DPH ANNUAL REPORT

2021

FOREWORD

There is no denying that this has been a difficult time for all of us; at an individual level, as a city, nationally and even globally. With the recent emergence of Omicron as the latest 'variant of concern' that is now infecting many people it is clear that the situation is far from over. As well as living with this new infectious disease, we are also living with considerable uncertainty about the disease itself and how it changes with each mutation. It is not surprising that so many of us are reporting worsening mental health and wellbeing than before the pandemic.

Throughout, I have been so impressed and proud of the way in which the people of this city have risen to the huge challenges that COVID-19 has brought with it. There are too many groups and individuals to name (and to miss any out would be a disservice) but so many of you have been 'everyday heroes' throughout this pandemic, doing what you can to keep others safe and well, both physically and mentally. You may not even realise how important your contributions have been, as I know so many people have just got on and done things without wanting attention or praise. This is my opportunity to say a heartfelt thank you.

From my perspective, my role and those of my fantastic colleagues have changed massively. I am conscious of how quickly and willingly the teams affected have had to change the focus of their work, quickly refining and honing skills to help the city to face COVID-19. It has been absolutely essential that we prioritise this, but it hasn't been without cost, and many of us have missed the work that we used to do.

COVID-19 continues to pose a particular risk to health inequalities. Some of us might be more prone to serious illness if infected, some of us might be more likely to be exposed through the work that we do or our living conditions, and some of us might be more likely to fall prey to misinformation which might stop us following advice and guidance. Tackling COVID-19 is tackling health inequalities, and so although our formal cycle of an annual focus of Thrive Plymouth has been halted, the city's work against health inequalities has continued unabated.

1 INTRODUCTION

In my Annual Report, I usually like to describe some of the amazing progress made towards the ambitions of Thrive Plymouth, our programme to tackle health inequality in Plymouth. However, for the last 18 months, many of the activities that our partners and Plymouth City Council deliver under the Thrive Plymouth banner have had to be halted or radically changed, because of COVID-19.

This was particularly the case in Year 6 of Thrive Plymouth, since we were focussing on the participation in arts, heritage, culture and hospitality and its connection to good wellbeing in the year of Mayflower 400; obviously, many of the planned events did not go ahead.
Instead, this Annual Report will reflect on some of the key information and experiences that the city has been through over the last 18 months since we had our first COVID-19 case in mid-March 2020.
This is not about reliving these difficult times, rather it is about recognising the strengths that have been shown across the city; being Good Neighbours, volunteering to support the vaccination efforts, and doing all we can to keep each other safe.

Thrive Plymouth is about partnerships, and this report also serves to recognise some of those partners; as always with the Annual Report, we can only showcase the few, but use them to highlight the work of the many.

2 THRIVE PLYMOUTH

2.1 What is Thrive Plymouth?

The way that we live our lives has an impact on our health. What might seem like small choices made today can have a large impact on our life expectancy – but perhaps more importantly, our health and how well we feel during those years of life. It is a common myth that people who live a long time have a long time in poor health; the opposite is true. At a population level, those groups of people who live the longest actually spend the shortest time in poor health.

So how do we help people to make healthier choices?

- 'Agency' is about the ability of individuals to make their own decisions and to enact them. In this context, we would need people to understand the benefits that healthier lifestyles can offer and to want to aspire to those benefits, to understand what to do, and then to make the changes and to sustain them.
- 'Structure' are those factors of influence which affect the person's agency. They could be linked to social, cultural or economic factors and are often very well established. For some groups (and some choices), they might provide support for change or they might form barriers for change.

Exactly how agency and structure influence our ability to make and sustain healthier choices is much debated; there are undoubtedly many factors that influence these and that is why supporting people to make healthier choices is complex and nuanced.

Thrive Plymouth recognises both of these, and also that structural factors in more deprived groups tend to form barriers to healthier behaviours. This philosophical basis for Thrive Plymouth is important to acknowledge since it recognises that although individuals have responsibility for actions that affect their health, positive actions could be enabled by changes to the structural contexts in which health-related choices are made.

Thrive Plymouth was adopted by Plymouth City Council on 11 November 2014. It strongly reflects the Council's endorsement of the Marmot policy objective of strengthening the role and impact of ill health prevention. It provides a mechanism for achieving the NHS Forward View aspiration of a radical upgrade in prevention and public health. Finally, it is a key delivery mechanism for the city's integrated health and wellbeing system as well as its aspirations for health and wellbeing set out in the Plymouth Plan. Thrive Plymouth draws on the approach to chronic disease prevention first presented by the Oxford Health Alliance.

Thrive Plymouth has three approaches;

- *Population-based prevention* is about the whole population making positive changes, big or small, to their lifestyle choices. This is because lots of people with a small risk of getting a disease can cause just as much ill health as a small number of people with a large risk. So everyone making even a small change will help Plymouth Thrive.
- *Common risk factor* is based on the fact that one unhealthy behaviour can be the basis of many diseases, and that several of these unhealthy behaviours tend to cluster in individuals and in less affluent groups. Focusing on these common risks and how they cluster is more effective.
- *Context of choice* acknowledges that despite an understanding of what is unhealthy, and good intentions to be healthier, change is hard to achieve. This is because we all make choices in settings we often don't control, where the healthy choice can be harder than the unhealthy one.

We want Plymouth to be a place where the healthy choice is always the easy choice.

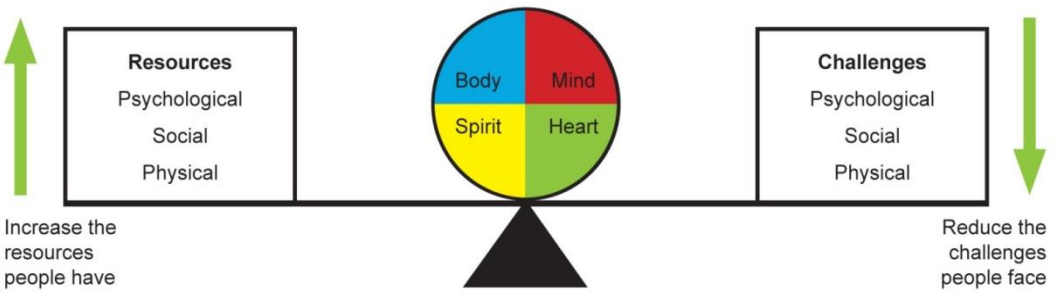
2.2 What are the healthy behaviours?

There are four well-established lifestyle behaviours (tobacco use, excess alcohol consumption, poor diet and lack of exercise), that can contribute to the development of respiratory diseases, cancers, coronary heart disease and strokes and lead to earlier death. Of course these are not unique to

Plymouth and these same risk factors and diseases cause premature deaths around the globe. Thrive Plymouth is seeking to promote healthier behaviours which means:

- being smoke free,
- drinking alcohol safely (only in moderation),
- eating healthily,
- being physically active.

In Thrive Plymouth, we also recognise the importance of mental wellbeing. We understand wellbeing to be a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society. Balanced wellbeing is when individuals generally have the psychological, social and physical resources they need to meet a particular psychological, social and/or physical challenge. When individuals have more challenges than resources, the see-saw dips, along with their wellbeing, and vice-versa.



Source: Based on Dodge, R., Daly, P., Huyton, J. & Sanders, L. (2012): The challenge of defining wellbeing. International Journal of Wellbeing, 2 (3), 222-235, DOI:10.5502/ijw.v2i3.4

2.3 Campaign topics

In addition to an ongoing focus on the four lifestyle behaviours, Thrive Plymouth has a specific annual focus which is built on each year.

- Year One (launched Oct 2014) the focus was promoting workplace health and wellbeing.
- Year Two we focused on schools and educational settings through promotion of the Healthy Child Quality Mark.
- Year Three we localised Public Health England's 'One You' campaign, which encourages people to put themselves first and do something to improve their own health. www.oneyouplymouth.co.uk/
- Year Four focused on promoting the five ways to wellbeing (Connect, Learn, Be Active, Notice, and Give).
- Year Five focused on connecting people through food.
- Year Six focused on participation in arts, heritage, culture and hospitality and the connection to good wellbeing in the year of Mayflower 400.

Year six was launched on 29th November 2019 to coincide with the Illuminate Festival at Royal William Yard which marked the opening of Mayflower 400. Our Thrive Plymouth plans for Year 6 centred on supporting our partners to maximise the health and wellbeing benefits of the events being planned, and support the opportunities to reach into different and varied communities. There is a large body of evidence which shows engaging with arts, heritage and culture are good for wellbeing, and we were all excited at what the year would bring.

However, due to events beyond our control, Year 6 had a radical change of direction as we put our annual focus on hold. In March 2020, the threat of an emerging novel coronavirus pandemic became a reality in the UK. Our small team of public health specialists had to refocus all of our attention on tackling COVID-19, with support from the wider public health workforce. As the situation worsened and we went into lockdown, events were postponed and we put the annual focus of Thrive Plymouth on pause; however, work on tackling inequalities continued.

While many events and activities were unfortunately unable to go ahead during 2020 due to the pandemic, others have been rescheduled for a later date. Activities in the city are advertised by 'What's on in Plymouth': https://www.visitplymouth.co.uk/whats-on

In a later section of this report, we will revisit Thrive Plymouth and our plan for revising and refreshing the work that we are doing to tackle inequalities.

3 THE COVID-19 PANDEMIC

This chapter sets out some of the facts of the pandemic and in particular how it impacted Plymouth.

3.1 Timeline and epidemiology

The data and graphs presented here were compiled towards the end of December 2021, just as the peak of wave three appears to have been reached – or at least the first of the peaks. Without the use of a crystal ball it is safe to say that we are expecting the next few months to be difficult for Plymouth, the country and the world; though with the vaccination programme, we should continue to see the much smaller proportion of people losing their life to COVID-19, compared to earlier in the pandemic.

COVID-19 is the disease caused by infection with a new virus called severe acute respiratory syndrome coronavirus 2 or SARS-CoV-2. This is a type of virus called a coronavirus, known to be of concern because they can be very severe and spread easily. There are many different coronaviruses, some of which exist in humans but a large number in different animals. Every now and then, the right conditions are met for the virus to spread into humans; and sometimes an infected human can spread the virus to others. This kind of a novel virus is of great concern as humans are unlikely to have any immunity and the virus can be very harmful.

It was first identified in Wuhan, China, in December 2019; despite a lock down, the virus was not contained and by early March 2020, though the rate of new cases appeared to be dropping in Wuhan and China as a whole, there were several areas of the world where concerns have heightened; Italy, South Korea and Iran in particular. The early indications was that this virus was creating a significant illness which was around 10 times more lethal than influenza.

The virus spreads through the air, usually as droplets and occasionally finely dispersed particles in the air. Droplets tend to fall from the air quickly and so simply keeping your distance from infected people can reduce spread; however, this can be harder than it seems and needs national intervention.

In the UK, initially early cases had connections through travel or close contacts (there were thought to be around 1,000 separate incidents), we quickly started to see evidence of community spread meaning that the disease had reached the UK.

On 13th March 2020, we became aware of the first case in a Plymouth resident; and by the 23rd March 2020, the need for a national lockdown was announced.

Between 13th March 2020 and spring of 2021, we have had a cycle of COVID-19 numbers being suppressed by lockdown measures, but then increasing again as those measures are reduced. Plymouth has on the whole followed the same trend as England though we have been at a lower level for most of the pandemic. We have seen two very significant mutated versions of the virus in that time, ones where a significant advantage was conferred due to the mutation making it able to out-compete the existing variant.

In December 2020, the UK vaccination programme began. This was a very significant point in the pandemic response; an intervention which reduced spread but most importantly prevented serious disease and deaths.

We really started to see the benefits of vaccination around spring 2021, when sufficient people who were vulnerable had been double-vaccinated and we saw hospitalisation and death rates reducing in those groups.

We started along the roadmap for the opening up of the economy, and it was during this time that we really began to see how people's behaviours could so easily change the course of the pandemic. The UEFA European Football Championships combined a strong motivation for social mixing, with one of the first opportunities to mix after restrictions were eased. Whether at organised games, watching at public venues, or just meeting in their own living room with family and friends, we saw a large peak in people with COVID-19 and in those isolating as contacts. The spike that we saw in Plymouth towards the end of July was extremely high and although it did fall off quickly, we have been left with case rates

around 350 per 100,000 in a seven day period – not far short of 1,000 people testing positive in a week. Unfortunately, the number of people in hospital has also been too high over this period; obviously this is bad in itself, but also because of the impact COVID-19 is having on our healthcare system. When rates are high, we have more people in hospital, and having people in hospital with a very infectious disease makes everything more difficult for staff to handle. The threat of spread within healthcare facilities is a very real risk. We also know that people in hospital with COVID-19 can have long stays, especially for those more severely impacted and needing intensive care. Having these Intensive Care Unit (ICU) beds occupied reduces the number of patients that can have their planned surgery with many people having to wait too long for treatment. In addition, when case rates are high, staff are affected and so we have reduced workforce able to be in work – of course this is important in health and social care, but also many other key jobs; lorry drivers bringing us supplies, bus drivers getting people to work, supermarket workers making sure the shelves are topped up.

At the time of writing, we know that even with the vaccination programme, we should expect a difficult winter.

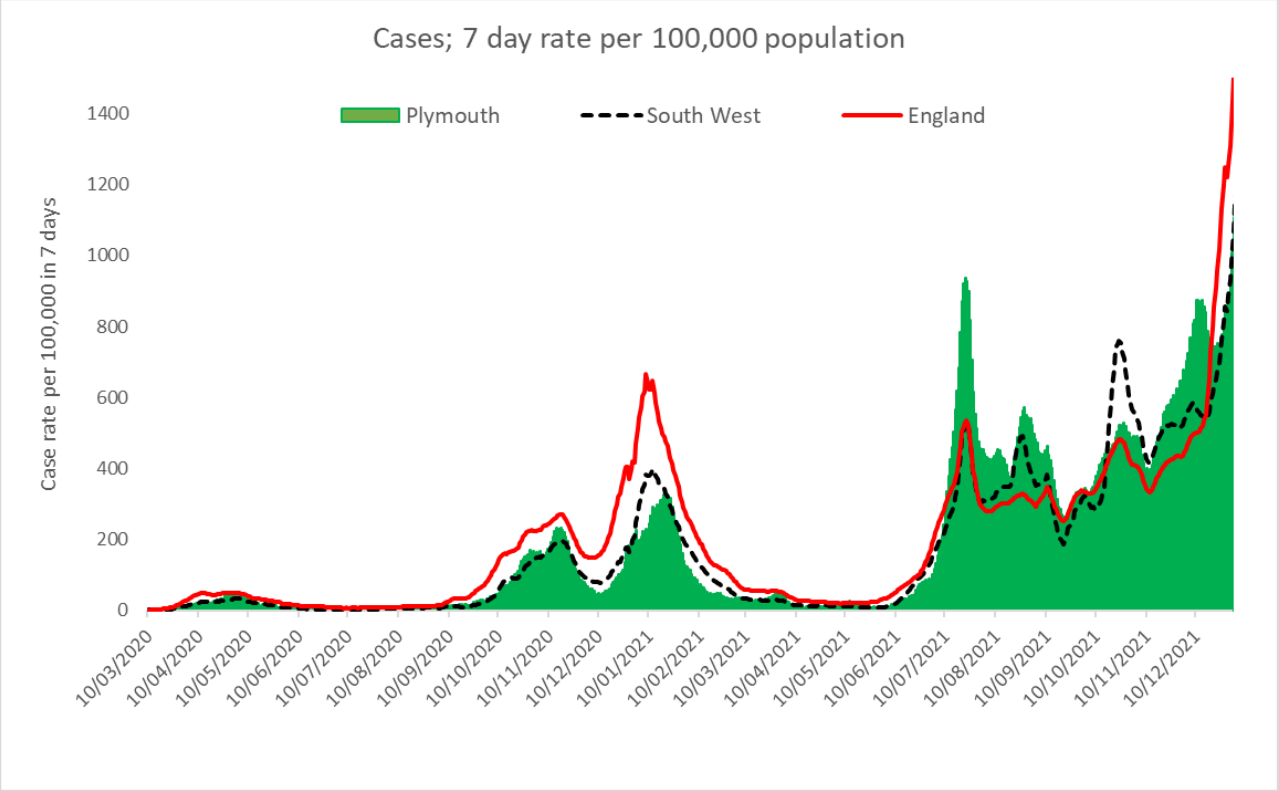


Figure 1. Case rates of COVID-19 from the start of the pandemic. In the early stages, testing was not widely available so the true rates will have been higher. Source; UK Government at https://coronavirus.data.gov.uk/

3.2 Longer term view

Many of us want to know when this pandemic will end. That is, unfortunately, a difficult question! There are two ways pandemics come to an end; either the transmission is so well controlled that we come to a point where there are no cases (such as Ebola), or the disease becomes part of our normal infectious disease landscape which is referred to as endemic. Being endemic, or something that we have to live with, does not mean that we do not have to take steps to manage the disease, and it will likely continue to mean some forms of practices that will help to keep rates down.

How easily we can transition into endemicity, and exactly what that looks like, does depend on many factors; some to do with the virus itself, others to do with our response. We (as a society) might

tolerate higher numbers of cases if the variant in circulation causes mild disease; conversely we might have to take more action to reduce numbers if a variant is more severe. Another key factor is vaccination; how well it works (especially in more vulnerable people) and also how many people have the vaccine. It is currently not clear how often vaccination might be needed; yearly such as for flu, or more often in response to different variants, or less often if an effective vaccine against a broad spectrum of variants can be found.

For many of the public, COVID-19 might have been their first brush with an infectious disease which requires additional actions such as testing, time off work, notifying contacts etc. However, this is common and established practice for many infectious diseases. We have yet to see what level of control and management COVID-19 will require.

3.3 The impacts of COVID-19

As part of our response to the COVID-19 pandemic, we sought to understand the wide-ranging impacts that COVID-19 had on people using a model or conceptual framework as listed below.

DIRECT IMPACTS

Infection with COVID-19

- Short term illness – may include hospitalisation
- Long COVID
- Death

INDIRECT IMPACTS

Impacts on

- Health behaviours (eating, drinking, smoking, moving)
- Mental health
- Vulnerable groups
- Lived Experience

Impacts of changes to

- Access to healthcare
- Income
- School and education
- Built and natural environment

In each case a literature review along with any Plymouth specific data was considered. It will come as no surprise that the vast majority of these impacts were negative, on cohorts of people and/or the population as a whole. The one exception to this centred around the final point, where people's reported experiences of accessing green spaces close to home was highlighted.

As we usually find, impacts (positive or negative) are not evenly distributed through the population; this has been no different for the impacts of the pandemic.

3.3.1 COVID-19-related health inequalities

Unfortunately, COVID-19 (like any other infectious disease) has highlighted inequalities. There is an overall gradient of increasing cases and deaths with increasing deprivation in addition to significant differences between ethnicities. Factors such as education, housing and employment, drives inequalities in physical and mental health, reduces an individual's ability to prevent sickness, or to take action and access treatment when ill health occurs.

This was evident early on in the pandemic, and was highlighted in 'Build back fairer; the COVID-19 Marmot Review'. This reiterated the health inequalities position in England before the pandemic; as discussed in my -YEAR Annual Report, since 2010 improvements in life expectancy in England had stalled. Life expectancy follows the social gradient – the more deprived the area, the shorter the life expectancy. This gradient has become steeper; inequalities in life expectancy have increased. Among women in the most deprived 10 percent of areas, life expectancy fell between 2010–12 and 2016–18.

'Build back fairer' highlights the inequities in risk of mortality from COVID-19 – which include those related to;

- underlying health conditions and disability,
- levels of deprivation,
- housing conditions,
- occupation,
- income and
- being from certain ethnic groups.

Conversely, the likelihood of mortality from COVID-19 is lower among people who are wealthy, working from home, living in good quality housing, have no underlying health conditions and are of White ethnicity.

Currently, the number of people who have died in Plymouth is lower than in other areas with similar demographics. It is not totally clear why this is the case, but our geographical distance from other large urban centres may well have helped.

Of course mortality is not the only indicator of harm through the pandemic, but it is by far the easiest to produce robust data on. As discussed in 3.2, as well as the direct harms from the virus there have been a wide range of indirect harms, and these too are not equally distributed across the population.

Build Back Fairer reiterates the earlier findings of the Marmot report – that we need to actively manage the wider determinants of health to create the conditions in which everyone can thrive. This requires 'proportionate universalism' – interventions and support available to all, but with a very clear focus on those most impacted and who need the most support because they are the most in need.

This is the approach that we have already been taking in Plymouth; we can be confident that we are doing the right things.

3.4 A focus on COVID-19 and mental health

The COVID-19 pandemic and the control measures to reduce transmission have impacted on almost all aspects of our lives. This is having profound health, economic and social consequences, all of which will impact on our mental health and wellbeing now and into the future. Moreover, these impacts are experienced differently by different groups. There is a risk that the pandemic may increase and entrench mental health inequalities that existed and were widening before the pandemic. It is crucial that we increase our knowledge of the broad impacts of the pandemic on mental health and wellbeing and the population groups that are more greatly affected. This will enable the mental health needs of our population and the hardest hit groups to be recognised and monitored so that appropriate support can be provided to mitigate the impact.

We developed a Mental Health Needs Assessment following on from a workshop led by the Health and Wellbeing Board. The aim of this needs assessment was to bring together what is known nationally and locally about the impact of the COVID-19 pandemic on mental health and wellbeing needs in adults and to make recommendations to the local system to improve the mental health of our population.

Good mental health is more than just the absence of mental disorders but is an essential component of good health. Mental health is a state of wellbeing in which an individual realises their own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to their community. Wellbeing can be described as the balance point between an individual's and community's resource pool and challenges faced. Stable wellbeing is when individuals or communities have the psychological, social and physical resources they need to meet particular psychological, social and/or physical challenges. Good mental health and wellbeing is strongly influenced by the conditions in which people are born, grow, live, work and age. Promoting mental wellbeing and supporting mental ill health is essential not only for individuals and their families, but to society as a whole. In the UK:

- One in four people will experience mental illness in their lifetime.
- One in six people experience mental illness at any one time.
- 75% of mental health conditions in adult life (excluding dementia) start by the age of 24.
- Mental ill health is estimated to cost the UK economy £105 billion a year in health care and loss of productivity costs.

Within the population there are also significant avoidable inequalities in mental health problems that exist between groups based on personal characteristics, stage of life and conditions of living.

3.4.1 Mental health and wellbeing during COVID-19

The evidence so far suggests that at a population level mental health and wellbeing worsened at the start of the pandemic in spring 2020. This was followed by a recovery in the summer of 2020 as lockdown was eased, but not to pre-pandemic baselines. More recent evidence suggests a further decline in population mental health in the winter of 2020/21.

There is no evidence of changes in rates of self-harm or suicide since the start of the pandemic, although there is some evidence of increases in self-harming thoughts and behaviours in some risk groups. This includes those who have experienced abuse or have financial worries.

The evidence suggests that the mental health of certain groups of people have been disproportionately affected by the pandemic. These groups cover a wide range of the population and include: young adults; adults with pre-existing mental or physical health issues; socially isolated people; adults with low household income, financial worries and/or who experienced a loss of income; Black, Asian and Minority Ethnic (BAME) men; those who were recommended to shield; carers; and frontline health and care staff.

Many of these are groups that were at higher risk of mental health problems before the pandemic, demonstrating the potential of the pandemic to increase mental health inequalities.

The total number of GP diagnoses of depression decreased in the pandemic. This is concerning because undiagnosed depression is risk factor for suicide.

3.4.2 Future mental health needs

The changes in mental health seen so far (when the health needs assessment was completed in mid-2021) may not be the full extent of the impact of the pandemic on mental health. This is because:

- It may be too early to see some of the impacts of the pandemic on mental health.
- The ongoing challenge of the pandemic may continue to affect mental health.
- The pandemic may have environmental, cultural and socio-economic impacts, which in turn will continue to impact mental health. Examples include the possibility of recession, rise in unemployment and rise in deprivation.

Predicting any future changes is fraught with many uncertainties but may signal areas that need closer monitoring.

The Centre for Mental Health report predicts that as a direct result of the pandemic, up to 8.5 million adults in England (almost 20% of the adult population) will need either new or additional mental health support. The vast majority of these will be in people who have existing mental health conditions or the general population. In Plymouth these figures equate to almost 27,000 of the estimated 39,000 people with common mental disorders requiring additional support and over 17,000 from the general population requiring new support for mainly moderate-severe depression or anxiety. However, it is unclear from the model what the level of need will be and the timeframes for when people may need services. In addition, the model is due to be updated in May 2021 with more current evidence, but at the time of writing, this is not yet available.

There are a number of risk and protective factors that are well known to influence mental health. The pandemic is likely adversely to affect many of these factors and so will adversely affect mental health into the future. Strengthening protective factors and minimising risk factors provides a focus for action by which the mental health demands and needs can be addressed in the recovery from the pandemic.

A collated summary of these discussions is presented below:

- **Service delivery models:** There has been a rapid change to remote service delivery to support clients since the start of the pandemic, with limited ongoing face-to-face work at a reduced capacity when possible for specific needs. Remote delivery was good for some individuals due to the convenience of access; however, other individuals would prefer or need face-to-face interaction. Providers generally considered remote interactions to be of poorer quality due to the difficulties of building a relationship and trust and ability to pick up on non-verbal cues and additional or hidden issues.
- **Level of need:** Some providers reported that they were managing a higher level of need through their phone lines than they were equipped to.
- **Demand:** Changes in demand and need since the start of the pandemic are difficult to accurately quantify because of the changes in service delivery models. Demand generally fell at the start of the pandemic and increased thereafter. In some cases, this demand has stayed below pre-pandemic levels, but in others it is has overtaken pre-pandemic levels. There is also a suggestion that reduced access to mental health services during the pandemic may be increasing mental health needs.

- **Ability to meet demand:** At the time, providers felt that they are able to meet the need that they are faced with, however, there are signs of increasing need across many services.
- **Challenges:** Challenges for providers include: staff wellbeing, recruitment and retention; having meaningful engagements with clients; reduced capacity; difficulty keeping up with guidance; circular signposting; difficulties for individuals to access formal mental health services at the time of need; poor transitions between services; uncertainty about the future and resources; escalation of needs due to the pandemic; and additional stressors, such as the British Exit from the European Union.
- **Improvements:** Potential service and system improvements suggested were: a blended approach of face to face and remote delivery; strengthening of collaboration between mental health teams, primary care, social prescribers and VCSEs; strengthening of public mental health, prevention and early intervention; clear messaging about services available; greater awareness of trauma informed practice; strengthening of organisations working at a community level; wider consultation with the community to understand needs, issues and concerns; and improving outdoor space for young people.

3.4.3 Conclusions from evidence and intelligence

Bringing all of these findings together, the Mental Health Needs Assessment concluded;

- **It is likely to be too early to see the extent of the mental health impact of the COVID-19 pandemic**. Further evidence is likely to emerge in the coming months and years and therefore the evidence base for the impact of the pandemic on mental health will become more robust. Furthermore, the future of the pandemic is uncertain and therefore the ongoing impact on mental health is also uncertain.
- Current national evidence and data suggests that **population level mental health and wellbeing is already being negatively affected by the pandemic.**
- Whilst the pandemic is a collective trauma, **the burden of distress is greater in certain groups**. The evidence shows that the mental health and wellbeing of some specific groups is disproportionately affected. Some of these groups correlate with the groups that are already more vulnerable to mental health issues and so **there is a risk that the pandemic will widen and entrench mental health inequalities.**
- There is evidence that **the pandemic is having a major impact on the risk and protective factors for mental health**. In general, the pandemic has increased the risk factors for mental health problems, especially in the already more vulnerable groups. This may therefore lead to increasing mental health needs and increasing socio-economic inequalities in the future.
- **In Plymouth, mental health services have seen varying patterns of demand and it is difficult to draw conclusions from the intelligence** we have so far due to the changes in service delivery and because there may be numerous explanations. The new First Response Unit and reduced access to GPs may have contributed in a reduction in referrals to the Community Mental Health Teams (CMHTs). In contrast, some of the services that do not require a referral but have changed to open access telephone lines have seen their demand increase.
- **National modelling predicts that there will be a very significant increase in mental health needs as a result of the pandemic**. Escalation of mental health needs as a result of the pandemic, may be seen across two main groups: those without pre-existing mental health issues and those with pre-existing mental health conditions.
- Escalation of needs may occur in the general population because a large number of people are likely to have had additional challenges to their wellbeing as a result of COVID-19. Whilst most people may not develop any or only mild mental illness, if a proportion of these develop mental

illness requiring service use, this is **likely to lead to a large rise in demand for mental health services**.

- **In the population with pre-existing mental illness,** additional needs may develop because of the challenges of the pandemic as with the general population, but, in addition, they are more likely to have had disruption to their care during this time, which may contribute to **relapse and/or escalating needs.**
- Local intelligence suggests that there has not been a sudden substantial increase in demand for mental health services in 2020. Providers are currently able to keep up with demand, but they are facing challenges. However, mental health is complex and multi-factorial. Individuals have different challenges and resources, and these have been affected in different ways and over a different timeframe. **Therefore, a predicted increase in mental health needs will not happen suddenly, but is more likely to be a slower, gradual and insidious increase.** Given the difficulty in managing current levels of mental health needs and the general increase in the prevalence of mental health conditions before the pandemic, this may in time become very difficult to manage in the system.

The widespread impact of COVID-19 and the social and economic consequences of the pandemic have highlighted the **urgent importance of promoting mental health and tackling mental ill health at a population level**. The burden of mental illness prior to COVID-19 was already significant and the pandemic is widely expected to increase this burden and exacerbate existing mental health inequalities.

A public mental health approach attempts to build the resources and resilience of individuals and communities so that they can face the challenges in their lives in order to prevent the onset, development and escalation of mental health problems. It aims to strengthen the protective factors for good mental health and reduce the risk factors for poor mental health at an individual and community level. This upstream approach will, in turn, impact positively on the NHS and social care system and there is evidence that a range of prevention activities are cost-effective. Targeted interventions aim to reduce mental health inequalities and improvement to mental health services will improve the lives of those who have developed mental health issues.

3.4.4 Mental Health Concordat

As a result of the presentation of the Health Needs Assessment the Health and Wellbeing Board members signed up to the Mental Health Prevention Concordat.

A number of specific recommendations were set out, framed around the five domains of the PHE Prevention Concordat for Better Mental Health.

- Understanding local needs and assets,
- Working together,
- Taking action for prevention and promotion, including reducing health inequalities,
- Defining success and measuring outcomes,
- Leadership and direction.

The PHE Prevention Concordat for Better Mental Health consensus statement.

The undersigned organisations agree that:

To transform the health system, we must increase the focus on prevention and the wider determinants of mental health. We recognise the need for a shift towards prevention-focused leadership and action throughout the mental health system, and into the wider system. In turn, this will impact positively on the NHS and social care system by enabling early help through the use of upstream interventions.

There must be joint cross-sectoral action to deliver an increased focus on the prevention of mental health problems and the promotion of good mental health at a local level. This should draw on the expertise of people with lived experience of mental health problems, and the wider community, to identify solutions and promote equity.

We will promote a prevention-focused approach towards improving the public's mental health, as all our organisations have a role to play.

We will work collaboratively across organisational boundaries and disciplines to secure place-based improvements that are tailored to local needs and assets, in turn increasing sustainability and the effective use of resources.
We will build the capacity and capability across our workforce to prevent mental health problems and promote good mental health, as outlined in the Public Mental Health Leadership and Workforce Development Framework Call to Action.

We believe local areas will benefit from adopting the Prevention Concordat for Better Mental Health.

We are committed to supporting local authorities, policy makers, NHS clinical commissioning groups and other commissioners, service providers, employers and the voluntary and community sector to adopt this concordat and its approach.

3.4.5 Ongoing developments

Plymouth has had many areas of strengths when embedding a public mental health approach. There are a wide range of services designed to support people when they need it; and in particular to try to prevent escalation of need. The ethos of Thrive Plymouth is to support people to maintain and improve their mental health where it might be at risk, whether through Wellbeing Hubs, workplace wellbeing offers by employers and the promotion of Five Ways to Wellbeing. Where services are required, there are offers designed to support people as and when they need it, with further capacity currently being developed through adult online mental health offers.

4 LIVED EXPERIENCES OF COVID-19

Whilst there were some incredibly dark days during the pandemic, there were also many positive stories about how communities came together to support each other. We found that the 'lived experience' was very important – while numbers on a graph might be important for some people, what really mattered was how our loved ones, friends, colleagues and fellow citizens were coping.

Within this report, we would also like to highlight some of the work of the University of Plymouth, -. Their 'Lived Experience of Covid-19' website contains a wealth of information on the research conducted during the pandemic – and we highlight some of this below.

(link to this is here https://www.plymouth.ac.uk/research/lived-experience-of-covid)

4.1 Good Neighbours Scheme - Supporting Vulnerable and Diverse Communities

Plymouth City Council has worked with communities during the COVID-19 pandemic to provide community-led solutions. In particular, it was becoming increasingly apparent that the pandemic had the potential to leave some of the city's most vulnerable residents isolated, distressed and worried.

In response to the challenges posed by coronavirus, the Plymouth Good Neighbours Scheme (PGNS) was set up to support the mobilisation of Plymouth's Voluntary, Community and Social Enterprise Sector, empowering residents, businesses and wider stakeholders to play a key role in safeguarding those most at risk. PGNS was set up to harness and organise the goodwill demonstrated during the pandemic and was developed by identifying old and new partners across the city and linking them with volunteers.

PGNS was promoted through a social media campaign and online forums. The Council produced case studies and profiles on some of the volunteers on Facebook and Twitter. PCC was able to call on the skills and experience of the 'Mayflower 400' team that included project managers, a volunteer co-ordinator and a bank of volunteers, as well as other employees to set up PGNS. It has interfaced with a wide range of groups – from Caring for Plymouth, which provides support for people who are extremely vulnerable, to the Devon and Cornwall Chinese Association (DCCA), who donated 34,000 face masks to the Council to be distributed to those in need.

An online volunteer response form was created to gather information from those interested in volunteering, with over 700 people registering. Community partners were involved from the start; key voluntary and community sector partners attended a twice-weekly planning and response meeting which focused on coordinating the volunteer response.

The projects were a success, helped by the co-operative values of collaboration and partnership working which were embedded into the projects from the outset. Successes were very many and very wide-ranging; from supporting more than 80 households in ending digital exclusion with the Plymouth Hope WiFi project, to the Biker 19 Group of motorcyclists delivering medication to vulnerable people shielded through the Council's Caring for Plymouth hub.

THE PLYMOUTH
GOOD NEIGHBOURS
SCHEME

Coordinating our voluntary response to coronavirus

The Council, working with our partners across the city, has continued to build on the lessons learned during this stage of the pandemic and to harness the collective power of so many volunteers across the city using the goodwill and infrastructure developed through PGNS to continue to support the most vulnerable residents.

4.2 Young People's concern for others

The events described in this section took place in the summer of 2020. As the lockdown measures were relaxed, we saw rates of infection start to increase in Plymouth and across the country. As expected there were different rates of increase among different groups of people, depending on their relative risk of exposure to transmission. Rates climbed highest among young adults (16-30) across the country and in Plymouth in late July and early August 2020. Our challenge was to work to reverse this increase by applying principles of social marketing to create active, purposeful and engaging messages.

We know that messages rooted in a rich understanding of their audience tend to chime and engage them better. We also, through previous insight work, knew that Plymouthians tend to love their city. We set out to build on this and started by talking to young people about their perceptions of COVID-19 and, in particular, to explore their views surrounding compliance with the key COVID 19-secure behaviours. We were looking for insights into what young people think and feel about COVID to inform our messaging.

Through our conversations, the young people we spoke to told us that their central concern s of them infecting other people they know.

They also told us that people know what the key COVID-19 behaviours are but;

- find official advice, confusing and some do not trust it.
- also want life to return to normal – for their wellbeing and the economy yet,
- they believe non-compliance is widespread among all ages.

We knew if we responded to these insights our communications would be more engaging and therefore have more impact.

This set us a creative challenge; to find a phrase that responded and reflected young people's central strong feelings of altruism. A phrase emerged from our team: "A good Janner looks out for their nanna"

We went on to use this phrase in our messaging and found that it did chime with people and helped to positively reframe a developing narrative about young people and COVID-19. The phrase was picked up both by local press and nationally as an example of effective communications.

4.3 Reducing social isolation in care homes during the pandemic; a care home manager's story

With thanks to Merafield Care home for sharing this story.

> *"From an activity perspective, one of the really momentous times for us through COVID, was our activity coordinator, we've done some work with the National Marine Aquarium and …the girl who was our link at the aquarium, she actually, arranged an interactive private tour of the aquarium, so we had the iPads, we had laptops, and obviously for different people throughout the home, for those residents, they got an interactive tour of the aquarium, so they were able to ask questions, you know about what the turtle was called, all those types of things. And it was just. ……Being a nursing home where we got a lot of our clients who are bed bound, who aren't physically able to go out, it brings a whole new meaning to actually like bringing activities to us. So to be able to actually have a tour of the aquarium via this type of platform was just amazing. ….*

We increased our infrastructure of IT, so we have more laptops, we have iPads, there's more things available to go forward. … Another example of that is also, linking in the community with the schools, so we, through our activity coordinator, we had a primary school who again via the use of laptops and iPads, the children sang, you know, a different song that they put together for the residents, during Covid times. So you know 'cause it takes a lot for a whole school to, the logistics of getting them to leave the school to come here to all those kind of risks that are associated as well, so it just meant that they were able to do that via a laptop platform. So yeah, that was another really good example"

What impact did that have in the care home?

"Massive, massive. Yeah, well, it's well-being of the residents, to have that, to sit with somebody even a particular resident I sat with who was just in awe of looking when we got to the big deep dive, tank type thing and just to have that was….. you know, there's some amazing feedback from that, wasn't there?

It was really good, really uplifting. And for the staff, it brings a level of excitement with the staff, which they're part of it as well. So you feel you are bringing something into the home which is, yeah, well it's just an all-round winner, isn't it?"

4.4 Lived experiences of Long COVID

Long COVID, or post-COVID-19 syndrome, describes a wide range of symptoms that persist for at least 3 months following a diagnosis of COVID-19. Some of these symptoms might be continued from the infection itself, while others seem to develop symptoms after even a mild case of COVID-19.

Evidence is still emerging on this, and many things are not currently understood. However, it is very clear that this is a significant problem for many people, with estimates as high as 10% of people who have been diagnosed with COVID-19 suffering from longer-term problems.

Long COVID is a significant concern for many of us. We wanted to highlight these risks to the population of Plymouth and we were very grateful that members of the public were willing to share their stories with us. Some of these can be found here;

Hear Charlie's story and why we all should worry about 'long-Covid'

Impact of long COVID – hear from Melanie

Impact of long COVID - hear from Tracey

Impact of long COVID - hear from Tracey's girls

4.5 Pandemic Poetry

There is considerable evidence that writing or reading poetry can be beneficial for health and wellbeing, for a variety of reasons from simply the distraction of the process itself, to a way to release emotion. The University of Plymouth, in conjunction with Nottingham Trent University, were awarded funding by the UK Arts and Humanities Research Council to develop a project to encouraging the writing, sharing, publication and discussion of poetry, to benefit the wellbeing of people across the world.

There are many poems on the site, and I have browsed them regularly. I have reproduced just one example below.

Poetry and COVID, A Project funded by the UK Arts and Humanities Research Council, University of Plymouth, and Nottingham Trent University.

Love Letter

By Paula Moore

This is a love letter to everyone who did not remodel the bathroom, learn a new language, or write a book during the pandemic.

To everyone who wants to hold on to the lessons learned but is just trying to hold it together.

To everyone who met the loneliness and loss sometimes with grace and sometimes by binge-watching Tiger King.

Reproduced from Poetry and COVID

4.6 The corona files; a journal of the pandemic year

The word 'unprecedented' has become a by-word for the coronavirus pandemic of 2020. Fast-evolving, it has up-ended lives around the world.

To capture this experience in words, images, and all manner of expressions for future researchers, as well as generate discussion now on how to process this event, University of Plymouth History students are collecting a diverse range of stories from their own communities: care homes, the NHS, mobile hair-dressers, family members, tattoo artists, to mention a few.

Once processed, we will add these to the innovative international digital archive, the 'Journal of the Pandemic Year: An Archive of COVID-19', where together, we can help to narrate our shared global experience of the Pandemic.

Share Your Story · A Journal of the Plague Year · COVID-19 Archive

5 NEXT STEPS FOR THRIVE PLYMOUTH

Looking forward to 2022, we are still facing uncertainty around COVID-19. We know that there has been a considerable impact on the health and the wellbeing of our population caused by the interventions required to manage the pandemic, as well as by the disease itself. We are now facing a time of considerable economic uncertainty, and this is likely to exacerbate inequalities.

Recovery from COVID-19, as well as ongoing response, requires our focus now, and therefore we will continue working on this.

In Spring 2022, we will launch Year 7 of Thrive Plymouth; a year to regroup, and to redouble our efforts to tackle health inequalities in the city. To take the best of what we have seen over the pandemic so far, and apply it to the wider challenges of inequality. The form that the launch takes will depend on COVID-19 to some extent and we will communicate this closer to the time.

- We will seek to understand the impacts of the pandemic on our city and our population; as a Compassionate City, we believe there is a need to reflect on our experiences, and acknowledge what we have been through. Though there has been much trauma, we believe that there have also been some positives which we want to help the city to build on. Working with partners across culture, arts and heritage (our Year 6 focus), we want to capture some of this to create a legacy.
- We will be looking at the previous foci of Thrive Plymouth, and assessing progress and where further action could be taken.
- We will be getting back to basics around our four lifestyle factors; helping people to consider any changes over the pandemic, and how they might want to tackle any negative ones, and embed and celebrate any positive changes.

For Thrive Plymouth 2022, please join us to focus on Plymouth as a kind city; a city seeking to listen, connect and heal.

Find more at our Thrive Plymouth Website; https://www.plymouth.gov.uk/publichealth/thriveplymouth

Join our Thrive Plymouth Network by emailing us at Thrive@plymouth.gov.uk