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?

- 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

What has continued?

- 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

What has changed?

- 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

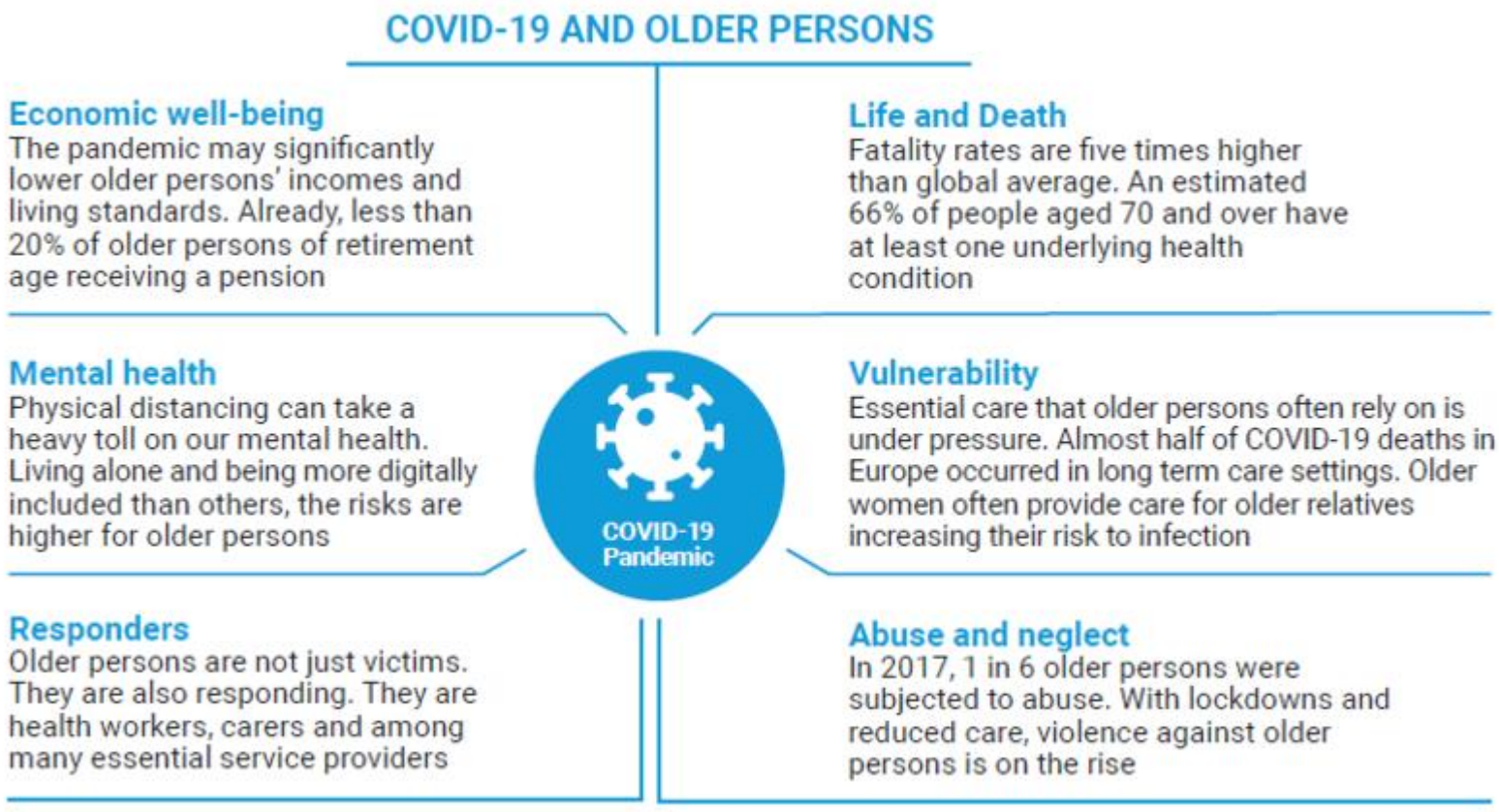
Assessing the Impact

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.

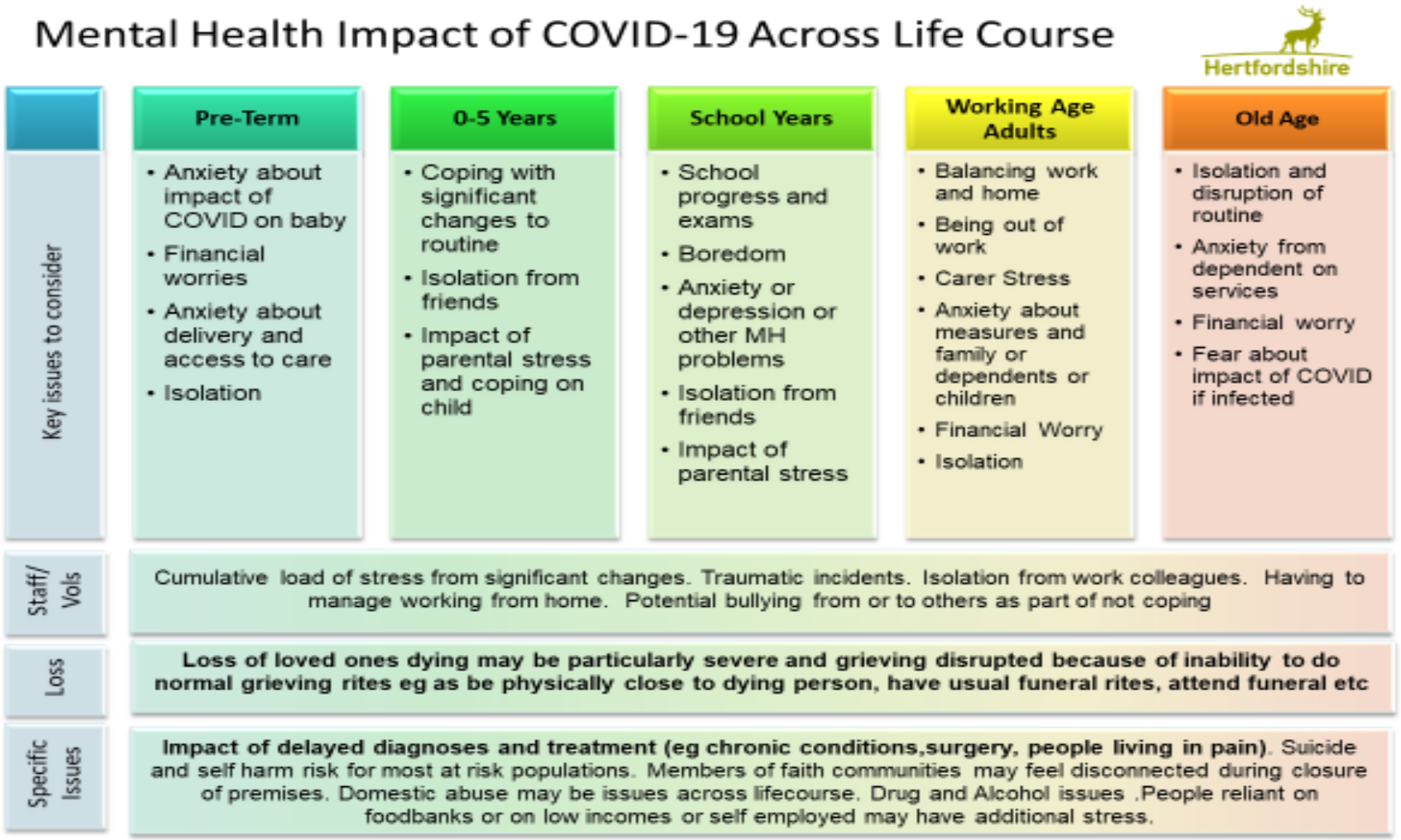
- **Physical health:** As a consequence of self isolation, older people may lack access to nutritious food, basic supplies, money, and medicines to support their physical health and social care. There is also an evidence base which suggests that isolation can lead to more sedentary behaviours and less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



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