Southampton City Health and Care Strategy

2020-2025

COVID Impact Assessment

Live Well Programme

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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?	What has continued?	What has changed?
• 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.	• 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.	• 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