake of immunisations and vaccinations** in areas of the city with the lowest uptake rates, and focus on vulnerable groups.
- For people with a **learning disability or severe mental illness**, improve the uptake of annual health checks and cancer screening.
- Improve access to advice, treatment and support to anyone concerned by their, or someone else's, use of **drugs or alcohol** to help them overcome the impact and improve their lives.
- Ensure access to services that improve **sexual health** outcomes for everyone.
- Reduce the number of **rough sleepers**.
- Explore different ways to **help those sleeping on the streets** and those who are homeless to access a range of service and accommodation options.
- Reduce the **health inequalities of the homeless population** through increased access to healthcare and accommodation.

Original Plan

What we said we were going to do (taken from the strategy):

Tackling the city's biggest killers

- Implement a new **smoking cessation** offer and deliver the city's tobacco control plan.
- All **patients at hospital will be asked if they smoke** and all smokers are offered support and advice to quit.
- Support patients to **improve their health before undergoing major surgery**, to help them recover better, such as by being more active.
- Implement the city's **physical activity and sports strategy**, including active places, active communities and active every day.
- Improve people's awareness of and understanding of the health risks associated with drinking too much **alcohol**.
- Increase the number of people successfully completing treatment and not re-presenting for **alcohol, opiates and non-opiates**.
- Continued **Alcohol care team** support at University Hospital Southampton, supported by community substance use disorder services.
- Promote **'making every contact count',** where all health and care staff, when the opportunity arises, have a brief conversation with an individual to encourage changes in their behaviour that have a positive effect on their health and wellbeing.
- Embed **prevention of risk factors** including smoking, alcohol, obesity and physical activity in all health and care pathways so that all patients will receive a brief intervention or be signposted to appropriate support.
- Increase coverage and effectiveness of **cancer screening** services, including:
- Increasing the uptake of Faecal Immunochemical Testing (FIT), helping to **detect colorectal cancer as quickly as possible.**
- Implementing the Targeted Lung Health Check programme to **detect lung cancer** in 55–74 year olds at an earlier stage.
- Implementing the **cancer Faster Diagnosis Standard**, resulting in patients receiving either a positive or negative diagnosis of cancer within 28 days.
- Implement **cardiovascular disease prevention and detection** programmes within primary care, including increasing the number of people at risk of stroke on anti-coagulation drugs.
- Expand **Cardio-Pulmonary Rehabilitation** to increase the number of patients being offered and accessing rehabilitation.
- Expansion of **community respiratory services** to improve earlier diagnosis, management and treatment of all respiratory disorders.
- Increase **diabetes risk detection** and the number of people offered and completing the Diabetes Prevention Programme and Structured Education Programmes
- Ensure that the refresh of the council's Local Plan (the plan for the future development of the city) supports health and wellbeing, including **green city and healthy environments.**

Original Plan

What we said we were going to do (taken from the strategy):

Improving mental and emotional wellbeing

- Implement “The Lighthouse” – a new community based facility that will support individuals in a recovery-focused way to manage their **mental health crisis**.
- Increase access to specialist community **perinatal mental health services** with extended periods of care from pre-conception to 24 months after birth.
- Improve access to **psychological therapy**, including expanding psychological therapy and wellbeing support for people with a **long term health condition.**
- Implement national guidance to improve outcomes for **people with co-occurring mental health and substance use conditions**, through the development and implementation of a strategic plan.
- Develop the **attention deficit hyperactivity disorder (ADHD)** pathway to provide integrated support for those with frequently occurring mental health co-morbidities and substance use conditions.
- Improve the uptake of **physical health checks** for people with SMI.
- Deliver a new model of **integrated primary and community care** for adults with serious mental illness (SMI).
- Increase access to Individual placement support (IPS) to **support people with SMI to find employment**.
- Improve 24/7 community based **crisis response and intensive home treatment service** to help prevent people being unnecessarily admitted into hospital.
- Inform and support the implementation of the **Suicide Prevention Plan** and the Hampshire and Isle of Wight STP Suicide Prevention programme, which includes action on self-harm, primary care, bereavement services and workplace health.
- Increased access to mental health services for **rough sleepers**.
- City-wide tackling of **mental health anti-stigma**, through communications, campaigns and events, and through supporting the Time to Change partnership.

Original Plan

What we said we were going to do (taken from the strategy):

Supporting people to build resilient communities and live independently

- Build opportunities, through volunteering and So Linked, to **help more people to access support and activities in the community**.
- Promote relationships between GP practices and voluntary and community groups to increase **social prescribing**.
- Maximise the use of **care technology**, to support people to self-manage their conditions and live independently.
- Link people up to support already available in their own families and communities.
- Ensure that **carers** have the help and support they need.
- Provide **short term, tailored social care** support to keep people independent in their own homes.
- Support younger generations to **prepare for older age**.
- **City of Culture** – improve overall wellbeing through cultural development and opportunities.
- Support adults to live independently through appropriate and accessible **housing options** with varying levels of flexible support.
- Work with people to **plan ahead** so they can prevent problems from getting worse and stay independent, reducing the likelihood of needing long term social care.
- Enable more individuals with **learning disabilities** to access community resources, volunteering, employment or other meaningful activities.
- Ensure **housing for people with learning disabilities** it is fit for future needs.
- Explore opportunities to apply for **Disabled Facilities Grants (DFG) for supported living housing adaptations** which will enable people with learning disabilities to live more independently, including improving fire safety.

Original Plan

What we said we were going to do (taken from the strategy):

Improving earlier help, care and support

- Develop easy access to **advice and information**.
- Ensure that **carers** feel supported and receive the help they need.
- Implement **e-consultations and video consultations** into all GP practices.
- Commission an increased range of health services from community **pharmacies**.
- **NHS 111 is the main gateway** used by patients to urgent care.
- Develop **clinical assessment within NHS 111** to include a wide range of clinical expertise so more people get the help and advice they need on a single call.
- Communication and education for patients and communities on **'choose well' and 'stay well',** to enable patients and carers to make informed decisions about the services they choose.

Improving joined-up, whole-person care

- Implement new models of **person-centred care for people with long term conditions**, such as longer appointments with a named GP or alternative clinician.
- Improve IT systems interoperability across GP practices to **improve access to information and patient records** to support assessment.
- Ensuring people have more **choice and control** about their care, such as making personal health budgets available to a greater range of people.
- Implement **personalised care for everyone diagnosed with cancer** to ensure they have a needs assessment, a care plan, wellbeing information and support.

Original Roadmap for Years 1 and 2

What we said we were going to do (taken from the strategy):

Year 1 2020/21

- **Lung Health Checks** fully implemented to increase the early detection and survivorship of lung cancer
- Patients will be able to receive a **definitive cancer diagnosis** within 28 days of referral
- **Cervical screening** implemented at more flexible timings
- Community **Cardiology and Respiratory** service developed
- Psychological therapy support available for people with cardiovascular or gastrointestinal conditions
- Development of an **Integrated Diabetes Service** that will be measured on improving outcomes for patients living with diabetes
- Introduce risk stratification to identify individuals with a **learning disability** who have the greatest need
- Expand portfolio of **housing options** for those with a learning disability/mental health need
- Implement "**The Lighthouse**" community based facility to support those experiencing a mental health crisis
- Pilot a complex nurse worker in **Homeless Healthcare** to work with people with complex needs, including mental health
- Review best practice models for mental health services accessed by **rough sleepers**

Year 2 2021/22

- New Southampton **Alcohol** Strategy launched
- All patients have access to **on-line and video consultations** for their GP surgery
- Every person diagnosed with cancer will have access **to personalised care**, including a care plan and health and wellbeing information and support
- **Follow-up support** for people who are worried their cancer may have recurred will be in place
- New **heart failure** and breathlessness services developed
- People with a **mental health** condition will be able to access digitally-enabled therapy
- **Therapeutic care** from inpatient mental health services will be improved
- Produce a proposal for an effective mental health pathway for **rough sleepers** to access integrated holistic, long term care and support

Where are we now?

Current Position: What has changed in response to COVID-19?

Prevention

	What has stopped?	What has continued?	What has changed?
Smoking	• Local stop smoking support on hold. • Some elements of the agreed recommendations of the city's new smoking cessation offer are delayed due to Covid 19 e.g. embedded stop smoking service in Mental Health Services, Drug and Alcohol Services, Learning Disability services. • Developing Smoking cessation (SC) pilots in Maternity, MH and Sub misuse services	• Commissioning for the Specialist Stop Smoking Service	• Temporary, emergency Covid 19 contract with UHS for stop smoking support for inpatients and outpatients has been arranged from 1.6.20 until the Lung Health Checks pilot commences or 31.3.21. This will also support maternity services stop smoking provision during Covid 19 • Possibly supporting rough sleepers with stop smoking intervention while in temporary accommodation during Covid 19 TBC • Potential to explore e-cigarette pilot in key settings (hostels/wards) • Some support identified in maternity setting to continue screening and brief interventions.
Alcohol	• TBC	• Plans for a new telephone support offer for Alcohol Brief Interventions through CGL have continued.	• TBC
Obesity & Physical Activity	• TBC	• TBC	• TBC

Current Position: What has changed in response to COVID-19?

Cancer and Long Term Conditions

	What has stopped?	What has continued?	What has changed?
Cancer	• National screening programmes – NHSE, PHE and Wessex Cancer Alliance are developing prioritised approach to restoration of national cancer screening programmes • Lung health check screening programme has been paused • Reduction in patients presenting with symptoms, two week wait referrals and some treatments • Work with primary care to ensure maximum use of Gateway C has been paused due to covid as pathways may have been amended • Work with primary care to ensure maximum use is made of FIT has been paused/ reduced • Macmillan Mobile Team have been off road, but are offering a virtual MISS service	• Essential cancer services. • Cancer surgeries for patients categorised as priority levels 1a, 1b and 2.	• Wessex Cancer Surgical Hub – programme to create process to prioritise and coordinate surgical demand and capacity across Wessex trusts, and set up a physical Cancer Surgical Hub at UHS • Systemic anti-cancer treatments, decisions made on case by case basis with input from MDT about treatment. In some cases, therapies given in alternative regimens, different locations or via other modes. • 28 day pathway has been impacted by covid, in particular in terms of endoscopy • Rapid Diagnostic Centre – plans revised, so for example telephony contact service will be managed from space in UHS not Otterbourne. Plan to go live with service in Poole by end of June • SafeFit national online programme was paused, but is now live on Macmillan's website • New weekly NHS Activity Collection requirement has been launched by NHSE. Information will be collected via Acute Trusts to support better understanding of cancer activity and waiting times locally

Current Position: What has changed in response to COVID-19?

Cancer and Long Term Conditions

	What has stopped?	What has continued?	What has changed?
Cardiovascular Disease Detection & Prevention	• Opportunistic AF detection • NHS Health Checks • Local improvement scheme for AF detection and management. • Working with local Pharmacies to improve blood pressure and AF management and promoting early detection. • Cholesterol improvement scheme in conjunction with HIOW STP.	• INR Star programme to manage patients on anticoagulation. • Ambulatory Blood Pressure Monitoring in Primary Care.	• Familial Hypercholesterolaemia clinics are being delivered digitally. • Reduction in people presenting at primary care and emergency departments with cardiovascular related symptoms
Cardiology & Respiratory Care	• Face to Face contacts in Cardiopulmonary Rehab. • Further integration of Mental Health support for Cardio-Respiratory services.	• Assessments for suitability of patients referred to Cardiopulmonary Rehab. • Our Community Cardiology service has worked hard to ensure patients are still receiving urgent diagnostics and assessment. • Our ICOPD has continued to provide consultant support to patients in most need. • Secondary care consultations for urgent Cardiac and Respiratory patients. • Urgent assessments for rapid access chest pain. • Improved access to advice and guidance across Cardiology/Respiratory Care. • Primary Care Medicine Management reviews by Clinical Pharmacists.	• Our providers have worked to improve digital and remote options for patients referred for Cardiopulmonary rehab including video consultations and digital options. • Our providers have worked to prioritise patient need by implementing a RAG rating system. • ICOPD service has provided welfare calls to the most at risk patients. • Cardio-Respiratory consultants can now connect with patients via telephone or video consultation. • Our Heart Failure teams have now moved further out into the community to provide urgent review through a combination of virtual review and home visits • Improving access to Cardiology-Respiratory diagnostics in the community via Secondary care outreach.

Current Position: What has changed in response to COVID-19?

Cancer and Long Term Conditions

	What has stopped?	What has continued?	What has changed?
Diabetes Prevention	• Primary Care have been unable to continue to refer sufficient numbers of patients into the programme during the Covid-19 Pandemic. • The delivery of the face to face service was temporarily paused from 18th March and remote delivery (to replace face to face) was started on 30th March.	• The digital delivery option for new referrals has continued- no pausing of this service. • Catering for Priority Groups: BAME populations: BAME bi-lingual educator continues to deliver some sessions. Deprived communities and working age: sessions during the day and out of hours continue.	• A remote delivery model (video conferencing to a group of patients, mirroring the face to face service) was commenced on 30th March 2020. This is available for new referrals and for existing patients who had started the face to face service. • Patients have the option to pause their journey- new referrals and existing patients who had started the face to face service. • Face to face delivery has not resumed. • Working age and deprived communities are catered for using current remote delivery model and digital option (if refuse remote) E.g., no travel difficulties. • Due to reduced phlebotomy Referrals can now be made for HbA1C and Fasting Glucose done up to 24 months earlier rather than 12 months from the date of referral. This will continue until April 2021.
Diabetes Service	• Some annual health checks • Face to Face structured education • Service Integration work	• Blood tests-limited capacity • Phone contact with patients • Online links sent to patients for structured education. • Review of patients at risk of DKA due to COVID-19 and actively managing them with sick day rules and escalating treatment.	• New virtual/video consultations • Adaptations for shielded patients • More home visits using practice nurses • More patients using technology. • Remote initiation of Insulin and GLP-1 [both injectibles] • Re-initiation of Local Improvement- Virtual review of 3 treatment targets [HbA1C, BP, Cholesterol] and escalating treatment. • Review of Type 2 diabetes mellitus (T2DM) at risk of hospitalisation and mortality due to Heart Failure and initiating medication (SGLT2i) • Risk stratification of T2DM and actively managing their risks with optimal use of HCP and remote reviews of patients.

Current Position: What has changed in response to COVID-19?

Mental and emotional wellbeing

What has stopped?

- Community face to face assessments and interventions stopped unless a clinical risk indicates this is required
- Development of maternity outreach clinics have been postponed until further notice
- Non urgent referrals for memory assessment are being added to waiting list
- Severe Mental Illness (SMI) comprehensive annual physical health checks in primary care
- Recovery college ceased courses as no virtual means of delivering course materials
- Individual placement support (IPS) moved to telephone support, and more support/advice provided for job retention
- IAPT LTC cardiovascular disease pathway development work stopped, and planning for gastroenterology on hold
- IAPT procurement, CCG board approval 20 May to direct award (commercially sensitive, PIN to be published)

What has continued?

- Admissions to acute in-patient services remains unchanged with access via usual gatekeeping protocols
- Acute mental health team (AMHT) continue with face to face assessment and interventions
- Community mental health teams (CMHT)
- Early Intervention in Psychosis - receiving treatment within 2 weeks
- Access to clinics to provide anti-psychotic medication depots and physical healthcare monitoring
- Access to bed based mental health rehabilitation remains unchanged, variable rehabilitation taking place due to compliance with national COVID guidance
- IAPT working at normal capacity

What has changed?

- CMHT replaced face to face assessments and interventions with use of telephone and digital platforms
- Psychology replaced face to face assessments and interventions with use of telephone and digital platforms
- Exploring opportunities for GP collaboration reducing risk related to multiple health professionals involvement to minimise COVID-19 risk
- IAPT increased number of psycho-educational online webinars offered
- IAPT increased the number of interactive online groups as an alternative to face to face treatment option
- In response to COVID-19 IAPT have developed a Coping with COVID Anxiety Webinar to provide early intervention
- Positive impact on use of out of area beds as a result of focussed discharge due to COVID
- Mental health liaison pathway changes, following triage model on site at UHS, individuals with . no physical health need who require full liaison assessment conveyed to alternative site
- Recovery college developing materials for virtual course delivery
- Solent Mind virtual offer for existing commissioned peer support; alternative online, text and telephone provision
- Commissioned Big White Wall (online courses, peer support with clinical moderation of site with risk flags) across HIoW ICS
- Mobilise Lighthouse to virtual working 4pm-midnight 7 days per week
- Individual placement support (IPS) moved to telephone support, and more support/advice provided for job retention
- NHS 111 online platform added to existing telephone offer enabling increased access to the 24/7 Mental Health Triage Service

Current Position: What has changed in response to COVID-19?

Learning Disabilities & Autism

What has stopped?

- Life Skills support has temporarily stopped. This was supporting individuals with LD to access community resources, volunteering and employment opportunities.
- Reduction in those people traveling independently (mainly bus networks)
- Work to review the local autism strategy is currently on hold.

What has continued?

- Housing development for people with LD has continued as there will still be a need for housing options in the future.
- Access to respite for adults with learning disabilities and their carers is still available at Weston Court and Rose Road.

What has changed?

- There continues to be a focus on LD annual health checks taking place however the health check will need to be adapted and there is current exploration of a blended approach that supports virtual/digital methods. This is currently being considered both nationally and the TCP/commissioners.
- Risk stratification to identify individuals with the highest level of need was fast tracked by the integrated LD team so that every individual known to the team was contacted and a risk assessment completed in relation to Covid-19 as well as any other urgent risks.
- LD day services have stopped almost all building based provision and moved to supporting people over the phone, online or in a small number of cases in person.

Current Position: What has changed in response to COVID-19?

Vulnerable Adults

	What has stopped?	What has continued?	What has changed?
Sex workers	• Developing options paper around support /services to sex workers • Face to face access to sexual health services (online limitations)	• Sex worker activity	• New women turning to sex work during financial difficulties. • Sex workers reported to be taking increased risks to continue working (more risky clients)
Domestic & social abuse victims	• Face to face	• Access to support services	• More online and telephone provision • Increased demand on support services
Rough sleepers	• ICU work on housing initiatives and schemes • Regional work around housing supply for MH clients. • Expand portfolio of housing options for those with a learning disability/mental health need • Pilot a complex nurse worker in Homeless Healthcare to work with people with complex needs, including mental health • Review best practice models for mental health services accessed by rough sleepers • Producing a proposal for an effective mental health pathway for rough sleepers to access integrated holistic, long term care and support	• Challenges with MH services making appropriate referrals (new property made new opportunity but hard to get referrals) • Daily contact and support from HHC to homeless setting	• More coordinated approach to single adult HRS allocations • Regional work around housing supply for homeless (new) • Having commissioner and housing leads in same conversation (regionally) • More coordinated approach to single adult HRS allocations • Daily combined homeless and HRS panels • Regional work around housing supply for homeless (new)

Current Position: What has changed in response to COVID-19?

Sexual Health

What has stopped?	What has continued?	What has changed?
• Implementing sexual health improvement plan and governance group being set up. • Significant number of face to face appointments • Review of services and future commissioning plans	• Critical service delivery	• Use of online, telephone and postal services • Increased use of postal, digital and telephone approaches

Assessing the impact of COVID

Assessing the Impact

Possible metrics	
Smoking, Alcohol, Obesity & Physical Activity	• Smoking prevalence deprivation SII (%)
Cancer	• Emergency presentations (%) • Two week wait (%) • 62 day standard (%) • Patient experience (%) • Bowel screening coverage (%) and uptake (%) • Breast screening coverage (%) and uptake (%) • Cervical screening coverage (%) • Early stage diagnoses (%), proportion of cancers diagnosed at stage 1 or 2 • 28 day faster diagnosis standard (%)
Cardiology & Respiratory	• A&E attendances for Breathlessness. • Non elective admissions and re-admissions for Stroke, COPD, Asthma, Cardiac related disorders. • RTT for Outpatient Cardio-Respiratory services including community services. • Number of patients receiving Advice and Guidance in Cardiology and Respiratory services. • Numbers of patients receiving Cardiopulmonary rehab (broken down by face to face vs virtual). • Numbers of deaths per month for non-COVID related Cardio-Respiratory disorders. • Numbers of patients admitted with COVID and Cardio-Respiratory related co-morbidity. • Referrals to Cardio-Respiratory services. • Consider undertaking patient engagement to understand the impact of covid on symptoms, the use of services and the impact that the new ways of working has had on their experience of services
Diabetes	• Three Treatment Targets-improving the 3 TT [BP, HbA1C, Cholesterol] and reducing long term Cardiovascular and Renal complications.

Assessing the Impact

Possible metrics	
Mental & emotional wellbeing	• Consider measurement of impact on quality, safety and patient experience (will need to link quality team into this) • Number/% of staff in services/teams who fall into high risk group and impact on services ability to achieve BAU • IAPT number of referrals, access by demographic, waiting times, recovery • IAPT changes to historical trends by presenting need , i.e. depression, anxiety, bereavement, stress, OCD • IAPT-LTC number of referrals, access by demographic, waiting times, recovery • Service users on a CPA in paid employment • Number of referrals to secondary care • Number of open cases in secondary care • Waiting times for CMHT • Access and waiting times to secondary care psychological therapies • Access and waiting times for liaison psychiatry triage, full assessment nd outcome (ED and ward) • Number of completed intensive home treatment episodes • Community re-referrals within 28 days of discharge, and 6 months of discharge • Number of admissions and discharges to acute in-patient care • Number of admissions within 28 days of discharge • Mental health act assessments and outcomes (S135, S136, admitted S2/S3) • UHS admissions related to self-injury (overdose and self-harm) • Number of suicides • Number and themes of safeguarding referrals
LD	• Number of clients accessing respite and number of nights accessed (monthly record) – would give information about increased carer stress or risk of breakdown (need to clarify as there has been a reduction in usage) • Number of LD deaths that are Covid related (need to clarify measure/benchmark with PH) – needs further discussion • Number of those living in settled accommodation (should slow down but not stop) • Number of those with a 'pause' in work or volunteering (need to ensure we can get the data re this)
Vulnerable adults	• Number of new homeless accommodated • Rise in demand on Domestic & sexual abuse services • Numbers of sex workers increased/ actively selling sex on streets • Number of rough sleepers increase/decrease
Sexual health	• Reduced numbers attending sexual health clinics (known to be sex workers) • Reduced numbers attending sexual health clinics (other vulnerabilities)

Exacerbation of existing needs and new needs

Public Health: What impact will COVID have on people in terms of exacerbating existing needs and new needs?

- **Covid-19 illness and death:** Those with pre-existing and serious conditions are more vulnerable to serious illness and death from covid-19.
  - Of the 33,841 deaths that occurred in March and April 2020 involving COVID-19 in England and Wales, 30,577 (90.4%) had at least one pre-existing condition, while 3,264 (9.6%) had none (ONS).
  - Males had a significantly higher rate of death due to COVID-19; the age-standardised mortality rate (ASMR) for males in England was 781.9 deaths per 100,000 males compared with 439.0 deaths per 100,000 females (ONS).
  - Research is underway to better understand why BMAE groups are over-represented in deaths from covid-19 (likely factors include deprivation, geography at ward level, occupation and that some BMAE groups are at higher risk of some underlying health conditions). See: https://www.ifs.org.uk/inequality/wp-content/uploads/2020/04/Are-some-ethnic-groups-more-vulnerable-to-COVID-19-than-others-V2-IFS-Briefing-Note.pdf

- **Economic wellbeing:** The savings and pensions of adults have and will be affected by the stock markets, which have fallen considerably and are likely to remain volatile for a number of years. It will be particularly difficult for those nearing pension age to recover losses. Young and older adults have been particularly impacted by furloughing and job losses to date. One-third of 18-24-year-old employees (excluding students) have lost jobs or been furloughed, compared to one-in-six prime-age adults, with these experiences also more common among employees in atypical jobs. Similarly, 35% of non-full-time student 18-24-year-old employees are earning less than they did prior to the outbreak, and 30 per cent of those in their early 60s, compared to 23%of 25-49-year-olds. See: https://www.resolutionfoundation.org/publications/young-workers-in-the-coronavirus-crisis/

- **Mental health:** Social distancing and the impacts of lockdown will (for many) exacerbate existing conditions such anxiety and depression, create "new" mental health need. There is a high risk that social distancing may turn into 'social isolation' for those without a strong network of family and friends and a way to connect to others outside the home (known higher risk groups are men and those that live alone). Financial stress, being out of work, and "juggling" work and family life, and sudden loss of loved ones (bereavement) will also be contributing to mental health stress.

- **Physical health:** The lockdown has been positive for many adults physical health (and an opportunity to encourage positive behaviour change, though has been negative for others. Those at higher risk of doing less physical activity are those that are isolated, which can lead to more sedentary behaviours*. Those living in areas of deprivation are likely to consume poorer quality diets and the impact of the pandemic on income and job security is likely to exacerbate the situation leading to both food insecurity and consumption of energy dense diet low in nutrients among those at greatest risk. Poor quality diet is a risk factor for a range of chronic conditions including DM, HT, CVD and some Cancers and is also a risk factor for obesity.

- **Vulnerability:** There is thought to be a high level of "hidden" need in as a result of the pandemic and lockdown measures including domestic violence and abuse and drug and alcohol use. These, with MH needs in parents, will be impacting on the wellbeing of children and young people.

* Kobayashi LC, Steptoe A. Social Isolation, Loneliness, and Health Behaviors at Older Ages: Longitudinal Cohort Study. Ann Behav Med. 2018 May 31;52(7):582–93.
Schrempft S, Jackowska M, Hamer M, Steptoe A. Associations between social isolation, loneliness, and objective physical activity in older men and women. BMC Public Health. 2019.

Exacerbation of existing needs and new needs

Public Health: What impact will COVID have on people in terms of exacerbating existing needs and new needs?

Mental Health Impact of COVID-19 Across Life Course

	Pre-Term	0-5 Years	School Years	Working Age Adults	Old Age
Key issues to consider	• Anxiety about impact of COVID on baby • Financial worries • Anxiety about delivery and access to care • Isolation	• Coping with significant changes to routine • Isolation from friends • Impact of parental stress and coping on child	• School progress and exams • Boredom • Anxiety or depression or other MH problems • Isolation from friends • Impact of parental stress	• Balancing work and home • Being out of work • Carer Stress • Anxiety about measures and family or dependents or children • Financial Worry • Isolation	• Isolation and disruption of routine • Anxiety from dependent on services • Financial worry • Fear about impact of COVID if infected
Staff/ Vols	Cumulative load of stress from significant changes. Traumatic incidents. Isolation from work colleagues. Having to manage working from home. Potential bullying from or to others as part of not coping				
Loss	**Loss of loved ones dying may be particularly severe and grieving disrupted because of inability to do normal grieving rites eg as be physically close to dying person, have usual funeral rites, attend funeral etc**				
Specific Issues	**Impact of delayed diagnoses and treatment (eg chronic conditions,surgery, people living in pain).** Suicide and self harm risk for most at risk populations. Members of faith communities may feel disconnected during closure of premises. Domestic abuse may be issues across lifecourse. Drug and Alcohol issues .People reliant on foodbanks or on low incomes or self employed may have additional stress.				

Exacerbation of existing needs and new needs

What impact will COVID have on people in terms of exacerbating existing needs and new needs?	
Smoking, Alcohol, Obesity & Physical Activity	• TBC
Cancer	• There has been a reduction/pausing of screening programmes, which will lead to a backlog and patients not receiving screening in line with pre-covid programme timescales • It is expected that we will see an increase of patients who require treatment but may not actively seek out treatment until they are severely symptomatic. • It is also expected that there will be a reduction in the number of patients attending appointments for investigations/assessments and for treatments. This is being seen in a reduction of two week wait referrals. In addition, some patients who are shielding have been unable to attend planned appointments. • The above factors will lead to an increase in the number of later stage admissions. This may impact negatively on survival rates, and it is expected that we will see an increase in mortality from cancer. • We may see an exacerbation of mental health needs from these patients which will further increase patients anxiety about their condition, this may lead to an increase in 999 calls and patients requiring support from mental health services. • We will need to ensure a proactive approach to patient care for those who are at risk.
Cardiology & respiratory	• It is expected that we will see an increase of patients who require treatment but may not actively seek out treatment until they are severely symptomatic. This will lead to an increase in the number of NEL admissions for all Cardio-Respiratory disorders. We may see an exacerbation of mental health needs from these patients which will further increase patients anxiety about their condition, this may lead to an increase in 999 calls and patients requiring support from mental health services. • It is expected that we will see an increase in all cause mortality from Respiratory and Cardiovascular disease disorders. • We may also need to support patients who have had serious infections COVID-19 with Rehabilitation programmes to help them return to normal life. • We will need to ensure a proactive approach to patient care for those who are at risk of disease exacerbation.
Diabetes	• TBC

Exacerbation of existing needs and new needs

What impact will COVID have on people in terms of exacerbating existing needs and new needs?	

Mental & emotional wellbeing	• Demand for mental health services and support will increase, assessment to quantify this demand is being completed at a regional level
	• Increased demand needs to be considered across the mental illness spectrum of need, ranging from common mental illness through to serious mental illness:
	    • Covid supressed demand
	    • Covid generated demand
	    • Assessing impact of covid altered interventions

LD	• TBC
Vulnerable adults	• Research is showing an increase in domestic abuse calls to national helplines (although reduced demand on Hampshire police) – could result in increased need for support/refuge/perpetrator programme capacity • Rough sleepers: If accommodation sourced for all those accommodated through the Everyone In scheme, then significant improvement in health and other determinants for a vulnerable population group • Still to see what the impact of changes to services will have on some of the vulnerable groups who lack access to phone, online or postal services. (sex workers, homeless, hidden populations)

Summary

What's worked well and what concerns do we now have?

	What has worked well during COVID and we should keep?	What are the concerns/unintended consequences we now need to address?
Smoking, alcohol, obesity & physical activity		Smoking • Delay in commissioning services results in lost funding – need prompt procurement of SSC service • Rapid roll out of pilots • Lost opportunities during Covid 19 (and focus on respiratory concerns by individuals) • Loss of short term funding (PH grant)
Cancer	• Development of process to prioritise and coordinate surgical demand and capacity across Wessex Trusts – Wessex Cancer Surgical Hub programme. Creation of standardised prioritisation framework, urgency/selection criteria and data flows. Ability to manage referrals and patients re-allocation across trusts according to capacity.	• Pausing of cancer screening programmes • Reduction in patients seeking treatment due to concerns about infection • Impact of shielding requirements • Need to ensure a proactive approach to restarting screening programmes, along with communications/ other campaigns to encourage people to attend appointments • Need to plan for virtual launch of lung health check programme • Need to increase take up of FIT in primary care, ensure maximum use of Gateway C, review/ continue work on Rapid Diagnostic Centre, address impacts to 28 day pathway
Diabetes	• Virtual consultations • Complex MDTs • Webinars • Podiatry Voluntary Service[not established yet] • Remote use of Structured Education. • Remote Initiation of Insulin.	• No eye screening • Patients not being reviewed • Patients not actively seeking help • Higher risk of complications from COVID and higher risk of mortality due to COVID in poorly controlled Diabetes patients. • Medication Compliance may get affected due to cessation of medication reviews. • Increase in obesity due to inactivity and poor diet. • Worsening of mental health due to isolation. • Increased risk of complications – like cardiovascular events, foot ulcers, amputations due to poor diabetes control and delayed seeking of help or delayed referral.

What’s worked well and what concerns do we now have?

	What has worked well during COVID and we should keep?	What are the concerns/unintended consequences we now need to address?
Cardiology & Respiratory	• Currently we do not know the medium to long term implications of the changes that have been made. • Patients have had wider access to digital or remote methods of care. • Improved community reach of secondary care services and joined up working across providers. • Proactive RAG rating of patients	Cardiovascular Disease • Reduced opportunistic detection of AF, leading to less patients diagnosed which may lead to an increase in the number of strokes. • Reduced opportunistic detection of Hypertension leading to less patients being diagnosed and managed appropriately. This may lead to increase in the number of patients having a Cardiac related event. Cardiology • Secondary care services are focusing on a high risk urgent patients, this may lead to long term increase in Cardiac events due to delayed follow up. • Secondary care services are now working out in the community which may lead to duplication with our Community Cardiology services. • The number of patients undergoing Cardiac Rehab has reduced. This will lead to an increased number of re-admissions for Cardiac related disorders. Respiratory • Reduction in numbers of patients being diagnosed with new Respiratory disorders. This may lead to an increased disease exacerbations. • Reduced number of patients going through Pulmonary rehab. This will lead to an increase in admissions/ re-admissions for respiratory disease. • We still do not have Asthma, Respiratory Physiotherapy and General Respiratory care in the Community. • Medicines management may now become an issue for patients requiring reviews as practices may not have seen patients face to face. • Patients may not actively seek care due to increased risk/shielding. • We must address the potential long term implications of Covid. • We must address the potential long term increased all cause mortality due to changes in prevention programmes such as smoking and CVD.

What’s worked well and what concerns do we now have?

	What has worked well during COVID and we should keep?	What are the concerns/unintended consequences we now need to address?
Mental health & emotional wellbeing	• Use of technology within services to undertake assessments and interventions when risk assessment indicates it is clinically safe • Lighthouse move to virtual model with citywide reach • Joint working across organisations to escalate and unblock issues as they arise • Releasing capacity in acute in-patient settings • Support discharge planning with daily funding decisions being made and daily HRS/hostel allocations being made • Big White Wall commissioned • Staff flexibility and use of redeployment to safely provide critical services	• To ensure standardisation and governance in place for virtual platforms • To consider service user experience • To consider outcomes/recovery impact on service user for changes made • Staff fatigue for front line staff • Impact of isolated and new working, understand training/education needs • Higher acuity of presentations • Higher acuity and risk being managed in the community, skills and confidence of staff • Presentation of individuals not previously known to services and/or discharged many years ago • Potential increase in suicides • Poorer physical health for a population who already experience greater health inequalities • Ability to diagnose new cases of dementia
LD	• Closer joint working with providers, including day services adapting their services to support remote delivery of some services • Increased use of adapted/easy read communication for people with learning disabilities and/or autism • Increased use of reasonable adjustments in health setttings (anecdotal evidence) • Increase in social media forums to support people with learning disabilities and/or autism e.g. UHS Facebook group, Southampton Mencap daily Fbk blog • SHFT LD Team undertaking Zoom training sessions for social care providers • Hospital passports now available on CHIE	• Potential for some individuals to have missed their annual health checks or cancer screening during lockdown (evidence is AHCs achieved 54% for 19/20, a reduction from 18/19) • Individuals not accessing usual day services or had support from the life skills team may have lost some of the skills they have learnt • Carer stress and fatigue, resulting in increased mental health needs and/or potential breakdown

What's worked well and what concerns do we now have?

	What has worked well during COVID and we should keep?	What are the concerns/unintended consequences we now need to address?

Vulnerable adults	• Sex workers have featured in forums about vulnerable adults
	• Domestic and sexual abuse Online & telephone support
	• Rough Sleepers
	    • Regional collaborative looking at housing with RSLs
	    • Having commissioner and housing leads in same conversation (regionally)
	    • Move of high % of homeless into accommodation has included a large number of those with MH needs
	    • Having a dedicated health team around homeless services worked well.
		• With no leads for sex workers the strategic & commissioning focus is reduced/ lost
		• Increased demand on domestic and sexual abuse services
		• Rough sleepers
		    • Allocation of accom. May not prioritise most appropriate, rather those in most temporary accommodation.
		    • Loss of oversight of housing pathways for vulnerable adults in city
		    • Loss of commissioners alongside housing leads
		    • More homeless if no other accom sourced
		    • Lost focus on complex needs (worker and sessions)
		    • MH pathways for rough sleepers to access long term care and support

Sexual health	• Online, telephone and postal services (as a strong component of service delivery) • Move to postal, online and telephone working	• Vulnerable groups have not been accessing services. Need to review data and target resources in R&R plan • Delivery of Sexual Health delivery plan • Lost contact with some vulnerable groups (sex workers, M2M)

Priorities and next steps

Short Term (next 4-6 weeks)	
Smoking, alcohol, obesity & physical activity	Smoking • Scope procurements options • Clarify budgets and allocations 2020/21 and 2021/22
Cancer	• Maintain essential cancer surgery and treatment, in line with national guidance. Exceptions made where clinicians consider that for an individual patient the risk of the procedure at the current time outweighs the benefit to the patient. • Continue to identify ring-fenced diagnostic and surgical capacity for cancer, with providers protecting and delivering surgery and treatment, including via work on Wessex Cancer Surgical Hub, and by making use of IS hospital and diagnostics capacity for cancer. • Focus on activity to bring referrals, diagnostics and treatment back to pre-pandemic levels at the earliest opportunity to minimise potential harm, and reduce the scale of the post-pandemic surge in demand. • Take action to encourage new two-week wait referrals and ensure provision of two week wait outpatient and diagnostic appointments at pre-COVID levels in protected environments. Provide support to primary care to identify and refer patients to cancer services, including by encouraging take up of FIT tests, re-starting lung health check programme, work on Rapid Diagnostic Centre. • Work with system partners to restore cancer screening programmes.
Cardiology & Respiratory	• Support secondary care to prioritise capacity for acute Cardiac surgery, Cardiology services for PCI and PPCI and interventional Neuroradiology for mechanical Thrombectomy. • Support secondary care to prioritise urgent Arrhythmia services plus management of severe Heart Failure and severe valve disease. • Support primary care to identify and refer patients to Cardiac and Stroke services. • Work with system partners to prioritise capacity for Stroke services - admission to hyper acute and acute Stroke units, Stroke Thrombolysis and mechanical Thrombectomy. • Work to increase urgent outpatient and diagnostic appointments - including direct access diagnostics to pre-covid19 levels. • Maximise our COPD & Asthma Pharmacist review project in primary care to pro-actively review patients who are at a medium to high risk of admission.
Diabetes	• Ensure Primary Care is aware of the changes to the Diabetes Prevention Programme • Encourage GP practices to sign up to the Diabetes LIS and actively improve the 3TT. • Risk stratification of diabetes patients for ongoing review. • Encourage remote initiation of injectables- support from Community Diabetes Team. • Refer to mental health services if risk of depression/self harm. • Use of Blood ketone meters in an unwell patient living with Diabetes, re-iteration of sick day rules in Type 1 and Type 2 patients. • Encourage participation in Webinars, Complex MDTs, Foot training- Offered by Specialist Team. • Able to identify and encourage referral of Type 1 patients who are poorly controlled to reduce risk of mortality with COVID-19, to Diabetes

Priorities and next steps

Short Term (next 4-6 weeks)

Mental Health & Emotional Wellbeing	• Work with partners to review mental health, emotional wellbeing, and suicide prevention during the covid-19 response and recovery recommendations that have been extracted from Local Resilience Forum; initial suggestions for a plan; approach, needs and opportunities, and actions for recovery workstreams May 2020 v4 • Once lead identified, work with partners across ICS to assess mental health surge/increase in demand • Work with all partners to understand impact of current social distancing guidance on restoration of non-critical services • Mobilise increased IAPT offer in line with investment/access expectations • IAPT-LTC confirm cardiovascular disease and gastroenterology pathway development approach for 20/21 • IAPT agree timescales for impact of COVID-19 (national webinars) to be reflected within local service offers • Identify options for progressing SMI physical annual health checks in primary care • Suicide prevention and bereavement support, STP wide suicide prevention innovation fund, initially focussed on development of scheme to be offered
LD	• With TCP/SHIP colleagues, introduce adapted process for GPs to complete LD annual health checks • Agree with day services what their service offer is whilst not operating a buildings based service. In partnership with Public Health colleagues, undertake a Covid risk assessment to support the commissioning position of day services usage. • Commence conversation with public health regarding how to apply risk assessment approach to life skills (employment) offer for people with learning disabilities
Vulnerable adults	Sex workers • Complete paper for DSA group and wider audiences as part of R&R planning Domestic and Sexual abuse • Support services to bid for funding to support new demand (short term). • R&R planning to commence Homeless • Loss of university / B&B accommodation • R&R planning to commence
Sexual Health	• R&R planning with SH services • Identify vulnerable groups to be targeted when face to face services resume.

Priorities and next steps

Medium Term (next 3-5 months)	
Smoking, alcohol, obesity & physical activity	• Use pandemic as an opportunity to promote sustained behaviour change in relation to physical activity, mindfulness smoking etc. • Promote MECC. Smoking cessation • Pilots reviewed and training provided to workforce • Specialists recruited in pilot settings • Scope e-cigarette pilot • Procurement option(s) pursued.
Cancer	• Continue to deliver cancer surgery and treatment, in line with national guidance. • Continue work on Wessex Cancer Surgical Hub, developing programme including physical hub, and evaluating medium-term plans/opportunities arising from this programme. • Continue activity to bring referrals, diagnostics and treatment back to pre-pandemic levels to minimise potential harm, and reduce the scale of the post-pandemic surge in demand. • Continue activity to encourage new two-week wait referrals and ensure provision of two week wait outpatient and diagnostic appointments at pre-Covid levels. Continue work on FIT testing and Rapid Diagnostic Centre • Continue work with system partners to restore cancer screening programmes, including formal (virtual) 'launch' of lung health check programme in August 2020. • Work with primary care to ensure maximum use is made of Gateway C. • Ensure 28 day pathway is fully operational at the earliest opportunity, addressing impacts of covid, e.g. on endoscopy
Cardiology & Respiratory	• Develop and embed a "new normal" for Cardio-Pulmonary Rehabilitation. • Restart Lung Function Testing. • Deliver and embed digital reviews as a first line, where clinically appropriate. • Continue further integration of IAPT within Cardio-respiratory services. • Support the roll out of CVD prevent by NHS E which will help to identify patients who are at high risk of a cardiovascular incident. • Continue to support Secondary care services to restart essential outpatient care whilst supporting the transformation of outpatients with new and innovative care models. • Understand the long term impact of COVID-19 on Cardio-Respiratory services as we may see an increase of the number of patients with Heart Failure, Acute Kidney Injury or a potential increase in long term use of Oxygen therapy.

Priorities and next steps

Medium Term (next 3-5 months)	
Diabetes	• Continue working towards an Integrated Diabetes Service • Improve service provided to Type 1 patients as there is now as Type 1 Specialist Nurse assigned during the pilot. • Encourage GPs and Nurses to build a good working relationship with the specialist team for flow of patients • Possible working at PCN level to improve outcomes. • Reducing Foot complications. • Reducing admissions and mortality due to heart failure.
Mental Health & Emotional Wellbeing	• Begin to pick up key priorities to implement Mental Health Matters (MHM) and the combined Five Year Forward View for Mental Health (FYFVMH) and Long Term Plan (LTP) for Mental Health commitments to improve local services and meet national targets. • These workstreams may be impacted by LTP national guidance, Mental Health Investment Standard, and contact negotiation decisions with providers that have been suspended until October. • Perinatal mental health NHSE funding evaluation and changes as proposed in LTP to expand PMHT capabilities • Adult SMI community care, explore opportunities and develop models for accelerated integration through PCN development bringing together primary care, IAPT, secondary care mental health services and voluntary sector • SMI physical annual health checks in primary care model of delivery in place • Secondary care and IAPT collaboration to jointly deliver "step 3.5" therapeutic 8 week course/brief intervention • Individual placement support (IPS) understand impact of COVID-19 on service model in the context of forecast recession and unemployment. Understand the Impact of any changes to "centre of excellence" assessment, and ability to achieve status by March 2021 • Therapeutic acute mental health in-patient care • Crisis resolution and home treatment (CRHT) service development improvement plan following completion of self-assessment against CRHTT CORE fidelity criteria • The Lighthouse consider changes to agreed 6 month evaluation criteria as a result of move to virtual offer • Bereavement support (and linking with the STP suicide prevention programme as this is a key priority area for that programme). • Support good communications across the system in promoting mental health and wellbeing, access to services, reducing stigma and sensitive approaches to media handling of suicide and suicidal behaviour • Leadership and championing across the system to reduce stigmatisation of mental ill health • Build the skills and confidence of the workforce through training and access to resources in identifying and managing poor mental health or crises, signposting to support

Priorities and next steps

Medium Term (next 3-5 months)	
LD	• Complete SHFT (LD health team and Intensive Support Team) review work. Agree specification and implementation plan • Explore further how to make best use of CHIE for city services that support the learning disabilities and/or autism community
Vulnerable adults	Sex workers • Options paper considered by DSA and wider forums • Domestic and Sexual abuse • R&R planning continues and changes start to be implemented Homeless • Loss of university / B&B accommodation. Move on options pursued. • Reinstate original focus fro complex needs – sessions & staff • Review best practice model for MH among rough sleepers • R&R planning continues and changes start to be implemented
Sexual health	• R&R planning continues and changes start to be implemented • Sexual health improvement plan updated and governance group established • Targeted face to face work with vulnerable groups prioritised.

Priorities and next steps

Long Term (6-12 months)	
Smoking, alcohol, obesity & physical activity	Smoking cessation • Secure new specialist SSC service • Provision of smoking cessation offer in MH, Substance misuse and maternity settings • Smoking cessation work within Lunch health check pilot reinstated.

Cancer	• Develop a Cancer service that meets the future needs of Southampton, including activity to:
	  • Promote awareness and take up of cancer screening programmes, including lung health checks, FIT
	  • Ensuring every person diagnosed with cancer has access to more personalised care
	  • Work with PCNs to help practices understand their cancer data and understand what they need to do to achieve earlier diagnoses; reduce referral variation between practices
	  • Work with communities where health inequalities are the greatest
	  • Ensuring information and pathways meet the needs of all communities, including for people with English as a second language and learning disabilities
	• Work with partners on behaviour change campaigns, e.g. smoking cessation.

Cardiology and Respiratory	• We will develop a community Cardiology and Respiratory service that meets the future needs of Southampton. • We will work with our PCN's to support the development of Direct Access Diagnostics for Cardio-respiratory disorders. • We will work to restart Cardiovascular disease and Smoking prevention programmes. • We will Work to embed a Population Health Management approach to Cardio-Respiratory care.
Diabetes	• Implement Integrated diabetes service • Reduce complications like-renal, cardiovascular, amputations • Working closely with primary care and easy flow of patients between services. • Working at PCN level with practices using each others skills in managing patients living with Diabetes.

Priorities and next steps

Long Term (6-12 months)	
Mental Health & Emotional Wellbeing	• Begin to pick up key priorities to implement Mental Health Matters (MHM) and the combined Five Year Forward View for Mental Health (FYFVMH) and Long Term Plan (LTP) for Mental Health commitments to improve local services and meet national targets. • These workstreams may be impacted by LTP national guidance, Mental Health Investment Standard, and contact negotiation decisions with providers that have been suspended until October. • STP led rehabilitation and reablement work co-production • Personality disorder models and pathway development with secondary care • Housing for people with SMI, complete housing needs assessment and publish market position statement • Rough sleeping mental health support mapping, gap analysis and research best practice models, to include trauma-informed approach to integrated working • Core mental health liaison services co-location and developed of single integrated team
LD	• Commence Autism Strategy review
Vulnerable Adults	Sex workers • Outcome of options paper taken forward is appropriate Domestic and Sexual abuse • R&R planning continues and changes implemented, encompassing more online and telephone support • Service review commenced Homeless • Finalise move on options for those in Covid temporary accommodation. • Service review of all HRS and inform commissioning – inclusion of MH long stay accom. • Review learning from RSI schemes and complex sessions/worker to inform future commissioning plans
Sexual Health	• R&R planning continues and changes implemented • Service review commenced and informs future commissioning intentions • Sexual health improvement group convened with action plan agreed

Southampton City Health and Care Strategy

2020-2025

COVID Impact Assessment

Age Well Programme

Content

- Recap of the Age Well Programme prior to COVID-19
- Where are we now? – what has changed in response to COVID-19?
- Assessing the impact of the COVID-19 response
- Summary and key priorities:
    - Short term
    - Medium term
    - Long term

Recap: Age Well Programme

Key Ambitions

(taken directly from the strategy document)

- Increase the number of older people with a **personalised care and support plan**
- Reduce the number of older people being referred for **adult social care**
- Reduce the rate of **emergency hospital admissions**, including readmissions
- Reduce the rate of older people having **discharge delays from hospital** (delayed transfers of care)
- Increase the percentage of older **people receiving reablement care after hospital discharge**
- Reduce permanent **inappropriate admissions into residential care**
- Increase the number of **carers having a carer assessment and receiving appropriate support**
- Increase access for older people with a common mental illness to **psychological therapies**
- Increase the number of **volunteers** supported to find a volunteering opportunity
- Reduce the percentage of older people reporting that they feel **lonely**

Original Plan

What we said we were going to do (taken from the strategy):

Reducing inequalities and confronting deprivation

- Develop **community based support and activities** across the city.
- Development of integrated **community transport** services to reduce isolation and improve engagement in community activities
- Work as a city to provide **good quality housing and warm homes**.
- Improve **access to appointments in general practice**, such as longer appointments for people with multiple long term health conditions.

Tackling the city's biggest killers

- Promote **healthy ageing**, including healthy eating, physical activity, smoking cessation and reducing alcohol consumption.
- Ensure that the **design of our neighbourhoods** positively influences physical activity levels, travel patterns, and social connectivity
- Support **self-management** to maintain active and healthy ageing in both physical and mental health.

Original Plan

What we said we were going to do (taken from the strategy):

Improving mental and emotional wellbeing

- Tackle **loneliness** by creating opportunities for connection and encouraging people to participate and get involved, such as through volunteering, developing communities and neighbourhood support and promoting opportunities for creative intergenerational approaches and activities.
- Increase public education to reduce the risk of **dementia** and further develop dementia friendly communities.
- Improve earlier diagnosis of **dementia** and ensure people receive appropriate support and education.
- Improve support for **carers**.
- Improve access for older people to **psychological therapies** in steps to wellbeing and specialist services.
- The **Older Person's Mental Health team will work more effectively with the Dementia crisis team** to prevent or delay admissions and support family and carers at home.
- Improve mental health **support to care homes and nursing homes**.

Supporting people to build resilient communities and live independently

- Expand and make best use of **retirement and Extra Care housing** to support people's independence.
- Develop **a community transport service** to make it easier for older people to get around the city.
- Increase the proportion of people being offered and receiving **rehabilitation and reablement care** to support recovery and help people maintain their independence.
- Promote use of **equipment, care technology and assistive technology** to support people's independence.
- Develop a broad offer of **community based support and activities** that enable more people to both access and be part of delivering support and activities in their local community, building on older people's opportunities for volunteering, peer support, being experts by experience.
- Ensure **carers** feel supported and receive the care they need.
- Simplify and streamline **'hospital to home' pathways** to ensure timely discharge from hospital and maximise opportunities for reablement.

Original Plan

What we said we were going to do (taken from the strategy):

Improving earlier help, care and support

- Develop a work programme to encourage and support local employers to promote employee health and wellbeing, **support employees to prepare for retirement and to be age friendly employers**.
- Promote **phased retirement and volunteering opportunities**.
- Empower **people approaching older age** to make positive choices for their health.
- Develop and promote an **exercise offer** across the city to promote physical activity and active ageing.
- Implement **enhanced healthcare support into to all residential and nursing homes** in Southampton, providing dedicated clinical support to homes with assessment and care planning, responsive advice and support.
- Implement **risk stratification approaches and anticipatory care planning** to promote proactive care.

Improving joined-up, whole-person care

- Develop **local health and social care teams** which bring together physical and mental health, NHS, housing and social care across statutory and non-statutory sectors, to provide coordinated, person-centred proactive care and support for people.
- Promote **integrated care planning and sharing of information** across health and social care to support high quality, proactive, joined-up care and support.
- Continue to **build high quality capacity within the community**, in particular home care and nursing home provision.
- Develop **multiagency services at the hospital front door**, enabling more people to be supported to return home quicker (same day emergency care).
- Develop **services available seven days a week**.

Original Roadmap for Years 1 and 2

What we said we were going to do (taken from the strategy):

Year 1
2020/21

- **Integrated community teams** bringing together physical, mental health services and social care across beginning to operate
- **Enhanced healthcare teams** supporting all residential and nursing homes across the city
- **Community navigators** (social prescribers) in place across Primary Care
- **Exercise classes** in place for people at risk of falling
- More **dementia friendly spaces** in place
- **Extra Care housing scheme at Potters Court** opens
- **Risk stratification** being rolled out to tackle inequalities and case manage people with the greatest needs
- Multiagency services at the **hospital front door**

Year 2
2021/22

- Integrated **community transport service** in place
- **Care technology** support becoming the norm in enabling people to maintain their independence
- Health and care professionals using **single care plans** enabled through technology
- Single **intermediate care team** operating across hospital, community & primary care

Where are we now?

Current Position: What has changed in response to COVID-19?

Tackling the city's biggest killers

What has stopped?	What has continued?	What has changed?
• Smoking cessation support within community pharmacies as a result of social distancing requirements • Specific focused work on promoting physical activity for older people • Supported self management which focuses upon staying healthy and active	• Developing a train the trainer style approach to support smoking cessation.	• Development underway of an alcohol brief intervention telephone line which will be available to all age groups

Current Position: What has changed in response to COVID-19?

Reducing inequalities and confronting deprivation

What has stopped?	What has continued?	What has changed?
• Community Based Support Activities/Services which are delivered in a group setting e.g. Southampton Living Well and falls exercise classes. • Development of an integrated community transport plan has paused.	• Community transport service to support discharge from hospital • Housing related support offer continues – with focus on remote working to support social distancing.	• Regular contact with clients who would normally be in receipt of services in a group setting e.g. HV for high risk SLW clients • Review of service offer underway for group settings to support social distancing and/or self isolation. • Primary care delivery adjusted to meet Covid-19 guidance – Hot and Cold sites and management shielded patients.

Current Position: What has changed in response to COVID-19?

Improving mental and emotional wellbeing

What has stopped?	What has continued?	What has changed?
• Pause in the dementia friendly city work which the Alzheimer's Society are leading • EHCH team contributing to dementia diagnosis work in care homes • Reduction in memory service offer – focusing their work on the most vulnerable in its place • Scanning for Dementia diagnosis	• Community Navigation service through SO:Linked. Promoting access, through new approaches, to support which will help with isolation. • Dementia Friendly volunteers discussion on opportunities DF work in their communities • CCG IAPT increased access funding secured for 20/21 • IAPT Teams working at normal capacity, referral to assessment currently completed in 24 hours • OPMH in-reach nurses working across the city supporting care/residential homes with dementia	• OPMH services are currently reviewing Royal College of Psychiatry best practice and evidence base to inform restoration plans • Confirm access to UHS scanning and understand impact of attending scan on the higher risk group • Review GP coding (for dementia) where a formal diagnosis is not made as scanning not taking place • Increase in online offer with the IAPT service – Webinars – including Coping with COVID Anxiety and online groups • IAPT considering a bespoke bereavement offer to respond to Covid-19 related demand • Improved links and joint working between EHCH and OPMH in-reach nurses and captured on city care and nursing home actin plan

Current Position: What has changed in response to COVID-19?

Supporting people to build resilient communities and live independently

What has stopped?

- Additional extra care provision and nursing home on RSH site has paused
- Potters court development paused – short delay as a result.
- Plans to increase the number of people receiving low level reablement – i.e. step up into level 3 care rather than step down from level 4.
- Review delayed (Foundations) - Plans to align processes and activity related to DFG, Equipment, handy person Scheme, care technology and low level reablement.
- Face to face contact with carers

What has continued?

- Implementation of the newly commissioned Joint Equipment Service.
- Promoting extra care as an alternative to other care environments
- Access to rehab and reablement – numbers increase over the past year.
- Admiral Nursing Service remains in place providing telephone contact/support for carers

What has changed?

- Simplification of hospital discharge pathways through an integrated community hub
- Carers in Southampton general communication to contacts database signposting to local support available
- Joint work being progressed with SHFT related to carer communications to include signposting to local support available
- Community OPMH services are doing telephone reviews of patients on existing caseloads who have been identified as high risk or at risk of significant deterioration of their mental health

Current Position: What has changed in response to COVID-19?

Improving earlier help, care and support

What has stopped?	What has continued?	What has changed?
• Delayed – PCN taking on the responsibility of the EHCH programme • Delayed – development of exercise offer across the city	• Enhanced care home support services – All care homes • Anticipatory care planning – driven by primary care and the 'shielded list' • Promotion of volunteering opportunities – through community hub and wider community and voluntary sector	• Risk stratification of overall primary care lists – instead shifting to a stronger focus on management of the 'shielded list' • Enhanced Care Home support – with additional elements underdevelopment as part of the Covid-19 response – • All homes covered

Current Position: What has changed in response to COVID-19?

Improving joined-up, whole-person care

What has stopped?	What has continued?	What has changed?
• Delayed - Integrated Care Team Development.	• Providing care and support to the most vulnerable. • Roll out of NHS net to access to care homes and with it access to other services – including support from infection prevention team • Building quality capacity in home care • Commissioning additional capacity and providing support for it's ongoing management • SDEC for the over 80's has continued to operate throughout	• Focus for integrated care – shielded patients • 7 day hospital discharge process implemented through Sembal House Hub. • 7 day response from community services developing at a faster pace • Sharing of information to promote prompt and timely discharge • Building quality capacity – focus on keeping residents safe and supporting providers to plan for greater degrees of complexity

Assessing the impact of COVID

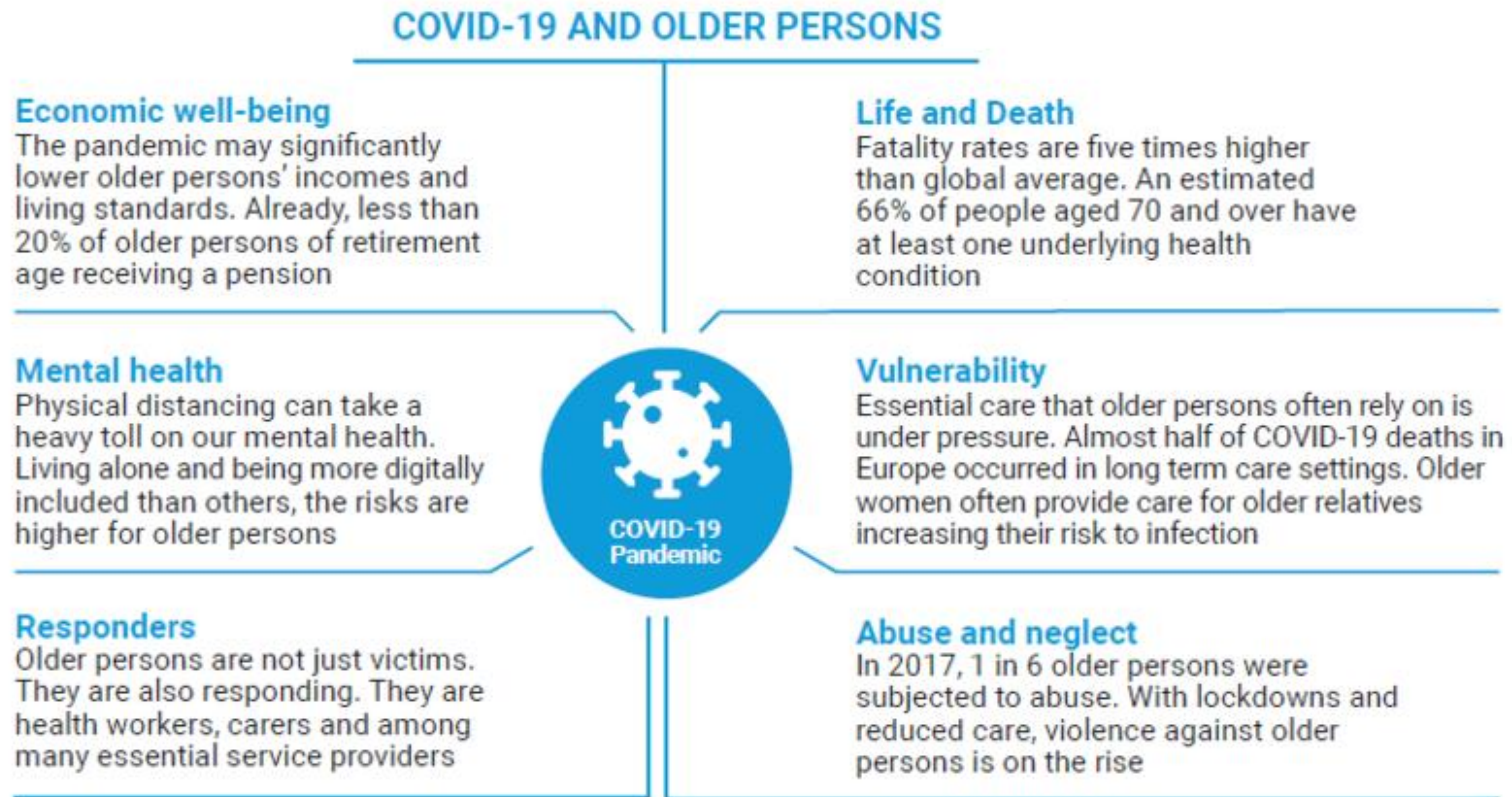
Assessing the Impact

Possible metrics

- Southampton’s rate of falls related admissions, such that it is the same as or less than its comparator areas
- People reporting “the professionals involved in my care talk to each other”
- Long lengths of stay (21 days or more) such that Southampton’s rate is the same as or less than its comparator authorities
- Access to housing with Care
- More people using telecare as a preventative intervention
- An increase in the numbers of good quality Anticipatory Care Plans
- More people accessing local support and activities in their communities
- An increase in community led support / activities available in each locality & an increase in volunteering
- More people feeling in control of their health and wellbeing (“I have the information I need; I am supported to understand and make choices, My independence is valued”)
- Reduction in people self-reporting as lonely; an increase in people feeling involved (“I feel part of my community”)

Exacerbation of existing needs and new needs

Public Health: What impact will COVID have on older people in terms of exacerbating existing needs and new needs?



United Nations Policy Brief: The impact of covid-19 on older people.
See: https://www.un.org/development/desa/ageing/wp-content/uploads/sites/24/2020/05/COVID-Older-persons.pdf

Exacerbation of existing needs and new needs

Public Health: What impact will COVID have on older people in terms of exacerbating existing needs and new needs?

- **Covid-19 illness and death:** Although all age groups are at risk of contracting COVID-19, older people face significant risk of developing severe illness if they contract the disease due to physiological changes that come with ageing and potential underlying health conditions.
  - In April 2020 in England and Wales, 91% of deaths from covid-19 were in people aged 65 years or over (ONS).
  - In April 2020 in England, dementia and Alzheimer disease was the most common main pre-existing condition found among deaths involving COVID-19 and was involved in 6,887 deaths; 20.4% of all deaths involving COVID-19 (ONS).

- **Economic wellbeing:** The savings and pensions of older people have and will be affected by the stock markets, which have fallen considerably and are likely to remain volatile for a number of years.

- **Mental health:** Social distancing and lockdown will (for many) exacerbate existing conditions such as anxiety and depression, create "new" mental health need, and is likely to make life more challenging for those diagnosed with dementia. There is a high risk that social distancing may turn into 'social isolation' for those without a strong network of family and friends and a way to connect to others outside the home, such as digital technology. While the value of online support is emphasised in the Guidelines, nearly half of those 75 years and over do not use or do not have access to the internet (Centre for Better Ageing). Belonging, participation, relationships and networks also important for social wellbeing.

- **Physical health:** As a consequence of self isolation, older people may lack access to nutritious food, basic supplies, money, and medicines to support their physical health and social care. There is also an evidence base which suggests that isolation can lead to more sedentary behaviours and less physical exercise*.

- **Vulnerability:** As well as being clinically more vulnerable to the symptoms of covid-19, older people can also vulnerable from a social perspective; they are more likely to be the victims of scams for example. As with other age groups, they will also be vulnerable to the negative affects of lockdown in relation to domestic violence and abuse and drug and alcohol use. However, there is also a risk that given their "clinically vulnerable status" to covid-19, old age is presented as a condition of frailty and vulnerability, when we want to empower older people.

* Kobayashi LC, Steptoe A. Social Isolation, Loneliness, and Health Behaviors at Older Ages: Longitudinal Cohort Study. Ann Behav Med. 2018 May 31;52(7):582–93.
Schrempft S, Jackowska M, Hamer M, Steptoe A. Associations between social isolation, loneliness, and objective physical activity in older men and women. BMC Public Health. 2019.

Exacerbation of existing needs and new needs

Public Health: What impact will COVID have on people in terms of exacerbating existing needs and new needs?

Mental Health Impact of COVID-19 Across Life Course

	Pre-Term	0-5 Years	School Years	Working Age Adults	Old Age
Key issues to consider	• Anxiety about impact of COVID on baby • Financial worries • Anxiety about delivery and access to care • Isolation	• Coping with significant changes to routine • Isolation from friends • Impact of parental stress and coping on child	• School progress and exams • Boredom • Anxiety or depression or other MH problems • Isolation from friends • Impact of parental stress	• Balancing work and home • Being out of work • Carer Stress • Anxiety about measures and family or dependents or children • Financial Worry • Isolation	• Isolation and disruption of routine • Anxiety from dependent on services • Financial worry • Fear about impact of COVID if infected

Staff/ Vols: Cumulative load of stress from significant changes. Traumatic incidents. Isolation from work colleagues. Having to manage working from home. Potential bullying from or to others as part of not coping

Loss: **Loss of loved ones dying may be particularly severe and grieving disrupted because of inability to do normal grieving rites eg as be physically close to dying person, have usual funeral rites, attend funeral etc**

Specific Issues: **Impact of delayed diagnoses and treatment (eg chronic conditions,surgery, people living in pain).** Suicide and self harm risk for most at risk populations. Members of faith communities may feel disconnected during closure of premises. Domestic abuse may be issues across lifecourse. Drug and Alcohol issues .People reliant on foodbanks or on low incomes or self employed may have additional stress.

Summary

What’s worked well and what concerns do we now have?

What has worked well during COVID and we should keep?	What are the concerns/unintended consequences we now need to address?

• Development of an integrated pull discharge model
• Collaborative working to support the shielded patients
• Working with Home Care and Care Home providers to understand better their position and seek to provide appropriate support, including –
    • Development of Care Home Support plan
    • Development of support offer to wider social care providers including supported living and home care
• Developing virtual and remote methods of delivering and coordinating care – generating greater flexibility in what is on offer.
• Testing technology to deliver clinical care in different ways.
• Building the community hub collaborative offer between community and voluntary sector and other statutory bodies.
	• Reduction in the face to face offer to our older residents, which will have contributed to isolation
	• Reduction in activities based work for our older residents to protect or shield – impacting functional abilities and with it risk of falls and other illness.
	• Reduction in some services which have been adjusted to reflect the current social distancing guidance and in so doing creating difficulties in delivering the care and support needed in the long term.

Priorities and next steps

Short Term (next 4-6 weeks)

- Utilise **communication** channels to reiterate and promote further information about: symptoms of covid-19, what to do if they become ill with suspected covid-19, care-seeking and what to do or routine medical needs, and where to access support and services. Disseminate information to ensure that older people have clear messages and resources on how to stay physically and mentally healthy during the pandemic.
- **Integrated Care Team development focusing on Shielded Patient list** – bringing together physical, mental health services, social care and community and voluntary sector
    - Work with partners to ensure all those that are extremely clinically vulnerable are considered as part of this work (shielded list)
- Expansion of the functions for **the enhanced healthcare team/service** supporting all residential and nursing homes across the city
- **SL3/Pathway 3 discharge to assess** capacity commissioned and implemented
- Building on the **community hub offer** with the community and voluntary sector and in so doing impacting on loneliness and isolation in the city.
- Strengthen **social inclusion** and solidarity during physical distancing, and promote ways to stay socially connected – and including for those without access to digital platforms.

Priorities and next steps

Medium Term (next 3-5 months)

- **Community navigators** (social prescribers) in place across Primary Care to compliment the SO:Linked offer – where these have not already been developed.
- Building on the **community hub offer** with the community and voluntary sector and in so doing impacting on loneliness and isolation in the city. Promote access to services that provide advice on savings and financial insecurity. Expand participation by older persons, share good practices and harness knowledge and data. Promote online and telephone participation in community/voluntary opportunities to promote social networks and social wellbeing.
- More **dementia friendly** spaces in place
- Further develop **multiagency integrated reactive care**
- Approaches to coordination and care – building on the Covid-19 response develop **new 'virtual' ways of working which support coordination, care delivery and with it integration**.
- **Discharge to assess model** – including 7 day working, closer integration of URS , palliative care and single pull model of delivery (e.g. sembal hub)
- Expand upon the pilot of **care home trusted assessment** – wider range of homes and consider other settings such as Home Care
- Review of the **Disability Facilities Grant** and options development
- Promote and embed **Making Every Contact Count (MECC)** in frontline staff's interactions with older people.
- Continue to promote **positive behaviour change** at a time when people may be more willing to adapt their behaviours.

Priorities and next steps

Long Term (6-12 months)

- **Exercise classes** in place for people at risk of falling
- **Extra Care housing scheme at Potters Court** undergoes final development stages in preparation for opening
- Building on the work undertaken with the shielded patient list**, risk stratification rolled out** to tackle inequalities and case manage people with the greatest needs
- **Single intermediate care team** operating across hospital, community & primary care
- **Care technology** support becoming the norm in many elements of health and care delivery in the city – including care homes links with the health care and promoting independence
  - Expanded use of patient activation and supported self management through technological opportunities
- Roll out of **personalised care and support planning** to services across the spectrum that makes up integrated care
- **Community bed offer and pathway development** – building on the work with these services during the pandemic
- Continue to promote the **wider determinants of health** to promote the health and wellbeing of older people, using the social determinants of health for active ageing as a framework

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Southampton City Health and Care Strategy

2020-2025

COVID Impact Assessment

Die Well Programme

Content

- Recap of the Die Well Programme prior to COVID-19
- Where are we now? – what has changed in response to COVID-19?
- Assessing the impact of the COVID-19 response
- Summary and key priorities:
    - Short term
    - Medium term
    - Long term

Recap: Die Well Programme

Key Ambitions

(taken directly from the strategy document)

- Increase the percentage of people in the last 3 years of life who are registered on a local end of life register
- Increase the percentage of people who have, or are offered, a personal health budget towards end of life (fast-track)
- Reduce the average number of patients per month who die in hospital whilst being delayed to be discharged
- Reduce the percentage of older people who die within 7 days of an emergency hospital admission
- Reduce the percentage of older people who die within 14 days of an emergency hospital admission

Original Plan

What we said we were going to do (taken from the strategy):

Reducing inequalities and confronting deprivation

- Support **more people to achieve their preferred place of care and death**.
- **Equitable provision** of end of life care and services available to all.
- **Develop staff** to support people who are less able to self-advocate their own care, such as people with a learning disability.
- Explore providing **end of life hospice care for children** and a hospice at home service.
- Improve **access to hospice services** including community support, day services and inpatient facilities if or when required.

Improving mental and emotional wellbeing

- **Support people to be clear about what to expect** as they approach and reach the end of their life.
- **Holistic needs assessments** will consider the person's wellbeing, psychological, spiritual and health and social care needs.
- **Carers** will be offered a holistic needs assessment to identify what practical and emotional support can be provided
- **Involving, supporting and caring for all people important to the dying person** is also recognised as a key foundation of good end of life care.
- Launch a new b**ereavement and psychological service.**
- Develop a process to **assess families post bereavement at day 21.**

Original Plan

What we said we were going to do (taken from the strategy):

Supporting people to build resilient communities and live independently

- Offer **Personal Health Budgets (PHBs)** for people in their last 12 weeks of life, to give people more choice and control around their end of life care.
- Develop a strategy to e**ngage and raise public and community awareness** and attitude of death and dying.
- **Volunteers** will be recruited, trained and developed to help support individuals, their families and communities.
- Support and encourage **local communities** to provide compassionate and practical help, pre and post bereavement.
- Engage and involve **local communities** and places of worship in the development and co-design of the local hospice.
- Encourage **schools** to support the development of an end of life programme for schools and colleges.

Improving earlier help, care and support

- **Early identification of people** thought to be within their last three years of life with a focus on older and frailer people and those with life limiting conditions, and those who may not, because of their condition, be able to communicate their end of life wishes in the future.
- All appropriate individuals in a **care home** will be on an end of life register and will have an advanced care plan discussion.
- Regular monitoring of people on the **end of life register** to provide timely intervention when required.
- Implement **proactive, personalised care planning** to support individuals to consider their end of life wishes early on in their illness or frailty.
- Improve **hospital discharge fast-track processes** to enable people at the end of their life to die in their place of choice.
- Improve **responsiveness within the community** to support individuals at the end of life and avoid unnecessary hospital admissions.
- Provide **support to individuals, their families/carers in times of crisis**.
- **24/7 help and support line and rapid, responsive support** for people in their own homes.
- People will have access to **timely pain control** and management of their symptoms.

Original Plan

What we said we were going to do (taken from the strategy):

Improving joined-up, whole-person care

- Develop and implement an effective **out of hospital end of life care coordination service** to allow more people to achieve their preferred place of care and death.
- Train and develop the **workforce within the home care and residential home services** to provide continuity of care.
- Use **Personalised Care and Support Plans, or Advance Care Planning**, to capture end of life care wishes.
- Develop a **workforce** which is confident and competent to discuss and capture end of life wishes.
- Proactive **working partnerships** between the NHS, social care, voluntary sector, charities and local communities.

Original Roadmap for Years 1 and 2

What we said we were going to do (taken from the strategy):

Year 1
2020/21

- **24/7 coordination centre** with access to rapid response 24 hour advice, support and home visits
- Development of **end of life champions**, linking with primary care and communities
- **Bereavement services** expanded
- Review the **provision of access to end of life services** for professionals and the families of children at or approaching end of life

Year 2
2021/22

- **Nurse-led unit in place at Mountbatten Hampshire Hospice**
- **Independent hospice provision** in place for Southampton
- **Everyone in a care home is identified on an end of life register with an advanced care plan in place**
- **End of life training** available to home care staff
- Work with **children's services and families** to design local end of life services for families and children

Where are we now?

Current Position: What has changed in response to COVID-19?

24/7 Coordination Centre

What has stopped?	What has continued?	What has changed?
	• Plans to develop and implement on track including management of NHS Solent PCSW service (contract now with Mountbatten Hampshire).	• 24/7 community hub instigated in response to COVID 19 – this was supported by H&IOW Community Foundation funding • Advice and support provided to stakeholders, including families for those specifically at EOL with COVID • Daily 3pm call • Strong and supportive relationships with GP's and SPCL have been developed in conjunction with Mountbatten and NHS Solent . • Collaborative approach resulting in no delays in the fast-track process, allowing people to be discharged responsibly and timely and prevented hospital admissions/kept people in their own homes, if this was their preferred place of care. • Mechanism for responsive access to EOL medication. • Community data uploaded twice daily to the national Capacity Tracker

Current Position: What has changed in response to COVID-19?

COVID Triage

What has stopped?	What has continued?	What has changed?
		SPCL • Clinical assessment of 111 (0800-2200 7 days per week) that pick up and arrange appointments for patients that are potentially EOL. • Hot Visits - Face to face assessments in the community • EOL primary care support for suspected / positive patients at home including nursing and residential care homes • Daily access to SPCL advice • EOL virtual ward for COVID patients – RAG rated and supported according to clinical need • Treatment Escalation Plans • Collaborative approach to palliative and end of life care with NHS Solent and Mountbatten Hampshire • Verification of Expected Death (VOED) training • Emergency stock of anticipatory care meds

Current Position: What has changed in response to COVID-19?

Bereavement & Psychology Service

What has stopped?	What has continued?	What has changed?
	• Bereavement support has continued to be provided to patients and families known to Mountbatten Hampshire • Recruitment to the team – vacancy for a counsellor; successful appointment commenced 1st April 2020	• 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 • Developed an information leaflet around managing resilience and managing stress (staff) • 24/7 telephone support for internal Mountbatten staff

Nurse-led beds at Mountbatten

What has stopped?	What has continued?	What has changed?
• Nurse led beds – shift to 2021/22, this is because training is now on hold for nurse prescribers due to COVID	• Recruitment of the Consultant nurse and Deputy Director of Nursing – successful appointment, role commences August 2020	• Restricted visiting in line with government guidance • Implementation of PPE and scrubs in line with government guidance

Current Position: What has changed in response to COVID-19?

Independent Hospice Provision

What has stopped?	What has continued?	What has changed?
• COVID 19 has resulted in the Mountbatten Fundraising being unable to implement their legacy and fund raising strategy.	• Rebrand to Mountbatten Hampshire	• Fund rising team working remotely • Profile in local community, greater awareness • Launched Mountbatten Hampshire COVID appeal • Implemented new Mountbatten website

Personalisation

What has stopped?	What has continued?	What has changed?
• Development of offer of PHB for patients eligible for fast-track	• Development of enablement and palliative rehabilitation, this focusses on what matters most to individuals	• Redeployed staff to manage staffing challenges in order to keep personalisation on the agenda • Uploaded an updated version of the Isle of Wight Advance Care Plan onto the Mountbatten website

Education and Training

What has stopped?	What has continued?	What has changed?
• Original end of life training programme	• Mandatory e-learning and social distanced face to face training	• Changes to the EOL training programme for residential and nursing homes • Method of delivery amended • This is scheduled to commence in October 2020 • Training sessions implemented for NHS Solent staff redeployed into end of life care • Virtual learning sessions set up for care homes around end of life care

Assessing the impact of COVID

Assessing the Impact

Possible metrics

- TBC

Exacerbation of existing needs and new needs

What impact will COVID have on people in terms of exacerbating existing needs and new needs?

- Likely to see an increase need for bereavement and psychology services
- People presenting late for diagnosis outside of COVID related illness – a whole cohort of patients have not flagged issues with their GP's
- Social isolation and loneliness

Summary

What's worked well and what concerns do we now have?

What has worked well during COVID and we should keep?	What are the concerns/unintended consequences we now need to address?
• Collaborative approach with Mountbatten, UHS, SPCL, SCCCG CHC and NHS Solent • Daily 3pm call to hold a virtual MDT • Staff flexibility and redeployment • New Fast-track approach	• Demand on psychology and bereavement services • Late diagnosis of diseases

Priorities and next steps

Short Term (next 4-6 weeks)

- Expansion of **bereavement offer** to residential and nursing homes
- Planning for the next period when measures are relaxed, e.g. reopening of day services, visiting arrangements

Medium Term (next 3-5 months)

- **Handover of PCSW service** from NHS Solent to Mountbatten Hampshire
- Commencement of **EOL education training programme** for the care and nursing home sector
- Development of **24/7 Care Coordination centre**
- Commencement of Consultant Nurse/Deputy Director of Nursing to start planning for **nurse-led beds**
- Expanding **bereavement service** provision including development of volunteers

Long Term (6-12 months)

- **Personalisation** – introduction of PHB's for patients eligible for CHC fast-track
- **Nurse led beds** at Mountbatten Hampshire
- **Social prescribing pilot** (this will link to the wider CCG initiative)
- Explore Mountbatten **discharge facilitator** to be based at UHS

DECISION-MAKER:		JOINT COMMISSIONING BOARD		
SUBJECT:		COVID-19: Health and Care services response		
DATE OF DECISION:		18 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 Joint Commissioning 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 response paper	

Documents In Members' Rooms

1.	N/A		
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.	N/A		

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SOUTHAMPTON CITY COUNCIL

NHS Southampton City Clinical Commissioning Group

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.

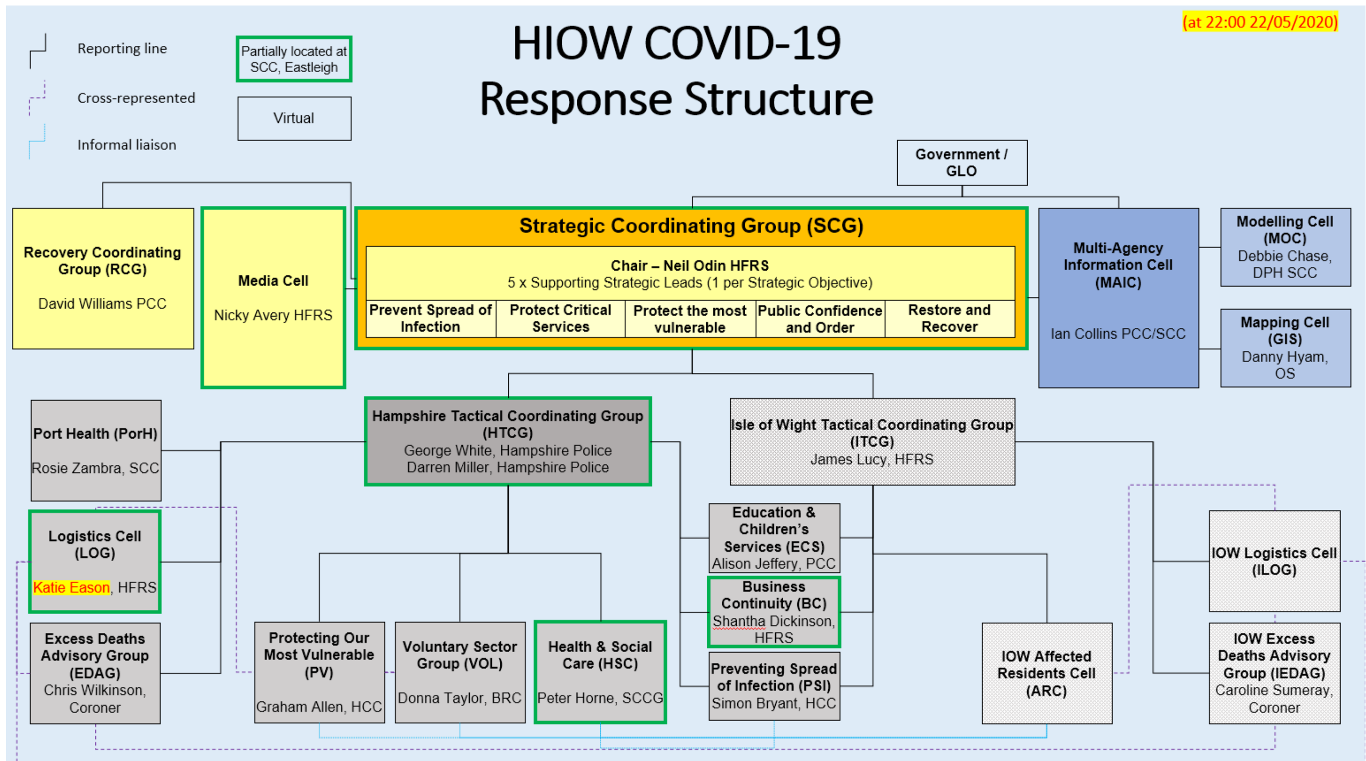
2.3. The Civil Contingencies Act divides local bodies into two categories, with different responsibilities:

- 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.

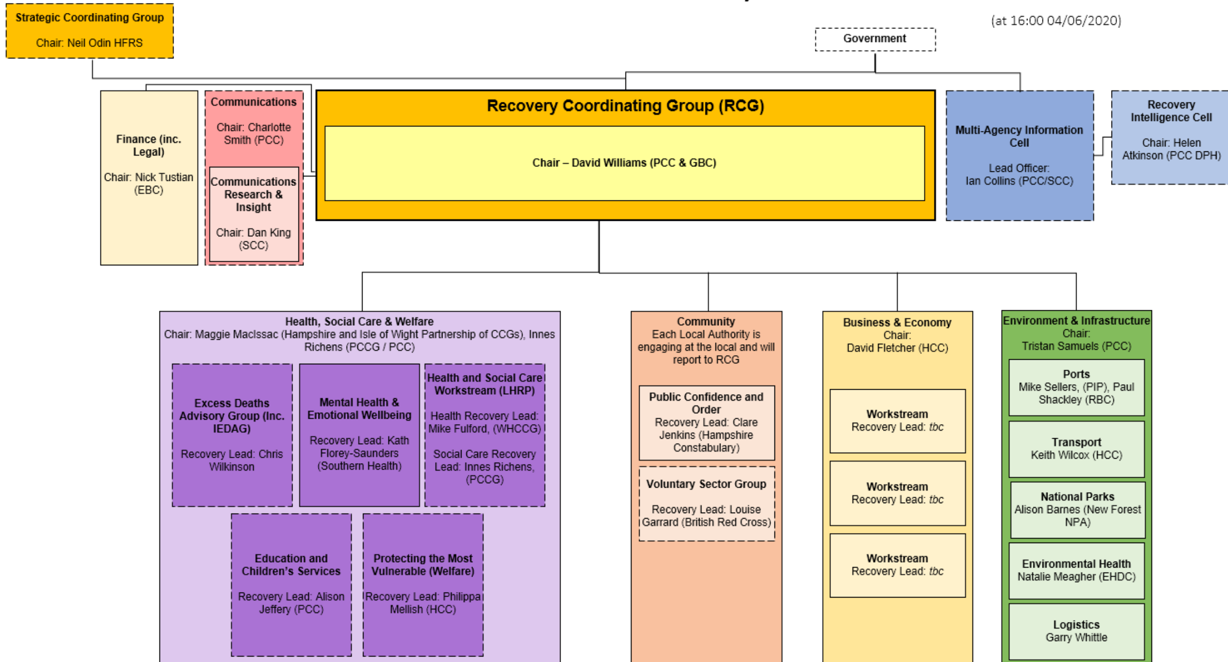
2.11. To ensure that Southampton and South West Hampshire health and care provision is optimised to address the COVID-19 threat, a multi-agency group of senior officer and clinical leaders meet regularly. The purpose is to ensure effective demand and capacity modelling, provide system wide oversight, 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).

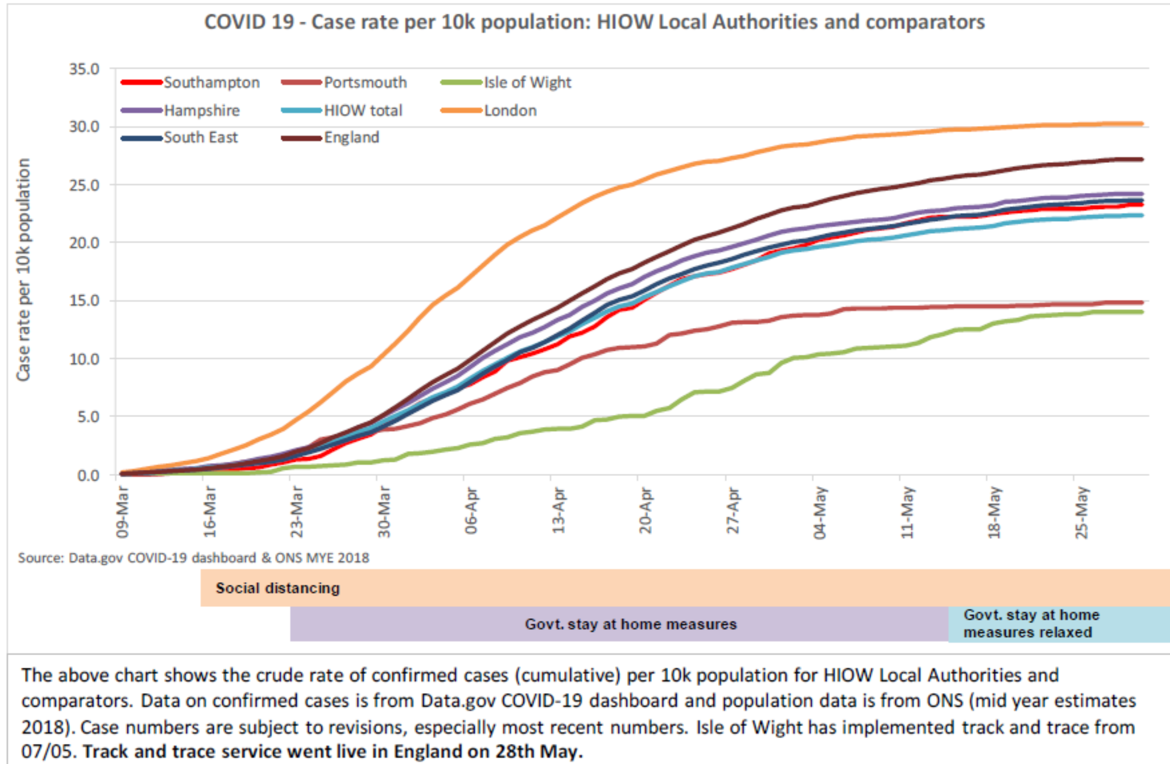
3.7. Key areas of focus going forward include:

- 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).

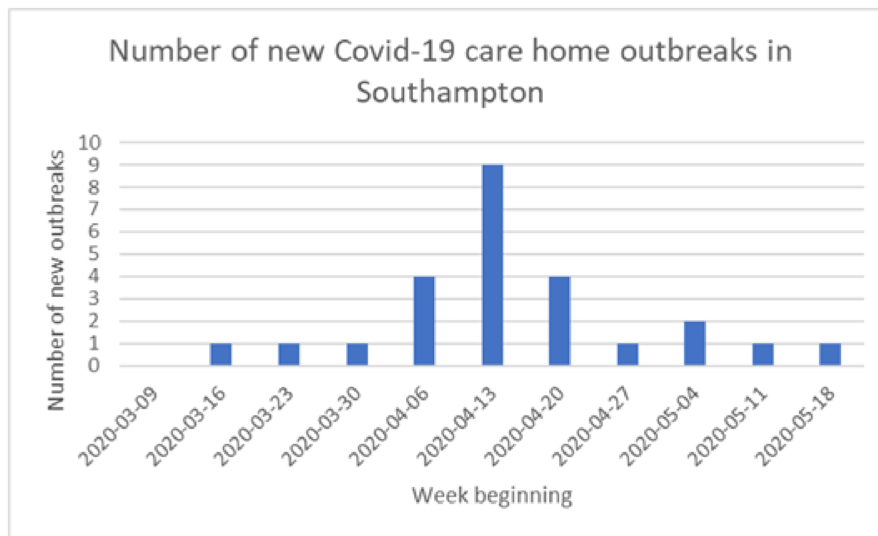


The above chart shows the crude rate of confirmed cases (cumulative) per 10k population for HIOW Local Authorities and comparators. Data on confirmed cases is from Data.gov COVID-19 dashboard and population data is from ONS (mid year estimates 2018). Case numbers are subject to revisions, especially most recent numbers. Isle of Wight has implemented track and trace from 07/05. **Track and trace service went live in England on 28th May.**

4.2 Outbreaks in Care Homes

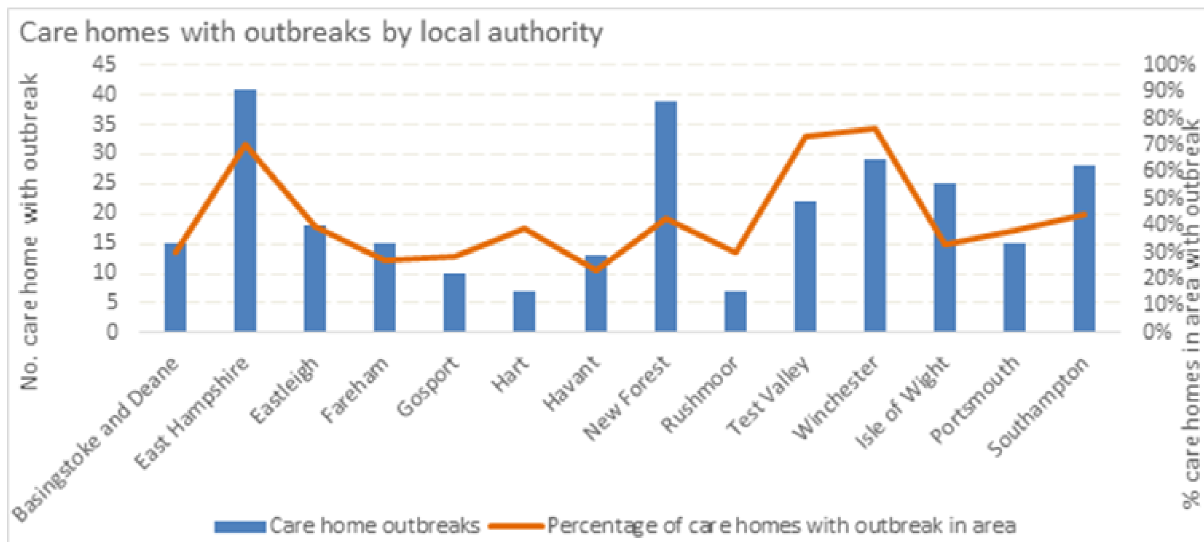
4.2.1 The first notification of an outbreak in a care home in Southampton occurred in the week commencing 16 March 2020. There was then a gradual increase in notification of new outbreaks in care homes in Southampton over subsequent weeks, peaking at nine new care home outbreaks in the week beginning 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

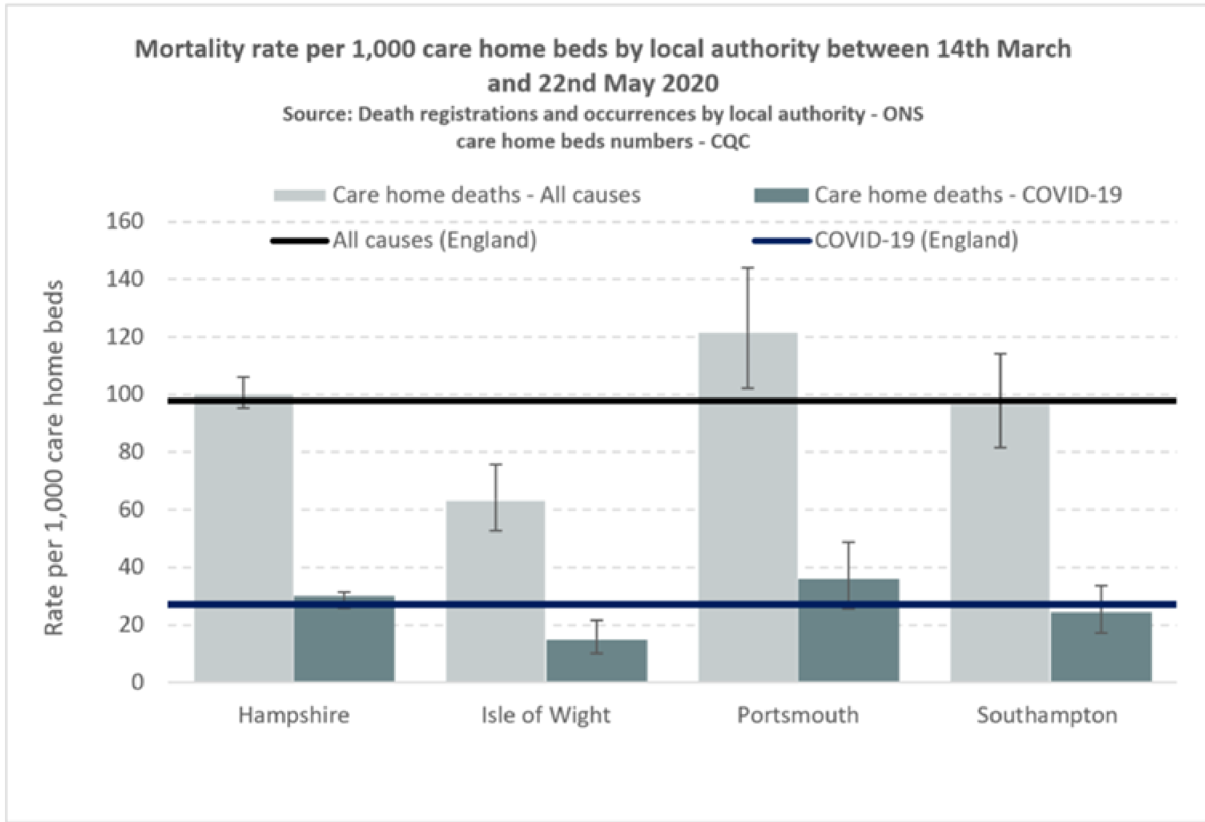
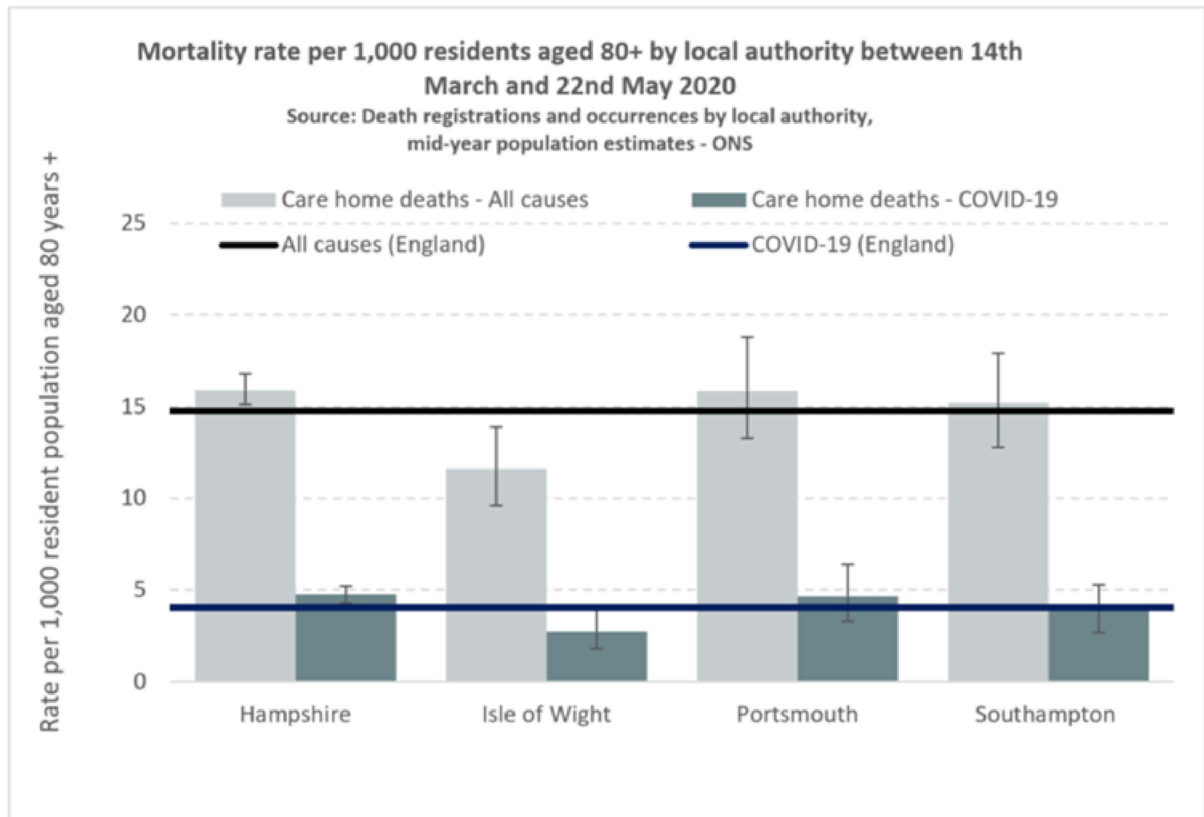


Figure 4: Mortality rate per 1000 care home residents aged 80 years and over



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.

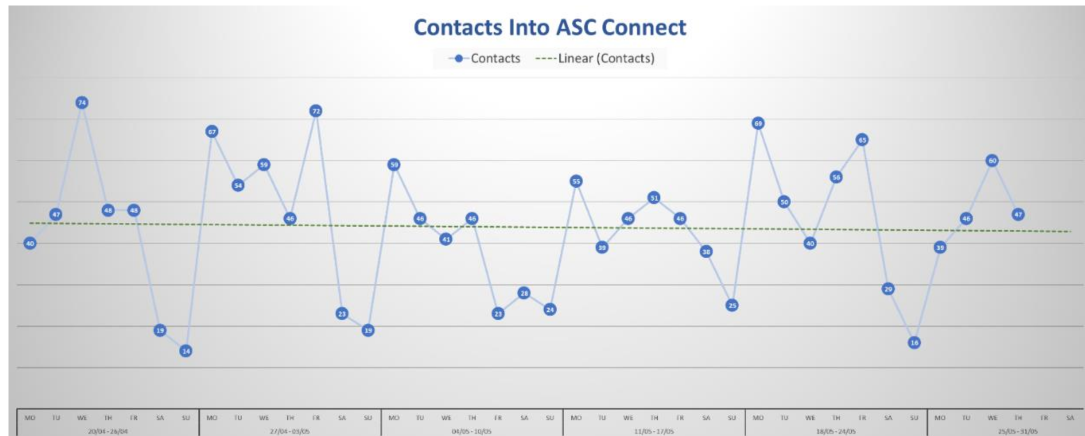
7.2.2. A tracker has been developed to build an evidence base should easements be invoked.

7.3. Adult Social Care Connect and social work teams

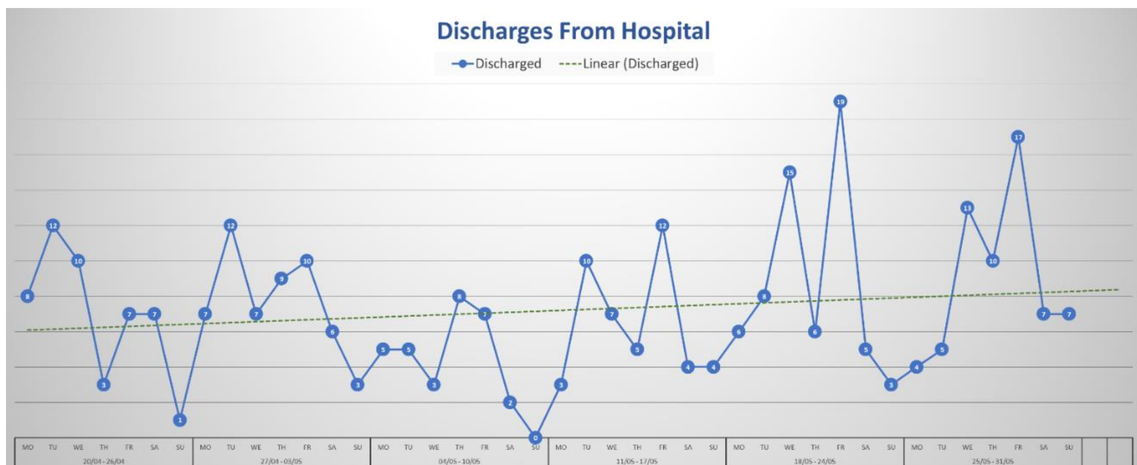
7.3.1. The ongoing demand on the service remains constant with no capacity issues at this stage. Safeguarding levels remain consistent. A focus on understanding levels of risk is ongoing especially as lockdown has now reduced slightly.

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.

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MINUTES

Meeting: **Better Care Southampton Steering Board on 10 February 2020 In the Seminar Room, Oakley Road, Ground Floor**

Present:

Jo Ash (JA)	Chief Executive	SVS
Stephanie Ramsey (SR)	Director of Quality and Integration / Director of Adult Social Services	SCCCG / SCC
Dr Nigel Jones (NJ)	Locality Lead / GP	East Locality
Dr Fraser Malloch (FM)	PCN Clinical Director / GP	Central PCN
Dr Ali Robins (AR)	Director	SPCL
Donna Chapman (DC)	Associate Director System Redesign	SCCCG/SCC
David Noyes (DN)	Chief Operating Officer	Solent NHS Trust
Naz Jones (NazJ)	Locality Lead	East Locality
Sarah Olley (SO)	Director of Operations	SHFT
Andrew Smith (AS)	Business Manager	Solent
Janet Ashby (JAy)	Head of Transformation	SPCL
Phil Aubrey Harris (PAH)	Associate Director of Primary Care	SCCCG

In attendance:

Andrew Gittins (AG)	Senior Administrator	SCCCG

Apologies:

Dr Mark Kelsey (Chair)	SCCG Chair	SCCCG
Sarah Turner (ST)	BCS Programme Lead	BCS
Jane Hayward (JH)	Director of Transformation	UHS
Matt Stevens (MS)	Lay Member	SCCCG
Julia Watts (JW)	Locality Lead	East Locality
Sundeep Benning (SB)	PCN Clinical Director/GP	West End Road
Dr Sara Sealey (SS)	Locality Lead / GP	East Locality
Janine Gladwell (JG)	Senior Transformation Manager /West Locality Lead	Solent

Item	Subject	Action
1.	**Welcome and apologies**	
	DN welcomed everyone to the meeting. Introductions were made and apologies for absence were noted, as above.	

2.	**Declarations of Interest** *A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship*	
	No conflicts of interest were declared.	
3.	**Southampton City 5 Year Health and Care Strategy** • **For BCSB to receive and consider latest version**	
	CY provided an overview of the Southampton 5 Year Health and Care Strategy, noting that the BCSB is responsible for overseeing the strategy. The strategy is being finalised shortly. It has been shared with the System Chiefs Group. The following comments and queries were made by the board: • There was a detailed discussion regarding the distinction between Better Care integration work and the 5 Year Health and Care Strategy. It was explained that Better Care and integration are included in the document, however the strategy is wider and focuses on the high level outcomes. • There has been feedback regarding age well and seeing the ageing population as an asset and representing them more positively. • It was agreed to reflect some more positive messages within the introduction of the document, and include some of the achievements, such as Integration, 0-19 work and Community solutions etc, but also recognise that we want to be more aspirational in the city. • DN noted the changing wider picture with for example STP and ICS.. Are we happy to keep this as a city strategy or should we be looking at it more widely. Generally the principles are the same however the council will be keen to keep as a City strategy. However it is important to be flexible to work with the wider system. It was added that to the public, 'place' is important. • JA advised that there isn't a connection to the Safe cCiy strategy, which incorporates domestic violence and alcohol etc. CY noted that this will be incorporated, especially in the public friendly version of the document. • NazJ suggested strengthening the inclusion of different populations/diversities. **ACTION: CY to circulate final draft for comment. Document to be agreed via individual organisation's governance processes before going**	**CY/ALL**

	through Cabinet and CCG Board in March. It was noted that reporting of achievements and activity data will go through this meeting going forward. **ACTION: DN suggested a refresh of the current implementation milestone plan once strategy has been approved, and include who is delivering the different aspects of the strategy to gain clarity.** There was a brief discussion regarding Behaviour change and it was agreed an update would be brought to a future meeting. **ACTION: Public health to provide an update on behaviour change at a future meeting.**	**CY** **SR/AG**
4.	**Primary Care Networks – Service specifications**	
	Phil Aubrey Harris attended the meeting to give an update on Primary Care networks. The service specifications have now been finalised and have been circulated. Significant investment now being made and major enhancements to additional roles to help secure 26,000 additional staff, including pharmacy technicians, care co-ordinators, health coaches, dietitians, podiatrists and occupational therapists and Mental health professionals from April 2021. Key comments and questions from the presentation are as follows: • SO asked where this work is being discussed and where it is taking place. Are GP practices employing these members of staff themselves? SHFT would like to be involved in discussions. Concerns expressed regarding employing staff from the same limited “pot”, and duplications across the city. • It was noted that employment needs to be within the PCN’s however the network can be city wide. • AR brought attention to the workforce meeting that is already in place which has these types of discussions. SHFT would like to be included in this. It was noted that there will be regular updates from the workforce group to the BCSB. • FM raised that the key to the workforce issues is shared roles, which is stated in the specification. • PAH recognised that the CCG are having the initial conversations with	

	the PCN clinical directors however needs to work more closely with the providers. • From PCN CD perspective NJ explained that CD's need to sit down together and be clear what they want as there are different views, no decisions have been made yet. • FM suggested pulling together a list of the type of roles to be employed and have providers included in them conversations. • **ACTION: PAH volunteered to convene a forum between CCG, PCN's, Providers and CD's** • There was a group discussion regarding Enhanced health in Care Homes (EHCH), and the work that is already in place and the importance of not losing that while the PCNs develop. • PAH summarised and talked through the next steps.	**PAH**
5.	**Integrated Care Teams (ICT)– to agree proposal for a city wide ICT group to define key principles of the model**	
	Moraig Forrest-Charde attended the meeting to give an update on Integrated Locality Care Teams Comments from the board are as follows: • People have different interpretations and definitions of 'Integration'. • The definition of an Integrated Care Team was debated, and the need to identify the level at which each service/capability best sits in terms of 'county wide', 'city wide' and 'locality/PCN wide'. As an example it was discussed regarding having 6 teams that all contain certain staff members such as mental health and social care workers. It was noted that for some services this could be possible but for others could be more of a challenge. • As an infrastructure SHFT are looking at a single point of access which is locality based so depends on where each service sits. • PAH is keen for primary care networks to be more involved in the Integrated Care Teams. • DN explained that the key part is to know and agree what we can deliver at PCN level, and find a way to link other things into the PCN's through a link worker for example. However what does that mean for	

	the PCN's, a management structure, MDT meetings etc? • Co-location was discussed, and making sure we don't duplicate this going forward. The agreed next steps to take this piece of work forward are as follows: 1. **ACTION: Arrange city wide task and finish group to define the key principles in partnership with localities and PCNs as soon as possible.** 2. **ACTION: Bring an update to the Better Care Steering Board, once task and finish group is in place.** The group discussed who would chair/co-chair this meeting going forward. Chris Sanford was suggested as a chair with his knowledge and experience with the Ageing Well group as well as being a PCN CD. The board agreed with this suggestion.	**ST/MFC** **ST/MFC**
6.	**Better Care Steering Board Terms of Reference**	
	The group reviewed the voting rights in the Board's Terms of Reference. It was agreed that each organisation has a vote, including PCN's who will have one nominated vote between them, and the localities will have one nominated vote. It was noted that Dr Mark Kelsey has invited Grainne Siggins, Director of Adult Social Services, from Southampton City Council to attend these meetings going forward. There was a suggestion of possibly having two representatives from the City Council, or possibly to co-opt additional city council staff when topics are relevant. DN to have a further discussion with MK regarding this.	
8.	**Minutes of the Previous Meeting (27.11.19) & Matters Arising**	
	The minutes of the Better Care Southampton Steering Board on 27.11.2019 were approved.	
9.	**RAID Log**	
	Risks and issues noted and RAID log updated. 38 – Transport to have an agenda item at a future meeting 41- Feedback on projects quarterly– Closed, however AG to work with CY and ST to ensure that there is a rota going forward to include regular updates.	**Agenda** **AG/CY/ ST**

	42- Communications strategy- to be reviewed at a future meeting. 44- IT update at the next meeting – MK to provide update on I.T at the March meeting **<u>Risks</u>** STP strategy- remains a risk. Jo Ash requested an update on the STP work taking place at this meeting. **ACTION: STP to provide an update at a future meeting. SR to clarify who would be best to provide that update.** It was agreed that a new risk would be added regarding workforce and managing it in relation to PCN development. Wording to be confirmed.	**Agenda** **Agenda** **SR/ Agenda**
10.	**Any Other Business and items for future meetings**	
	SR updated on the partnership agreement which has been discussed with Legal. She raised the following queries: • Sickness and Maternity for short term posts - It was agreed that if maternity cover is required, all parties would discuss how to take forward. It would not be the sole responsibility of the employing organisation. • Recruitment - if someone leaves post, it is a decision of all parties to reemploy or not. If the decision is to re-employ, then the employing organisation of the post will do this. • Conflicts of Interests to be incorporated. • Statement around premises equipment and support- all parties to make available the necessary premises and equipment to enable post holder to perform duties of role. • Accountability and reporting – even though an overall agreement is in place, each person will have their own accountability and line management etc. (JD) • Grievances – SR to clarify regarding cross indemnity issues, however the group agreed to liability being across all parties. • Secondment Agreements – SR to clarify with Legal as currently the staff isn't on secondment. • Redundancy – This will be paid by all the parties not just the	

	employer. **ACTION: SR to share the updated DRAFT partnership agreement.**	**SR**
11.	Close	
Date of next meeting: Tuesday 3rd March 2020, Seminar Room, NHS Southampton City CCG, Oakley Road, Millbrook, Southampton, SO16 4GX		

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MINUTES

Meeting: **Better Care Southampton Steering Board on 3rd March 2020**
In the Seminar Room, Oakley Road, Ground Floor

Present:

Dr Mark Kelsey (Chair)	SCCG Chair	SCCCG
Rob Kurn (RK)	Deputy CEO	SVS/HWS
Andrew Smith (AS)	Business Manager	Solent NHS Trust
David Noyes (DN)	Chief Operating Officer	Solent NHS Trust
Naz Jones (NazJ)	Locality Lead	East Locality
Dr Sara Sealey (SS)	Locality Lead / GP	East Locality
Janine Gladwell (JG)	Senior Transformation Manager /West Locality Lead	Solent
Dr Fraser Malloch (FM)	PCN Clinical Director / GP	Central PCN
Stephanie Ramsey (SR)	Director of Quality and Integration / Director of Adult Social Services	SCCCG / SCC
Donna Chapman (DC)	Associate Director System Redesign	SCCCG/SCC
Dr Ali Robins (AR)	Director	SPCL
Janet Ashby (JAy)	Head of Transformation	SPCL
Sarah Olley (SO)	Director of Operations	SHFT

In attendance:

Hannah Gehling (HG)	Administrator	SCCCG
Abbie Richardson (AR)	Planning and Performance Manager	SCCCG
Debbie Chase (DC)	Interim Director of Public Health	SCC

Apologies:

Phil Aubrey Harris (PAH)	Associate Director of Primary Care	SCCCG
Grainne Siggins (GS)	Executive Director Wellbeing (Health and Adults)	SCC
Sarah Turner (ST)	BCS Programme Lead	BCS
Jane Hayward (JH)	Director of Transformation	UHS
Jo Ash (JA)	Chief Executive	SVS
Dr Nigel Jones (NJ)	Locality Lead / GP	East Locality
Matt Stevens (MS)	Lay Member	SCCCG
Julia Watts (JW)	Locality Lead	East Locality
Sundeep Benning (SB)	PCN Clinical Director/GP	West End Road

Item	Subject	Action
1.	**Welcome and apologies**	
	MK welcomed everyone to the meeting. Introductions were made and apologies for absence were noted, as above.	

2.	**Declarations of Interest** *A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role is, could be, or is seen to be impaired or otherwise influenced by his or her involvement in another role or relationship*	
	No conflicts of interest were declared.	
3.	**Quarterly Performance Report**	
	Abbie Richardson discussed the quarter 3 performance report. A summary showed the difference between the performance and the plan. A&E activity is 11% above planned activity, and short stay non-elective activity is 7% above the plan. The performance summaries are shown in different graphs by month and activity. It was highlighted that falls and frailty and non-elective admissions are decreasing in activity. The activity was broken down by PCN, for each different activity. The majority of PCN's are showing a similar trend to last year, with the most PCN's having an increase in A&E attendances and in the West PCN there has been an increase in the falls and frailty admissions. At the last A&E Delivery Board, a 10 week improvement project was announced to start at the end of February. The feedback recognised the good work undertaken by A&E. There has been an increase in the amount of children and young people, but this may be due to coding changes. The non-elective activity has seen a small dip in December; however the data is now split into age groups. There was a peak for older people in December. Falls and Frailty are now below planned activity. The delayed transfers in care (DToCs) are 6.8% in December, compared to the 3.5% target. UHS have seen the biggest increase in DTOC's. Southampton are benchmarked the 4th worst in the country for DTOC's. However, it is being investigated whether different CCG's code their information in a different way. The rehab and reablement activity is lower than last year. Looking into the next few months, there will be a slight increase in referrals. MK explained that we need to think where the big issue is for A&E. It was discussed that the Better Care Southampton Steering Board need to think about what they can do differently to support A&E. DC explained that the non-	

	elective rates by PCN are being looked into. SR explained that the focus of the Integrated Care Teams, under the frailty model, will increase the admission avoidance work. NazJ questioned what the reasons were for the increased falls. DC explained that Adrian Littlemore has completed some work around people falling and found that the majority of falls are people falling within their own homes overnight or in the early morning. The falls and frailty work that has taken place hasn't impacted as expected. FM questioned whether you can see if these people are accessing primary care or not. It was stated that the CCG are looking into how we can get better access to primary care data. MK stated that most of the attendances to A&E where people that needed to attend rather than go to primary care. **Action: To look at non-elective for people with a 0 length stay to see what the reasons are for attendance.**	**DC**
4.	**Update on the locality projects and the Integrated Care Team Programme**	
	<u>West</u> JG explained that they are currently focusing on frailty in the West. The virtual ward is led by Solent, however it is being pushed to be more inclusive and to try and get GP's to refer straight into the ward. As part of the project, an integrated dashboard is going to be created to enable ; staff to prioritise more effectively. . The virtual ward is currently not being fully utilised. There are ongoing conversations about the information governance part of the project. MK questioned what solutions have been looked into for the dashboard and suggested making contact with the West digital team. A survey will be sent out to the GP's to see what would be useful for them. There will be weekly meetings to discuss the patients discharge plans, and how other admissions could be avoided. Investigating best route to facilitate GP involvement. It was agreed that all the right elements are in place, however how can the organisation go one step further to integrate better. conversations. It was agreed that co-location is a large piece of work, which needs time to allow individuals to work together. DC explained that ST has drafted a 100 day plan, that is going to the integration care plan meeting. This will give a step by step guidance of what needs to be happening.	

	Central/North AS stated that the CMHT piece of work has just been closed and it awaiting its review. There are two key things that are being worked on: • how we identify high risk drinkers and how we support them, • how we can work with SO:linked and community partners about how to increase engagement.. AS explained that the patient passport work has been superseded by the integration work. SO stated that there is an investment in 2021, for alcohol work. The workshop held had a good spread of attendees. It discussed how can they identify what harmful drinking is and how best to support people. **East** SS stated that they are currently going through a period of rationalisation. A breastfeeding task and finish place has been set up. . The COPD WASP project questionnaire has been sent out to all stakeholders to complete, and a meeting have been arranged to discuss the outcome. The Nursing Integration Pathway is now part of the integration management. The different nursing providers are being looked at within the different localities. NazJ stated that there is a workshop coming out about wound care. There has been engagement with all practices and SPCL. It is interesting to see which surgery had to do the most wound dressing. The data can be shared after discussions at the work group. The high intensity user work has been stopped, and an email will be sent to all primary care teams. The social prescribing work is really positive and three new prescribers have been recruited to. MK questioned whether there are currently any blocks, it was agreed that there are no current blocks.	
5.	**IT to support integrated working – Update**	
	MK talked through the digital slides. MK explained that the 5 missions of the digital programme are: • Integrated Health and Care Records • Digitisation and Infrastructure • Intelligence and Analytics	

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- Digital Access and Empowerment
- Digital Workforce

Focusing on the Intelligence and Analytics there needs to be better support for front line staff to be able to understand digital knowledge.

We need to make sure that the system is fully adopted and there is still digital access to records. The workforce need to be trained up, so that they can share their knowledge with colleagues and others.

It was questioned whether there are any timeframes on the items. MK explained that a road map has been created and was updated last year to cover 2021. A lot of work is being undertaken about e-consult with GP's, digital access and patient held records. The My Maternity App, has had 2 individuals use it throughout their pregnancy.

Action: Once the road map has been completed, MK to share with the group.

GP's have had universal WIFI installed, and in the next financial year all GP's should have Gove Rome. This means that if anyone has access to Gove Rome then they will be able to use the WIFI, without needing a password. BT are also providing a faster bandwidth within the next few months.

The re-procurement for CHIE (Care and Health Information Exchange) has been awarded to Orion .Care Homes can now access CHIE, however they will have to purchase their own laptop for them to be able to access the system. The care homes are also starting to get an NHS.net account.

It was explained that the Wessex Care funding is still in place, however it has deferred £1 million into the new financial year. The One Medication Record is being developed which allows medical information to be shared across organisations. Once this has been created it will be linked in with CHIE.

Action: MK to look into initial training for the launch.

Action: HG to share digital slides with the attendees.

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MK

HG

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<td>**Behaviour Change**</td>
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DC stated that she is now the interim Director for Public Health.

A review has been undertaken after the behaviour change service contract finished early. The review is focusing on the aspects of smoking, exercise, weight or alcohol intake. A series of proposals are being developed and they will be considered against the 5 year Health and Care strategy. The idea is to

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	be able to offer a targeted service for individuals. SS stated that the GP smoking provision is fragmented and only a small proportion of GP's have been part of the piloted schemes. It was questioned whether the support will be offered across the city or whether it will be more focused to certain pockets. NazJ questioned what ages are being looked at because it seems that more younger age people are taking up smoking. AS explained that there is no evidence that more younger people are taking up smoking or using e-cigarettes. DC explained that 12 months ago e-cigarettes could not be prescribed, however now there is one that doctors are prescribing. The proposal to support the tobacco strategy is the most important and it will require some work to be completed over the next couple of months. It was questioned whether there is a link between the high dependency users and the ethnicity groups. There are some risky behaviour clusters which are known about. It was questioned whether this is something that the PCN's could support with.	
7.	**STP Update**	
	MK stated that the STP will become Integrated Care System (ICS) by the end of September 2020. In order for this to happen, an application has to be completed and sent to NHSE by July. An ICS CEO will need to be appointed to. On March the 27th there will be the first ICS meeting. There will be representation from all providers and an increased amount of clinical involvement. There will be a spread of individuals geographically and job types. The HIOW response to the NHSE Plan will be signed off at the first ICS meeting. It was discussed that each ICS should have a single CCG under them. There are currently 8 separate CCG's, 6 of which Maggie Macissac is CEO for. There are ongoing discussions about how we will become a single CCG. MK explained that work will still need to be completed on a city, acute, HIOW and ICS Level. Southampton City Council are keen to keep work focused on the city, and make sure the spend continues where it is needed.	

	It was discussed that the communications with staff need to be clear and the same across all CCG's and partners to make sure people know where they are. **Action: To have a communications plan brought to the next meeting.**	**MK**
8.	**Delayed Transfers of Care (DTOC)**	
	DC stated that the better care support group have been offered 15 days from the Better Care Local support team to look into areas the requested areas to be focused on. There are six main things that are going to be focused on. • The pathways out of hospital • Admission avoidance work • Are we collecting the right data • Market Development • System Leadership • Mental Health Delays SR explained that the LGA have been asked to lead this work.	
9.	**Minutes of the Previous Meeting & Matters Arising**	
	The minutes of the Better Care Southampton Steering Board on 10/02/2020 were approved.	
10.	**RAID Log**	
	SR and DC will update the action tracker and send out after the meeting.	
11.	**Any Other Business and items for future meetings**	
	Items for future meetings • April Meeting – Workforce Update • April Meeting – Communications Update • Transport Strategy/Planning • STP Update DC stated that ST has been working with the communications team to develop a communications newsletter to be sent fortnightly. Everyone has contributed photos and brief descriptions. It was discussed who should receive the newsletter. It was agreed that Mk will send the newsletter to all	

	staff and organisations, and primary care will send the newsletter to practices. RK stated that the Kings Fund Programme, is where money can be granted to the NHS to support an idea to improve the work for the idea. If the Better Care Steering Group wanted to put an idea together, this would need to be completed by the 27th March. RK explained that there are two phases to get through. DC circulated a brief paper containing some more details about the phases and the work that needs to be completed. MK stated that there is stuff within the health and care strategy, about what needs to be improved in 2020/21. **Action: SR to get PA to arrange a meeting to discuss the options.** It was stated that the final version of the 5 year Health and Care strategy are currently going through CCG Board and SCC Cabinet. This strategy will work across the whole city. COVID-19 - DC stated that the Prime Minister has provided a statement about the country moving into the mitigation phase, and to plan for the worst case scenario. There is currently a lot of uncertainty about what will happen in the future. Organisations need to be prepared because they could lose up to 20% of the work force, and they will be unable to work for over a week. There is currently no immunity to COVID-19, and at least 2 cases have been people re-infected with COVID-19. Currently young children are not being affected by COVID-19. The main message the needs to be share, is to reinforce people needing to wash their hands to reduce the risk of catching COVID-19. DC explained that is anyone needs any advice or guidance to then look at the gov.uk website as it will contain the latest up-to-date information.	**SR**
11.	Close	
Date of next meeting: Tuesday 7th April 2020, Seminar Room, NHS Southampton City CCG, Oakley Road, Millbrook, Southampton, SO16 4GX		