Oversight and Governance
Chief Executive's Department
Plymouth City Council
Ballard House
Plymouth PL1 3BJ

Please ask for Democratic Support Officer
T 01752 305155
E democraticsupport@plymouth.gov.uk
www.plymouth.gov.uk
Published 08 November 2022

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

Wednesday 16 November 2022
2.00 pm
Council House

Members:
Councillor Mrs Aspinall, Chair
Councillor Deacon, Vice Chair
Councillors Finn, Harrison, McDonald, Murphy, Nicholson, Partridge, Mrs Pengelly, Reilly, Salmon, Tuffin and Wheeler.

Members are invited to attend the above meeting to consider the items of business overleaf. For further information on attending Council meetings and how to engage in the democratic process please follow this link - Get Involved

Tracey Lee
Chief Executive

Health and Adult Social Care Overview and Scrutiny Committee

1. Apologies

To receive any apologies for non-attendance from Committee members.

2. Declarations of Interest

To receive any declarations of interest from Committee members in relation to items on this agenda.

3. Minutes **(Pages 1 - 10)**

The Committee will be asked to confirm if the minutes of 07 September 2022 are a correct version, for the record.

4. Chair's Urgent Business

To receive any reports on business which, in the opinion of the chair, should be brought forward for urgent consideration.

5. Health and Adult Social Care Policy Brief: **(Pages 11 - 14)**

6. Risk Monitoring Report: **(Pages 15 - 22)**

7. COVID and Flu Update: **(Verbal Report)**

8. Public Health Commissioning: **(Pages 23 - 34)**

9. Life Expectancy and Health Expectancy: **(Pages 35 - 54)**

10. Thrive Plymouth: **(Pages 55 - 62)**

11. Active to Thrive: **(Pages 63 - 78)**

12. Children's Healthy Weight Plan: **(Pages 79 - 116)**

13. From Harm to Hope: **(Pages 117 - 124)**

14. Dashboard- Review of Indicators PHOF: **(Pages 125 - 136)**

15. West End Health Hub: **(To Follow)**

16. Tracking Decisions **(Pages 137 - 140)**

For the Committee to review the progress of Tracking Decisions.

17. Work Programme **(Pages 141 - 142)**

For the Committee to suggest items to add to the work programme.

18. Exempt Business

To consider passing a resolution under Section 100A(4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following item of business on the grounds that it involves the likely disclosure of exempt information as defined in paragraph 3 of Part 1 of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000.

18.1. Private Meeting

Agenda

MEMBERS OF THE PUBLIC TO NOTE:
that under the law, the Committee is entitled to consider certain items in private. Members of the public will be asked to leave the meeting when such items are discussed.

This page is intentionally left blank

Health and Adult Social Care Overview and Scrutiny Committee

Wednesday 7 September 2022

PRESENT:

Councillor Mrs Aspinall, in the Chair.
Councillor Deacon, Vice Chair.
Councillors Finn, Harrison, McDonald, Murphy, Nicholson, Partridge, Mrs Pengelly, Reilly, Salmon, Tuffin and Wheeler.

Also in attendance: Craig McArdle (Strategic Director for People), Anna Coles (Strategic Director of Integrated Commissioning), Tony Gravett MBE (Healthwatch Plymouth), Ross Jago (Head of Governance, Performance and Risk), David Bearman (Devon Local Pharmaceutical Association), Sue Taylor (Devon Local Pharmaceutical Association), Councillor John Mahony (Cabinet Member for Health and Adult Social Care), Dafydd Jones (GP), Jo Turl (Director of Commissioning, Devon ICS) and Elliot Wearne-Gould (Democratic Advisor).

The meeting started at 14:00 and finished at 17:00.

Note: At a future meeting, the Panel will consider the accuracy of these draft minutes, so they may be subject to change. Please check the minutes of that meeting to confirm whether these minutes have been amended.

11. **Declarations of Interest**

Member	Interest	Declaration
Councillor Natalie Harrison	Personal	Councillor Harrison's partner was a patient at Beacon Medical

12. **Minutes**

The Committee agreed the minutes of 13 July 2022 as a correct version, for the record.

13. **Chair's Urgent Business**

The Chair, Councillor Mary Aspinall, requested an update on 'delayed transfers to care', from Anna Coles (Service Director of Integrated Commissioning). It was reported that-

a) At this time, the average delay at University Hospitals Plymouth was 9 days, Devon's average was 4.5 days, and Cornwall's average was 22.4 days;

b) Meetings were being held with the National Discharge Taskforce to discuss ongoing challenges with delays;

c) Overall, there had been significant improvement to delays since the last meeting of the Health and Adult Social Care Overview and Scrutiny Committee.

In response to questions from the committee, it was reported that-

d) Delayed transfers to care were an ongoing issue, and updated figures would be brought to the next Health and Adult Social Care Overview and Scrutiny Committee meeting.

The Chair, Councillor Mary Aspinall, advised that a response had been received from a letter sent to the Prime Minister and Secretary of State for Health, concerning delays to ambulance handovers. As this was proposed in a motion on notice at Full Council on 20 June 2022, the response would be circulated to all members.

The Chair, Councillor Mary Aspinall, advised that a holding email had been received in response to a letter sent to the head of dental provision for the NHS Southwest region, outlining concerns with current service provision. Plans were being constructed for a scrutiny session in October, to analyse Plymouth's dental concerns.

14. **Health and Adult Social Care Policy Brief**

Sarah Gooding (Policy and Intelligence Advisor), outlined the Health and Adult Social Care policy brief to the committee, and highlighted the following points-

a) The Women's Health Strategy had been published in July;

b) The Health and Care Act had issued guidance around Integrated Care Strategies, and how scrutiny committees could work with new systems of integrated care partnerships. Further detail would be published shortly.

The Committee agreed to note the report.

Ross Jago (Head of Governance, Performance and Risk) delivered the Risk Monitoring Report to the committee, and highlighted the following points-

a) There were five risks on the report pertinent to Health and Adult Social Care, including one red risk (Workforce), and one new risk (Adult Social Care Reform);

b) The Risk Register should form part of the regular Health and Adult Social Care Overview and Scrutiny Committee work programme, so risks could be appropriately monitored and addressed.

Following questions from the committee, it was reported that-

a) The Risk Monitoring Report was designed to track and mitigate potential risks relating to the council's statutory duties and obligations, and did not denote certainty that these risks would occur;

b) Mitigating measures had been put in place to counter the risks present on the report.

The Committee agreed to note the report, and-

1) Continue to receive the Risk Management Register as a standing agenda item;

2) Add Adult Social Care Reforms to the work programme.

15. **Healthwatch Plymouth**

Tony Gravett (Healthwatch Plymouth) presented an overview of citizens' experiences with Pharmacy and General Practise to the committee, and highlighted the following points-

a) There had been a distinct change in how General Practise services were being delivered, transitioning away from face to face towards digital provision and E-consult. This had resulted in some significant challenges for patients in accessing services, with many original designs of E-consult "not fit for purpose";

b) Feedback received by Healthwatch had shown that not all citizens had the desire, physical, or technical ability to use digital systems. It was therefore essential to ensure a mixed-access method to services;

c) In Healthwatch's opinion, patient safety was beginning to be affected by misdiagnosis and/or lack of integrated care provision, in some isolated cases;

d) Healthwatch had seen an increase of complaints relating to medication and prescriptions in a number of pharmacies in Plymouth. This had included prescriptions not being available for collection at allotted times, prescriptions going missing, and temporary unplanned closures of pharmacies due to staffing issues;

e) High demand and additional pressures placed on health services appeared to have been causing a decline in basic coordination and service standards, leading to concerns for patient safety.

In response to questions from the committee, it was reported that-

f) It was difficult for patients to explain their symptoms accurately through E-consult, leading to potential errors through misinterpretation and misdiagnosis. This was often avoided through face to face appointments with General Practitioners (GPs).

g) There was significant variation in the standard of services provided by GP practices across Plymouth. Some practices had maintained a primarily face to face approach, while others struggling with workforce pressures had transitioned further towards online delivery. It would take ongoing work to standardise the methods and quality of care provided by GP practices across Plymouth.

h) From feedback submitted to Healthwatch, it appeared that some areas of care had improved since their decline during the pandemic however, many other areas had not, due to ongoing demand, staffing, and supply pressures.

The Committee agreed to thank Mr Gravett for the report, and praised the work of Healthwatch staff.

16. **Primary Care** (To Follow)

Jo Turl (Director of Commissioning, NSH Devon ICS) introduced the draft Primary Care Strategy to the Committee, and highlighted the following points-

a) Healthwatch's report had portrayed a valuable and fair representation of issues currently facing Plymouth's health services. Demand for health services had increased after the pandemic, and had caused many issues for patients in accessing services;

b) The Primary Care Strategy before the Committee was a draft work, with greater scrutiny and consultation required before its publication. Comments and engagement from the Committee were welcomed to help shape a robust policy, capable of producing a reliable care strategy for future years;

c) There was a specific requirement for the policy to address patient access issues and demand, as well as the role of general practice in a holistic system, supported by pharmacy, community teams, and voluntary sector;

d) It was important to note that not all health issues were best addressed through face to face appointments with medical professionals. A blended approach to access, as well as the inclusion of pharmacy and the voluntary sector could often be more convenient, efficient and effective;

e) Service provision methods were unlikely to return to those pre-pandemic. Instead, methods such as E-consult were being continually modified and improved to enhance patient satisfaction, while also managing high demand.

Dafydd Jones (GP) presented a GPs perspective to the Committee, and highlighted the following points-

a) Dafydd had been a GP for 11 years, working in a range of areas and practices across the city;

b) GP services were facing significant challenges from high demand and capacity limitations. This undoubtedly impacted upon patient experiences and outcomes;

c) A strategy document was warmly welcomed, bringing essential long-term management of future demand and capacity issues for Plymouths health and care services.

In response to questions from the committee, it was reported that-

d) GPs did not get professional fulfilment from phone and online contact. These were merely methods introduced to best manage high demand and low capacity;

e) Within the past 2 years, Dafydd's surgery had lost the equivalent of 3 full-time GPs, with recruitment proving unsuccessful. The average training period for prospective GPs was 5/6 years at medical school, followed by 5 years of experience post medical school;

f) Dafydd's surgery received around 1,000 calls on a typical Monday, and around 600 per day Tuesday-Friday. This was combined with around 1,200-1,500 E-consults per week, an increase of around 25% over past 2 years;

g) The Primary Care Strategy would undergo further consultation and review to set ambitions local targets for service provision. A final version was expected to be produced before the end of December 2022.

The Committee agreed-

1) To note the drat Primary Care Strategy;

2) To recommend to Jo Turl and the Devon ICS, that the final Primary Care Strategy must include a variety of access methods to ensure inclusivity (digital, phone, & in-person), to allow Patients to access GP services in a timely manner;

3) To recommend that the Committee be offered a briefing within a GP practise, to gain experiences of GP's work.

17. **Pharmacy** (Verbal Report)

Tony Gravett MBE (Healthwatch Plymouth) delivered the 'Pharmacy Patient Experience Report' to the Committee, and highlighted the following points-

1) Healthwatch had produced the report in response to a request for information from Public Health Plymouth, during the drafting of the Pharmaceutical Needs Assessment 2022-25;

2) It had been surprising to note the high level of feedback received regarding Plymouth's pharmacy services, in comparison to those in Devon and Torbay;

3) Community pharmacy was increasingly alleviating pressure from General Practise and Emergency Department services however, ongoing staffing issues were limiting capacity and potential.

In response to question from the Committee, it was reported that-

4) The report had been shared with the Public Heath teams in Devon, the Local Care Partnership Boards, the Devon Local Pharmaceutical Committee, and NHS Devon ICS;

5) Healthwatch were aware of regular supply issues for certain medications however, this did not regularly feature in survey responses. Instead, responses had often highlighted prescription delays, or changes to medication dosage;

6) Community pharmacy had significant potential to alleviate pressures on other health services, but required sufficient funding, staffing, and ongoing restructuring.

The Committee thanked Tony Gravett MBE, and-

1) Agreed to note the report.

David Bearman and Sue Taylor Delivered the 'Community Pharmacy Update Report' to the Committee, and highlighted the following points-

a) The Devon Local Pharmaceutical Committee represented all NHS community pharmacy contractors in the Devon area (224 Pharmacies);

b) There were an estimated 1.6 million consultations provided by community pharmacies per day. Per week, pharmacies gave symptom advice to over 730,000 people, and advice about existing medical conditions to over 263,000 people. These informal consultations were estimated to save over 24 million GP appointments per year;

c) The acuity of patient's symptoms presenting at pharmacies for advice and treatment had risen during the Covid-19 pandemic;

d) The current pharmacy contract (2019-24) was a 'flat cash' contract. This meant that pharmacies received the same funding each year, for the 5 year contract. Pharmacies were expected to expand their service provision each year, or would receive a reduction in funding. This had forced pharmacies to make efficiencies of 37-50% in order to manage the funding squeeze, inflationary pressures, and increasing demand for clinical services;

e) Some pharmacies had outsourced prescriptions to central hubs in order to increase efficiency. This had often led to a reduction in staff numbers at local pharmacies;

f) There was a national shortfall in pharmacists and technicians. The Southwest faced significant staffing challenges, with a very low uptake in pharmacy school applications, and no school of pharmacy in Plymouth. There were 400-500 pharmacist vacancies in the southwest, with around 91% of pharmacies experiencing staff shortages;

g) There were increasing issues with medication stocks and supply. This had forced pharmacies to use additional staffing-hours to source medications, as well as consulting with GPs to substitute medications or alter dosages. This was consuming an estimated 5.3 hrs per pharmacy, per week.

h) Pharmacies had experienced increased abuse and aggression towards staff, leading to difficulties recruiting and retaining staff. This had also led to additional costs of installing security measures;

i) There was a broad lack of public recognition towards the financial struggles of pharmacies, as well as ongoing recruitment and retention issues. In the past year, pharmacies in Devon had been open for 98% of their contracted hours, with temporary closures impacting only 2% of contracted time. This highlighted the importance and value of pharmacy services;

j) In comparison to the national average, Devon had one of the highest rates of pharmacy closures however, these trends were beginning to be reflected across the country;

k) Devon was one of the best performers for pharmacy services within their sole control. The New Medicines Service (NMS), Lateral Flow testing, blood pressure monitoring, and Ambulatory blood care monitoring were all performing above the national average. Furthermore, there had been 124,000 flu vaccinations delivered in Devon alone, last year;

l) Despite the challenges faced, there was significant potential for pharmacies to reduce inequality, improve prevention, and improve primary care access through the GP community pharmacy consultation service. Pharmacies were seeking to deliver better outcomes by expanding the New Medicines Service, and Discharge Medication Service, reducing the length of hospital stays, and likelihood of readmission. The utilisation of the electronic Repeat Dispensing Service also had potential to increase efficiency for pharmacy and general practise, reducing the demand for medication related GP appointments;

m) There were significant opportunities for efficiency and modernisation improvements in the future, with pharmacy commissioning transitioning from NHS England, to the Integrated Care Boards (ICB). This would bring potential to expand services, drive integration, and remodel pharmacy staffing.

In response to question from the Committee, it was reported that-

a) There were 5-6 wholesalers that Devon pharmacies used for medications. Occasionally 'out of stock issues' effected all suppliers, leading to additional staff-hours spent sourcing alternative medications and consulting with GPs;

b) The Devon Local Pharmaceutical Committee was working closely with Derriford Hospital to enhance the use of the Discharge Medicines Service. This had significant potential to reduce hospital-stays and provide patients with additional assistance with medications;

c) The new commissioning service would enable pharmacies to remodel their business and service provision, providing enhanced management of workload to help alleviate staffing, demand and economic pressures;

d) Work was ongoing between pharmacies in Devon, and the Bath Pharmaceutical School, to encourage students and graduates to pursue placements in the Southwest, thus helping to alleviate staffing pressures. The Southwest had faced significant challenges attracting pharmaceutical graduates from Bath, who tended to secure placements with acute trusts.

The committee thanked David Bearman and Sue Taylor for the report and-

1) Agreed to note the report

2) Agreed to request at a later date, a report from Derriford Hospital, regarding the effectiveness and ongoing expansion work of the Discharge Medicines Service.

Change to the Order of Business

Following approval of the Chair, the Order of Business was changed to bring forward item 11, Tracking Decisions, and item 12, Work Programme.

18. Tracking Decisions

The Committee agreed to note that all tracking decisions had been actioned.

19. Work Programme

The Committee agreed that Public Health Indices, and Winter Health Preparedness would be brought to the next meeting.

20. Exempt Business

The committee considered passing a resolution under Section 100A(4) of the Local Government Act 1972 to exclude the press and public from the meeting for the following item of business on the grounds that it involved the likely disclosure of exempt information as defined in paragraph 3 of Part 1 of Schedule 12A of the Act, as amended by the Freedom of Information Act 2000.
Cllr Finn Proposed this Motion;
Cllr Nicholson Seconded this Motion;

The committee agreed this motion.

(i) Part II (Private Meeting)

21. **Cavell Centre Briefing** (Verbal Report)

Clive Shore delivered an update report on the West End Health Hub/ Cavell Centre to the Committee.

The Committee agreed to note the report, and to seek further updates in the near future.

This page is intentionally left blank

Health and Adult Social Care Overview and Scrutiny Committee

Date of meeting:	16 November 2022
Title of Report:	**Health and Adult Social Care Policy Brief**
Lead Member:	Councillor Dr Mahony Portfolio holder for Health and Adult Social Care
Lead Strategic Director:	Anna Coles (Strategic Director for People)
Author:	Alan Knott (Policy & Intelligence Advisor)
Contact Email:	Alan.Knott@Plymouth.gov.uk
Your Reference:	HASC PB 1161122
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report

To provide Health and Adult Social Care Overview and Scrutiny Committee with the latest national picture in respect of policy announcements and legislation relating to health and social care.

Recommendations and Reasons

For Scrutiny to consider the information provided in regard to their role and future agenda items.

Alternative options considered and rejected

N/A

Relevance to the Corporate Plan and/or the Plymouth Plan

Delivery of the Corporate Plan and Plymouth Plan needs to take account of emerging policy and the legislative picture.

Implications for the Medium Term Financial Plan and Resource Implications:

N/A

Carbon Footprint (Environmental) Implications:

N/A

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:

** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*

N/A

Appendices

**Add rows as required to box below*

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	2	3	4	5	6	7
A	Health and Adult Social Care Policy Brief							

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are unpublished works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	2	3	4	5	6	7

Sign off:

Fin	N/A	Leg	N/A	Mon Off	N/A	HR	N/A	Assets	N/A	Strat Proc	N/A
Approved by: Giles Perritt, Assistant Chief Executive Date approved: 4 Nov 2022											

POLICY BRIEF

Health and Adult Social Care Overview and Scrutiny

16 Nov 2022

The information within this Brief is correct at the time of approval for publication and contains relevant recent announcements made by Government and its departments and regulators.

GOVERNMENT POLICY, LEGISLATIVE ANNOUNCEMENTS AND NEWS

£50 million to tackle health inequalities through research

First ever investment for local authorities to research into health inequalities affecting their local area. £50 million awarded to 13 local authorities across the UK. Plymouth City Council and our academic partner, the University of Plymouth, have been awarded more than £4.7 million from The National Institute for Health and Care Research (NIHR), the research partner of the NHS, public health and social care for a Health Determinants Research Collaboration (HDRC).

The Health and Social Care Secretary sets out new plan for patients

Health and Social Care Secretary announces the government's new 'Our plan for patients' to improve care for patients. The plan includes:

- An expectation that anyone who needs an appointment should get one at a GP practice within 2 weeks – and patients with the most urgent needs should be seen within the same day
- Help so people get out of hospitals and into social care support, the government is launching a £500 million Adult Social Care Discharge Fund
- Plan to reflects changes to pension rules to retain more experienced senior clinicians and exploring strengthening how we use volunteers in the health service, including to support ambulance services

Framework agreement between DHSC and Health Education England 2022 to 2025

The framework document has been agreed between the Department of Health and Social Care (DHSC) and Health Education England (HEE) in accordance with HM Treasury's handbook 'Managing Public Money' (MPM) (as updated from time to time) and has been approved by HM Treasury.
The framework document sets out the broad governance framework within which HEE and DHSC operate. It sets out HEE's core responsibilities; describes the governance and accountability framework that applies between the roles of DHSC and HEE; and sets out how the day-to-day relationship works in practice, including in relation to governance and financial matters.

NHS set to boost GP workforce ahead of winter

From this month, over a thousand GP's assistants will be recruited to help reduce time GPs spend on administrative tasks. GP assistants will also be trained to do blood pressure checks, heart rate and blood tests as well as arranging appointments, referrals and follow up care for patients.
Local areas can also recruit up to 1,250 digital transformation leads across the country who will take on responsibilities such making sure practices are using the latest technology to offer more telephone lines and offering support with the NHS app

Care Quality Commission - State of Care 2021/22

The State of Care is the CQC's annual assessment of health care and social care in England. The report looks at the trends, shares examples of good and outstanding care, and highlights where care needs to improve.

This page is intentionally left blank

Health and Adult Social Care Overview and Scrutiny Committee

Date of meeting:	16 November 2022
Title of Report:	**Risk Monitoring Report**
Lead Member:	Councillor Mark Shayer (Deputy Leader and Cabinet Member for Finance and Economy)
Lead Strategic Director:	Giles Perritt (Assistant Chief Executive)
Author:	Ross Jago, Head of Governance Performance and Risk
Contact Email:	Ross.jago@plymouth.gov.uk
Your Reference:	RS/RM
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report

The attached report (Appendix A) provides an update on the Strategic risk register pertinent to the committee. The register offers additional information including detail on Key Controls and Sources of Assurance and how progress against mitigation will be measured.

Adult Social Care reforms have been highlighted as a risk. There are a number of reforms that will create financial uncertainty in terms of being able to accurately understand the impact on costs and resources. This amber risk has been scored as 'Likely' to happen and a 'Major risk' to the operation of the council.

Recommendations and Reasons

The Health and Social Care Overview and Scrutiny Committee is recommended to:

1. Note the current position.
2. Consider whether any risks identified should be programmed for further discussion by the Committee.

Reason: As part of the Committee's responsibility for monitoring the implementation and ongoing processes for identifying and managing key risks of the authority.

Alternative options considered and rejected

Effective risk management processes are an essential element of internal control and as such are an important element of good corporate governance. For this reason alternative options are not applicable.

Relevance to the Corporate Plan and/or the Plymouth Plan

The Strategic Risk and Opportunity Register includes links to the Corporate Plan priorities – monitoring of control action for strategic risks therefore contributes to the delivery of the council's core objectives.

Implications for the Medium Term Financial Plan and Resource Implications:
None arising specifically from this report but control measures identified in Directorate Operational Risk and Opportunity Registers could have financial or resource implications.

Financial Risks
None arising specifically from this report but control measures identified in Directorate Operational Risk and Opportunity Registers could have financial or resource implications.

Carbon Footprint (Environmental) Implications:
Failure to deliver against actions in the Climate Emergency Action Plan and Corporate Carbon Reduction Plan are included on risk registers.

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*
The risk registers specifically supports the council's overall governance arrangements.

Appendices
**Add rows as required to box below*

Ref.	**Title of Appendix**	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**

Background papers:
**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are unpublished works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**

Sign off:

Fin	N/A	Leg	N/A	Mon Off	EJ/8851/8.11.22	HR	N/A	Assets	N/A	Strat Proc	N/A
Originating Senior Leadership Team member: Giles Perritt											
Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 08/11/2022											
Cabinet Member approval: Councillor Mark Shayer (Deputy Leader and Cabinet Member for Finance and Economy) Date approved: 08/11/2022											

Strategic Risk update table one

Table one provides an update on strategic risks with mitigation that is fully influenced by Plymouth City Council.

Table one – Strategic Risks fully mitigated by Plymouth City Council

Risk Register No.	Description	Mitigation	Risk Score	Previous risk rating	Current risk rating	Risk Owner
1	The Council's expenditure exceeds the resources available to meet that expenditure within the medium term financial plan period (2022/23-2025/26)	The Council has also taken the following steps (1) to adopt a 5 year MTFP moving forward rather than a 1 year or 3 year model (2) to adopt a system of monthly financial reporting to Directorate Management Teams, Corporate Management Team, and Cabinet and Quarterly to Full Council, with monthly consideration of directorate level financial issues at each Scrutiny Committee In addition the Council has introduced a system of detailed monitoring of the delivery of savings targets so that a view is published monthly in Cabinet reports. This will also include any significant issues which emerge from the cost of living crisis. The Council also holds an annual review of fees and charges and has annual and ongoing programmes of work to identify and understand potential savings opportunities. The governance system of the Council - as unpacked in the Annual Governance Statement comprise a rigorous system of financial control. It is of critical importance to the Council and City that CMT and Cabinet select means of reducing the costs of the Council to fully mitigate the forecast budget shortfalls in future years. This is underway but until this work is completed later in 2022 the risks will remain at the current level. The Deputy leader/PFH for Finance is meeting each week with S151 Officer and Strategic Director for	25	**Red** ⬆ Red since May 2022	**Red** ▬	David Northey

Risk Register No.	Description	Mitigation	Risk Score	Previous risk rating	Current risk rating	Risk Owner
		Customer & Corporate Services to review the 2022/23 Monitoring position. There are also Member & Officer Budget Working Subgroup meetings every 2 weeks to monitor progress on 2023/24 budget.				
9	Increased and sustained pressure on Adult Social Care budget due to increased costs of providing care, growing numbers of people and increased complexity of need. As this is a statutory service and largest single budget it could have a significant impact on the Authorities overall financial position.	- Real time management information - Strong Reablement Offer - Established Review Programme - Commissioning Intentions and Commissioning Activity to develop new models of care - Budget containment meetings in place - Focus on reviews and reablement to right size packages of care including focused work on 18 to 64's - Emergency Plan to cover need to prioritise critical services	16	**Amber**	**Amber**	Anna Coles

Strategic Risk update table two

Table two provides an update on strategic risks with mitigation that is influenced by Plymouth City Council but is also dependent on other outside factors.

No.	Description	Mitigation	Risk Score	Previous risk rating	Current risk rating	Risk Owner
5	Lack of adult social care workforce and growing fragility of Adult Social Care Market leading to inability of Authority to meet statutory duties and meet eligible need.	- Establishment of Community Capacity Command Centre to provide greater oversight of market and capacity - Local Authority has set up a Care Company to ensure continuity of provision in the event of market failure - Care Home liaison work being undertaken by Livewell Southwest, to increase levels of support to Residential and Nursing care marker	20	**Red**	**Red** Red since Oct 2021	Anna Coles

No.	Description	Mitigation	Risk Score	Previous risk rating	Current risk rating	Risk Owner
		- Risk to be continued to be monitored through contract monitoring and market intelligence - Supporting market wide workforce recruitment / retention across residential and domiciliary sector - Remodelled bed bureau launched to support Care Homes to manage complex discharge cases - Incentive payments to workforce - Managing risk through winter strategy for the domiciliary care market.				
7	Ongoing COVID-19 rates (with potential for further peaks) affect city's recovery / reset plans.	The key mitigation of vaccination has now reached around 85% (one or more doses) of those eligible. There have been reductions in the mitigations (reduced testing, support payments and legal need for self-isolation) and this has created uncertainty around case rates and the risk of delayed detection of new variants. The longstanding advice to the general public remains in place and is re-emphasised at regular intervals.	16	Amber	Amber	Ruth Harrell
8	Failure to reduce Health Inequalities will mean our poorest residents continue to live shorter lives as well as more years in ill health. Mounting evidence that COVID-19 is having differential health impacts across communities, adding to existing health inequalities. This is through either the disease itself or the mitigations put in place. There is an ongoing impact of	Persistent action across the Council is required at many levels to tackle inequalities by addressing the wider detriments of health. The Public Health Team and partners continue to work with employers (year one focus) and schools (year two focus) to influence healthier lifestyles. The team continues to embed and promote the national One You campaign across the city. The 'five ways to wellbeing' has been adopted across the City as the single approach to improving mental wellbeing. The work that started in year five on 'people connecting through food' is ongoing with a number of new initiatives developed. The intention was that the year six focus would be arts, culture, heritage and health (using the Mayflower 400 commemorations as the vehicle for delivery). However, this year was curtailed as a result of the pandemic and a	16	Amber	Amber	Ruth Harrell

No.	Description	Mitigation	Risk Score	Previous risk rating	Current risk rating	Risk Owner
	this due to the economic downturn. The primary role of the ODPH and the Public Health Team in particular is now to try to manage COVID-19 in the city, therefore protecting most deprived communities from further negative impacts.	two year pause was put on the programme. Subsequently, Thrive Plymouth Year seven was launched in May 2022 with a focus on Listening and Reconnecting. 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 and apply to the wider challenges of inequality. Evidence has been provided to the Health and Wellbeing Board on the risk of widening health inequalities which partners are working together to try to mitigate. The Local Care Partnership priorities are being refreshed and includes tackling inequalities. Both of these routes bring partners together to understand the issues and the steps needed to tackle health inequalities in the City. In addition to this, to support the work of the Council's cross-party Child Poverty Action Plan Working Group, a high level review of the evidence of the impacts of the pandemic on the mental wellbeing of children and young people has been carried out. As already stated, the primary role of the ODPH and the Public Health Team in particular is now to minimise the impact of COVID-19 in the city therefore protecting most deprived communities from further negative impacts.				
10	Adult Social Care (ASC) Reforms - There are a number of reforms to ASC that will create financial uncertainty in terms of being able to accurately understand the cost and resources impact once reforms have been	This risk will continue to be monitored closely as the reform programme progresses. We will assess the impact of charging reforms on 'trailblazer' local authorities who are early adopters of these reforms. We will continue cost of care exercises locally, including working with our local care market to better understand impact on finance and resources.	16	**Amber** New risk	**Amber**	Anna Coles

No.	Description	Mitigation	Risk Score	Previous risk rating	Current risk rating	Risk Owner
	implemented. It is not clear whether any additional monies will be made available for local authorities and there is currently no reliable way of forecasting impact. Examples of reforms include; Fair cost of care Charging reforms Local Protection Safeguards Care Quality Commission Assurance programme	We will continue engagement with Local Government Agency and regional and national groups (such as ADASS) to determine approach to managing all reforms. We will continue to seek to understand impacts of all reforms through our established reform programmes, and will consider potential use of Offers and Asks due to cost of new burdens on the service.				

Health and Adult Social Care Overview and Scrutiny Committee

Date of meeting:	16 November 2022
Title of Report:	**Public Health Commissioning**
Lead Member:	Councillor Dr John Mahony (Cabinet Member for Health and Adult Social Care & Planning)
Lead Strategic Director:	Ruth Harrell (Director of Public Health)
Author:	Sarah Lees
Contact Email:	Sarah.lees@plymouth.gov.uk
Your Reference:	Click here to enter text.
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report

To summarise the current services commissioned by Public Health from the ring-fenced Public Health Grant and identify any areas of exception.

Recommendations and Reasons

1. To note the contents of the report.

Alternative options considered and rejected

None

Relevance to the Corporate Plan and/or the Plymouth Plan

Commissioned public health services help to reduce health inequalities and focus on prevention and early intervention. The commissioned services contribute to the Health and Wellbeing ambitions of the Plymouth Plan, in particular on addressing health inequalities [HEA1], delivering the best outcomes for children, young people and families [HEA2], supporting adults with health and social care needs [HEA3] and delivering accessible health services [HEA9]

Implications for the Medium Term Financial Plan and Resource Implications:

None

Financial Risks

None

Carbon Footprint (Environmental) Implications:
None

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*
Click here to enter text.

Appendices
**Add rows as required to box below*

Ref.	**Title of Appendix**	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**
A	Public Health Commissioning Update							
B	Equalities Impact Assessment (if applicable)							

Background papers:
**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are <u>unpublished</u> works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**

Sign off:

Fin	pl.22.23.263	Leg	EJ/38851/7.11.22(4)	Mon Off	Click here to enter text.	HR	Click here to enter text.	Assets	Click here to enter text.	Strat Proc	Click here to enter text.
Originating Senior Leadership Team member: Sarah Lees											

Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 04/11/2022
Cabinet Member approval: Councillor Dr John Mahony (Cabinet Member for Health and Adult Social Care and Planning) Date approved: 07/11/2022

This page is intentionally left blank

PUBLIC HEALTH COMMISSIOINING UPDATE BRIEFING

Office of Director of Public Health

BACKGROUND

Public health concerns the health of the population rather than the individual and has a rationale of protecting population health, preventing illness and promoting health and wellbeing. It aims to reduce inequalities in health and to improve health care quality and equity. It uses intelligence at its core to understand the health of populations and the opportunities for improving this using an evidence based approach. At its heart is a prevention approach – preventing people from becoming ill is not only better for people but also makes economic sense. The 5 Year Forward View[1] stated that the future health of the population, the sustainability of the NHS and the economic prosperity of the country all now depend on a radical upgrade of the prevention approach and of public health. This is because the evidence demonstrates that public health interventions are cost saving at a local and national level and offer significant returns on investment in the medium and long term.[2]

Under the Health and Social Care Act 2012 responsibility for local public health was transitioned from the NHS to local authorities and funding provided for this through an annual Public Health Grant from the Department for Health. The grant allocated to Plymouth, since its introduction, has been below the target allocation to meet the needs of the local population. There was an initial £3million shortfall. The current Public Health Grant for 2022/23 is £15.9 million and 85% of that grant value is spent on services that are commissioned to deliver all the mandated functions of public health in the local authority and to protect and improve the health of the local population.

In 2022 the Government have introduced additional targeted funding for substance misuse treatment through a separate Supplementary Substance Misuse Treatment and Recovery Grant. This amounts to £770,000 for Plymouth in 2022/23 and is due to rise in future years to around £1.2 million.

THE PUBLIC HEALTH COMMISSIONED SERVICES

Sexual and Reproductive Health

Open access sexual and reproductive health services are provided through an integrated service called SHiP [Sexual Health in Plymouth] and through contraception services from GPs and Pharmacies. These services currently cost approximately £2.8 million per year.

SHiP is provided by a collaboration of University Hospitals Plymouth (UHP) NHS Trust, Livewell South West, The Zone and the Eddystone Trust. The service provides sexual health advice and information, testing and treatment for STIs and all forms of contraception. It prioritises prevention and self-management and makes best use of new treatments and technologies. The service operates as part of a broader system of sexual and reproductive healthcare services commissioned by NHS Devon and NHS England that include abortion services, HIV treatment and care services, a Sexual Assault Referral Centre and cervical screening programme.

Rates of sexually transmitted infections (STIs) in Plymouth are high when compared to England averages and rates in nearest neighbour areas. The numbers of recorded infections are likely to be

[1] NHS 5 year forward view. UK Government. October 2014

[2] Masters R et al. Return on investment of public health interventions: a systematic review. J Epidemiol Community Health 2017;71:827-834

higher than reported as surveillance of STI diagnosis does not provide a full measure of prevalence because many infections are asymptomatic and undiagnosed.

The rate of teenage conceptions in Plymouth has fallen significantly in recent years from 54.7 per 1,000 females aged 15-17 in 1998 to 15.5 in 2020. Rates in Plymouth are slightly above the England average of 13.0.

In 2020 the total abortion rate per 1,000 female population aged 15-44 years was 18.1 which is slightly lower than the England rate of 18.9.

Late diagnosis is the most important predictor of HIV related morbidity and short term mortality. The estimated diagnosed prevalence of HIV in Plymouth is low. However between 2019 and 2021 57.1% of new HIV diagnoses in Plymouth were late diagnoses (8 cases).

Whilst access to contraception in Plymouth is good, there has been disruption to provision during the COVID-19 pandemic. The provision has now returned to pre-COVID levels.

The recent outbreak of Monkeypox in the UK has resulted in increased workload for local sexual health services due to the need to respond to contact tracing and identification and the delivery of vaccinations as determined by national policy.

Sexual ill-health has been estimated to cost the NHS more than £700 million a year.[3] The cost of treating STIs in England, Wales, and Northern Ireland has been calculated at approximately £165 million per year.[4] The lifetime treatment costs for each new case of HIV infection is between £280,000 and £360,000[5]. The cost of HIV care in the first year after diagnosis is twice as much for someone with a late diagnosis.[6]

Investing in sexual health services can deliver significant cost savings for the NHS and local authorities. Quality services and interventions that focus on prevention, screening and prompt treatment and partner notification can control disease, prevent unwanted pregnancies and avoid costly health complications and treatments.

[3] HIV and other Sexually Transmitted Infections in the United Kingdom in 2003. Health Protection Agency, 2004.

[4] Health Protection in the 21st century Understanding the burden of disease: preparing for the future. Health Protection Agency, 2005.

[5] Health promotion for sexual and reproductive health and HIV: strategic action plan 2016-2019. Public Health England. 2016.

[6] NICE local government briefings HIV testing. NICE, June 2014. http://www.nice.org.uk/advice/lgb21/resources/non-guidance-hiv-testing-pdf

Complex Needs (Substance Misuse Treatment and Support)

Substance misuse has been seen as two separate issues, namely illegal drug misuse, particularly heroin and crack cocaine, and alcohol misuse and Plymouth has higher than national average levels of both categories of misuse. In addition we have seen levels of addiction to prescribed drugs and to drugs sourced on the internet rise to unprecedented levels over the last decade. Whilst drug and alcohol use is seen across the population, drug and alcohol *problem use* is concentrated in our deprived neighbourhoods and our most vulnerable population groups and as such is a drive of health inequalities. It is important to view substance misuse as part of a complex needs system, because it is closely related to adverse childhood experiences (ACE) and should be seen more as a means of coping with psychological distress, rather than as an illness in and of itself. Substance misuse is also strongly associated with homelessness, mental illness, domestic violence, child protection, acquisitive crime (drugs), violent crime (alcohol), unemployment, anti-social behaviour and early disease and premature death.

Of note relating to our local context;

- Plymouth has higher rates of opiate and crack use than national average.
- Plymouth has higher rates of drug poisoning admissions to hospital than national average
- Plymouth has higher rate of drug related deaths than national average.
- Plymouth treats a higher percentage of opiate and crack users than the national average [61% compared to 50%] and has 98% compliance with waiting time
- Our services are efficient, effective and amongst the lowest unit cost in the region.
- Plymouth's treatment cohort tends to be older, sicker, more likely to be injecting and have more complex needs than the average and rates of discharge are therefore lower than the national average [proportion in treatment for more than 6 years 35% compared to 27%].
- Patterns of addiction are changing in recent years drug markets have changed with increased internet access driving a rise in 'grey' markets for prescription drugs such as valium and strong pain killers. We have a larger proportion of prescription (POM) only and over the counter (OTC) addicts in treatment than the national average.
- Plymouth has seen levels of chronic pain and mental illness rise over the last 10 years and we are now an outlier for pain prescribing and anti-depressant prescribing. We are seeing increasing numbers of people addicted to prescribed drugs in Primary Care and specialist pain services.
- Substance misuse is also a significant driver of demand for Children's Social Care with estimates of between 35% and 40% of all cases being related to substance misuse.

Our Public Health investment for substance misuse treatment and support is all provided within the Plymouth Alliance for Complex Needs contract. The services provided include community based drug and alcohol treatment services, detox provision, day services, support and recovery services along with additional prescribing from GPs and supervised consumption from Pharmacies. The current level of investment for this is approximately £4.5 million (covering adults and young people). The Substance Misuse Treatment and Recovery Grant is providing an additional £770,000 of investment in 2022/23 to increase community treatment capacity and to work to reduce the record numbers of drug related deaths. This funding will be used to provide additional capacity within the existing Plymouth Alliance partners.

It is estimated that every £1.00 spent on drug treatment saves £2.50 in costs - principally in criminal justice cost savings through reduced offending (without methadone treatment the average heroin user spends £1400 per month on drugs, mainly funded through acquisitive crime, sex working and drug dealing); through reduced demand on childrens services; reduced costs to hospitals through

reductions in ED attendance, infectious diseases due to blood borne viruses, liver and lung disease, overdoses and early deaths.

In addition around 44% of people in mental health services also have substance misuse problems [dual diagnosis] which delays recovery and leads to frequent relapse and around 70% to 80% of people in substance misuse issues also have mental health problems (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)). A Joseph Rowntree Foundation report found 70% of the homeless population suffer from substance misuse.

Apart from the primary purpose of treating some of our most marginal and deprived people, substance misuse services also underpin delivery of childrens social care, homelessness services, offender services and a range of health services.

Health Improvement

The opportunity and challenge to improve health in the Plymouth population is great. Life Expectancy in Plymouth is consistently below the England average for both males and females. This is closely associated with levels of deprivation, which for the most part explains the well documented and long standing health inequalities that exist amongst our local population. Our data demonstrates that local people in our most deprived neighbourhoods not only live shorter lives, but they also live more of their lives in poor health.

Thrive Plymouth is our city wide initiative to create a social movement to work collaboratively to reduce health inequalities and improve the health of local people. We know that 4 lifestyle behaviours [smoking, diet, alcohol and physical inactivity] are key drivers of more than half of the premature deaths in the city and that these lifestyle behaviours are modifiable. We also know that to enable people to adopt healthier lifestyles is a very complex issue, influenced by social determinants, including environments, education, income, people's own sense of wellbeing and emerging evidence is now demonstrating the lifelong impacts of adverse childhood experiences.

As is detailed in the Life Expectancy and Public Health Indicator reports, in terms of the 4 lifestyle behaviours, our local position is worse than England average in relation to the prevalence of smoking tobacco and of being overweight or obese. It is in line with the England average in terms levels of physical activity in adults and is better than England average for hospital admissions for certain alcohol specific conditions.

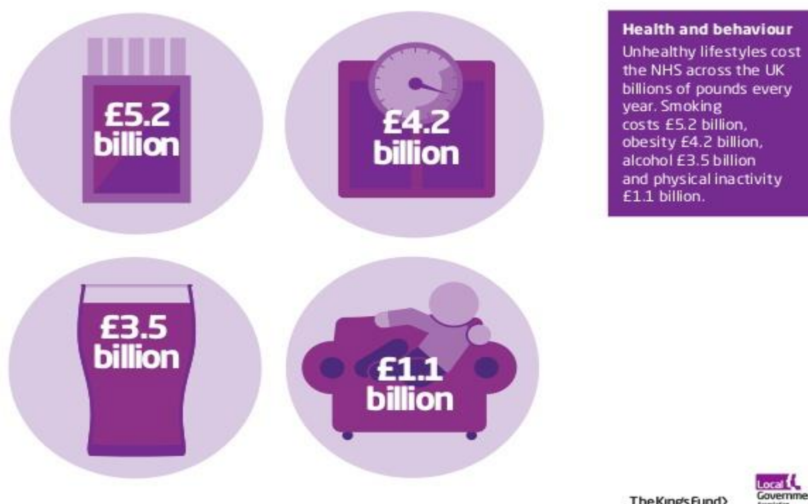
Current services commissioned for general health improvement include an integrated health improvement service delivered by Livewell Southwest and called One You Plymouth. This service is provided for the whole local population and delivers a person-centred and holistic offer. It is structured to inform, enable and support people, according to their needs and preferences, to make lifestyle improvements and includes smoking cessation, tier 1 and 2 weight management, physical activity interventions and brief interventions for alcohol. It also includes capacity building by the provision of training to local people and organisations, for example Make Every Contact Count [MECC] training and mental health awareness and prevention training. The service targets face to face

support within the most deprived neighbourhoods of the city and is aligning delivery to be present in the wellbeing hubs. In a year the service provides advice to around 5,500 individuals. 1,500 receive face to face interventions and around 1,000 people receive training of one type.

Additionally there are investments in Primary Care [GPs and Pharmacies] to support smoking cessation and to deliver NHS Healthchecks to the eligible populaiton. There are also small investments with VCSE providers to support health improvement in some groups with additional needs.

Current investment is approximately £1.33 million per year.

The costs to the NHS of unhealthy lifestyles is considerable and so the opportunities are not only in improving health but also in reducing health-care costs.



There is a wide range of evidence on the effectiveness and cost effectiveness of public health interventions. Of the public health interventions considered by NICE, 30 are cost saving, 141 were estimated to cost less than the £20,000 per quality-adjusted life year [QALY][7] threshold and of those 69 cost less than £1,000 per QALY.[8] As an example, for every £1 invested in stop smoking services £2.37 will be saved on treating smoking-related diseases and reduced productivity and £12.87 would be saved overall if QALY gains are valued at £20,000 per QALY.[9] Generally health improvement and promotion interventions have been found to have a median return on investment of 2.2 and a median cost-benefit ratio of 14.4.[10] Analysis of the NHS Health Checks programme identifies a cost per QALY of £3,000. Healthcare system savings are identified through the prevention of heart attacks and strokes and the early detection and treatment of disease.

The investment made in our health improvement services is therefore impactful not only on individuals, but on our health and care system as a whole.

[7] The quality-adjusted life year is a generic measure of disease burden, including both the quality and the quantity of life lived. It is used in economic evaluation to assess the value for money of medical interventions. One QALY equates to one year in perfect health.
[8] Owen L et al : The cost-effectiveness of public health interventions. Journal of Public Health 2011 Vol 34 No1 pp 37-45
[9] Pokhrel S, Owen L et al : Cost of disinvesting from stop smoking services : an economic evaluation based on the NICE Tobacco Return on Investment model. The Lancet 2016. Published online 25/11/16
[10] Masters R et al. Return on investment of public health interventions: a systematic review. J Epidemiol Community Health 2017;71:827-834

Public Health Nursing (Children and Young People)

Children and young people's health, wellbeing and development can be affected in many ways and by many factors in the period between conception and adulthood. The Child Health Profile shows that the picture for child health in Plymouth is mixed.[11]

Children in Plymouth are more likely to be exposed to smoking in pregnancy and thereafter, less likely to be breastfeed or achieve a good level of development at school entry than England. About a fifth of families with children aged under 5 are considered vulnerable due to multiple risk factors including parental mental health and substance misuse, dependence on benefits, social isolation, violence in the home and parents or children identified with special needs. Our obesity figures are mixed compared to England, but with nearly 1 in 5 children being obese by year 6, it is a significant health problem.

An estimated 10% of children aged 5-16 years have a clinically diagnosable mental health disorder and about 1 in 10 young people will self-harm. About half of adults with life-time mental health illness (excluding dementia) present by age 14 years. We have seen the impacts of the COVID-19 pandemic on children and young people manifest in many ways, including increasing levels of self-reported anxiety and isolation, a drop in school readiness and as yet an uncertain picture in terms of risk taking behaviours around substance misuse [drugs and alcohol].

There is an abundance of evidence that now describes the impact that adverse childhood experiences [ACE's] can have on lifelong health and wellbeing outcomes. These experiences range from suffering verbal, mental, sexual and physical abuse, to being raised in a household where domestic violence, alcohol abuse, parental separation or drug abuse is present. Studies estimate that 47% of individuals (adults) experienced at least one ACE and 9% had experienced four or more.

The Public Health Nursing Service is commissioned by Public Health and provided by Livewell Southwest and consists of health visiting, family nurse partnership and school nursing. The service leads on the delivery of the Healthy Child Programme 0-19 to ensure a healthy start for every child.[12] They provide care across four levels covering universal through to targeted and underpinned by their role in safeguarding:

Health Visitors provide a range of services to support parents with pre-school aged children. Health visitors are trained nurses or midwives with specialist training in family and community health. They deliver 5 mandated checks (which means reach across the whole of the child population in the crucial first 1000 days) and deliver against 6 impact changes (transition to parenthood, maternal mental health, breastfeeding, healthy weight; managing minor illness / accidents; healthy 2 year old and school readiness. They also support families with additional needs through targeted interventions including support for breastfeeding and nutrition, maternal low mood, developmental problems and in partnership to families with higher levels of need including safeguarding.

The Family Nurse Partnership, is a specific intensive home visiting programme for first-time young mums and families because teenage parents and their children are at risk of a range of poor outcomes.

The School Nursing Service works to improve the health and wellbeing of school aged children and young people to reduce health inequalities and so also maximise learning and achievement. The six school aged years high impact areas are: resilience and emotional wellbeing; keeping safe: managing risk and reducing harm; improving lifestyles; maximising learning and achievement; supporting complex and additional health and wellbeing needs and seamless transition and preparation for adulthood. The school nursing service also delivers the mandated National Child Measurement Programme.

Current annual investment in these services is approximately £5.1 million.

---

[11] Child and Maternal Health - Data - OHID (phe.org.uk)

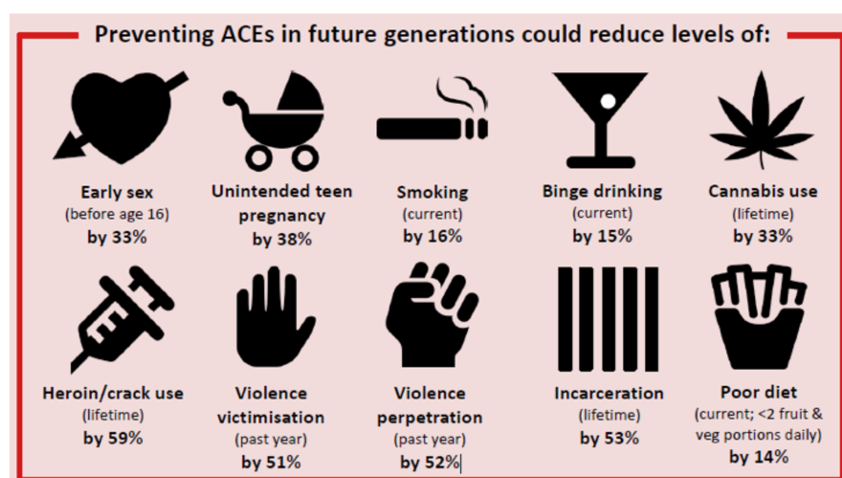
[12] https://www.gov.uk/government/publications/healthy-child-programme-0-to-19-health-visitor-and-school-nurse-commissioning

As with heath improvement interventions for adults, interventions can be very cost effective to the health and care system as well as beneficial to individual children, young people and families. The evidence shows that intervening early in the life is cost-effective across the life course. Social Return on Investment studies show returns of between £1.37 and £9.20 for every £1 invested in the early years. [13]

Perinatal mental health problems are estimated to cost the UK £8.1bn each year and a single case of perinatal depression is estimated at around £74,000. The high prevalence of this condition means that, even when averaged over all births, the cost is still nearly £7,000 for every woman giving birth in any one year. Nearly three-quarters (72%) of this cost relates to adverse impacts on the child rather than the mother. The Health Visitor's universal mandated checks identify women who may be experiencing mental health issues, providing early intervention and also mitigating this effect for children[14]

Mental health excess costs are estimated at between £11,030 and £59,130 annually per child. The annual costs of hospital self-harm admissions in England &Wales was £40 million (2014/15). Public Health Nursing supports the development of protective factors including secure attachment, developing communication skills, supportive parenting, positive school climate and whole school approaches. Early intervention avoids children and young people falling into crisis and avoids expensive and long-term interventions as adults.[15]

Investment in Public Health Nursing is demonstrated to provide immediate and lifelong benefits.



Source: http://www.cph.org.uk/wp-content/uploads/2014/05/ACE-infographics-BMC-Medicine-FINAL-3.pdf

[13] https://www.gov.uk/government/publications/health-matters-giving-every-child-the-best-start-in-life/health-matters-giving-every-child-the-best-start-in-life

[14]http://eprints.lse.ac.uk/59885/1/__lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauer%2C%20M_Bauer_Costs_perinatal_%20mental_2014_Bauer_Costs_perinatal_mental_2014_author.pdf

[15]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575632/Mental_health_of_children_in_England.pdf

This page is intentionally left blank

Health and Adult Social Care Overview and Scrutiny Committee

Date of meeting:	16 November 2022
Title of Report:	**Life expectancy and Healthy Life Expectancy**
Lead Member:	Councillor Dr John Mahony (Cabinet Member for Health and Adult Social Care & Planning)
Lead Strategic Director:	Ruth Harrell (Director of Public Health)
Author:	Ruth Harrell
Contact Email:	Ruth.harrell@plymouth.gov.uk
Your Reference:	Click here to enter text.
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report

The report looks at recent trends in life expectancy (LE) and in healthy life expectancy (HLE) in the Plymouth population. It compares our rates with England and with nearest statistical neighbours with similar demographics.

This highlights some positive performance and trends, especially in LE, and in male HLE, but shows a disappointing lack of progress in improving female HLE.

These measures, LE and HLE, are regularly considered within the Public Health Outcomes Framework. This report is also in response to a Motion on Notice from Plymouth City Council on 21st March 2022.

Recommendations and Reasons

1. To note the contents of the report
2. To recommend that the Director of Public Health continues work to understand this issue, including analysis of further data as and when it becomes available, and seeking latest evidence as it becomes available.
3. To receive a further report in one years' time

Alternative options considered and rejected

None

Relevance to the Corporate Plan and/or the Plymouth Plan

Reduced health inequalities is a key priority within both the Corporate Plan and the Plymouth Plan.

Implications for the Medium Term Financial Plan and Resource Implications:

None

Financial Risks

None

Carbon Footprint (Environmental) Implications:

None

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:

** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*

None

Appendices

**Add rows as required to box below*

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**
A	LE and HLE in Plymouth 2022							
B	Equalities Impact Assessment (if applicable)							

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are unpublished works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**

Sign off:

Fin	DJN 22.23.226	Leg	EJ/38851/24.10.22/(2)	Mon Off	Click here to enter text.	HR	Click here to enter text.	Assets	Click here to enter text.	Strat Proc	Click here to enter text.

Originating Senior Leadership Team member: Ruth Harrell
Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 20/10/2022
Cabinet Member approval: Cllr John Mahony *approved by email* Date approved: 21/10/2022

This page is intentionally left blank

LIFE EXPECTANCY AND HEALTHY LIFE EXPECTANCY IN PLYMOUTH

DPH October 2022

Contents

Executive Summary 2
Definitions 3
Life Expectancy (LE) 3
Healthy Life Expectancy (HLE) 3
Statistical significance 3
Background 4
What causes differences in life expectancy? 4
Historical changes 4
Recent trends in lIFE EXPECTANCY 5
National trends pre-Covid-19 5
Gender gap 5
National trends through Covid-19 6
Local trends in life expectancy 9
Recent trends in Healthy Life Expectancy 11
National Trends 11
Local trends 11
What affects LE and HLE? **Error! Bookmark not defined.**
Conclusions **Error! Bookmark not defined.**
Appendix 1 14
LE calculated for Plymouth Neighbourhoods 14
References 14
PCC reports 14

EXECUTIVE SUMMARY

Nationally;

Life expectancy (LE) had been increasing, with a relatively steady gradient over the last 50 years. This gradient reduced over the last decade meaning that LE on average was increasing, but increasing slowly. Further analysis shows that LE was still increasing quickly for wealthier groups but was actually dropping for more deprived groups, for females in particular. This was reported on in the Plymouth DPH Annual Report 2019 'Building wellbeing and resilience in a time of austerity'

The Covid-19 pandemic caused a sudden reduction in LE; with a larger drop for men than for women. Again, this was larger in more deprived groups than in wealthier ones.

In Plymouth;

Smaller numbers make the trends more difficult to prove but we believe we had seen similar patterns in LE general trends pre-pandemic.

Our lower death rates due to Covid19 during the pandemic mean that for the pandemic year 2020, Plymouth's LE was very similar to England average. LE in Plymouth for both males and females compares very well to statistically similar neighbours. The inequality gap by deprivation was lower in Plymouth for female than for England, and the same for males.

Healthy life expectancy for males in Plymouth is good, ranking at the top of our statistical neighbours and similar to England. However, there is a different story for females, with HLE being low compared to England and also compared to our statistical neighbours. The reasons for this are not understood, especially as the same risk factors are indicated for both LE and HLE.

This requires further work to understand the issues and to address them, both locally and nationally.

DEFINITIONS

Life Expectancy (LE)

Life expectancy is an estimate of how long someone might live; it can be calculated from any age e.g. LE at birth. We use LE at birth throughout this document.

It is worth noting that someone who has already survived past childhood will have a longer LE than given at birth. For example, if someone had a life expectancy at birth of 88 years but has lived to 88, then their life expectancy is now 93 years.

This is based on the age that people in the area die, and is calculated using death certification data; three years worth of data is used to help us to see trends.

Healthy Life Expectancy (HLE)

Healthy life expectancy is an estimate of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self reported good health. The prevalence of good health is derived from responses to a survey question on general health. For a particular area and time period, it is an estimate of the average number of years a newborn baby would live in good general health if he or she experienced the age-specific mortality rates and prevalence of good health for that area and time period throughout his or her life. Figures are calculated from deaths from all causes, mid year population estimates, and self reported general health status, based on data aggregated over a three year period. Figures reflect the prevalence of good health and mortality among those living in an area in each time period, rather than what will be experienced throughout life among those born in the area. The figures are not therefore the number of years a baby born in the area could actually expect to live in good general health, both because the health prevalence and mortality rates of the area are likely to change in the future and because many of those born in the area will live elsewhere for at least some part of their lives.

This is calculated from responses to a question on general health in the Annual Population Survey (APS) conducted by the Office for National Statistics (ONS) and therefore is self-reported.

Statistical significance

Both of these measures are calculated, and are therefore estimates. We use the term statistical significance to consider whether the difference between two numbers such as LE is likely to be a genuine difference in real terms (statistically significant) or whether it might just be due to the way in which the estimates are calculated. The smaller the dataset, the more difficult it can be to see whether two measures are really different; for example, the smaller the geographical area, the fewer deaths will have occurred and so it is more difficult to make meaningful comparisons. There are mathematical equations that allow us to say whether we think two numbers are similar, or whether we think there is a genuine difference between them.

BACKGROUND

What causes differences in life expectancy?

Life expectancy is a calculation of the average age that people living in the area live to. Much information is contained within this, and it does not take account of the distribution of the deaths other than the average. You could have a similar life expectancy for an area caused by a small number of deaths in children or the large number of deaths in older people; the average figure does not tell you this level of detail. Therefore the life expectancy data which has to be interpreted along with other sources of information. It is worth considering historical data to put this into context.

Historical changes

We have some measurements for life expectancy going back to the 1700's but these became more accurate from 1837 when registration of all deaths became required; the life expectancy for a baby girl born in England then was 43 years.

Although the average Life Expectancy was 43, we know that many children died in infancy. There were no vaccinations or antibiotics and many of the illness that we consider to be minor – or that have been eradicated – would have killed many of the children affected. The reduction in childhood deaths has made a massive difference to overall life expectancy. [2]

- Many women died giving birth; without many of the healthcare treatments that we take for granted today, childbirth was a lottery, but was also difficult to avoid.
- Work tended to be a dangerous place to be, and many men in particular worked in environments where serious accidents and exposure to dangerous materials without any protection were the norm. We see the legacy of this still in Plymouth's high rates of mesothelioma caused by asbestos, for example.
- If someone survived childhood, then it was not unusual for them to live to their 70s; life expectancy for someone who survived childhood was mid 70's from 1837 up until around 1920's.[2]

There is a persistent story of improvement since records began. Childhood vaccinations and antibiotics made a huge positive difference, as did improvements in living and working conditions. As healthcare improved, and became accessible to all, we have continued to see improvements.

Though the main trend has been to improve, there have been variations to this. Some events had an immediate and marked effect; the two World Wars, and particularly virulent strains of influenza. Others have a more gradual impact, which can be much harder to spot, such as the rise of smoking where the impact can be seen from years to decades after the behaviour starts. It can be difficult to understand how much of a contribution each element makes, and of course different things can interact at the same time.

This highlights that the 'average life expectancy' hides a great deal of information that we need to know more about to understand what is really going on.

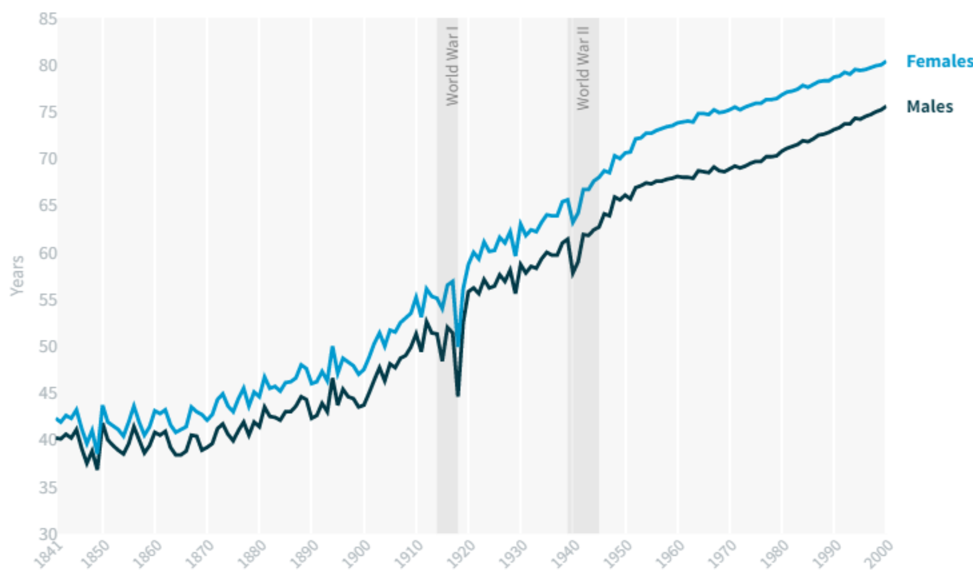


*Figure 1 LE at birth, England and Wales, Kings Fund [**Error! Bookmark not defined.**]*

RECENT TRENDS IN LIFE EXPECTANCY

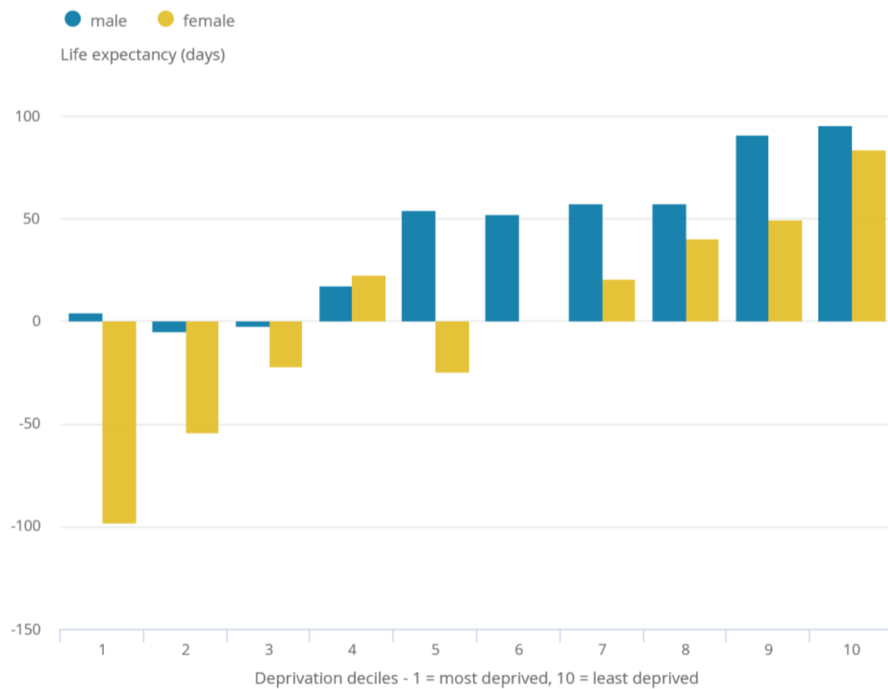
National trends pre-Covid-19

In my Annual Report 2019, I highlighted that there had been a slow-down in the increasing trend of life expectancy. This was highlighted by the Office of National Statistics

> *Life expectancy at birth in the UK did not improve in 2015 to 2017 and remained at 79.2 years for males and 82.9 years for females.*
>
> *ONS, September 2018*
>
> *In England, the growth in the female inequality came from a statistically significant reduction in LE at birth of almost 100 days among females living in the most deprived areas between 2012 to 2014 and 2015 to 2017, together with an increase of 84 days in the least deprived areas.*
>
> *ONS, March 2019*

The slowdown had been seen across the UK, at similar rates but with some slight differences in details of trends. The UK is not alone is seeing this slowdown of improvements; many other developed countries have seen this too. However, the UK is second only to the US in terms of severity of the slowdown.

This was especially important as there was a very clear change with deprivation (see



Source: Office for National Statistics

Figure 2), which showed that LE had continued to grow for the less deprived groups (male and female) but had reduced for women in the more deprived groups.

Since then, further data has been released still covering the pre-covid-19 times, which uses data from 2017-2019. That showed a slight improvement in LE; positive news, although still well below the trajectory which might have been expected had the slow down not occurred.

Gender gap

Since records began, women have tended to live longer than men. The extent of the gap has varied, as have the underlying patterns; the gap is driven by a combination of occupational risk (historically much higher for men than women), healthcare provision around maternity (including contraception), and risk-taking behaviours.

In the 19th century, the gap was relatively small as infectious diseases (often but not always in childhood) killed many and so dominated the statistics. The gap began to widen, peaking at over 6 years in 1971 as poor working conditions and smoking reduced men's LE, but improved maternity care and lower rates of TB increases women's LE.

Recently the gap narrowed to below 4 years, with LE increasing more quickly in males (largely due to reduced smoking and better treatments for cardio vascular diseases).

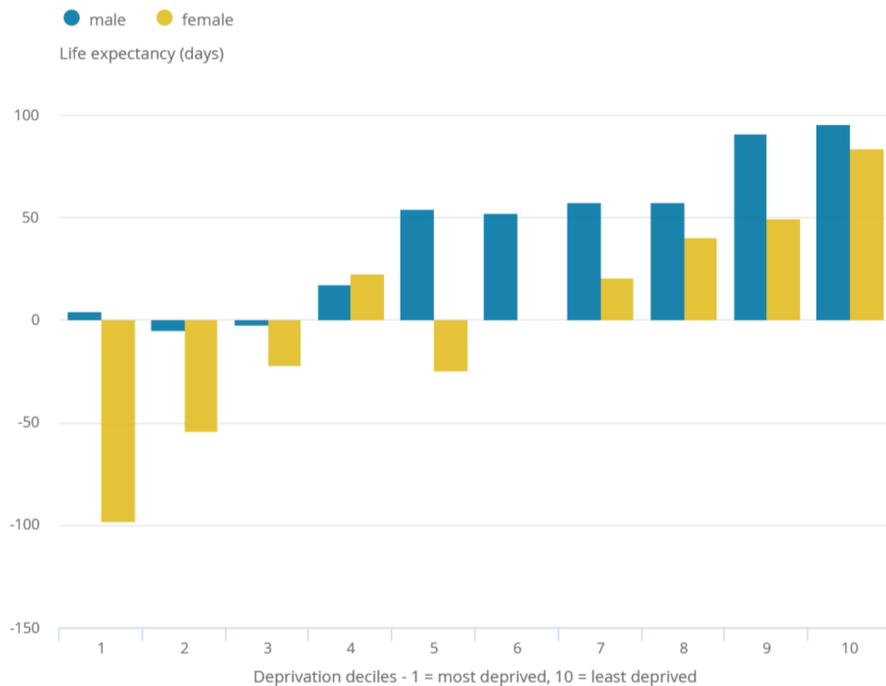


Figure 2 Change in LE in days between 2012 to 2014 and 2015 to 2017, by national deprivation decile, England and Wales, 2015 to 2017, ONS published March 2019 Health state life expectancies by national deprivation deciles, England and Wales: 2015 to 2017, ONS, published March 2019

In summary, prior to Covid19, we were seeing a national trend of a slowing down of LE improvements, with in fact a shortening of life expectancy for the most deprived groups of females.

National trends through Covid-19

The official ONS figures for LE are robust and are preferred as a reference source. They use an average of three years of deaths data, and so information for the impact of covid is limited as only one data point including the pandemic impact has been published, for 2018- 2020 (Figure 4), which obviously dilutes the impact since only 1 of the 3 years on the average was impacted by the pandemic. However, this is government data and is therefore the most reliable and robust source to use.

In Figure 3, shading has been added to the ONS graph to help to differentiate the three trends which can be observed; zone 1 green is showing a broadly steady increase of LE over time, zone 2 (blue) is still showing an increase, but one which is much slower than before, and then zone 3 (orange) which includes the initial pandemic impact. This has shown a reduction in LE for men, and no change for women, even when considering that this is the average over the three years, two of which were not within the pandemic.

Figure 4 uses the same data but displays it differently, taking the change in LE in between the sets of 3 years. This also shows the zones described above, with a relatively uniform change from year to year becoming much small, and then showing an actual reduction in LE in 18-20.

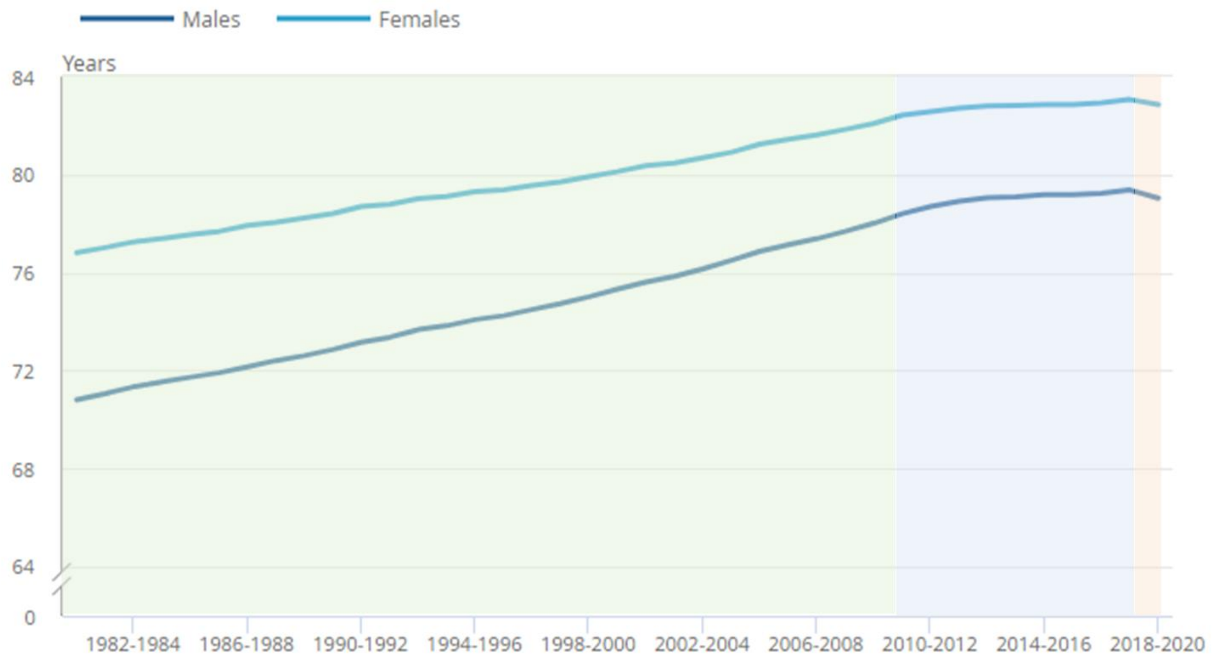


Figure 3 LE at birth for males and females, UK, between 1980 to 1982 and 2018 to 2020 (colours added by author)
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2018to2020

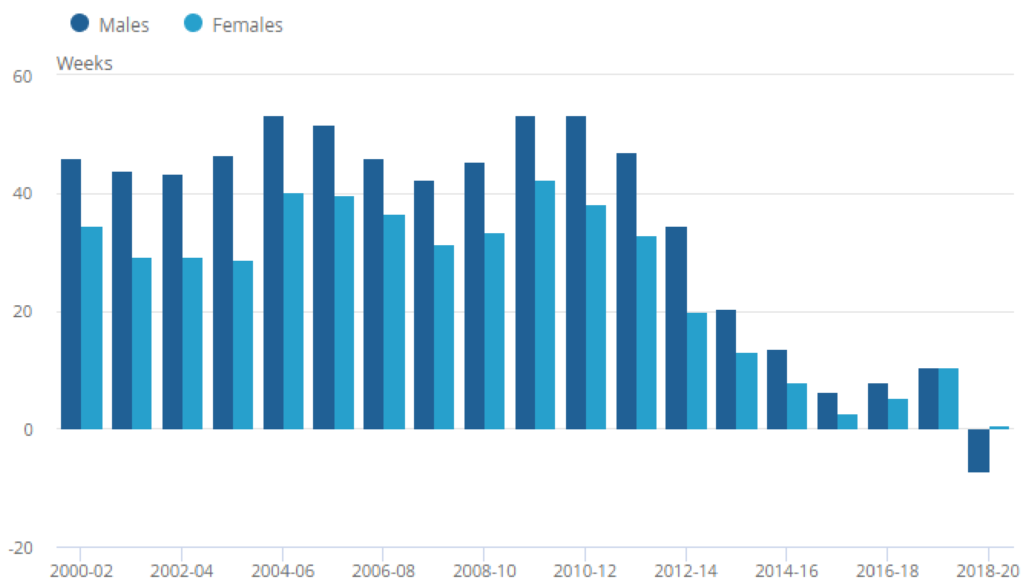


Figure 4 Change in LE at birth for each period, in weeks, compared with previous non-overlapping time period, UK. 1997 to 1999, to 2018 to 2020.

The Kings Fund produce their own analysis, based on the same raw data. They show the LE per year, rather than using the average of three years which the ONS analysis uses. This means that each point is slightly less accurate; one would be careful not to read too much into very slight changes year – on-year, but is very useful.

They report that;

By 2019, life expectancy at birth in England had increased to 79.9 years for males and 83.6 years for females. However, the Covid-19 pandemic caused life expectancy in 2020 to fall to 78.6 years for males and to 82.6 years for females, the level of a decade ago.

As can be seen on the graph, the data for 2021 is a little better, but still a very significant drop from pre-pandemic levels.

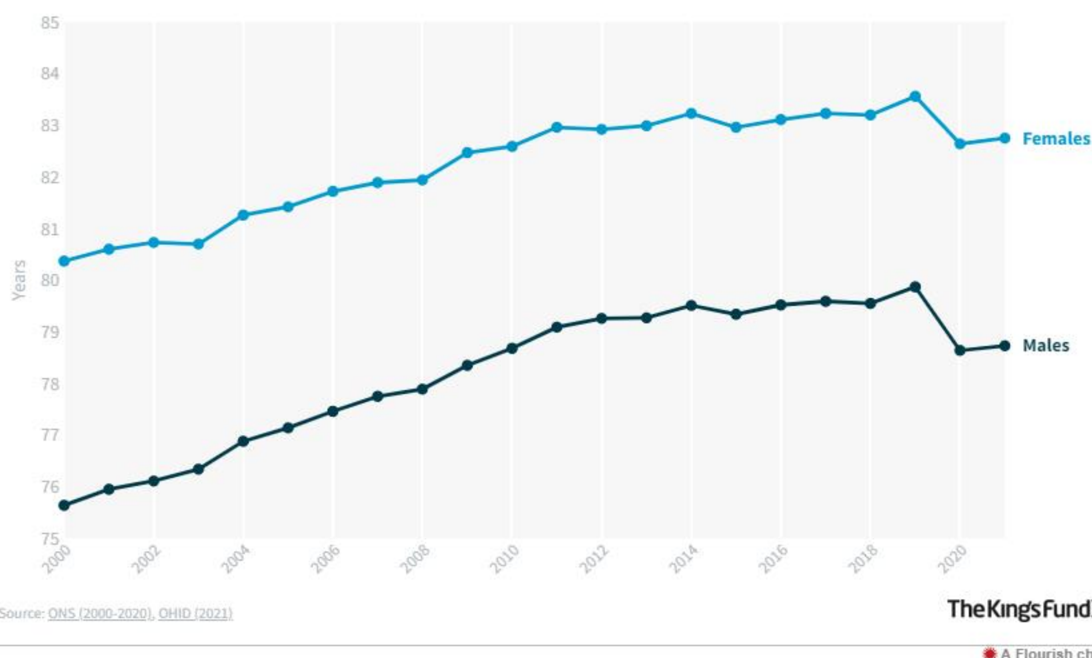


Figure 5 LE at birth for single years, including 2020 and 2021 (What is happening to Life expectancy? Updated Aug 2022, Kings Fund)

Forward Look

Although it is not advisable to calculate LE for part years, we can look at the mortality data and in particular excess deaths which means a higher number of deaths than one might expect to see, using historical data (2015-2019).

Overall, from the start of the pandemic (taken as 21st March 2020) to date, there have been around 10% more deaths than expected.

So far, the number of excess deaths in the year 2022 has been significantly less than the same period in 2021, or 2020.

However, we do not yet have a stable pattern to covid peaks, and we have also seen concerning excess mortality when we are not in high rates of covid, and so it is difficult to predict what might happen in 2022 overall.

Local trends in life expectancy

Comparative data is provided by UK Health Security Agency as part of the Public Health Outcomes Framework (PHOF). This is calculated both as the three year rolling average, but is also shown as a yearly figure. Both of these are shown in Figure 6, for males and females. The three year average curves have the same issue as the ONS data previously mentioned which is that the impact of the pandemic is less clear since it is one of the years of the 2017-19 rolling average, and two of the 2018-2020 years.

Life expectancy at birth	Plymouth Value	England Value	Gap	Rank compared to similar areas
Using three- year rolling average for 2018-2020				
Females	82.5	83.1	0.6	1 (Best)
Males	78.8	79.4	0.6	1
Using one year data for 2020				
Females	82.4	82.6	0.2	1
Males	78.8	78.7	0.1	1

Table 1Showing data taken from the UK HSA PHOF. The rank uses 15 comparator areas identified by Chartered Institute of Public Finance and Accountancy (CIPFA) and a high rank means that LE in Plymouth is high

This shows that;

- LE in Plymouth is consistently below the England average for both males and females. This is closely associated with levels of deprivation.
- However, LE in Plymouth is consistently high compared to the similar comparator areas.
- In the pandemic years, LE for England dropped overall due to excess deaths
- It also dropped in Plymouth but by a lesser amount. This reflects the lower Covid-19 death rate in Plymouth which is one of the lowest across the country.
- This meant that the gap between Plymouth and England reduced during the pandemic.

Although of course the reduction in the gap is a positive outcome, this has been achieved through the LE for England worsening which is not the way in which we would have wanted to see this come about. Our aim is of course to see increasing LE for all, but with faster increases for the more deprived groups pushing the overall average up.

Comparisons with similar areas

Comparing Plymouth's LE with other similar areas, identified using CIPFA

- Male LE in Plymouth is equal highest
- Female LE is second highest

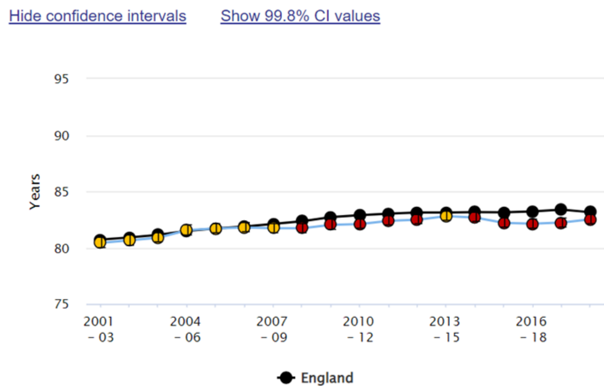
Inequality in LE

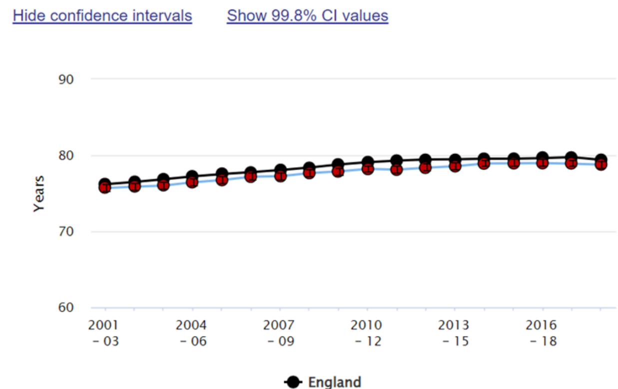
Inequality in Life Expectancy is also shown in the PHOF; this shows the gap in LE between the most deprived and least deprived deciles. It is calculated using three year averages, and so, although it does include 2020, this averaging will reduce the impact of pandemic. This shows that;

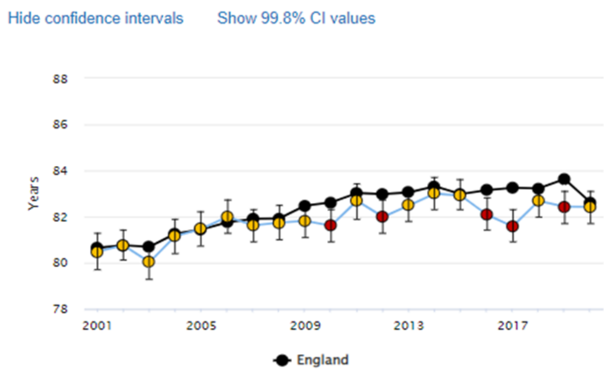
- For males, in England the gap in LE at birth has increased slightly (by 0.6 of a year) over the last decade

- for Plymouth the gap is approximately the same as for England, within statistical significance

- For females, in England the gap in LE at birth has increased (by 1.1 of a year) over the last decade
  - for Plymouth the gap in LE at birth has remained has reduced and is now statistically significantly below that for England







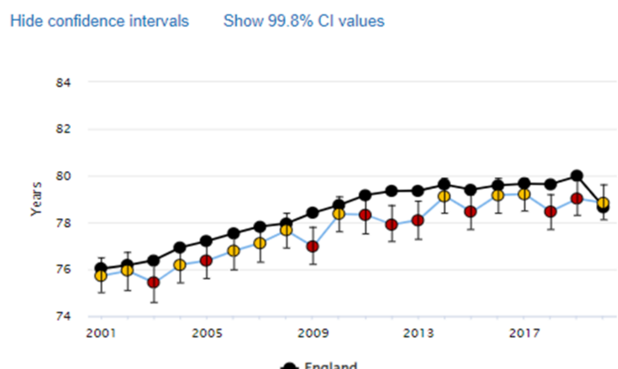
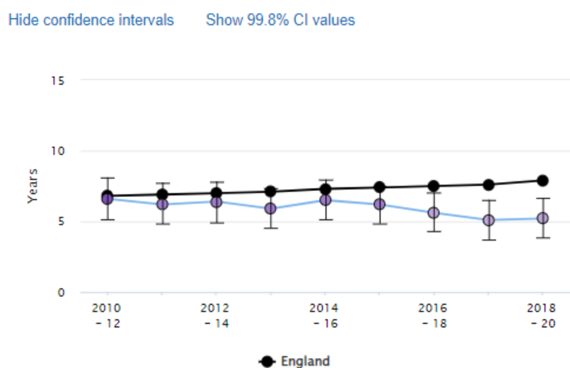


Figure 6 Public Health Outcomes Framework Life expectancy in Plymouth compared to England



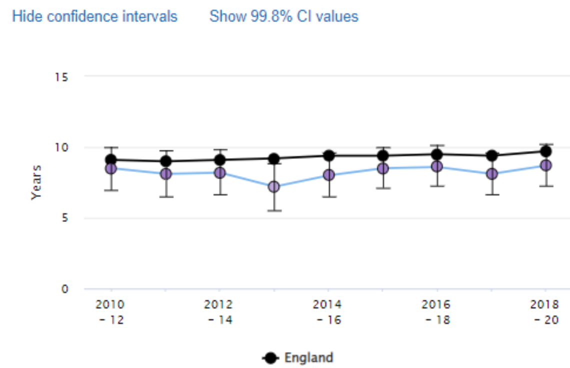


Figure 7 Inequality in Life Expectancy in Plymouth compared to England for women and for men (PHOF). The points represent the gap between LE in the most deprived 10% and the least deprived 10%.

RECENT TRENDS IN HEALTHY LIFE EXPECTANCY

Healthy life expectancy is a measure of how long a person would expect to live in good health based on contemporary mortality rates and prevalence of self reported good health. This is calculated from responses to a question on general health in the Annual Population Survey (APS) conducted by the Office for National Statistics (ONS).

This has only been calculated since 2011 and so is a relatively new data set, with limited trend data.

National Trends

HLE for England has shown little change since 2009-11 when the data was first calculated.

- HLE for males at birth in 2009-11 was 63.0 years. It reached a peak of 63.4 between 2012 and 2018, and has slight reduced since them to 63.1 years for 2018-20.
- HLE for females at birth in 2009-11 was 64.0 years. It has fluctuated a little and was 63.9 in 2018-20.

Local trends

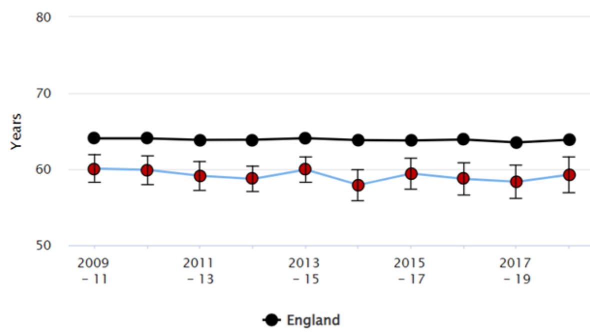
HLE for Plymouth population is;

- 59.3 years for women (significantly lower than England). There has been a reduction over time, though this is not statistically significant, and there is no evidence of a worsening trend.
- 64.3 years for men (similar to England). There have been changes over time but these are small; previously (up until 2015-17) Plymouth was significantly below England but is now similar.

When we consider Plymouth's HLE compared to similar areas using the CIPFA comparator areas, we see that;

- For females, despite having the highest ranking LE, the HLE is one of the worst compared to similar areas (12/16)
- For males, as well as having the highest LE of the comparators, Plymouth also has the highest HLE

This means that a female in Plymouth tends to report worse health than a similar woman (age, deprivation etc), but does not die any earlier. This is illustrated in Figure 9.



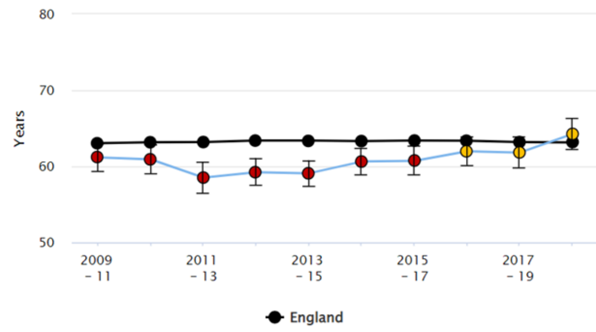


Figure 8 Health life expectancy trends with time, for Plymouth and for England.

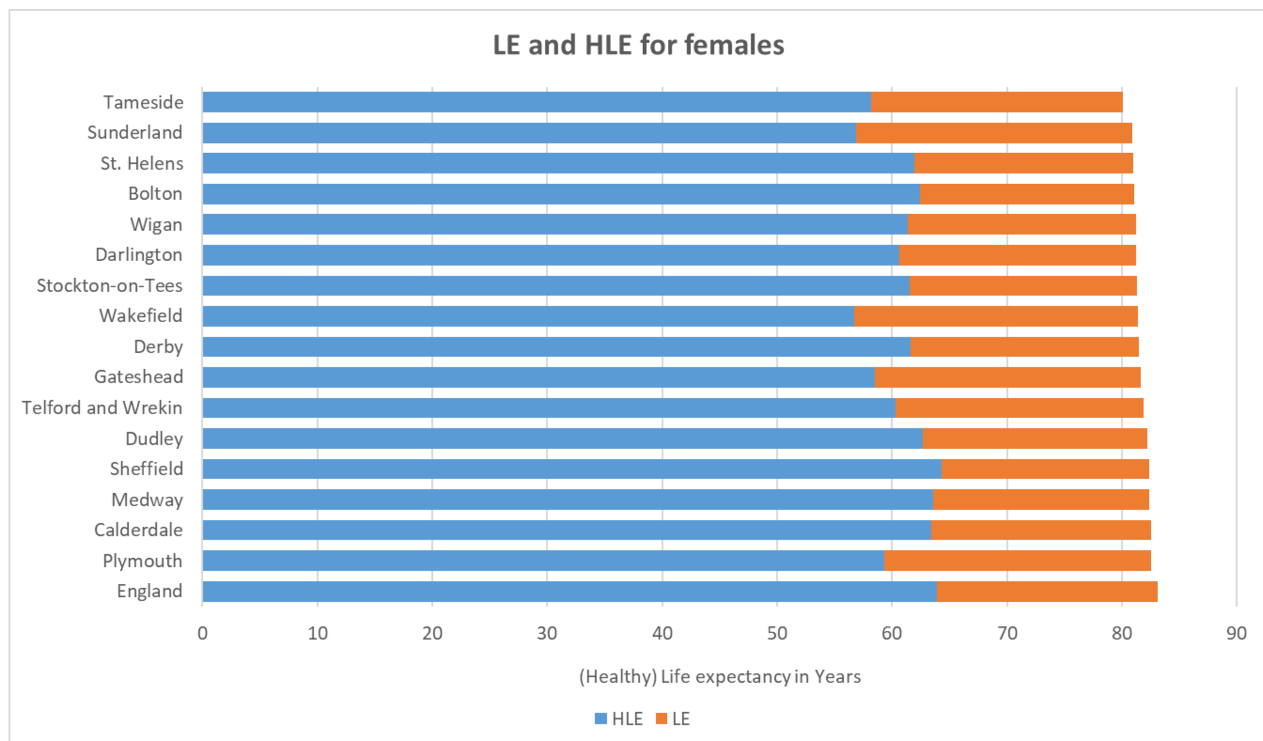


Figure 9 Length of life (life expectancy) split into healthy LE showing time lived in poor health in orange; for Plymouth and statistical (CIPFA) neighbours. Using data from PHOF.

Why is female HLE lower in Plymouth than we would expect?

Looking at the range of information available, there are some statistics around health and wellbeing that appear to support this HLE and some which do not, and no clear cause for this difference. For example;

- Plymouth does have a low disability-free LE for women – below the England average,
- Social isolation is highlighted as an issue for adults in Plymouth – often (but not always) women
- In terms of self reported wellbeing, Plymouth does not have low rates for satisfaction, happiness, or high rates for anxiety.

- Under 75 mortality rate considered preventable – Plymouth has higher rates than England, but is one of the lowest rates compared to similar areas.
- Health improvement
  - Adult obesity is slightly worse than England but mid table compared to similar areas
  - Adult smoking is much worse than England and high compared to similar areas
  - Physical inactivity is similar to England and mid table compared to similar areas
  - Admissions due to alcohol are similar to England and low compared to similar areas

There is emerging evidence around female employment in Plymouth;

Although there may be some pointers, there is no conclusive reason as to why Plymouth female HLE is low. HLE has not been used for long enough to have evidence from places who have managed to improve HLE; there is no concrete evidence to differentiate between the risk factors for LE and for HLE. And yet, there are large variations. This is an area for further work and research.

APPENDIX 1

LE calculated for Plymouth Neighbourhoods

Neighbourhood in alphabetical order	Life expectancy 2018-2020	Range of estimate	
		Lower	Upper
Barne Barton	79.3	76.6	81.9
Beacon Park	82.8	80.5	85.1
Chaddlewood	85.9	83.1	88.6
City Centre	80.5	78.4	82.6
Colebrook, Newnham, & Ridgeway	82.9	81.7	84.1
Derriford West & Crownhill	82.4	80.1	84.6
Devonport	76.1	74.4	77.8
East End	77.6	75.4	79.9
Efford	79.9	78.4	81.4
Eggbuckland	85.3	83.5	87.1
Elburton & Dunstone	82.2	80.5	83.8
Ernesettle	78.8	76.7	80.9
Estover, Glenholt & Derriford East	81.8	80.1	83.6
Ford	82.2	80.0	84.4
Goosewell	85.4	82.3	88.5
Greenbank & University	76.0	74.0	77.9
Ham & Pennycross	81.5	79.6	83.4
Higher Compton & Mannamead	82.6	81.4	83.7
Honicknowle	81.4	79.9	82.9
Keyham	80.2	77.6	82.7
Leigham & Mainstone	81.7	79.1	84.4
Lipson & Laira	82.5	79.4	85.5
Manadon & Widey	82.0	80.3	83.7
Morice Town	75.9	72.6	79.2
Mount Gould	80.3	78.2	82.4
Mutley	76.1	73.9	78.4
North Prospect & Weston Mill	78.7	76.6	80.7
Peverell & Hartley	81.6	80.2	82.9
Plympton St Maurice & Yealmpstone	82.2	80.9	83.6
Plymstock & Radford	83.7	82.4	85.0
Southway	81.2	79.0	83.3
St Budeaux & Kings Tamerton	79.0	77.3	80.6
Stoke	77.9	76.6	79.1
Stonehouse	75.9	74.1	77.7
Tamerton Foliot	80.3	77.9	82.7
Turnchapel, Hooe & Oreston	82.3	80.5	84.1
Whitleigh	80.6	78.3	82.9
Widewell	83.3	80.6	86.1
Woodford	81.9	80.0	83.9
Plymouth	**80.6**	**80.3**	**80.9**

REFERENCES

PCC reports

DPH Annual Report 2019 Part 2
https://www.plymouth.gov.uk/sites/default/files/Thrive%20report%20year%204%20%2011_19%20v2%20web_1.pdf

ONS

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/nationallifetablesunitedkingdom/2018to2020

Health and Adult Social Care Overview and Scrutiny Committee

Date of meeting:	16 November 2022
Title of Report:	**Thrive Plymouth Year 7 (22/23) : Listen and Reconnect**
Lead Member:	Councillor Dr John Mahony (Cabinet Member for Health and Adult Social Care & Planning)
Lead Strategic Director:	Ruth Harrell (Director of Public Health)
Author:	Sarah Lees
Contact Email:	Sarah.lees@plymouth.gov.uk
Your Reference:	Click here to enter text.
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report

Thrive Plymouth was adopted by Plymouth City Council on 11 November 2014 as a 10 year health improvement plan for the City, which aims to reduce health inequality. This summary paper provides an update on the Thrive Plymouth Year 7 campaign 2022/23 with this year's focus on 'Listening and Reconnecting' across the Thrive Plymouth Network, but also the people with whom we work, between our organisations and the wider public.

Recommendations and Reasons

1. Note the contents of the report

Alternative options considered and rejected

None

Relevance to the Corporate Plan and/or the Plymouth Plan

Thrive Plymouth is our 10 year plan which aims to reduce inequalities and supports the Plymouth Plan aim to become a Healthy City

Implications for the Medium Term Financial Plan and Resource Implications:

None

Financial Risks

None

Carbon Footprint (Environmental) Implications:
None

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*
Click here to enter text.

Appendices
**Add rows as required to box below*

Ref.	Title of Appendix	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	2	3	4	5	6	7
A	Briefing report : Thrive Plymouth Year 7 (2022/23)							

Background papers:
**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are unpublished works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	2	3	4	5	6	7

Sign off:

Fin	pl.22.23.264.	Leg	EJ/38851/7.11.22(2)	Mon Off	Click here to enter text.	HR	Click here to enter text.	Assets	Click here to enter text.	Strat Proc	Click here to enter text.
Originating Senior Leadership Team member: Sarah Lees											
Please confirm the Strategic Director(s) has agreed the report? Yes 07/11/2022											

Cabinet Member approval: Councillor Dr John Mahony (Cabinet Member for Health and Adult Social Care)

Date approved: 07/11/2022

This page is intentionally left blank

THRIVE PLYMOUTH YEAR 7 (2022/23) : LISTEN AND RECONNECT BRIEFING

Office of the Director of Public Health

1. BACKGROUND TO THRIVE PLYMOUTH

'Thrive Plymouth' is the 10 year programme which aims to improve health and wellbeing in Plymouth whilst narrowing the gap in health status between people in the city.

Thrive Plymouth was adopted by Plymouth City Council on 11 November 2014. It strongly reflects the Council's endorsement towards the objective of strengthening the role and impact of ill health prevention. 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 and further developed in San Diego.

Figure 1 – The Thrive Plymouth construct

It is being led by the Office of the Director of Public Health, Plymouth City Council. The programme is based on the local 4-4-54 construct, i.e. that poor diet, lack of exercise, tobacco use and excess alcohol consumption are risk factors for coronary heart disease, stroke, cancers and respiratory problems which together contribute to 54% of deaths in Plymouth (i.e. 4-4-54). Positive mental wellbeing across the whole population as the foundation of a healthy lifestyle can support changing these behaviours, thus reducing chronic illness and prevent associated deaths. Wellbeing is important because evidence shows that people with high levels of wellbeing live longer, have lower rates of illness, recover faster from illness, stay well for longer, have more positive health behaviours and generally have better physical and mental health. Research also shows that better wellbeing means that we will find it easier to naturally make better decisions about how we can improve our health. We all know, for example, that if we are free from tobacco, drink less alcohol, are physically active and eat healthily, we will feel better now and live longer, healthier and happier lives. In addition to an on-going focus on the four behaviours and wellbeing as a foundation, the Thrive Plymouth programme also has a specific annual focus, with which to engage our local partners and population.

Thrive Plymouth Annual Focus

Year 1	2014/15	Workplace health and wellbeing
Year 2	2015/16	Schools
Year 3	2016/17	Localising the national 'One You' campaign
Year 4	2017/18	Mental wellbeing
Year 5	2018/19	People connecting through food
Year 6	2019/20	Mayflower 400
Paused	2020/21	On hold due to COVID-19
Paused	2021/22	On hold due to COVID-19
Year 7	2022/23	Listen and Reconnect
Year 8	2023/24	TBC
Year 9	2024/25	TBC
Year 10	2025/26	TBC

2. YEAR 7 FOCUS : LISTEN AND RECONNECT

Thrive Plymouth Year 7 seeks to understand the impacts of the pandemic on our city and 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. The annul focus for the year is therefore 'Listen and Reconnect'. The year will bring focus on listening and reconnecting across the Thrive Plymouth network, but also the people with whom we work, between our organisations and the wider public.

The COVID-19 pandemic highlighted that the health inequalities persisting in our society affect the things which enable us to live well. Difficulties and issues in access to employment, housing, education, our social networks and spaces, will have had an impact on health inequalities experienced here in Plymouth. As COVID-19 restrictions lifted and we learn to live with COVID-19, it is important for us as a city to meaningfully listen and reconnect with each other. Public health want to help the city to build on and take the best of what we have seen over the pandemic, and apply it to the wider challenges of inequality.

It is hoped that in building the city's capacity to listen, we can begin to regroup and redouble our efforts to tackle health inequalities and get 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

3. YEAR 7 LISTEN AND RECONNECT LAUNCH, OFFER AND ASK

A virtual event was held in May this year to formally launch Year 7. Over 100 people attended the launch event, representing existing members of the Thrive Plymouth network, alongside organisations from health and social care, the voluntary sector, council staff, mutual aid networks, primary care providers, schools and businesses. Following the launch, over 20 people shared a reflection, over 30 people made pledges to join the Thrive Plymouth Network and engage in the year 7 programme.

The main programme for the year focuses on a range of training workshops, with a view to sharing best practice around listening and evidence-based behaviour change tools, bringing the network and city together in our physical spaces. The programme is keen to showcase and support approaches, and projects, used locally to 'listen and connect'. The year's training offer has been co-designed with Livewell Southwest, Theatre Royal Plymouth, Public Health Team and St Luke's Hospice Plymouth.

The offers encourage all organisations that participate in the Thrive Plymouth network (80 members as of May 2022) to build their capacity for listening, to encourage reconnection among those around themselves, and enable the public to share their pandemic experiences and stories with regards to health, wellbeing and tackling inequality.

Our Offer:

- Appreciative Inquiry Training
- Compassionate Friends Awareness
- Motivational Interviewing Workshops
- Our Space Workshop
- Solutions Focused Therapy Workshop
- Every Mind Matters Resources & Tips – Lifting out of loneliness
- Thrive Plymouth Network Meetings
- Support with 'Listening and Reconnecting' and actions going forward

Our Ask:

- Join the Thrive Plymouth network
- Attend training and workshops and network meetings
- Conduct an appreciative inquiry in your community/setting
- Take Compassionate Friends Awareness session into your settings/communities
- Share Every Mind Matters tips for lifting people out of loneliness
- Promote safe spaces for conversation, reflection and connection

4. PROGRESS SO FAR IN YEAR 7

- In June 6 workshops were delivered as part of the offer and all were well attended with more than 30 organisations taking part.
- All attending committed to using the learning to support their workforce wellbeing and the populations they work with.
- Further workshops on Appreciative Inquiry have been requested and will be scheduled to meet demand.
- 10 pledges to be Compassionate Friends and engage in local Compassionate Cafes which support those experiencing loss and bereavement.
- Every Mind Matters materials shared with 98 organisations who used them to promote World Mental Health Day and Lifting people out of Loneliness
- First Thrive Network meeting for 2 years took place in September. 30 attendees sharing what each has been doing or is planning to do this year, what they need help with and what evaluation is planned.
- Appreciative Inquiry approach being taken in community conversations in Devonport and in review of NHS Healthcheck programme
- Hope in the Heart programme has captured narratives and worked with people with lived experience using trauma informed and compassionate approaches
- Network members working on ways to share findings from appreciative inquiries and other approaches being taken e.g. in Belong in Plymouth

This page is intentionally left blank

Health and Adult Social Care Overview and Scrutiny Committee

Date of meeting:	16 November 2022
Title of Report:	**Active to Thrive**
Lead Member:	Councillor Dr John Mahony (Cabinet Member for Health and Adult Social Care & Planning)
Lead Strategic Director:	Ruth Harrell (Director of Public Health)
Author:	Claire Beney, Active Devon
Contact Email:	Ruth.harrell@plymouth.gov.uk
Your Reference:	Click here to enter text.
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report

Active to Thrive is Plymouth's collaborative Physical Activity, Sport and Leisure plan. This sets out the long-term vision for 'Plymouth to be the most physically active coastal city in England by 2034', and has an associated set of themes and actions to make that happen. This report considers progress against each theme against the short term outcomes that were set. This work is being taken forward by a wide range of providers and enablers of physical activity across Plymouth.

The report also updates on the Plymouth Pathfinder, a project funded by Sport England to explore ways in which physical activity can contribute to improving outcomes for young people who may have experienced childhood trauma and/or may have special educational needs.

Recommendations and Reasons

1. To note the contents of the report

Alternative options considered and rejected

None

Relevance to the Corporate Plan and/or the Plymouth Plan

Reduced health inequalities is a key priority within both the Corporate Plan and the Plymouth Plan. Physical activity is a driver of better health and wellbeing, but contributes to health inequalities between some groups of the population; Active to Thrive seeks to widen involvement and participation and therefore reduce inequalities.

Implications for the Medium Term Financial Plan and Resource Implications:

None

Financial Risks

None

Carbon Footprint (Environmental) Implications:
None

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*
None

Appendices
**Add rows as required to box below*

Ref.	Title of Appendix	Exemption Paragraph Number (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	2	3	4	5	6	7
A	Active to Thrive Update Report							
B	Equalities Impact Assessment (if applicable)							

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are unpublished works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	Exemption Paragraph Number (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	2	3	4	5	6	7

Sign off:

Fin	DJN 22.23.251	Leg	EJ/38851/24.10.22 (1)	Mon Off	Click here to enter text.	HR	Click here to enter text.	Assets	Click here to enter text.	Strat Proc	Click here to enter text.

Originating Senior Leadership Team member: Ruth Harrell

Please confirm the Strategic Director(s) has agreed the report? Yes

Date agreed: 20/10/2022

Cabinet Member approval: Cllr John Mahony *approved by email*

Date approved: 31/10/2022

This page is intentionally left blank

ACTIVE TO THRIVE UPDATE

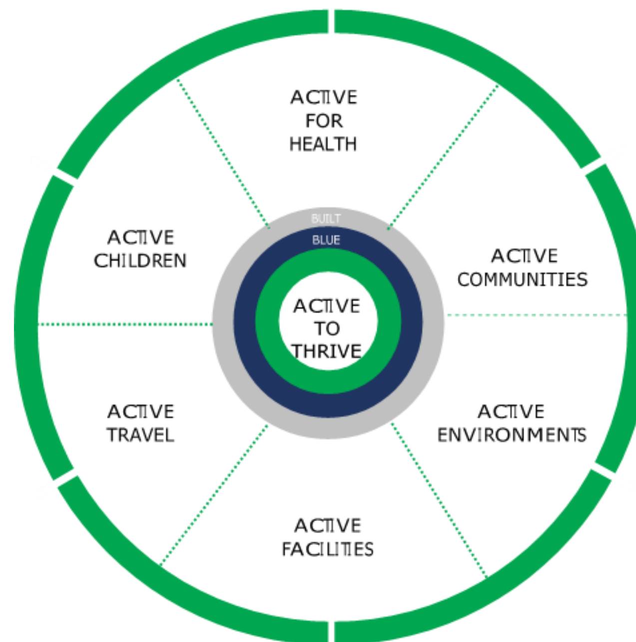
ODPH

CONTEXT AND BACKGROUND

Active to Thrive is Plymouth's collaborative Physical Activity, Sport and Leisure plan. The plan was developed following a number of conversations with Plymouth City Council staff, Councillors and community partners in 2021and early 2022. The action plan and theory of change was presented to CMT in February 2022 and the plan was adopted in April 2022.

Active to Thrive is underpinned by a Theory of Change which aims to capture the actions and long term change desired from a committed focus in increasing activity levels in Plymouth.

The long-term vision is for '***Plymouth to be the most physically active coastal city in England by 2034'***. The following themes arose from the conversations in 2021:-



Active for Health: Is where we use Physical activity, sport and leisure as an evidenced means to help prevent and manage chronic disease and long-term conditions enabling the people of Plymouth to live a full life whilst relieving the pressure on health and social care services.

Active Communities: Is where people are empowered to access social and physical activity, sport & leisure. Communities at the heart of the decision-making process, so that anything planned, implemented or delivered is based on their needs and that they are part of sustaining activities and interventions.

Active Environments: Places where people can be active easier and which are more appealing for everyone, whether that's in how they choose to move around their local neighbourhood or a dedicated space for physical activity & sport.

Active Facilities: Is where buildings are designed and utilised to enable, empower and encourage people to move in a way that meets their needs and wants, where they feel like they belong and can move in a safe and inclusive way

Active Travel: Is about travelling actively for everyday journeys people make from place to place, rather than solely for leisure or fitness. Examples may include walking or scooting to school or cycling to work – active travel can offer a convenient, accessible and affordable way to move more

Active Children and Young People: Is where young people receive positive and fun experiences in physical activity, sport & leisure, where they are heard and their needs are paramount. It provides a good start to their life and enhances their lives now and into adulthood.

The Theory of change captured the key change programmes/projects or interventions and stakeholders that are needed to produce these outcomes.

THEORY OF CHANGE

The current Theory of Change (included as Appendix A) sets out the 'inputs' that already exist in the Plymouth system that are contributors to this work and include Plymouth City Council (PCC) departments, Plymouth Active Leisure Ltd (PAL), Active Devon as the local Active Partnerships, variety of local delivers and partners in the Voluntary and community sector (VCSE) and the natural blue, green and build assets in Plymouth.

Short term outcomes have been captured that are intended to be achieved within the first 1-2 years of Active to Thrive with the intention that there is a continuous learning loop in place to learn, adapt and change to ensure that the short term outcomes lead to the medium term outcomes and onwards to meet the end goal. In addition to the vision statement that Plymouth is the most physically active costal city, the end goal is also articulated as 'increasing physical activity to support tackling the health inequalities across Plymouth'. There is a specific focus on the 8 most deprived neighbourhoods in Plymouth to ensure that projects and programmes are supporting those that will benefit most.

Also articulated in the theory of change are the areas of policy alignment with wider strategic initiatives in the City.

Progress against Theory of Change

Since April 2022 2 workshops have been held to support action planning against the theory of change and capture progress against the short term outcomes. During these sessions emerging work that contributes to overall outcomes has been captured and these now appear in the latest Theory of Change.

The additions typically reflect additional investment into the City, such as the Walking, wheeling & cycling Social Prescribing Pilot, The Outdoor Partnership pilot and new funding for multisports facilities. The 'Active to Thrive' network is key to ensure that existing and new opportunities are aligned and are being delivered in a joined up way.

An additional theme of '**Active for All'** has also been added to further strengthen the commitment to inclusion and ensure this is embedded throughout the other 6 strategic themes. This theme is designed to be cross cutting in nature but may also involve specific project delivery and funding.

Outlined below in brief is the progress against the short-term outcomes. It's important to note that these outcomes are expected to deliver over the next 1-2 years, so not all areas have progress to report at this stage. As an example, the Health & Wellbeing Hubs are pivotal in linking the community to activity providers and are intended to provide support for physical activity outcomes. Whilst the Hubs continue to connect their communities with physical activity providers, their current focus is on meeting the various needs that are emerging from their communities during this cost of living crisis. As such, further development of the physical activity agenda will be deferred to early 2023, which will also align efforts with upcoming physical activity programmes in the city.

Strategic Theme	Short term outcomes (1-2 years)	Progress in 2022
Active for Health	Health & Wellbeing Hubs are playing a pivotal role in using movement to meet relevant community needs Walking, wheeling & cycling social prescribing pilot delivering across the City. Ramblers Wellbeing walks in place across city.	Ongoing activity mapping to aid in connecting hubs with activities. Walking, wheeling & Cycling social prescribing project has been secured by PCC and will be introduced at the November Active to Thrive meeting. Ramblers wellbeing walks are in place across the City and are coordinated by Livewell. Livewell Plymouth and Active Devon are in partnership to deliver Falls prevention work in Plymouth, training several new PSIs (Postural Stability Instructors) to deliver evidence based strength and balance classes on referral.
Active Communities	A network of physical activity providers, with a particular emphasis on the 8 most deprived neighbourhoods, is established, ensuring improved collaboration and connectivity Place based work underway in Devonport. Active through Football delivering to high priority communities.	Mapping has taken place in relation to 2 of the deprived neighbourhoods to understand the activity providers operating in that location and understand gaps. Newly appointed Community Builders will also support with this work. Additional resources have been committed to Devonport to support the redevelopment of Brickfields. Active through Football project is targeted and focused delivery by Argyle Community Trust to high priority communities.
Active Environments	The National Marine Park is pivotal in testing new ways to engage diverse communities with becoming active. Connecting Actively to Nature (CAN) and Naturally Healthy delivering in Plymouth.	The National Marine Park delivered 12 weeks of summer campaign with a variety of offers for physical activity targeting those that may be new to activities. Focus for the coming few months as funding in place for more CAN project sin Plymouth. Walking group meeting regularly at Central Park in a partnership between South West Coast Path Association and Eldertree. CAN opportunities being explore with Improving Lives Plymouth, Age UK Plymouth, National Marine Park and wellbeing hubs. Naturally Healthy along with the Devon Local Nature Partnership are involved in planning for the Devon Nature recovery strategy and are incorporating elements that connect communities to nature for leisure and health and wellbeing as well as nature recovery. New investment - The Outdoor Partnership pilot has been secured by PCC which is a focus on supporting people to be active in the natural environment. They will be joining the November meeting to ensure that activities are aligned with

		those already underway by existing programmes.
Active Facilities	Plymouth Active Leisure Ltd is established and effectively responding to the needs and wants of the local communities they serve, to be Active to Thrive Community facilities and activities mapped across City.	Plymouth Active Leisure Ltd opened its doors in April 22 and key focus is on ensuring that it's viable and delivering. PAL have been part of the community conversations in Devonport to support the offer for Brickfields. In a difficult operating environment, intention is to ensure PAL is viable and then ensuring new initiatives can be trialled to bring in users who may be less familiar with the facilities on offer from built facilities. Mapping is underway and will be further supported by the Community Builders.
Active Travel	Active to Thrive themes are implemented into E bike and green mind implementation, with particular focus on key communities	Green Mind is successfully connecting communities to the parks and green spaces via initiatives such as the Love Parks Week. New investment – The Department of Transport is piloting active travel through social prescriptions, walking, wheeling and cycling, will be offered by GP's as part of a new trial to improve mental and physical health between 2022-25.
Active Children	The Sport England funded Plymouth Pathfinder is pivotal in testing new ways to engage and support children and young people with trauma and SEND, improving their resilience and wellbeing to make better life choices into adulthood. Implement Active Schools in identified schools. Children & Young People Healthy weight plan.	This project is covered under section (4) providing a detailed update on the project. Via Active Devon two primary schools are being supported to adopt the Active Schools framework and conversations are underway with headteachers in relation to supporting Secondary Schools. Funding in place to support two secondary schools in Plymouth. The C&YP healthy weight plan (PCC Public Health) aligns with relevant physical activity outcomes within the Active to thrive plan.
Active for All	Underpinning strategic theme which cuts across all activities and desired outcomes. Supporting a relentless focus on inclusion and increasing diversity across all strategic themes.	Together Fund project in place for Devon & Cornwall refugee service.

Bringing the network together is leading to some tangible actions as a result of sharing news, funding opportunities and upcoming projects. To illustrate this point, following the network meeting in September 2022, £20,262 of funding has been identified and secured resulting in a variety of projects to support physical activity outcomes.

Active Devon is creating a new partnership with YMCA Plymouth. This will see the re-commissioning of their indoor climbing wall along with the appointment of a new operating partner who are keen to take on the promotion and delivery of a range of climbing sessions, making the facility accessible to all

including disabled and para climbers and targeting populations who have not felt that climbing is for them. As a result the YMCA intends to set up a regular activity based youth club, encouraging young people from St. Budeaux and surrounding areas to use the facilities, with free mini-bus travel being arranged in order to reduce any barriers to participation.

A focus on young people with SEN has resulted in internal investment to Routeways to create 'Mark the Park'. This will provide useful information about parks in the local area including a number of key areas such as accessibility, facilities and safety. Routeway's service users will carry out the mapping which also act as a resource for staff who would be able to factor in these ratings in their planning. Essentially, Mark the Park would be a mechanism to produce Risk Assessments for the parks often used by Routeways and subsequently families of children with special needs.

Following an opportunity to engage through POP+ with other partners interested in supporting residents with mental health needs, a partnership is developing between Friends and Families, Colebrook S.W. and Active Devon to support men aged 35-54 in the west of the city. Public Health insight identified this area and demographic as being at most risk of suicide. Staff at William Sutton Hall will work alongside staff at Friends and Families to deliver a range of activities from gardening to table tennis in a welcoming environment with refreshments and further support if needed.

PATHFINDER PROJECT 'DEEP DIVE'

The Pathfinder project within the Active to Thrive Theory of Change is a Sport England funded project with an initial delivery period of 2 years. This project commenced delivery in 2021 and aims to deliver better outcomes for 2 groups of vulnerable young people in Plymouth:

- those who have experienced childhood trauma
- or (and) who have special educational needs

Through the Pathfinder Theories of Change (Appendix B) there has been an exploration of two ways in which the work might support better outcomes for young people. The first focuses on physical activity as a mediator to wellbeing for these young people. It is about the direct impact of activity and movement on young people's resilience and their ability to achieve their potential. The second notes that wellbeing is an emergent property of the system around young people. This theory plots an indirect route to wellbeing, which involves bringing young people and partners in the system together to agree what good outcomes would look like, and to make changes to ensure the whole system works towards these. In Pathfinder, the two approaches are mutually reinforcing, ie engaging in physical activity in order to generate stories to bring about system transformation.

The project has been delivering across 3 Secondary schools in Plymouth, exploring different approaches to delivery, namely:

- Weekly curricular sessions
- Bi-weekly curricular sessions
- A pastoral based and after-school club offer

Mapping across the 3 catchment areas has identified a varying degree of community based opportunities. Where these opportunities exist, young people are starting to being referred into activities and clubs they tell us they would like to participate in. Barriers to participation, such as transport, accessibility and cost, are being addressed if possible.

Where existing opportunities are limited, we are investigating different approaches to connect young people to opportunities for activity. For example, we have developed a partnership programme to provide martial arts skills to girls living in Keyham who attend Stoke Damerel Community College and were affected by last summer's shootings.

Using the Revaluation approach to real-time evaluation, sixteen storying sessions have been carried out so far, at different levels of the system. These include face-to-face storying workshops with staff in each school/community system. Similar messages have been heard across these sessions, including the following:

Participating young people's attitudes to physical activity are moving in a positive direction; they feel more confident and friendship groups are growing.

Relationships are being developed with positive adult role models (youth workers, Argyle Community Trust staff or community deliverers). This is a key element in the individuals' development and ability to make positive informed decisions relating to their lives.

Meanwhile there is emerging evidence from these schools that young people who take part in Pathfinder can achieve better educational outcomes than they otherwise would. Initial feedback from staff at Marine Academy Plymouth has shown that young people's behaviour has improved during the programme, with fewer referrals to the Compass unit (23% fewer during Pathfinder compared to before, for the same group of young people). There are also positive effects in relation to young people's attendance. Further analysis is underway to explore these effects across the whole cohort.

Story sessions have also been held with the Council and related agency staff members across a range of functions including education, public health, children's services and Police. These sessions have revealed consistent views across the system among those working to support vulnerable young people, including:

- There is a deep commitment across the Council and related agencies to place based working and to providing integrated support for vulnerable young people.
- Pathfinder is working with others to embody and model a trauma-informed approach to working with young people across Plymouth.
- The support system for vulnerable young people in Plymouth is suffering an acute lack of capacity: in terms of youth workers, youth centres, foster placements. Joining the system together better will also require plugging gaps.
- Opportunities for activity are very unevenly distributed across the city; opportunities of all sorts for young people in the North of the city are few, and they also suffer a lack of mobility.
- Time is scarce across all sectors and settings; this particularly restricts time for supervision, learning and CPD opportunities
- Transitions from primary to secondary school, and then from education to adult life (NEET or not) are moments of high risk for vulnerable young people; support services should plan ahead and share information better to ensure best possible outcomes, and prevent young people falling out of the system.
- Parents are critical to young people's outcomes; they often carry their own trauma, and can become further traumatized through their interactions with the system. Parenting support may be beneficial, especially if provided early.

All three schools committed to take part in Pathfinder in 2022/23, and we are looking to provide sessions for new year groups, as well as continuing to be there for young people who have already been a part of Pathfinder in 2021/22.

After one year in three secondary schools in Plymouth, Plymouth Pathfinder has delivered much-needed fun, and physical activity opportunities, to 90 vulnerable young people (and has brought funding to local organisations supporting those VYPs). Triggered transformations in the lives of a few of these vulnerable young people (i.e. delivered on Theory of Change 1) Not yet delivered on its aspirations for cross-system transformation (i.e. Theory of Change 2) but has gathered a lot of learning and stories on how to create value for vulnerable young people

The focus for Pathfinder in 22/23 is to:-

- Deliver revised in-school and after-school activities, building connections to other support providers wherever possible, while focusing more on sharing stories and building a learning loop in the top system
- Consider the best ways to build on and extend the value from Plymouth Pathfinder beyond this school year. In view of the value created by the programme to date, this is likely not to involve replication and roll out of the current model. Current thinking is around transforming the in-school role from youth worker to social prescriber, and piloting this role (whether through Plymouth Pathfinder or not). In parallel, Plymouth Pathfinder's role in convening the system around accounts of value for vulnerable young people could continue, in the person of the Plymouth Pathfinder lead manager.

NEXT STEPS

The next 'Active to Thrive' meeting is taking place on the 17 November 22. The Outdoor Partnership will be updating attendees on the project and undertaking a gap analysis of existing work taking place in Plymouth. In addition further progress against the theory of change will be captured and funding opportunities will be shared to continue to maximise value for Plymouth residents.

Conversations will also take place with Sport England with regards to the Pathfinder project and understanding plans for any continuation of this work or similar work in Plymouth. Maximise value from the last phase of the project and continue to innovate.

APPENDIX A

Theory of Change – Active to Thrive

Inputs	Short term Outcomes	Medium Term outcomes	Long Term Outcomes	End Goal	Plymouth Plan Strategic Outcomes and Policy Links
PCC Departments (staff) Plymouth Active Leisure Ltd Blue, Green and Built Assets	Short term outcomes (1-2 years) Health & Wellbeing Hubs are playing a pivotal role in using movement to meet relevant community needs Walking, wheeling & cycling social prescribing pilot delivering across the City. Ramblers Wellbeing walks in place across city. A network of physical activity providers, with a particular emphasis on the 8 most deprived neighbourhoods, is established, ensuring improved collaboration and connectivity Place based work underway in Devonport. Active through Football delivering to high priority communities.	Inclusion and trauma informed training is mandatory for delivery partners working with adults with disabilities and long-term health conditions in order to access PCC facilities and funding Communities at the heart of the decision-making process, so that anything planned, implemented or delivered is based on their needs and that they are part of sustaining activities and interventions. S106 planning decisions encompass the Active to Thrive themes to support great easy of being physically active for the most underserved communities	Physical activity, sport and leisure is used to prevent and manage chronic disease and long-term conditions enabling the people of Plymouth to live a full life whilst relieving the pressure on health and social care services. The people Plymouth are empowered to access social and physical activity, sport & leisure. More people are indicating they are finding being physically active easier	Increasing physical activity to support tackling the health inequalities across Plymouth *Plymouth to be the most physically active coastal city* *in England by 2034*	**Healthy City** People in Plymouth live in happy, healthy, safe and aspiring communities, where social, economic and environmental conditions and services enable choices that add quality years to life and reduce the gap in health and wellbeing between communities. **Policy HEA1** Addressing health inequalities, improving health literacy. **Policy HEA3** **S**upporting adults with health and social care needs. **Policy HEA9** Delivering accessible health services and clinical excellence. **Policy HEA4** Playing an active role in the community. **Policy HEA5** Delivering strong and safe communities and good quality neighbourhoods. **Policy INT8** Celebrating diverse communities.

	The National Marine Park is pivotal in testing new ways to engage diverse communities with becoming active.	A minimum of 5 community groups in key identified wards are enabled to directly manage or influence the management of their facility			**Policy HEA7** Optimising the health and wellbeing benefits of the natural environment.
	Connecting Actively to Nature (CAN) and Naturally Healthy delivering in Plymouth.				**Policy GRO6** Delivering Plymouth's natural network.
	Plymouth Active Leisure Ltd is established and effectively responding to the needs and wants of the local communities they serve, to be Active to Thrive	Communication channels are in place to promote active travel options across the city with physical activity & movement offers			**Policy INT5** Celebrating Plymouth's sporting excellence.
					Policy GRO1 Creating the conditions for economic growth.
	Community facilities and activities mapped across City.	There is a focus on activities that enable social connection rather than competition	More underserved communities are indicating that the feel like they belong and can move in a safe and inclusive way in the city's facilities		Policy GRO5 Enhancing Plymouth's sporting facilities.
					Policy HEA6 Delivering a safe, efficient, accessible, sustainable and health-enabling transport system.
					Policy GRO4 Using transport investment to drive growth.
					Policy INT6 Enhancing Plymouth's 'green city' credentials.
			More people are demonstrating they are walking to school, cycling to work or everyday journeys people make – rather		Policy HEA2 Delivering the best outcomes for children, young people and families.

	Active to Thrive themes are implemented into E bike and green mind implementation, with particular focus on key communities		than solely for leisure or fitness Increase in positive experience of physical activity in children & young people to ensure a lifelong habit.		

Pathfinder - Theory of Change 1

Problem or Issue	Enablers and Conditions	Activities	Outputs	Intermediate Outcomes	Long Term Outcomes	Aim/End Goal
Not all children are 'ready for school', resilient or robust. **Some children are not leaving school with the optimum skills they need to set them up in the best way for adulthood and for becoming parents themselves** **If children and young people have good levels of wellbeing they are more likely to be successful in life**	All partners must commit to a systems-based, multi-agency approach and have a clear ethos All partners must take a Trauma Informed Approach at all times Our approach must be attractive and rewarding Interventions must be fit for purpose and sustainable Interventions must be right for the participants Activities must be led by the right staff, be in the right place and delivered at the right time	We will work with up to 3 school systems, starting with secondary school age pupils but look down the life course towards primary schools, nurseries etc. We will identify other services that cohort might be having, e.g. Police, ASB teams, social care and youth teams We will work with deliverers to develop opportunities where children and young people can connect with others We will identify opportunities for young people to develop through volunteering We will ensure an element of mentoring from an appropriately trained adult We will focus on young people who are showing signs of disengaging from education and/or are developing or exhibiting higher risk behaviours either as a result of their environment or their disability We will look to the environment to make use of green and blue spaces as well as the built environment We will carry out an evaluation that will enable partners to work together more effectively across boundaries so that physical activity is integrated into the recovery process for children and families	*More children and young people experiencing the activities on offer* *A long-term increased participation in clubs and groups* Observed change in participants' ability to connect with others and improve their coping mechanisms and resilience Children achieving their best in GCSEs and in choosing and meeting requirements for their next steps Reductions in NEETs as they leave school Reductions in high-risk behaviours and any specific issues identified.	More access to participation in sport/physical activity A better understanding of the benefits of this access Positive changes resulting from taking part (e.g. increased knowledge, skills, improved attitudes and behaviour) Reduced exclusions from school Improvements in behaviour including exclusions from lessons and improved anger management Improvements in mental wellbeing Teachers reporting improvements in their classes (and their wellbeing)	Young people making positive choices. They are constructively engaged and future oriented Young people benefit from increased wellbeing, enabling them to be more resilient to the challenges they face and more likely to enable them to make healthier choices. Through the evaluation we will create a transitional system to capture the learning from this.	**To help a cohort of children and young people in Plymouth to maximise their potential, to develop coping strategies and tools to support them into adulthood and to support the next generation of families** **To support children and young people to have increased wellness so they become more resilient**

Pathfinder - Theory of Change 2

Problem or Issue	Enablers and Conditions	Activities	Outputs	Outcomes	Aim/End Goal
The local system isn't sufficiently connected to deliver to its maximum potential for vulnerable young people **Not all children and young people in Plymouth will have the opportunity to reach their potential** **Some children are not leaving school with the optimum skills they need to set them up in the best way for adulthood and for becoming parents themselves**	All partners must commit to a systems-based, multi-agency approach and have a clear ethos All partners should take a Trauma Informed Approach across their work Our approach must be attractive and rewarding Interventions must be fit for purpose and sustainable Interventions must be right for the participants	We will undertake storying to learn from partners about their experiences of working with these groups of young people We will gather the learning from this in a number of ways We will map the opportunities available across the 3 catchment areas We will offer support to community based organisations willing to support these young people We will identify and engage with key partners to better understand the current landscape in Plymouth Through a Revaluation approach we will measure, in real time, the value of our work in a complex system.	Local authority service leads work together to minimise duplication or gaps in provision Partners, stakeholders, staff and volunteers are developed and trained Partners collaborate to ensure that young people with SEN and those who have experienced childhood trauma know how and where to access sustainable, high quality physical activity opportunities	Stakeholders, partners and policy makers are influenced at a local level Issues are raised & understood and lessons shared across Plymouth Young people and their families have less interactions with system partners Education partners report positive changes (e.g. increased knowledge, skills, improved attitudes, wellbeing and behaviour) and reduced exclusions from school	**The creation of a transitional system that has captured the learning from Plymouth Pathfinder.** **A Plymouth wide system that works to help young people with SEN and those who have experienced childhood trauma to maximise their potential, to develop coping strategies and tools to support them into adulthood and to support the next generation of families**

Health and Adult Social Care Overview and Scrutiny Committee

Date of meeting:	16 November 2022
Title of Report:	**Compassionate Approach to Children and Young People Health & Weight: Strategic Action Plan**
Lead Member:	Councillor Dr John Mahony (Cabinet Member for Health and Adult Social Care & Planning)
Lead Strategic Director:	Ruth Harrell (Director of Public Health)
Author:	Dave Schwartz
Contact Email:	Dave.Schwartz@plymouth.gov.uk
Your Reference:	Click here to enter text.
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report

The report provides background and context to a new plan to address health and weight amongst our children and young people in the city. Weight is a highly complex issue with research identifying 108 factors that can have an influence. Current data reflects a continuing increase in overweight or obesity for our children and young people (and whole population) with forecast modelling predicting this to continue until at least 2040 without any significant change to what we do. Giving our children and young people the best start to life includes the need to maximise opportunities for health benefits / gains including through tackling inequalities. The plan that we have developed aims to transform our approach through taking a whole system approach and committing to the long-term delivery of it. In order to do this it is key that all stakeholders can provide support and challenge to this shared endeavour and this report provides Scrutiny with the opportunity to do this.

Recommendations and Reasons

1. To note the contents of the report
2. To seek Scrutiny Committee's support in this work
3. To receive a further report in one years' time

Alternative options considered and rejected

None

Relevance to the Corporate Plan and/or the Plymouth Plan

Reduced health inequalities is a key priority within both the Corporate Plan and the Plymouth Plan. Delivering the best outcomes for children, young people and families within both the Corporate Plan and the Plymouth Plan

Implications for the Medium Term Financial Plan and Resource Implications:

- Minimal: Additional new investment for the first 3 years is relatively low and estimated to be £63,140. Year One is £23,820. This investment is sought from PCC Public Health and also the ICS. Failure to get this investment will not affect implementation of the plan. System support to stakeholders will be promoted in order to collaborate to bid for grants when identified as needed from national and other sources.

Financial Risks

None. Delivery of the plan is not dependent on new investment from PCC.

Carbon Footprint (Environmental) Implications:

None

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:

** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*

The plan includes activity that will support families experiencing the cost of living crisis and child poverty.

The plan has a specific section on inequalities that will seek to ensure access to the opportunities and benefits that we aim to deliver are available to underserved populations and that their voice is heard.

Appendices

**Add rows as required to box below*

Ref.	**Title of Appendix**	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	**2**	**3**	**4**	**5**	**6**	**7**
A	A Compassionate Approach to CYP Health & Weight; Strategic Action Plan							
B	Equalities Impact Assessment (if applicable)							

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are unpublished works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	**Exemption Paragraph Number** (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	**2**	**3**	**4**	**5**	**6**	**7**

Sign off:

Fin	DJN 22.23.254	Leg	EJ/38851/1.11.22 (2)	Mon Off	Click here to enter text.	HR	Click here to enter text.	Assets	Click here to enter text.	Strat Proc	Click here to enter text.
Originating Senior Leadership Team member: Ruth Harrell											
Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 01/11/2022											
Cabinet Member approval: Cllr John Mahony *approved by email* Date approved: 01/11/2022											

This page is intentionally left blank

A COMPASSIONATE APPROACH TO CYP HEALTH & WEIGHT: STRATEGIC ACTION PLAN

DPH October 2022

Contents

Executive Summary 2
Definitions 3
Background 4
Data 6
What are we going to do? 9

EXECUTIVE SUMMARY

Childhood obesity and excess weight are significant health issues for children and their families. There can be serious implications for a child's physical and mental health, which can continue into adulthood. The number of children with an unhealthy and potentially dangerous weight is a national public health concern[i].'

Research and policy guidance recognises that obesity is a highly complex issue. There is no simple solution but a whole system approach is clearly identified as key.

Our plan (A Compassionate Approach to Children and Young People Health & Weight – Strategic Action Plan 2023 -2033) is bold and ambitious and will be delivered in 3 phases over 10 years with a clear focus on achieving key success criteria at the end of that period. System management will be overseen by a system optimisation group who will report into the Healthier and Happier Partnership Board.

We are not looking to commission new services first and foremost but focus on creating a shared endeavour that will enable a wide range of stakeholders to achieve collaborative advantage. As a system, we would be looking to support stakeholders and partners to bid for funding as and when it is required. There is a very strong focus on supporting and strengthening community assets and addressing weight stigma, tackling inequalities and maximising opportunity for health benefit.

Nationally (NCMP data 19/20)

- Prevalence of obesity and overweight among children in Year Reception (Year R) has been steady for the past 10 years. Forecasts[ii] are suggesting a steady increase between now and 2040 with the higher rate of increase amongst those children living with obesity
- Prevalence of obesity and overweight among children in Year 6 has seen a gradual increase over the past 10 years. Forecasts suggest the rate of this increase will continue to rise between now and 2040 with the higher rate of increase amongst those children living with obesity
- At a national level, obesity rates are highest in the most deprived 10% of the population and are more than twice that of the least deprived 10% according to data from the 2018 to 2019 National Child Measurement Programme (NCMP) data.

In Plymouth (NCMP data 19/20)

- Prevalence of obesity and overweight among children in Year R has seen a very gradual increase over the past 10 years, however the Plymouth data is worse than the England average across this whole period. Forecasts are suggesting a steady increase between now and 2040 with the higher rate of change amongst those children living with obesity
- Prevalence of obesity and overweight among children in Year 6 has been mainly similar to the England average and on 3 occasions was better than the England average over the past 10 years. Forecasts suggest the rate of this increase will rise between now and 2040 with the higher rate of increase amongst those children living with obesity
- For (18/19) Year R the prevalence of combined overweight and obese children was 4.5 percentage points higher in the most deprived group of neighbourhoods (26.7%) than in the least deprived (22.2%).
- For (18/19) Year 6 the prevalence of combined overweight and obese children was 11.0 percentage points higher in the most deprived group of neighbourhoods (37.4%) than in the least deprived (26.4%).

KEY DEFINITIONS

Overweight

Children are classified as overweight (including obese) if their BMI is on or above the 85th centile of the British 1990 growth reference (UK90) according to age and sex.

Obese

Children are classified as obese if their BMI is on or above the 95th centile of the British 1990 growth reference (UK90) according to age and sex

The body mass index (BMI)

This is a measure that uses height and weight to work out whether weight is healthy. A child's BMI tells us if their weight is right for their height, and the result is given as a centile (or percentile). The BMI calculator takes into account age and sex, as well as height and weight

National Child Health Measurement Programme

The Government's National Child Measurement Programme (NCMP) takes place annually to measure children in reception (aged 4–5 years) and year 6 (aged 10–11 years) in mainstream state-maintained schools in England. Independent and special schools are excluded. Local Authorities (LAs) in England are required to measure children in mainstream state-maintained schools during the school year with the programme running between September and August each year to coincide with the academic year. In previous years, over a million children have been measured annually as part of the programme. Note, in this report we have primarily used the latest validated (not provisional) data. We have used 2019 /20 validated data as the last whole programme undertaken. We have referenced findings from 2020/21 however this was a 10% national representative sample only. We are awaiting validation of the latest 2021/22 findings.

Weight Stigma[iii]

Negative attitudes towards, and beliefs about, others because of their weight

Note:

Evidence indicates that weight stigma can be harmful to individuals' wellbeing, with psychological, behavioural and social consequences for those affected by obesity.

Psychological outcomes can include; depression, anxiety, low self-esteem, poor body image, self-harm and suicide. Behavioural outcomes can include; unhealthy weight control practises, binge-eating, and avoidance of physical activity and health screening. Social outcomes can include; social rejection by peers, poor quality of interpersonal relationships, potential negative impact on academic outcomes, the denial of jobs and promotions, the reduction of earning potential, biased attitudes from health care professionals, and stereotypes in the media.

BACKGROUND

What causes differences in weight?

The UK Government Foresight Programme produced a landmark report in 2007, 'Tackling Obesities: Future Choices'[iv]. The authors identified 108 different key factors that can influence an individual's weight. The report notes;

'causes of obesity *are extremely complex encompassing biology and behaviour, but set within a cultural, environmental and social framework. There is compelling evidence that humans are predisposed to put on weight by their biology. This has previously been concealed in all but a few but exposure to modern lifestyles has revealed it in the majority. Although personal responsibility plays a crucial part in weight gain, human biology is being overwhelmed by the effects of today's 'obesogenic' environment, with its abundance of energy dense food, motorised transport and sedentary lifestyles. As a result, the people of the UK are inexorably becoming heavier simply by living in the Britain of today. This process has been coined 'passive obesity'. Some members of the population, including the most disadvantaged, are especially vulnerable to the conditions.'*

Consequences of obesity

Obesity increases the risk of a range of chronic diseases, particularly type 2 diabetes, stroke and coronary heart disease and also cancer and arthritis. From a children and young people perspective there are implications around stigmatisation, bullying, low self-esteem and school absence. Additional health risks include high cholesterol, high blood pressure, bone and joint problems and breathing difficulties[v]. The 'Foresight' report noted that NHS costs attributable to overweight and obesity are projected to double to £10 billion per year by 2050.

COVID

During COVID a reduced representative NCMP programme was undertaken nationally (2020). In Plymouth 8 primary Schools contributed to the programme instead of all of them. National findings[vi] showed significant increases in obesity prevalence compared to the previous year (pre-COVID) for both Year R and Year 6. Inequalities widened in prevalence of obesity when comparing most deprived to least deprived areas with pre-COVID data.

Provisional national findings[vii] for the 2021/22 programme is suggesting a reduction in prevalence compared to the data from the reduced programme undertaken during the Pandemic in 2020. However, the provisional data looks like it is an increase when compared to the pre-COVID data so reflecting a continuing increase in trend. The higher than expected peak during COVID is likely to reflect the specific impact of COVID and also be affected by the smaller cohort measured.

Data

National data from the NCMP and surveys undertaken with adults show increasing prevalence of overweight or obesity. In Plymouth, our data shows this trend for school reception children and adults over 18 years old and these have remained worse than the England average over the last 10 years. Our Year 6 data is increasing but we have managed to remain similar to the England average increase over this time.

There are examples of good work in the City. Some of this work can have short-term benefit with a smaller number of people experiencing longer-term (sustainable) benefit. However with 27.7% children in reception, 33.5% in year six (both from 2019/20) and the adult survey showing 68.8% (2020/21) as overweight or obese in Plymouth positive impact is not taking place at a population level. The data is clear in that over this 10 year period (and longer) prevalence of overweight and obesity is worsening.

Appreciative Enquiry

Prior to the Pandemic we had undertaken appreciative enquiry with families who would have been eligible for a Tier 2 Weight Management Programme. A Tier 2 programme is usually characterised by being time limited i.e. 12 weeks, and provided 3 to 4 times per year with a maximum limit of 20 children or young people per cohort. Eligibility was linked to being greater than or equal to the 91st

centile in regard to BMI. In Plymouth we had taken the decision to de-commission this service due to persistent low levels of recruitment and retention of children and young people and little impact on BMI for those who completed the programme. Through appreciative enquiry we found that the following issues were common:

- Childhood trauma (adverse childhood experiences)
- Parental emotional health and wellbeing issues
- Multiple and complex need
- Basic needs not being met
- Existing multiple professional involvement

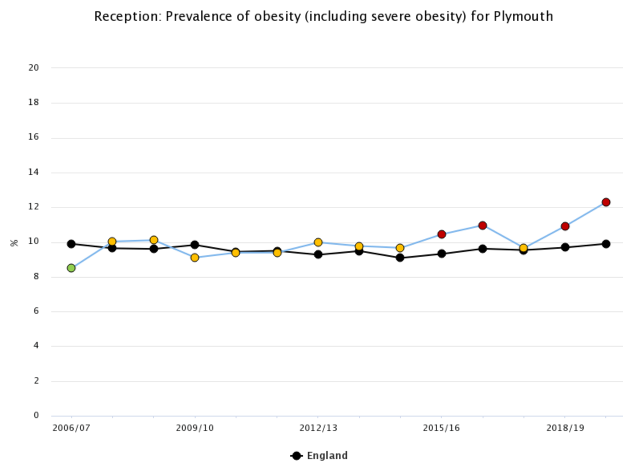
Thematic analysis from the insight gained insight identified the following:

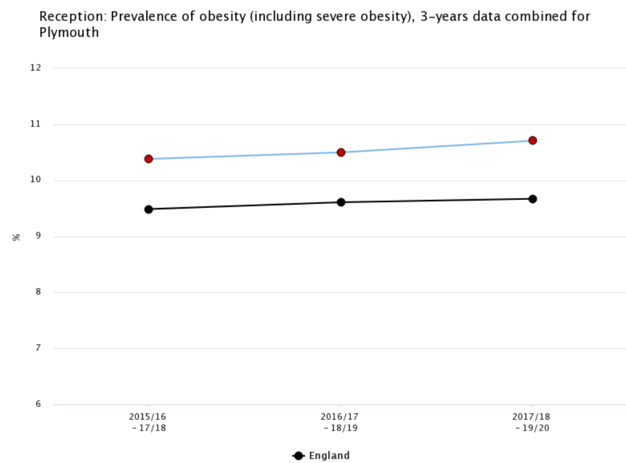
- Individual based offer is not effective for CYP and their families by the time they 'meet threshold' for referral
- Relationship based approaches are key
- Personal qualities valued over professional expertise
- Clear link between obesity outcomes and trauma
- Systems thinking, not service thinking

These findings led to reviewing our whole approach and was key in shaping the development of our plan. This key learning has been shared regionally and has been influential in other local authority area work as has our development of this plan over the past year.

DATA

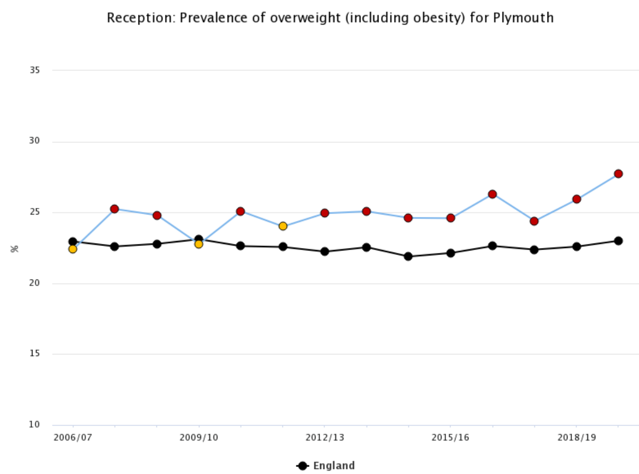
Year R

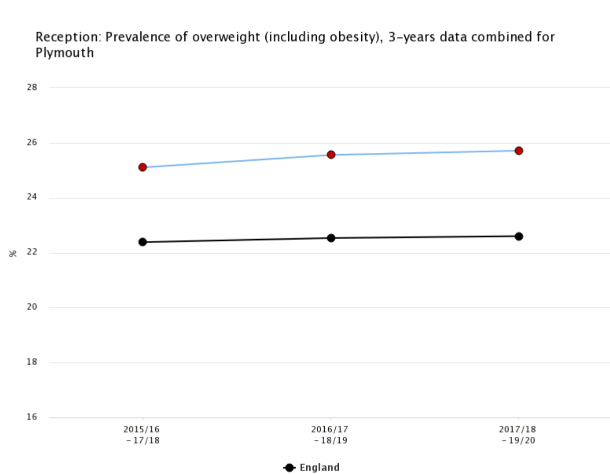




Over the past 10 years the England average has remained fairly stable for Year R. Plymouth has seen a gentle increase but has over this period been consistently higher (worse) than the England average. The last two years reflected suggest a steeper increase in prevalence.

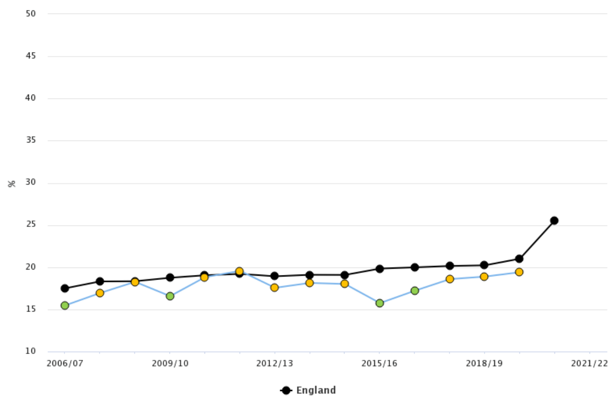
Year R

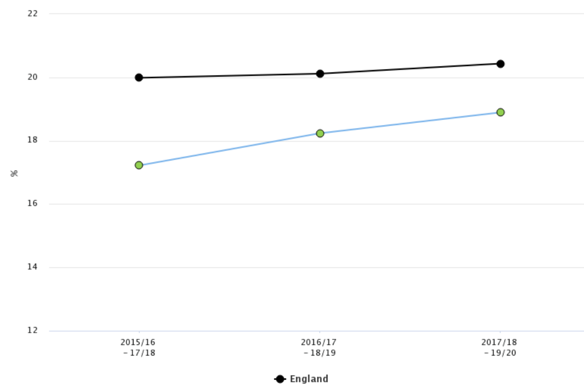




Over the past 10 years the England average has remained fairly stable for Year R. Plymouth has seen a gentle increase but has over this period been consistently higher (worse) than the England average. The last two years reflected suggest a steeper increase in prevalence.

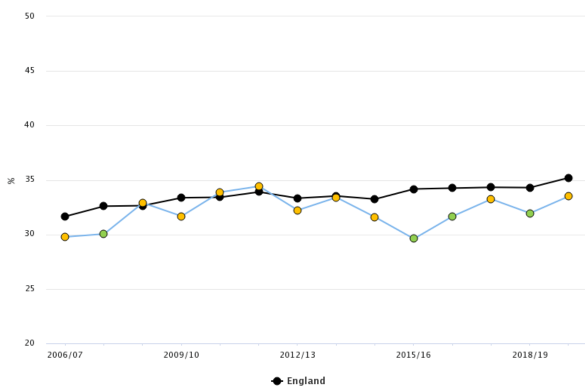
Year 6

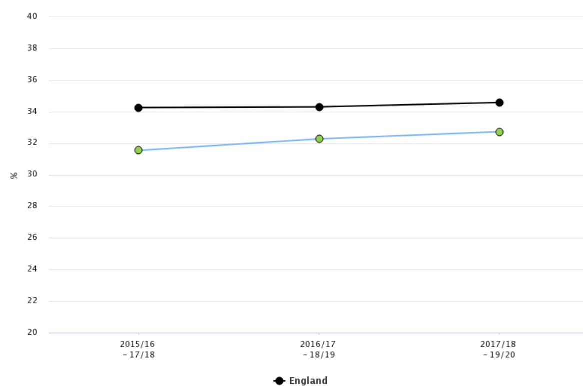




Over the past 10 years, the England average has shown a gentle increase. The annual graph (left side) includes data for the national representative sample during the COVID pandemic in 2020. That data shows a sharp increase. There is no corresponding Plymouth data for that year has the sample was too small (8 schools only in Plymouth). The aggregated 3 year data (right had side) shows Plymouth better than the England average but with that difference narrowing due to a worsening situation in Plymouth after 2015/16.

Year 6





Over the past 10 years, the England average has shown a very gentle increase. The aggregated 3 year data (right had side) shows Plymouth better than the England average but with that difference narrowing due to a worsening situation in Plymouth.

Comparison with statistical neighbours

Year R

Reception: Prevalence of overweight (including obesity) 2019/20 — Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↑	-	-	23.0	22.8	23.1
Neighbours average	–	-	-	-	-	-
Gateshead	↑	5	-	29.4*	26.7	32.7
Wolverhampton	→	11	-	28.6*	26.7	30.7
Plymouth	→	-	-	27.7*	25.6	30.2
Walsall	→	9	-	27.4*	25.4	29.4
Dudley	→	3	-	27.1*	25.3	29.1
Rochdale	→	10	-	26.1*	23.9	28.1
Telford and Wrekin	→	6	-	26.1*	23.9	28.8
Darlington	→	12	-	25.8	23.4	28.6
Medway	↑	13	-	25.5	23.9	27.3
Wigan	→	7	-	25.4	24.1	26.9
Calderdale	↑	8	-	23.1	21.4	25.0
Southend-on-Sea	→	14	-	22.4*	19.7	25.1
Sunderland	→	15	-	22.1	20.7	23.7
Stockton-on-Tees	→	1	-	21.6*	19.6	24.2
Derby	→	2	-	21.5*	19.8	23.4
Bolton	–	4	-	*	-	-

Reception: Prevalence of overweight (including obesity), 3-years data combined 2017/18 - 19/20 — Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	363,329	22.6	22.5	22.7
Neighbours average	–	-	-	-	-	-
Wolverhampton	–	11	2,370	27.7	26.8	28.7
Wigan	–	7	2,795	26.2	25.4	27.0
Plymouth	–	-	1,765	25.7	24.7	26.8
Dudley	–	3	2,440	25.5	24.6	26.4
Walsall	–	9	2,385	25.4	24.5	26.3
Darlington	–	12	850	25.0	23.6	26.5
Gateshead	–	5	1,195	24.9*	23.7	26.2
Telford and Wrekin	–	6	1,310	24.6	23.6	25.9
Rochdale	–	10	1,840	24.5	23.5	25.5
Medway	–	13	2,255	24.2	23.4	25.1
Sunderland	–	15	2,060	24.0	23.1	24.9
Calderdale	–	8	1,675	23.9	22.9	24.9
Derby	–	2	1,970	23.0	22.1	23.9
Southend-on-Sea	–	14	1,125	22.5*	21.4	23.7
Stockton-on-Tees	–	1	1,325	22.3	21.2	23.3
Bolton	–	4	1,840	22.0*	21.1	22.9

Plymouth has the third highest prevalence levels for overweight including obesity compared to the statistical neighbours for both 2019/20 and also the 3 year aggregated data

Year 6

Year 6: Prevalence of overweight (including obesity) 2019/20 — Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↑	-	-	35.2	35.1	35.3
Neighbours average	–	-	-	-	-	-
Walsall	→	9	-	44.6*	42.4	46.9
Dudley	↑	3	-	42.1	40.4	43.8
Wolverhampton	→	11	-	42.0	40.1	43.8
Telford and Wrekin	→	6	-	40.0	37.9	42.3
Derby	→	2	-	38.9	37.2	40.6
Rochdale	→	10	-	38.8	36.9	40.8
Wigan	→	7	-	38.6	37.1	40.3
Gateshead	→	5	-	38.5	36.5	40.8
Darlington	→	12	-	37.8	35.1	40.5
Sunderland	→	15	-	36.9	35.1	38.6
Medway	→	13	-	36.9	35.3	38.6
Bolton	→	4	-	36.1	34.5	37.6
Calderdale	→	8	-	35.0	32.9	36.9
Stockton-on-Tees	→	1	-	34.8*	32.4	37.6
Plymouth	→	-	-	33.5*	30.9	35.8
Southend-on-Sea	→	14	-	33.4	31.3	35.5

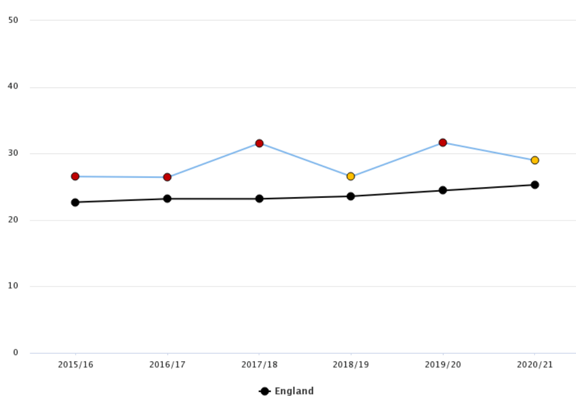
Year 6: Prevalence of overweight (including obesity), 3-years data combined 2017/18 - 19/20 — Proportion - %

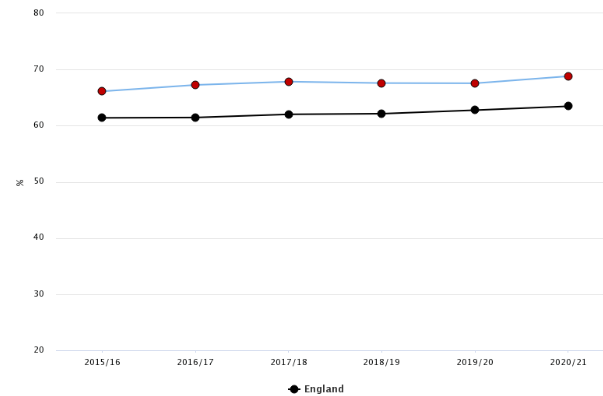
Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	576,642	34.6	34.5	34.6
Neighbours average	–	-	-	-	-	-
Wolverhampton	–	11	3,990	43.0	42.0	44.0
Walsall	–	9	3,745	41.5	40.5	42.6
Dudley	–	3	4,200	40.4	39.4	41.3
Sunderland	–	15	3,535	39.0	38.0	40.0
Rochdale	–	10	3,205	38.4	37.4	39.5
Telford and Wrekin	–	6	2,320	37.9	36.7	39.1
Gateshead	–	5	2,225	37.7	36.5	39.0
Derby	–	2	3,625	37.6	36.6	38.6
Wigan	–	7	4,035	37.4	36.5	38.3
Darlington	–	12	1,305	36.5	34.8	38.0
Stockton-on-Tees	–	1	2,155	36.0	34.8	37.3
Medway	–	13	3,465	35.8	34.8	36.7
Bolton	–	4	4,085	35.8	34.9	36.6
Calderdale	–	8	2,505	34.9	33.8	36.0
Southend-on-Sea	–	14	1,930	33.0	31.8	34.3
Plymouth	–	-	2,130	32.7	31.6	33.9

Plymouth has the 15th highest (2nd lowest) prevalence level for overweight including obesity compared to the statistical neighbours for 2019/20 data and the 16th highest (i.e the lowest) for the 3 year aggregated data

The data for statistical neighbours highlights the stark difference for Plymouth when comparing Year R and Year 6. Note : Even where Plymouth is 'green'(better than the England average) this is still reflecting an increase in prevalence but at a percentage lower than the England average.

Adults (for reference)





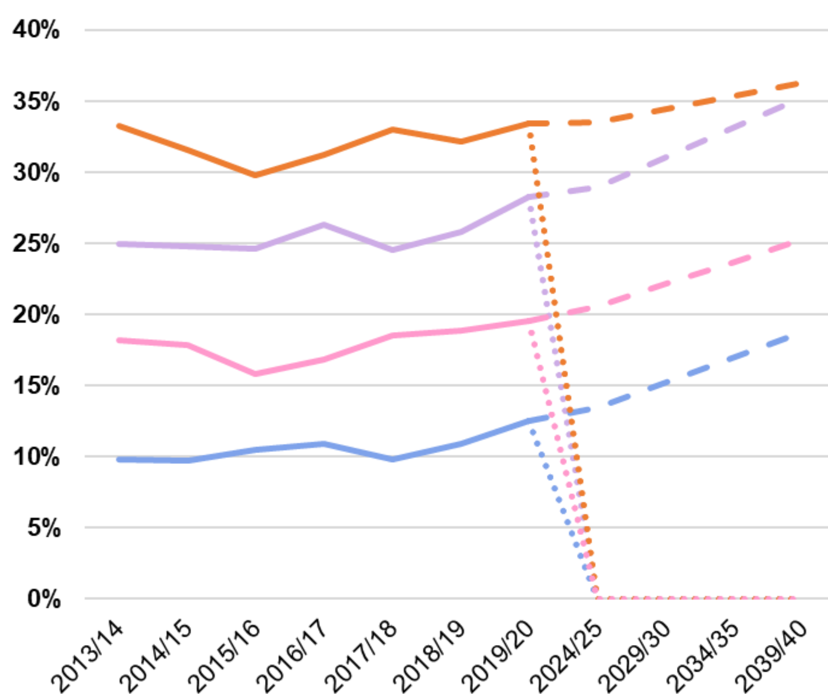
Both these graphs reflect gentle increases over time at both a national level and for Plymouth. Plymouth has been continually higher (worse) than the England average in both graphs. The 20/21 data for adults classified as obese gives a figure of 29% and for overweight or obese 68.8%. Comparing this to the children and young people data at Year R and Year 6 shows a steady continual increase over time in prevalence. Note the adult data source is from the Active Lives Adult Survey – Sport England

Forecasts

Children and Young People – forecasts from Local Government Association: The Future health challenges: public health projections - childhood obesity[viii]

PLYMOUTH:	2020	2025	2030	2035	2040
Reception					
Overweight & Obese:	**28.2%**	**29.0%**	**31.1%**	**33.2%**	**35.3%**
Obese:	**12.5%**	**13.4%**	**15.2%**	**17.0%**	**18.7%**
Year 6					
Overweight & Obese:	**33.5%**	**33.5%**	**34.4%**	**35.3%**	**36.3%**
Obese:	**19.6%**	**20.5%**	**22.1%**	**23.7%**	**25.3%**

England:	2020	2025	2030	2035	2040
Reception					
Overweight & Obese:	**23.0%**	**23.2%**	**23.7%**	**24.2%**	**24.7%**
Obese:	**9.9%**	**10.2%**	**10.7%**	**11.1%**	**11.6%**
Year 6					
Overweight & Obese:	**35.2%**	**36.2%**	**37.5%**	**38.9%**	**40.2%**
Obese:	**21.0%**	**22.3%**	**23.8%**	**25.3%**	**26.8%**



Projected child obesity prevalence across England, 2020-2040. Likely future levels of child obesity, assuming that trends in child obesity continue in their current trajectory.

These forecasts will have many caveats but provide the current 'best' modelling on possible trajectories. In these forecast both Year R and Year 6 prevalence for categories overweight and obese, and also obese, will continue to steadily rise across this whole timeframe. Year R is forecast to remain higher than the England average whilst Year 6 is below the

England average. The increases for both Year R and Year 6 are primarily driven by the increase in percentage of children and young people's living with obesity.

WHAT ARE WE GOING TO DO?

Successfully tackling obesity is a long term, system wide commitment. There is no single or simple solution. The evidence is very clear that policies aimed solely at individuals will be inadequate and that simply increasing the number or type of small-scale interventions will not be sufficient to reverse this trend. Significant effective action to prevent obesity at a population level is required.

National Government is best placed to influence some elements of the 'obesogenic environment' e.g. reduction and reformulation measures focused on salt, sugar and fat content of foods. There is however much that we can influence at a local authority level but this will take time if we want to make a real difference. Our plan aims to provide a framework for us to influence what we can do to create the best possible opportunities for our children, young people (and families) to thrive and experience health benefits.

Reviewing the literature and reflecting on what children, young people and families have told us means that we need to be bold, with the aim of transforming what we do to one of a whole system approach.

The Plan:

- Covers a 10 year period and aims to provide Plymouth with an opportunity to transform our approach to this complex issue
- Is based on a whole system approach with ambition reflected through success criteria which if achieved would reflect significant progress / impact
- Brings together a wide range of existing services and planned developments along with some specific 'local' new initiatives. Through this we seek to promote a shared endeavour creating collaborative advantage which minimises the need for significant new investment
- Has four priority areas, namely: whole system development; my team and my community; children and young people system (services) and inequalities
- Will aim to tackle weight stigma and be compassionate
- Have a strong focus on building individual, family and community assets; empowering people to take up or create activities that work for them
- Supports good and effective links with the University Hospital Plymouth Tier 3 Complications of Excessive Weight (Pilot) Service
- Links with wider stakeholders from local authority planning and economic development partners as well as the business community
- Utilises a 'Human Learning Systems[ix]' approach to drive continual learning through discussion and dialogue with children, young people and families , staff and volunteers and system leaders to inform the management of a complex system
- Will be overseen by a system optimisation group which will focus on learning shared by the system and also be informed through key data, to help inform, adapt and flex design to achieve the success criteria and 'manage the system'

---

[i] Childhood obesity: applying All Our Health - GOV.UK (www.gov.uk)
[ii] Future health challenges: public health projections - childhood obesity | Local Government Association
[iii] Weight-Stigma-Position-Statement.pdf (obesityhealthalliance.org.uk)
[iv] Project Report (publishing.service.gov.uk)
[v] Childhood obesity: applying All Our Health - GOV.UK (www.gov.uk)
[vi] National Child Measurement Programme, England 2020/21 School Year - NHS Digital
[vii] National Child Measurement Programme, England, Provisional 2021/22 School Year Outputs - NHS Digital
[viii] Future health challenges: public health projections - childhood obesity | Local Government Association
[ix] Human Learning Systems | Centre For Public Impact (CPI)

A COMPASSIONATE APPROACH TO CYP HEALTH & WEIGHT: STRATEGIC ACTION PLAN

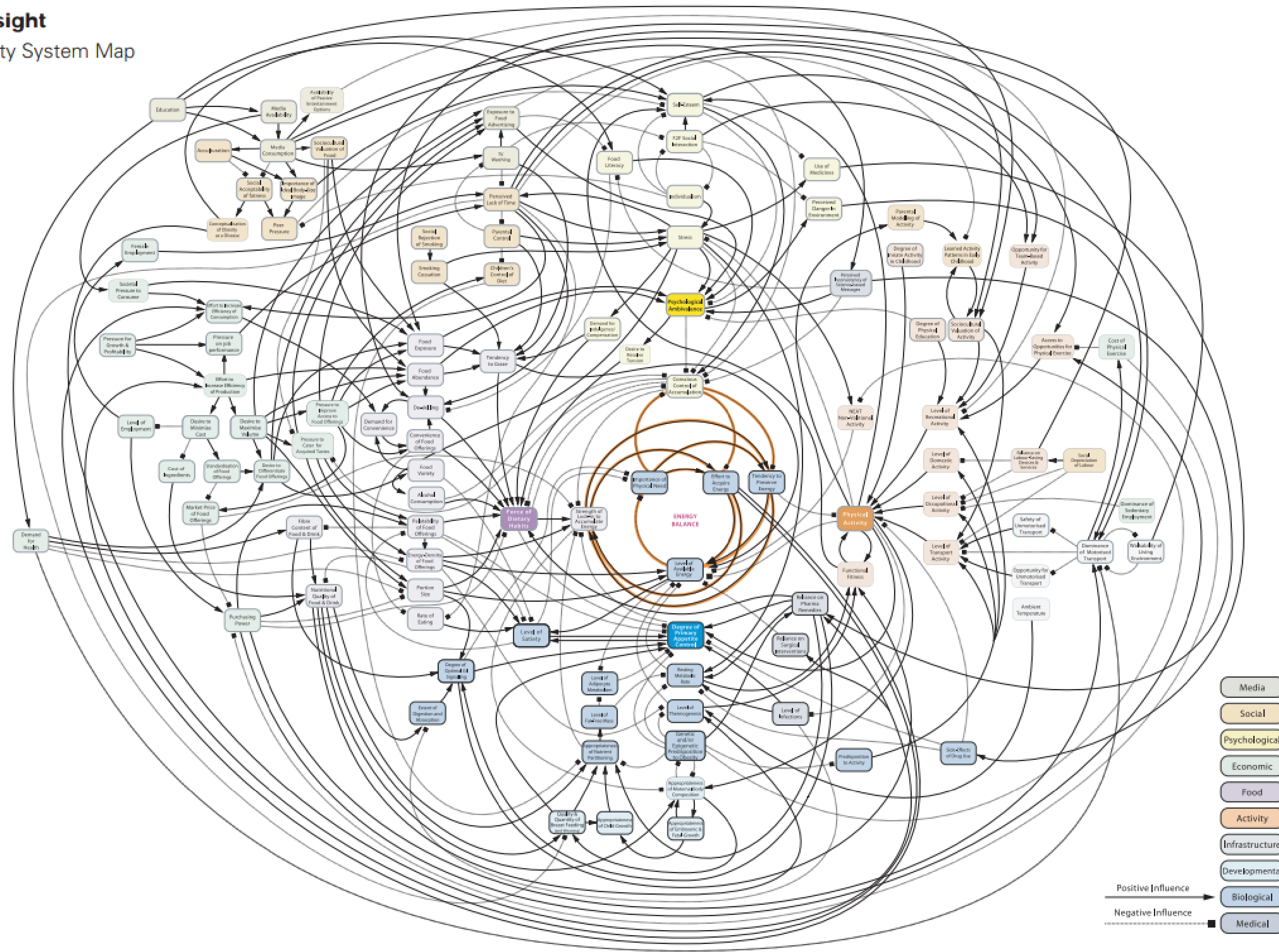
Supporting health gain / benefit for children and young people in respect to weight

Plymouth: Our Action Plan 2023-2033

Version 3.0: Phase One Year One (P1Y1): Reviewed annually (next review Jan 2024)

PLYMOUTH: Version 3.0 **PHASE ONE YEAR ONE** 211022

Foresight
Obesity System Map



Our Plan

The ‘Obesity System Map’ from the ground-breaking report, ‘Tackling Obesities – Future Choices’* reflects the complexity of the challenge for health improvement in regard to weight with 108 factors identified that can be an influence.

Work on our Plan started through insight gained from listening to local families eligible for a weight management service. Their lives revealed complexity, family strengths and significant challenges. It was clear that there was no simple solution.

The Plan for Plymouth reflects this complexity through being bold and transformational. We will create a shared endeavour that maximises collaborative advantage, along with continual learning to ensure the approach remains relevant to our children, young people and families; and keeps us on course for achieving the success criteria over its 10 years

*Tackling obesities: future choices - GOV.UK (www.gov.uk)

How will we know we are successful – success criteria by 2033

Using the Phases Template (page 7) and learning from across the system (page 8) to inform reviews that will determine (1) system progress toward this criteria, (2) key learning and (3) what we may need to do that is new or requires change. Reviews are annual and at the end of each phase.

1. *Breast feeding initiation will be significantly better than the England average by 2028 and be sustained through to 2033
2. *Breast feeding at 6-8 weeks will be similar to the England average by (2028): and significantly better than England average by 2033
3. *NCMP at reception (Overweight & Obese): trend is toward or is similar to England average by 2028 & significantly better than the England average by 2033
4. *NCMP at Yr6 (Overweight & Obese): trend is toward being significantly better than the England average by 2028 & significantly better than the England average by (2033)
5. *NCMP (Overweight & Obese): YrR and Yr6 have a continuing downward trend of prevalence by 2033 (3 continuous years)
6. Feasibility of this criteria determined during Year One: We will aim to agree a number of conditions that children & young people present with to the health system that are associated with living with obesity. Numbers presenting will be benchmarked in 2023. We will aim to reduce the number for each condition compared to the baseline in 2023 so that the fewest number are in 2033. Measure to be developed.
7. Feasibility of this criteria determined during Year One: We will aim to agree (hereditary or genetic) health conditions[1] and types of neurodiversity that are likely to increase both vulnerability to and complications from living with obesity. By 2033 diagnosis of any of these should always lead to early provision of information, advice and support to help reduce vulnerability to and complications from living with obesity. Measure to be developed
8. 90% of children and young people achieve the daily recommendations from the Chief Medical Officers Physical Activity Guidance (2019 and 2022) by 2033[2]. Measure to be developed
9. 95% of all state funded schools achieve school food standards (2026); 100% of schools by 2033
10. Voice of families / CYP reflect positive experiences of system and services used – including those transitioning into adult services. Measure to be developed
11. System is demonstrably asset based; reflects continual learning from CYPF / communities / workers & volunteers; is trauma informed & compassionate[3] and has offers that are local to where residents live, with access to targeted and specialist support if necessary. Measure to be developed
12. Use of language that supports a compassionate and health gains based approach is understood and used routinely across system by services and workers. Measure to be developed

* Consideration, where possible, of comparison with statistical neighbours will be made, with the aim to be the best of our statistical neighbours by 2033

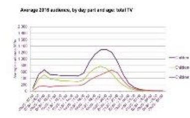
[1] E.g. X-fragile syndrome; Duchenne muscular dystrophy; Down Syndrome; Williams Syndrome; Learning Disability; Autism (further work to develop this in Phase One Year One))
[2] Supporting Active to Thrive vision: 'Plymouth to be the most physically active coastal city in England by 2034'
[3] Everybody in Plymouth is fully able to pursue their own health goals in respect to their weight and are fully supported to do so by society, without judgement or assumptions. They feel valued as an individual just the way they are

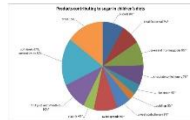
Success Criteria	**Most recent data and source** Benchmarking to be completed during autumn 2022 following publication of latest breast feeding and NCMP data		**Current & Data Source**
1 Breast feeding initiation	Plymouth 67.6% :England 67.4% Similar 2018/19	Public health profiles - OHID (phe.org.uk)	**OHID**
2 Breast feeding at 6-8 weeks	Plymouth 41.0%:England 47.6% Worse 2020/21	Public health profiles - OHID (phe.org.uk)	**OHID**
3 NCMP at Year Reception (Overweight & Obese)	Plymouth 27.7% :England 23.0% Worse 2019/20	Public health profiles - OHID (phe.org.uk)	**OHID**
4 NCMP at Year 6 (Overweight & Obese)	Plymouth 33.5% :England 35.2% Similar 2019/20	Public health profiles - OHID (phe.org.uk)	**OHID**
5 NCMP (Overweight & Obese) – trend direction	YR R = worsening: Yr6 = worsening	Public health profiles - OHID (phe.org.uk) Public health profiles - OHID (phe.org.uk)	**OHID**
6 Reduce number of children & young people that present to the health system with health conditions that are associated with living with obesity (tbc)	Feasibility of measure to be determined and measure to be agreed Phase one Year One	ICS / UHP	**ICS / UHP**
7 All children & young people with (agreed) hereditary/ genetic health conditions / neurodiversity that increases vulnerability to and complications from living with obesity, when diagnosed are provided with information, advice and support (tbc)	Feasibility of measure to be determined and measure to be agreed Phase one Year One	ICS / UHP	**ICS / UHP**
8 90% of children and young people achieve the daily recommendations from the Chief Medical Officers Physical Activity Guidance	Measure to be developed - during Phase one Year One	SHEU/ Active Devon survey	**PH**
9 95% of all state funded schools achieve school food standards (2025)	Measure to be developed - during Phase one Year One	Audit under Food Standards Agency and DfE	**TBC**
10 Qualitative feedback from families / CYP reflect positive experiences of system and services used – including into transition with adult services	Measure to be developed - during Phase one Year One	Evaluation / survey / appreciative enquiry / shared learning	**TBC**
11 System is demonstrably asset based; learning influenced; trauma informed & compassionate and has clear local offers to where residents live with access to targeted and specialist support if necessary	Measure to be developed - during Phase one Year One	Audit / shared learning	**TBC**
12 Use of language that supports a compassionate and health gains based approach is understood and used routinely across system by services and workers	Measure to be developed - during Phase one Year One	Survey / audit / shared learning	**TBC**

This Plan supports delivery of the following key strategic plans

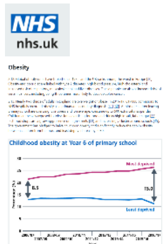
THE PLYMOUTH PLAN 2014-2034 : Plymouth Plan
Plymouth Plan 2020

- Policy HEA1 Addressing health inequalities, improving health literacy
- Policy HEA2 Delivering the best outcomes for children, young people and families
- Policy HEA4 Playing an active role in the community
- Policy HEA7 Optimising the health and wellbeing benefits of the natural environment
- Policy GRO5 Enhancing Plymouth's sporting facilities
- Policy GRO6 Delivering Plymouth's natural network





Childhood obesity: a plan for action:
Childhood obesity: a plan for action - GOV.UK (www.gov.uk)



NHS Long Term Plan – Obesity : NHS Long Term Plan » Obesity
NHS Long Term Plan

Plymouth Healthy Weight Declaration
Healthy weight declaration (plymouth.gov.uk)

A Bright Future 2021 to 2026: Children and young people's plan and partnership for Plymouth | PLYMOUTH.GOV.UK
Children and young people's plan and partnership for Plymouth

Active to Thrive Strategic Action Plan:
Active Devon & Plymouth City Council

The Plan will:	How:
Focus on health gains	Rebalance the focus on weight to maximise the focus on health improvement / benefit
Be trauma informed / compassionate	Take into account the impact of trauma; understand what an individual may have more influence over or little or no influence over in regard to behaviours; Avoid contributing to weight stigma / tackle weight stigma – '*everyone is valued just the way they are*'
Be delivered through a whole system approach	Build a whole system approach creating a shared endeavour and maximising collaborative advantage for positive outcomes and funding opportunities; Influence what we can - create environments and opportunity across systems /communities, for health improvement / benefit
Reflect the complexity and scale of challenge (There are 108 factors that can contribute to obesity[4])	Recognise human systems are complex[5] and sustainable change takes time; Focus on long-term goals (success criteria); CYPF and wider stakeholders inform dynamic learning & review, reflecting lived experience leading to continual improvement in approach: bespoke solutions – listen - adapt – change – empower
Be based on the lived experience of the population served	Focus on relationships; support connections between people; build / facilitate community assets; collaborate; recognise the strengths and limitations of services and the strengths of community / people; empower people; health literacy. Use of Appreciative Enquiry and approaches that recognise the complexity of lived experience and importance of relationships
Have a strong focus on prevention	Be asset based; enable people and communities to thrive; influence determinants wherever possible; ensure early access to help if needed
Tackle inequalities	Recognise the role and impact of social inequalities and determinants in shaping lives and use this to inform what is done to make a difference
Be delivered in line with the iThrive model	Framing the approach in terms of thriving; information & advice; getting help; getting more help; getting risk support

[4] Tackling obesities: future choices - project report (2nd edition) (publishing.service.gov.uk)

[5] Human Learning Systems

Phases of the Action Plan 2023 – 2033: Reviews to use this framework.

Year & Phase	Characterised by	System Status:	End of Phase Position re Success Criteria
Phase 1 2023-2025 Year 1 & 2	• Establishing / enhancing building blocks for change • Developing a shared endeavour across system including with relevant adult services • Communication across system – sharing the vision (the success criteria): • Dynamic learning with annual review (i.e. learn, develop, change and adapt if necessary) • End of Phase 1 Review, with Plan reviewed and refined for following phase(s)	**Status: Emerging/developing (Forming)** • Initial design implementation • Bring together system stakeholders to achieve collaborative advantage • Workforce development & empowerment • Learning from CYPF & stakeholders beginning to inform system development / progress • Identify gaps and develop solutions • Quick wins possible	Low impact • Limited effect on trends
Phase 2 2026-2028 Year 3 -5	• System changes embedded • Shared understanding of endeavour in place • Communication across system – reinforcing the vision / staying on track (success criteria) • Dynamic learning with annual review (i.e. learn, develop, change if necessary)End of Phase 2 Review, revisions will lead to updated Plan for following phase	**System status: Maturing (Norming)** • System offer established as reflected in graphic • Some medium to longer term benefits being realised • System beginning to realise collaborative advantage • Workforce capability increases • Learning from CYPF & stakeholders informing system development / progress • System solutions improve	Moderate impact • Slow down worsening trends • Stop worsening trends • Improving trends continue to improve
Phase 3 2029-2033 Year 6 to 10 and on-going / sustainable	• System design ambition reached and fully functioning • Shared endeavour normalised • Communication across system increasingly informed through references to impact being made • Dynamic learning with annual review (i.e. learn, develop and change if necessary)End of Phase 3 Review, with decision on continuing beyond year 10	**System status: Fully embedded (Performing)** • System effective – impacting positively on trends • Medium to longer term wins being realised • System stakeholders maximising collaborative advantage • Learning from CYPF & stakeholders continuing to inform system development / progress	High impact • Improving trends

PLYMOUTH: Version 3.0 **PHASE ONE YEAR ONE** 211022

PLYMOUTH: COMPASSIONATE APPROACH TO CYP HEALTH & WEIGHT

CONCEPTUAL GRAPHIC OF WHOLE SYSTEM
SHARED ENDEAVOUR SUPPORTING COLLABORATIVE ADVANTAGE

CYP HUB & SPOKE

GETTING MORE HELP / RISK SUPPORT & MANAGEMENT

Specialist MDT clinic with individualised multi-component care plans

CYP SYSTEM COMMUNITY

GETTING ADVICE / GETTING HELP GETTING MORE HELP

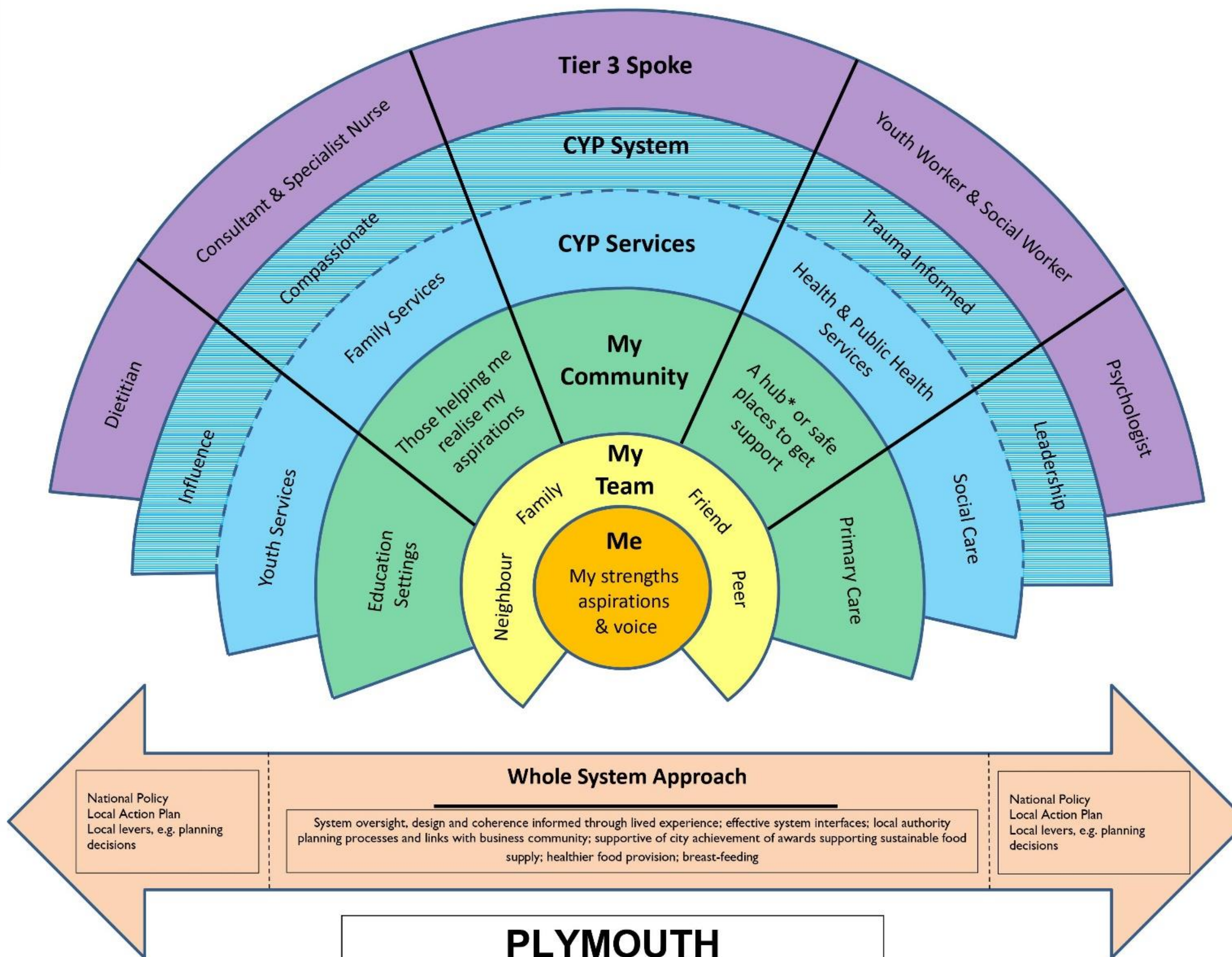
Supporting heath gains through conversation, information, advice and support

CYP SYSTEM & COMMUNITY

THRIVING / GETTING ADVICE

Building health literacy, resilience and wellbeing through:
Locally based support
Networks / Peer support
All Hubs
Social prescribing
Access to services including primary care
Digital platforms

*Hubs include:
Family & Wellbeing Hubs



PLYMOUTH

Integrated system design concept- V11 August 2022

REVIEW AUGUST 2023

"I will achieve health gains* with support from:"

"A specialist team that will support me if I have complex medical issues associated with my weight"

"Children and young people services that I have a relationship with"

"Safe networks and places I can go in my local community"

"My close social networks who are important to me"

"The leaders in my city who make decisions that affect me"

***Health gain:** a measured improvement in the health of a person or a population
Source: National Institute for Health and Care Excellence
Glossary | NICE

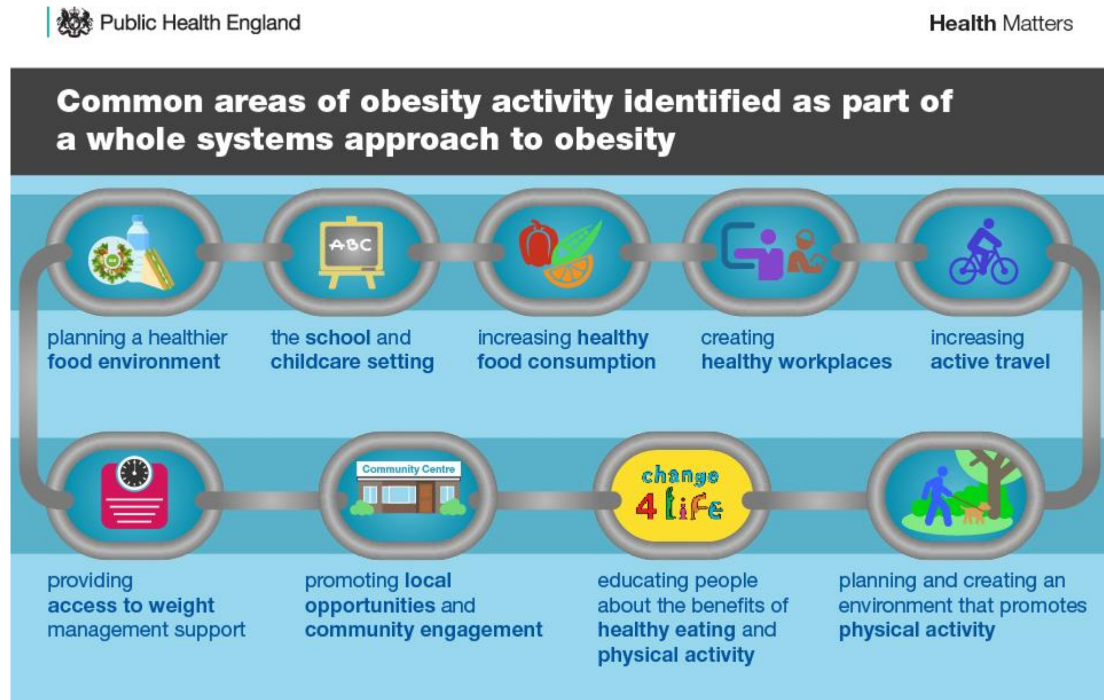
Plymouth: Our Action Plan 2022-2032

A compassionate approach that supports health gains for children and young people with respect to weight

Whole systems approach

"A local whole systems approach responds to complexity through an ongoing, dynamic and flexible way of working. It enables local stakeholders, including communities, to come together, share an understanding of the reality of the challenge, consider how the local system is operating and where there are the greatest opportunities for change. Stakeholders agree actions and decide as a network how to work together in an integrated way to bring about sustainable, long term systems change".

Health matters: whole systems approach to obesity - GOV.UK (www.gov.uk)



Health matters: whole systems approach to obesity - GOV.UK (www.gov.uk)

What is a compassionate approach to weight?

There are mixed messages regarding, food, weight, body image and health. Views on what is 'healthy' and what a 'healthy body' looks like can be very rigid. People, in general, can identify what 'healthy' or 'unhealthy' choices are, but struggle to put this into practice. For the vast majority of people, dieting or restricting food for weight loss only works in the short term, potentially leading to harmful weight cycling and disordered eating patterns; behaviours we wish to prevent especially amongst our children and young people. Obesity disproportionately affects disadvantaged communities and is strongly associated with inequality. Most interventions focus on individual responsibility to change behaviour, without addressing the underlying determinants that impact on health, wellbeing and people's ability to take care of themselves. Feelings of shame around weight are not motivators for change nor effective in eliciting long-term behaviour change. What makes matters worse for individuals is that they have little control over the socioeconomic factors that influence the quality of their diet and opportunities for physical activity.

A compassionate approach:

- Is sympathetic and realistic regarding circumstances and human behaviour
- Takes away individual blame and challenges assumptions
- Builds up an individual's strength, self-efficacy and self-worth, and provides a clear message that everyone is valued and are "good enough".
- Intervenes upstream at a population/community level wherever possible and makes individual intervention a last option
- Accepts and respects the inherent diversity of body shapes and sizes, and that we can promote health and wellbeing without focusing on being a certain body size
- Is a 'gentler' approach to food and nutrition that supports a positive relationship with food and eating; does not place moral value on one food over another; does not shame or police
- Supports physical activities that allow people of all sizes, abilities, and interests to engage in enjoyable movement, to the degree that they choose
- Recognises that this is a long term approach

(Adapted with thanks from Doncaster Council – who are a trailblazer in this work and coordinate a national Practice Group on the compassionate approach)

ACTION PLAN 2023-2028 (PHASES 1 AND 2)

The Plan brings together existing and new activity to support a coherent whole system approach (as reflected in the graphic – page 8). This creates the opportunity for a high level of collaborative advantage through which we will aim to achieve the ambitious success criteria set out. It is expected that actions and in some cases priorities will change and adapt, informed through system learning and also reflecting changing circumstances (complexity). This is key to ensuring we make progress over the 10 years toward achieving our success criteria through our shared endeavour

Strategic Focus	Priority	Action	Outcome and / or End of Plan Position	Phases covering duration of action			Lead
				Phase 1 (Year 1-2)	Phase 2 (Year 3-5)	Phase 3 (Year 6-10)	
Whole System Development							
	A1 System Optimisation	• Optimisation Group initiated by December 2022 comprising key stakeholders • Routinely meets across lifetime of Plan • Reports to Healthier and Happier Strategic Partnership	Success criteria achieved				Public Health / System Optimisation Group
	A2 Reporting to Child Poverty Working Group (CPWG)[6] – see Action B5	• Provide updates to CPWG on relevant Actions noted in this Plan • Seek support and influence to address challenges or take opportunities	3 year target Reduce the prevalence of overweight including obesity in the most deprived areas[7] of the city in Reception and Year 6 compared to baseline NCMP data (2021 / 2022 academic year)				Public Health
	A3 Active to Thrive Strategic Plan	Ensure the plan is aligned to Active to Thrive across the whole 10 years and supports delivery of activity of benefit to CYPF	Children and Young People have positive physical activity experiences that encourage a lifelong love of				Active Devon / System

[6] Child Poverty | PLYMOUTH.GOV.UK

[7] Agree most deprived areas based on the 5 schools that report the highest proportion of children who are overweight (overweight and obese)

			movement and enable improved resilience and wellbeing.				Optimisation Group
	A4 Contribute to city being a Sustainable Food Place (City)[8]	Align relevant activities in Plan wherever possible and ensure they are captured to support Sustainable Food Places Framework e.g. Best Food Forward (BFF) Award	Achievement of Sustainable Food Cities Silver Award (on-going up to 2028)				System Optimisation Group / Food Plymouth
			X number of food providers will have signed up to the BFF scheme and received an award / certificate for a high number of pledges / commitments As a consequence of BFF award children and families will choose more healthier options if these are offered				
	A5 Contribute toward case for implementation of Healthier Food Advertising Policy Toolkit[9]	Learn from other trailblazers, use evidence base from London and work with Sustain to explore implementation of a LA-wide policy to limit unhealthy food advertising across city	Advertising space in the city has shifted from promotion of unhealthy to healthier food products There is little or no impact on revenue for businesses and the LA				PCC (Transport) / Sustain
	A6 Planning decisions support 'healthy places'	Input into planning process / decision in respect to take-away outlets and proximity to education settings Explore scope of influence to include leisure (Plymouth Active) and other health promoting facilities (hospitals, health centres, WB hubs)	Decisions limit increase in take-away outlets close to education settings or those with a clear health focus				PCC / Public Health
	A7 Develop on-going communication strategy	Agree Phase 1 Plan that covers: • Promotion of Plan / Graphic • Workforce Development offer	Stakeholders are well informed and able to support and / or benefit from Plan				Public Health & PCC / wider system Comms

[8] Members | Sustainable Food Places
[9] Healthier Food Advertising Policy Toolkit | Sustain (sustainweb.org)

		• Local Offer – 'Our Plymouth' • Stigma / Language Annual review of priority areas for following year					Teams tbc (cm/ds)
	A8 Information on local offers and support is available online	Build on 'Our Plymouth' online 'Community Self-Help Map' to provide information on local healthy lifestyle offers and support for CYPF Help your local community - Our Plymouth	Map is reported as being known and used by organisations and communities				PCC
	A9 Improving the health literacy of the population	Maximise access to information and resources for individuals, families, communities and all stakeholders	Relevant information and resources are reported as being easy to access and helpful				System Optimisation Group
	A10 Learning from best practice re compassionate approach / whole system working	On-going collaboration with key trailblazers Bolton; Doncaster; Gloucester (and others identified over lifetime of Plan)	Learning and reflecting from various trailblazers can be shown to have informed our system Learning from delivery of our Plan has been utilised by other trailblazers (areas)				Public Health
	A11 Develop Social Prescribing offer	• Task and Finish Group implemented • Pilot(s) is /are developed and evaluated • If successful - learning used to incrementally roll out across system	Delivery of Pilot(s) Roll out of service CYP receiving social prescribing offer have improved wellbeing and engage in activities / groups that lead to health gains				CYP Social Prescribing Steering Group
	A12 National Child Measurement programme	Work with local; regional and national planners to support improved wording on NCMP promotion & outcome communication sent to families reflecting a compassionate approach	Improved communication to families Improved experience by parents / carers Reduction in complaints from families				Public Health

		Explore use of findings from KENT from their work on improving the parent / carers experience of NCMP					
	A13 Food Systems Equality Project (all age)	Undertake a 5 year research project involving the University of Plymouth, led by the University of Reading, using co-design, co-production and participatory methods. Innovating products, supply chains and policies relating to healthy and sustainable diets.	Changes identified and implemented to the food system to deliver improved nutritional public health and wellbeing for citizens from disadvantaged communities with enhanced environmental sustainability				University of Plymouth
My Team and My Community							
Note reference to cost of living indicates action has direct impact to help mitigate impact of cost of living challenges 2022/23	B1 Engaging with communities	(a) Promotion of Plan within communities via existing networks; Wellbeing Hubs / Family Hubs / Education Settings / other community networks	Community networks in all localities across the city are aware of Plan				PH & PH Engagement Team
		(b) Consultation, evaluation and appreciative enquiry methods are utilised to ensure voice of child, young person and family is heard across lifetime of Plan including for annual reviews and end of phase reviews	Insight, feedback and views from children, young people and families influence local offers, services and system design				System Optimisation Group
		(c) • Establish small budget for proof of concept (Approx. 3-5K) • Agree process for local people /groups to access funding to develop grass roots activity in support of Plan	Proof of concept tested Community members engage in activity to support Plan and support health gain / benefits for individuals				PH/TBC

	B2 Maximising take up of Healthy Start (Cost of living)	(a) Routine and on-going promotion	Steady uptake over each year				Public Health (c/m)
		(b) Registration drive at drop-in clinics in support of changes in 2022	Parent(s) / Carer(s) attending are supported to register Numbers for city are increased over period of drop-ins				Public Health & University of Plymouth staff and students
	B3 Improving families knowledge on early child healthy lifestyles	Source and distribute the Food Talk Game to all CC Clusters and linked early years settings, City College, UoP and PMU students	Families report use of information learnt				EPS
	B4 Maximising take up of Fit and Fed[10] (Cost of living)	• Delivery of events to eligible CYP • Annual Review	Number of places taken up maximise the number on offer				Sports Develop-ment Unit / Community Connections
	B5 Delivery of Child Poverty Working Group (CPWG) actions (Cost of living)	• Increase access to and take up of health promoting activities – including access to setting / travel / support (connecting) • Promote healthy food options across city in line with Plymouth's 'Best Food Forward' award scheme • Support development of cookery 'classes' for students and parents in areas of high child poverty (sustainable / locally grown / supply chains / affordable)	3 year target- Reduce the prevalence of overweight including obesity in the most deprived areas of the city in Reception and Year 6 compared to baseline NCMP data (2021 / 2022 academic year)[11]				Child Poverty Working Group and Public Health

Page 107

[10] Fit and Fed | PLYMOUTH.GOV.UK
[11] This is focussed on the 5 schools identified as being consistently in the highest reported levels of overweight and very overweight

	B6 Increasing access to Cooking Sessions (Cost of living)	• Delivery of sessions across city with more sessions available in areas of higher deprivation • Continue across Yrs 1, 2 and 3	Families report use and benefit at home following attendance				Food is Fun / (CC)Family Hubs
	B7 Increasing awareness of how to make nutritious and affordable meals (Cost of living)	Food Aid providers collaborate to create or signpost 'customers' to videos / resources to help make meals for families with children	Videos / resources are used Feedback from Food Aid customers is positive				Food Aid providers
	B8 Increasing the number of breastfeeding friendly venues in city	Promote engagement of settings across Plymouth to achieve the Latch On Breastfeeding Welcome Kite mark[12]	Number of quality assured settings that welcome Mums to breastfeed is increased compared to baseline				Latch-On; / Maternal Infant Child Nutrition Group
	B9 Improving infant nutrition through Family Hubs and associated networks	(a) Breastfeeding Peer Support Groups are supported and developed further in line with service expectations agreed with DfE and DHSC (OHID)	Numbers engaging in Peer groups increase over a year Peer Groups reflect communities they are based in Increase in proportion of women continuing to breastfeed at 6-8 weeks				Maternal Infant Child Nutrition Group
		(b) Partnership working between maternity, health visiting and peer support teams	Increase in proportion babies whose first feed is breastmilk Increase in proportion of women continuing to breastfeed at 6-8 weeks				Maternal Infant Child Nutrition Group
	B10 Maximising the role of Education Settings	(a) • Enhanced HCQM focus on nutrition; sustainability and activity and wellbeing	Schools achieving award over this period will have demonstrated commitments in these areas				PCC Education, Participation and Skills

[12] LA-Kitemark-leaflet-FAW-140319.pdf (plymouth-latchon.org.uk)

		• Link with BFF scheme (above)					
		(b) • School Food Standards Pilot delivered • On-going Audit embedded	Audit provides intelligence on current food standards and where required actions for schools to achieve the standard 95% of schools achieve standard by 2025				PCC Environmental Health Service / Devon Trading Standards
		(c) Explore with Active Devon in Phase One Year One opportunities to: • Support /enable structured and unstructured play in Early Years Settings • Develop intergenerational play opportunities to support movement across the family unit	Develop opportunities yes/no. If yes Action to be updated with following possible outcomes: More children in early years' settings are engaged in structured and unstructured play to support their physical literacy. Children enjoy play and want to repeat it. Families involved with intergenerational play opportunities report benefit				Active Devon /
		(d) Promotion of the 'Daily Mile', 'Walk to School' and 'Cycle to School' in partnership with schools and EY settings	Increase (from baseline) in amount of schools signed up and undertaking regular activity as part of school day 90% by 2032				Public Health / Education Participation and Skills Active Devon / School Sports Partnership
		(e) Findings are reviewed from the Plymouth Pathfinder (Sport England) project to engage and support children and young people with	Learning is used to inform service planning and design across system				Active Devon / System

		trauma and SEND, improving their resilience and wellbeing to make better life choices into adulthood					Optimisation Group
	B11 Improving access to activity – in schools	(a) Test resources to support schools to increase physical activity within school-time or as a home learning activity	Learning is used to inform service planning and design Increased physical activity in school-aged children targeted by the intervention(s). Children enjoy the activities and want to repeat them				Public Health / Schools
		(b) Explore with Active Devon in Phase One Year One • Schools have the opportunity sign up to the Creating Active Schools Framework (CAS)	Develop opportunities yes/no. If yes Action to be updated with following possible outcomes: Schools are aware of the benefit of adopting an active schools approach and /or have signed up to the Creating Active Schools Framework				Active Devon / Plymouth School Sports Partnership
	B12 Improving access to activity – in the community (Cost of living)	(a) Targeted use of vouchers to support transport to and / or engagement in activity with a school in area of high deprivation	Learning is analysed and used to inform system and service planning and design Those taking up use of vouchers report benefit				Public Health / School
		(b) Explore with Active Devon in Phase One Year One Wider access to school facilities beyond school day (community)	Develop opportunities yes/no. If yes Action to be updated with following possible outcomes: Schools are aware of the support, resources and guidance available to them to enable them to open their school facilities beyond the school day.				Active Devon / Plymouth School Sports Partnership

			Increased offer for communities to engage with physical activity in school based facilities beyond the school day. An increased number of CYP and pre/post-natal people take up the offer.				
		(c) Develop and support opportunities for sport and physical activity in the community via leisure centre(s), sports club(s) or independent activity	Increased opportunity to engage with physical activity in community An increased number of CYP and pre/post-natal people take up the offer				Sports Develop-ment Unit
	B13 Increasing food choices for Secondary School aged CYP	Create a higher nutritious burger (compared to outlets in city) and test in a secondary school in partnership with a professional Chef / School Catering Company / School	Feedback on burger is positive including CYP stating they would choose this again Burger can be produced at scale and is economically viable If positive • Feedback shared with education catering providers • Feedback shared with take away outlets across city to promote possible wider use				Public Health / School / Professional Chef
CYP System (Services)							
	C1 Complications from Excess Weight Pilot - UHP implementation	Successful completion of the Pilot (2021-2023) Implementation and embed (2023/2024)	Pilot delivered and reports positive outcomes On-going delivery				University Hospital Plymouth

	C2 Achieve effective interface across T3 CEW Service and wider system offer	(a) Engagement in Devon HW Steering Group covering initial Pilot period up to 2024	Attendance at meetings (On-going)				University Hospital Plymouth / Public Health
		(b) Development of innovative 'pathway' that links CYPF engaging with T3 with opportunity to take up activity / support of their choice in their community	CYP and families waiting to engage with T3; during engagement with T3 and following discharge from T3 are aware of support CYPF engage with activity / support of their choice				University Hospital Plymouth / Public Health
	C3 Obesity in pregnancy	(a) Promote benefits of a healthy pregnancy to women of childbearing age Ensure access to appropriate information, advice and support on healthy eating and physical activity to promote a healthy pregnancy	Pregnant women report use of information, advice or support to promote a healthy pregnancy prior to conception and in early pregnancy				Maternal and Infant Nutrition Group
		(b) Promote being active for ante-natal and post-natal women through improving system wide awareness of information and resources available that support the CMO guidelines	Improved levels of activity				Active Devon
	C4 Implementation of new PHN Service offer	PHN (Health Visiting and School Nursing) offer to system is finalised and promoted Annual review	Offer is delivered and feedback from stakeholders is positive and used to improve service				Livewell Southwest
	C5 Rollout of Workforce Development programme	Annual Plan Developed Year One Awareness raising to be available for all of CYP system (including Plan / compassionate approach / resources / tools / roles) Brief Advice	Children's services across the whole system are able to provide opportunistic conversation and brief intervention to support health gains in respect to weight Paid and volunteer workers across system are more confident:				Public Health / System Optimisation Group

		Stigma / language Yr 2 TBC Yr 3 TBC	• in understanding their role as part of a shared endeavour • in providing information, advice, signposting and where appropriate support • in aligning their work with a compassionate approach				
	C6 Effective interface with Adult System	Colleagues working in the Adult System and Children & Young People System, review and identify areas for improvement in regard to: • Transitions • Families • SEND These areas should be reviewed annually	Safe and effective transition to adult services Where an adult (in an adult service) is a parent / carer (of children) then wherever possible information, advice and support will take account of children				Public Health / Livewell Southwest / Livewell Southwest tbc
	C7 Effective interface with system responding to CYP eating disorders	Ensure on-going links with colleagues working within eating disorders services	Clarity of system offers and messaging No communication and messaging should increase risk of disordered eating Collaborative advantage gained Wider system aware of responsibility re communication and messaging				Public Health / Livewell Southwest / University Hospital Plymouth ICS MH Commissioning
Inequalities							
	D1 Ensure populations at higher risk of overweight or obesity have access to local offers / services	(a) Agree on specific populations to focus on e.g. • CYPF in areas of higher deprivation • CYP with a medical or biological condition that places them at higher risk of obesity • SEND	CYPF from any of the identified populations: • have early access to information, advice and support when needed • are able to take up local offers or access services that can contribute to reducing risk				Various linked to populations / Public Health

		• Ethnicity • Children in Care Develop plans to ensure equity of service access or local offers and access to information and advice; to be informed through the voice from these populations					
		(b) Review current mechanism for early identification of CYP with a medical or genetic condition that places them at higher risk of obesity and identify any actions for improvement	Health professionals are able to routinely provide information, advice, support and signposting to local offers and services				Public Health / Livewell Southwest/ University Hospital Plymouth
	D2 Digital Poverty	All messaging and communications focused on families and the community must take account of digital poverty to ensure maximum reach	Children, young people and families without any or adequate digital access continue to have access to and receive information that is available to all				All

Guidance / Resources:

- Whole systems approach to obesity - GOV.UK (www.gov.uk)
- Health matters: whole systems approach to obesity - GOV.UK (www.gov.uk)
- Human Learning Systems | Centre For Public Impact (CPI)
- Tool - Single Double Triple Loop Learning.pdf (tamarackcommunity.ca)
- 1.-Exploring-the-New-World-Report-MAIN-FINAL.pdf (collaboratei.com)
- Childhood obesity: applying All Our Health - GOV.UK (www.gov.uk)
- Getting research into practice: A resource for local authorities on planning healthier places
- Tackling obesities: future choices - GOV.UK (www.gov.uk)
- Weight management: lifestyle services for overweight or obese children and young people (nice.org.uk)
- MAC01741_NN_UK_HCP_Obesity_Guidelines_FA1a (easo.org)
- Weight-Stigma-Position-Statement.pdf (obesityhealthalliance.org.uk)
- UK Chief Medical Officers' physical activity guidelines for disabled children and disabled young people: infographic (publishing.service.gov.uk)
- Physical activity for early years: birth to 5 years (publishing.service.gov.uk)
- Physical activity for children and young people: 5 to 18 years (publishing.service.gov.uk)
- Doncaster's Compassionate Approach to Weight - Doncaster Council
- School sport and activity action plan (publishing.service.gov.uk)
- School food standards: resources for schools - GOV.UK (www.gov.uk)
- Early years high impact area 4: Supporting healthy weight and nutrition - GOV.UK (www.gov.uk)
- Thrive Plymouth | PLYMOUTH.GOV.UK
- People Connecting through Food | PLYMOUTH.GOV.UK
- Future health challenges: public health projections - childhood obesity | Local Government Association
- National Child Measurement Programme, England 2020/21 School Year - NHS Digital
- Public health profiles - OHID (phe.org.uk)
- Changes in the weight status of children between the first and final years of primary school - GOV.UK (www.gov.uk)
- Qualitative_opportunites_into_user_experiences_t2_t3_weight_management_services.pdf (publishing.service.gov.uk)
- Changing behaviour in families (publishing.service.gov.uk)
- Pervasiveness, impact and implications of weight stigma - eClinicalMedicine (thelancet.com)
- A systematic review to identify the programme characteristics, and combinations of characteristics, that are associated with successful outcomes (ioe.ac.uk)
- Changing the narrative around obesity in the UK: a survey of people with obesity and healthcare professionals from the ACTION-IO study | BMJ Open
- A community-based motivational personalised lifestyle intervention to reduce BMI in obese adolescents: results from the Healthy Eating and Lifestyle Programme (HELP) randomised controlled trial - PubMed (nih.gov)

This page is intentionally left blank

Health and Adult Social Care Overview and Scrutiny Committee

Date of meeting:	16 November 2022
Title of Report:	**From Harm to Hope: Government's 10 year Drug Strategy**
Lead Member:	Councillor Dr John Mahony (Cabinet Member for Health and Adult Social Care & Planning)
Lead Strategic Director:	Ruth Harrell (Director of Public Health)
Author:	Gary Wallace
Contact Email:	gary.wallace@plymouth.gov.uk
Your Reference:	Click here to enter text.
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
To outline the impact of the strategy on city services and structures

Recommendations and Reasons
1. Note the contents of the report

Alternative options considered and rejected
None

Relevance to the Corporate Plan and/or the Plymouth Plan
Plymouth has higher than national average rates of both alcohol and other drug abuse. Drug and alcohol *problem use* is concentrated in our deprived neighbourhoods and our most vulnerable population groups and as such is a driver of health inequalities.

Implications for the Medium Term Financial Plan and Resource Implications:
None

Financial Risks

None

Carbon Footprint (Environmental) Implications:
None

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:

** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*

Click here to enter text.

Appendices

**Add rows as required to box below*

Ref.	Title of Appendix	Exemption Paragraph Number (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	2	3	4	5	6	7
A	Briefing report : From Harm to Hope (2022/23)							

Background papers:

**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are unpublished works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	Exemption Paragraph Number (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	2	3	4	5	6	7

Sign off:

Fin	DJN. 22.23 .267	Leg	EJ/38851 /7.11 .22(2)	Mon Off	Click here to enter text.	HR	Click here to enter text.	Assets	Click here to enter text.	Strat Proc	Click here to enter text.
Originating Senior Leadership Team member: Gary Wallace											
Please confirm the Strategic Director(s) has agreed the report? Yes 07/11/2022											

Cabinet Member approval: Councillor Dr John Mahony (Cabinet Member for Health and Adult Social Care)

Date approved: 08/11/2022

This page is intentionally left blank

From Harm to Hope: The National 10 Drug Strategy

Background
In December 2021, the government published a new 10-year drugs strategy, 'From Harm to Hope'[1] backed by additional funding for 2022 to 2025, to start to reverse the impact of the disinvestment of the previous decade.

The Strategy seeks to deliver the findings and recommendations of Dame Carol Black's landmark Independent Review, including a new long-term approach, with changes to oversight and accountability, delivered by the whole of Government.

The 10-year commitment sets out the expectations of how the whole of Government and public services will work together and share responsibility for delivery. This is specified in 'Guidance for Local Delivery Partners', June 2022.

Part 1of the Black review looked at demographics, demand, drug markets and enforcement. Part 2 reviewed prevention, treatment and recovery. The recommendations of those reviews formed the basis of the From Harm to Hope strategy. Chapters 2 and 4 of the strategy are concerned with breaking supply chains and producing a generational shift in drug demand and are largely concerned with actions at a national level. Chapter 3 – Delivering A World Class Treatment and Recovery System and Chapter 5 – Setting up For Success: Partnerships and Accountability, are the areas that will be delivered at a city level.

Delivering a World Class Treatment and Recovery System
Dame Carol Black found a national system of treatment that has significantly contracted in the last decade, where many specialist roles have been lost, caseloads are very high and capacity is not sufficient to meet demand. In addition, drug related deaths are at unprecedented levels and predicted to rise further and prevention activity is limited. She stated: "that the public provision we currently have for prevention, treatment and recovery is not fit for purpose, and urgently needs repair." The Harm to Hope Strategy sets out the pathway to repair our services and is backed with significant investment. It also clearly sets out 9 areas where the new money can be spent;

- System coordination and commissioning eg more commissioning capacity
- Enhanced harm reduction provision eg increased naloxone provision
- Increased treatment capacity eg additional treatment staff
- Increased integration and improved care pathways between the criminal justice settings, and drug treatment eg pathways from courts/prison
- Enhancing treatment quality eg reducing caseloads
- More access to residential rehabilitation and inpatient detoxification
- Better and more integrated responses to physical and mental health issues
- Enhanced recovery support eg supporting people at the end of treatment
- Expanding the competency and size of the workforce

Plymouth drug and Alcohol services are part of the Plymouth Alliance, our ground breaking integration of complex needs services in the city. Whilst our services did not experience the huge cuts seen in other areas they have contracted by around 20% in the last decade. Demand has risen significantly in recent years, caseloads are

very high and a number of highly specialist posts have been lost. In addition, drug markets and patterns of consumption have radically changed with the advent of internet sales, County Lines supply routes and new synthetic drugs, and our services have not had sufficient capacity to flex around these emerging trends.

The new investment will be phased in over three years, with the target at the end of that period for a 20% increase in numbers in treatment, and a significantly expanded workforce. The government particularly wants to see increases in nurses, pharmacists, psychologists, specialist medical staff and social workers. The Plymouth detailed plan for this year and outline plans for the following two years has been accepted by OHID and meets all the requirements of the strategy. Over the three years of the plan it will deliver 55 additional posts in substance misuse services and is projected to increase numbers in treatment by 21% at year three. The detail of our plan, including the financial investment, is set out in the accompanying agenda paper: Public Health Commissioning Update, under the heading 'Complex Needs Services'. Whilst this is a drug strategy, we are also able to focus on alcohol treatment and we plan significant expansion in alcohol treatment as well as drugs.

Setting up For Success: Partnerships and Accountability
Previously, Plymouth had a separate Drug and Alcohol Board. Over time, the responsibilities of this Board have been included within both the Health and Wellbeing Board, who have oversight of the Joint Strategic needs Assessment and of overall health and wellbeing, and the Community Safety Partnership, as Community Safety Partnerships have responsibility, through the Crime and Disorder Act to provide a multi-agency response to drugs and alcohol.

The renewed focus on substance misuse treatment, and alongside that the significant increase in the amount of work required to deliver the new Strategy, requires the constitution of a new Drugs Strategy Partnership Group, accountable to the Health and Wellbeing Board (but with clear links to the Community Safety Partnership) to discharge the priority tasks and partnership functions required for the new Strategy.

The Government recognises that these local partnerships are a key structure in delivering the strategy, stating: "At the heart of our objectives will be effective multi-agency partnerships that bring to life the principles of comprehensive treatment and recovery alongside tough and effective enforcement and ambitious prevention to reduce drug use for the long term."

These new structures are called Combatting Drug Partnerships and the guidance identifies key principles and structures to support the formation of effective partnerships and asks local areas to:

- form a clearly defined partnership structure based on a geographical extent that is logical to local residents and consistent with existing relevant arrangements
- select a senior responsible owner (SRO) who can represent the partnership nationally, reporting to central government for its performance, and who can offer challenge and support to local partners to drive improvement and unblock issues when necessary
- involve all those people and organisations affected by drugs in developing joint solutions to these issues

It has been agreed that our Combatting Drug Partnership will be set up on our unitary footprint. This makes the scope coterminous with the CSP and the Local Authority footprint; this is the geography on which drug and alcohol treatment services are commissioned. Issues requiring a larger geographical response, typically drug market interdiction and supply side action, will be managed at the existing Peninsula Strategic Crime and Drugs partnership, to ensure a consistent approach for our partners with a peninsula footprint. Dr Harrell our DPH will be the inaugural Senior Responsible Officer (in the majority of partnerships across the country the DPH is the SRO). It is a requirement that the following be represented on the partnership:

- elected members
- local authority officials (including expertise in relevant areas to include substance misuse, housing, employment, education, social care and safeguarding)
- local NHS strategic leads (e.g. clinical commissioning groups, primary care networks and integrated care partnerships)
- NHS England and Improvement
- the Office for Health Improvement and Disparities region
- substance misuse treatment providers
- voluntary, community and social enterprise sector
- people affected by drug-related harm
- primary care representatives
- mental health treatment providers
- local schools and FE representatives
- Job Centre Plus
- police representatives
- Police and Crime Commissioners
- Probation Service
- the Youth offending service
- prisons and young offender institutions

How the partnership will work

The Drug Strategy Partnership Group will provide a focused point of reporting and scrutiny thereby ensuring an open and transparent partnership with clear ownership, responsibility and accountability.

- Provide advice and data to support a robust local needs assessment to identify and understand the needs of those impacted.

- Provide expert advice and data to support the development of local strategy, agreeing the appropriate steps needed to meet the needs identified.

- Support Safer Plymouth and the health and wellbeing system locally to effectively engage with those impacted and expert services in understanding the range and complexity of needs.

- To achieve strategic and operational alignment across member organisations, Board, Forums and Groups providing consistent, quality, joined up responses for in accordance with the local Strategy and national direction.

- Receive Drug Related Death Reports and drive forward the implementation of the recommendations.

- Adopt a Human Learning System approach to continual learning and improvement.

- Take a Trauma-informed approach.

- Hold an overview of and influence the development and implementation of strategies and commissioning intentions that hold the potential to impact the Drugs Strategy and to work in partnership to ensure a joined-up approach to addressing drugs and alcohol.

- Take a Co-production approach to all of our work.

Alcohol
While the 10-year drugs strategy focuses on the use and supply of illegal drugs, local partnerships are urged to ensure that their plans sufficiently address alcohol dependence and wider alcohol-related harms. This should include considering the multiple complex needs of people who use alcohol as well as other drugs, and including alcohol in relevant activity and performance monitoring, considering deaths, hospital admissions and treatment for alcohol as well as other drugs.

Summary
Drug and alcohol services have seen significant cuts in the last decade, losing many key specialist and medical roles. Caseloads are currently very high, drug related deaths are at record levels and demand is simultaneously growing and changing in nature. From Harm to Hope seeks to comprehensively address all of these issues and comes with considerable additional investment, it also recognises that the scale of the challenge of rebuilding services is such that it also necessary to bolster local delivery both through an increase in specialist commissioning, governance and system stewardship and by setting up robust local partnerships to oversee delivery and provide a point of accountability.

Health and Adult Social Care Overview and Scrutiny Committee

Date of meeting:	16 November 2022
Title of Report:	**Public Health Indicator Update**
Lead Member:	Councillor Dr John Mahony (Cabinet Member for Health and Adult Social Care & Planning)
Lead Strategic Director:	Ruth Harrell (Director of Public Health)
Author:	Robert Nelder (Consultant in Public Health)
Contact Email:	robert.nelder@plymouth.gov.uk
Your Reference:	PH indicators 2022
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report

This report provides a high-level overview of public health in Plymouth. The indicators are drawn from the Public Health Outcomes Framework (PHOF). This is because the (former) Public Health England (PHE) General Health Profiles are no longer produced as a separate product. This report therefore includes the majority of indicators that were historically included in the PHE General Health Profiles, but instead drawn from the PHOF.

The selection of indicators requires balancing the need to highlight important public health topics and the need to focus on problems that can be addressed by local services. As the report also needs to reflect health throughout all stages of life, there is a limit to the number of indicators that can be provided for any one issue. Where possible, an indicator is selected that will draw attention to potential issues, so that these can considered.

Recommendations and Reasons

1. To note the contents of the report
2. To recommend that the Public Health Team continues to work with partners to address the issues highlighted in the report
3. To receive a further report in one year's time

Alternative options considered and rejected

Not applicable

Relevance to the Corporate Plan and/or the Plymouth Plan

Improving the health and wellbeing of the population and reducing health inequalities is a priority within both the Corporate Plan and the Plymouth Plan

Implications for the Medium Term Financial Plan and Resource Implications:
None

Financial Risks
None

Carbon Footprint (Environmental) Implications:
None

Other Implications: e.g. Health and Safety, Risk Management, Child Poverty:
** When considering these proposals members have a responsibility to ensure they give due regard to the Council's duty to promote equality of opportunity, eliminate unlawful discrimination and promote good relations between people who share protected characteristics under the Equalities Act and those who do not.*
None

Appendices
**Add rows as required to box below*

Ref.	Title of Appendix	Exemption Paragraph Number (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
		1	2	3	4	5	6	7
A	Briefing report title							
B	Equalities Impact Assessment (if applicable)							

Background papers:
**Add rows as required to box below*

Please list all unpublished, background papers relevant to the decision in the table below. Background papers are unpublished works, relied on to a material extent in preparing the report, which disclose facts or matters on which the report or an important part of the work is based.

Title of any background paper(s)	Exemption Paragraph Number (if applicable) *If some/all of the information is confidential, you must indicate why it is not for publication by virtue of Part 1of Schedule 12A of the Local Government Act 1972 by ticking the relevant box.*						
	1	2	3	4	5	6	7

Sign off:

Fin	DJN22.23.250	Leg	EJ/38851/1.11.22	Mon Off	Click here to enter text.	HR	Click here to enter text.	Assets	Click here to enter text.	Strat Proc	Click here to enter text.

Originating Senior Leadership Team member: Robert Nelder
Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 28/10/2022
Cabinet Member approval: *[electronic signature (or typed name and statement of 'approved by email/verbally')]* Cllr Dr John Mahony (approved by email) Date approved: 29/10/2022

This page is intentionally left blank

PUBLIC HEALTH INDICATOR UPDATE

ODPH

LIFE EXPECTANCY AND CAUSES OF DEATH

1. Life expectancy at birth (male)

Period	Count	Value (Years)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2018-20	N/A	78.8	Red	2

Life expectancy at birth for males is significantly below the England average. Plymouth has the second highest life expectancy in our comparator group. Plymouth looks to be following the national trend of a slight decrease in the last few years after at least two decades of an increasing trend.

2. Life expectancy at birth (female)

Period	Count	Value (Years)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2018-20	N/A	82.5	Red	2

Life expectancy at birth for females is significantly below the England average. Plymouth has the second highest life expectancy in our comparator group. Plymouth looks to be following the national trend of a levelling off (*maybe a very slight decrease*) in the last few years after at least two decades of an increasing trend.

3. Under 75 mortality from all causes

Period	Count	Value (DASR per 100,000)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2018-20	2,459	361.8	Red	1

The under 75 mortality rate is significantly higher than the England average. Plymouth has the lowest rate in our comparator group. In the last two decades, the rate has fallen for both Plymouth and England, although the last five years the rate has stopped falling in both Plymouth and England as a whole.

4. Under 75 mortality rate from all cardiovascular diseases

Period	Count	Value (DASR per 100,000)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2017-19	530	79.1	Red	6

The under 75 mortality rate is significantly higher than the England average and is in the better half of our comparator group. In the last two decades, the rate has been falling but looking at the short term (last few years) this downward trend has stalled.

5. Under 75 mortality rate from cancer

Period	Count	Value (DASR per 100,000)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2017-19	953	141.6	Red	5

The under 75 mortality rate is significantly higher than the England average and is in the better half of our comparator group. In the last two decades, the trend has continued to decrease in line with the national pattern.

6. Suicide rate

Period	Count	Value (DASR per 100,000)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2019-21	-	10.7	Amber	10

The suicide rate in Plymouth is similar to the national average and is in the worse half of our comparator group. However, the rate is based on small numbers and small variations could change this situation. Rates look to be fairly static, over time, in Plymouth and this is very much in line with the national picture.

INJURIES AND HEALTH

7. Killed and seriously injured (KSI) rate on England's roads

Period	Count	Value (Crude rate - per billion vehicle miles)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2020	82	107.2	Amber	14

The rate of KSI on Plymouth's roads is similar to the England average, but higher compared to most of our comparator group. Over the last four years, the rate has remained relatively static.

8. Emergency hospital admission rate for intentional self-harm

Period	Count	Value (DASR per 100,000)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2020/21	560	211.4	Red	10

The rate of emergency hospital admission for self-harm is significantly higher than the England average and is at the higher end of our comparator group. The trend in Plymouth in downward and the gap to the England average has reduced.

9. Emergency hospital admission rate for hip fractures (65+)

Period	Count	Value (DASR per 100,000)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2020/21	255	507	Amber	2

The rate of hospital admission for hip fractures is similar to the England average and is the second lowest in our comparator group. The trend looks to be similar for Plymouth over the last few years.

10. Percentage of cancer diagnosed at early stage

Period	Count	Value (%)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2019	704	56.3	Amber	4

The percentage of cancers diagnosed at stages one and two is similar to the England average and is in the better half of our comparator group. Over the last few years, the percentage has remained relatively static for Plymouth.

BEHAVIOURAL RISK FACORS

11. Hospital admission rate for alcohol-specific conditions

Period	Count	Value (DASR per 100,000)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2020/21	1,225	504	Green	4

Hospital admission for alcohol-specific conditions are lower than the England average and one of the lowest in our comparator group. There has been a downward trend in Plymouth for the rate.

12. Smoking prevalence in adults (Annual Population Survey (APS))

Period	Count	Value (%)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2019	-	18.5	Red	16

The prevalence of smoking in adults (18+) based on the APS survey is significantly higher than the England average. Plymouth has the highest prevalence of our comparators. Plymouth's rate has been decreasing in line with the national average.

13. Percentage of physically active adults

Period	Count	Value (%)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2020/21	-	68.8	Amber	1

The percentage of physically active adults (based on the active lives adult survey) is similar to the England average. Plymouth has the highest percentage of active adults in our comparator group. The pattern has been stable over the last few years in Plymouth.

14. Percentage of adults classified as overweight or obese

Period	Count	Value (%)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2020/21	-	68.8	Red	6

The percentage of adults classified as overweight or obese is significantly higher than the England average and is in the lower half of our comparator group. Plymouth's rate has remained relatively static over the last few years.

CHILD HEALTH

15. Teenage conception rate

Period	Count	Value (Crude rate per 1,000)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2020	-	15.5	Amber	5

The teenage conception rate in Plymouth is similar to England average and is one of the lowest in our comparator group. Plymouth's rate continues to reduce.

16. Baby's first feed breastmilk

Period	Count	Value (%)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2018/19	1,840	67.6	Amber	3

The percentage of baby's first fee is breastmilk is similar to England average. Plymouth has one of the highest rates in our comparator group. There aren't enough data points to suggest a trend.

17. Infant mortality rate

Period	Count	Value (Crude rate per 1,000)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2018 - 20	29	3.7	Amber	4

The rate of infant mortality in Plymouth is similar to England average. Plymouth has one of the lowest rates in our comparator group. There is a slight downwards trend in Plymouth matching England's direction of travel.

18. Year 6: Prevalence of obesity (including severe obesity)

Period	Count	Value (%)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2019/20	-	19.4	Amber	

Plymouth has a similar rate of obesity in year 6 children to the England average. Data collection issues over the COVID period make it hard to compare with other LAs. The trend looks to be slightly increasing matching England's direction of travel.

INEQUALITIES

19. Deprivation score (IMD 2019)

Period	Count	Value (score)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2019	-	26.6	N/A	10

Plymouth's deprivation score is above the England average and around the middle of our comparator group

20. Smoking prevalence in adults in routine and manual occupations

Period	Count	Value (%)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2020	-	20.3	Amber	5

The percentage of adults in routine and manual occupations in Plymouth who smoke is similar to the England average, and is in the better end of our comparator group.

WIDER DETERMINANTS OF HEALTH

21. Percentage of children in low income families (relative low income)

Period	Count	Value (%)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2020/21	8,064	16.8	Green	2

The percentage of children in low income families is significant lower than the England average. It is one of the lowest in our comparator group. The trend is following England's however - which is increasing.

22. Average GCSE attainment (average attainment 8 score)

Period	Count	Value (Mean Score)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2020/21	128,494	49.1	Red	9

The mean attainment 8 score is significant lower than the England average and around the middle of our comparator group.

23. Percentage of people in employment (16-64)

Period	Count	Value (%)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2020/21	127,700	76.7	Amber	3

The percentage of people aged 16-64 years in employment in Plymouth is similar to the England average. Plymouth has one of the highest percentages in our comparator group. Over the last 10 years, the percentage has increased slightly.

24. Homelessness – households owed a duty under the Homelessness Reduction Act

Period	Count	Value (Crude rate per 1,000)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2020/21	1,990	17.8	Red	12

The rate of homelessness in Plymouth is significantly higher than England average. Plymouth has one of the highest rate in our comparator group. The rate has increased compared to the previous year.

25. Violent crime - hospital admission rate for violence (including sexual violence)

Period	Count	Value (DASR per 100,000)	Compared to England (RAG)	Rank against the CIPFA nearest neighbours (1=best,16 = worse)
2018/19 – 20/21	265	33.3	Green	3

The rate of hospital admission for violence is significantly below the England average and is one of the lowest rates in our comparator group. Over the last 10 years, the rate of hospital admissions due to violence has decreased in Plymouth.

****

Definitions

RAG Status – Plymouth's value is red when it is significantly worse than England. Plymouth's value is green when it is significantly better than England. Plymouth's value is amber when it is not significantly different to England.

CIPFA Neighbours – Plymouth's CIPFA Neighbours are listed below. These LAs have been selected by the Chartered Institute of Public Finance and Accountancy as most similar LAs to Plymouth.

Stockton-on-Tees	–	1
Derby	–	2
Dudley	–	3
Bolton	–	4
Gateshead	–	5
Telford and Wrekin	–	6
Wigan	–	7
Calderdale	–	8
Walsall	–	9
Rochdale	–	10
Wolverhampton	–	11
Darlington	–	12
Medway	–	13
Southend-on-Sea	–	14
Sunderland	–	15

This page is intentionally left blank

HEALTH AND ADULT SOCIAL CARE OVERVIEW SCRUTINY COMMITTEE

Tracking Decisions Log 2022 - 23

Please note that the Tracking Decisions Log is a 'live' document and subject to change at short notice.

For general enquiries relating to the Council's Scrutiny function, including this committee's work programme and tracking decisions, please contact Elliot Wearne-Gould, Democratic Support, on 01752 398261

Minute No.	Resolution	Target Date, Officer Responsible and Status	Response
07 September 2022	The Committee Agreed to: 1) Circulate to all members, a copy of the letter received from Ministers in response to a Motion-on-Notice from the City Council, relating to ambulance delays in Plymouth; 2) Circulate to this committee, a copy of the holding email received in response to a letter to Rachel Pearce regarding dental service concerns in Plymouth; 3) Add the 'Risk Register' as a standing item on the agenda; 4) Add 'Adult Social Care Reforms' to the Work Programme.	**Date:** September 2022 **Officer:** Elliot Wearne-Gould (Democratic Support) **Status:** 1) Complete 2) Complete 3) Complete 4) Complete 5) Ongoing- Added to work programme 6) Ongoing- Added to work programme	Letters circulated to members as requested. Work programme updated.

	5) Request at a future date, an update from Derriford Hospital on the progress of the Discharge Medicines Service (Pharmacy) 6) Request at the next meeting, an update on delayed transfers to care.		
07 September 2022	The Committee agreed- to recommend that a letter be written to the appropriate minister, recommending that the cap be raised on medical school places, to enable more GPs/ doctors to train.	**Date:** ASAP 2022 **Officer:** Anna Coles **Status:** In Progress	Anna Coles organising draft letter 18/10/2022
07 September 2022	The Committee agreed- to recommend that an opportunity be made for Committee members to gain experience working with/ shadowing GPs –	**Date:** ASAP 2022 **Officer:** Dafydd Jones (GP) **Status:** In Progress	Dafydd Jones (GP) - I am aware that quite a bit of work has been happening in recent weeks including the production of a video to provide insight into the world of Plymouth General Practice including some of the new roles introduced in recent years into Plymouth General Practice. This would potentially fulfil this brief and could then be seen by all members if felt suitable. If, thereafter, some of those key counsellors sitting on H&ASC OSC felt they required further insight, I would be more than happy to support but would just need to consider the logistics of this and approach here. I have cc'd Paul Green (as associate director primary care at Devon ICB) and Keri Ross as Comms Lead who has been supporting/leading the work described above. I hope this is satisfactory to begin with and suspect this work (where the audience of the footage was Plymouth MPs) would be really insightful for our local OSC councillors
07 September 2022	The Committee agreed- to recommend to NHS Devon ICS, that any final version of a 'Primary Care Strategy', must include a variety of means of access to GP services such as phone,	**Date:** September 2022 **Officer:** Jo Turl (NHS Devon ICS) & Suzanne Smart (Deputy Director of Commissioning-	Jo Turl- We are hoping to sign-off the General Practice Framework this month so we will be able to share it after that. I can confirm that these points are covered within the strategy, and I will ask Su if she can send you the appropriate paragraphs.

	digital and walk in. These must also be answered/ responded to in a reasonable timeframe.	NHS Devon) **Status:** Complete- Response received. (Future Scrutiny required)	Suzanne Smart- Following feedback from the engagement undertaken on the draft General Practice strategy for Devon, including that of the Plymouth Health and Social Care Committee in September, a revised version of the strategic framework was supported by NHS Devon's Primary Care Commissioning Committee at the end of October. The revised strategic framework has retained the core components which focus on workforce, estates, digital and population health management, many aspects of which are how improvements for patient access to General Practice services will be made. The strategic framework focusses on the timely delivery of services to the local population and makes clear the need to support both patient access in a responsive way, as well as the continuity of care which is particularly important for many patients. It makes clear that Practices will have to work across their Primary Care Network and as part of neighbourhood multi-disciplinary teams in order to deliver reliable and accessible services to their local population. With regard to the specific feedback from committee about access to GP services such as phone, digital and walk in, these areas are covered in: The case for change – demonstrating why timely access for on the day (walk in) care is needed The strategic principles – stating the need for access to General Practice services, and how utilisation of the range of professionals within the General Practice team will support this The implementation of the strategy – outlining the inclusive approach for patients who may not have digital access If you need specific sections of the strategy copied over please do let me know and I can do this.

13 July 2022 Health and Adult Social Care Policy Brief- *Minute 6*	The committee sought further clarification- regarding PCC's intentions to apply for grant funding for 'Women's reproductive wellbeing in the workplace'.	**Date:** August 2022 **Officer:** Sarah Gooding (policy and Intelligence) **Status:** Complete	The original announcement was dated 13 May and the application window has now closed. This funding was specifically aimed at organisations in the VCS who specialise in women's wellbeing services, so PCC would not have been able to submit an application directly but only support a bid from a relevant VCS organisation. The announcement was included in our weekly policy brief back in May and would have been circulated to relevant colleagues at the time.
13 July 2022 Healthwatch Plymouth- *Minute 7*	The committee agreed to recommend- that The CCG recommission Healthwatch to repeat their survey of ED attendance at a future date to track changes since lockdown.	**Date:** August 2022 **Officer:** Jo Turl (NHS Devon ICS) **Status:** Complete	We would like to undertake the survey again and would like to do this in the spring once we have implemented our system improvement plan and hopefully it a little less busy after winter. We should then be able to measure any improvements we have seen.
13 July 2022 Urgent and Emergency Care, Plymouth – *Minute 8*	The committee agreed- to invite Dr Dafydd Jones & Jo Turl back to report on Integrated Urgent Care Services and 111, once PPU had assumed the contract from Devon Doctors in October 2022.	**Date:** August 2022 **Officer:** Craig McArdle/ Anna Coles **Status:** Complete	Item provisionally scheduled for February H&ASC OSC meeting.

HEALTH AND ADULT SOCIAL CARE OVERVIEW SCRUTINY COMMITTEE

Work Programme 2022 - 23

Please note that the work programme is a 'live' document and subject to change at short notice. Please also not this is currently a draft document, under consideration with the chair and council officers.

For general enquiries relating to the Council's Scrutiny function, including this committee's work programme, please contact Elliot Wearne-Gould, Democratic Support, on 01752 398261

Date of meeting	Agenda item	Prioritisation Score	Reason for consideration	Responsible Cabinet Member / Officer
13 July 2022	Urgent and Emergency Care (Includes: Ambulance Handovers, Admission Avoidance, Hospital Flow and Improvements Discharges)		Long delays and wait-times for ambulances, elective surgery, GP appointments, and out of hour's services.	Cllr John Mahony
07 September 2022	Primary Care. (Includes GP services and Pharmacy)		Long waiting lists and lack of availability.	Cllr John Mahony
	Part Two Briefing -Cavell Centre		Requested by committee. Concerns over timetables/ funding.	Cllr John Mahony. Anna Coles.
16 November 2022	Risk Monitoring Report & Policy Brief			Alan Knott & Ross Jago
	Dashboard- Review of indicators			Rob Nelder
	Public Health Commissioning			Sarah Lees
	Life expectancy and healthy life expectancy			Ruth Harrell
	Thrive Plymouth			Rob Nelder
	Active to thrive			Ruth Harrell
	Children's healthy weight plan			Dave Schwartz/ Julie Frier

	From Harm to Hope			Gary Wallace
	Covid and flu update			Ruth Harrell
	West End Health Hub			Jo Turl
08 February 2022	Mental Health (Children and Young People)			Cllr John Mahony
	Integrated Urgent Care Services and 111 update.			Cllr John Mahony

Additional Meetings to be Scheduled to cover:

-Dentistry

Select Committee:
Mental Health – TBC
Future Items:
Implementation of Health and Wellbeing Hubs
Health and Social Care Workforce
Adult Safeguarding Board – check when last came to the board
Delayed Transfers to Care Update (Regular)
Community Empowerment Framework
Dental Health
Workforce (retention and career pathways)
Learning from Covid, (support to the care home market and how to develop training and support in a sustainable way)
Impact on care homes and care sector due to Covid
Care package
Care agencies
Reports from primary care, secondary care and domiciliary on carbon reduction
Update from Derriford Hospital on Pharmaceutical 'Discharge Medicines Service' progress.
Adult Social Care Reforms