#healthyplym

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HEALTH AND WELLBEING BOARD

Thursday 30 June 2022
10.00 am
Warspite Room, Council House

Members:
Councillor Dr Mahony, Chair
Councillors Nicholson, Aspinall, McDonald

Statutory Co-opted Members: Strategic Director for People, Director of Children's Services, NHS Devon Clinical Commissioning Group, Director for Public Health and Healthwatch.

Non-statutory Members: Livewell SW, University Hospitals Plymouth NHS Trust and the Voluntary and Community Sector.

Members are invited to attend the above meeting to consider the items of business overleaf.

This meeting will be webcast and available on-line after the meeting. By entering the room, the board are consenting to being filmed during the meeting and to the use of the recording for the webcast.

The Council is a data controller under the Data Protection Act. Data collected during this webcast will be retained in accordance with authority's published policy.

For further information on attending Council meetings and how to engage in the democratic process please follow this link - http://www.plymouth.gov.uk/accesstomeetings

Tracey Lee
Chief Executive

Health and Wellbeing Board

1. To note the Appointment of the Chair

The Board will be asked to note the appointment of Councillor Dr. John Mahony as chair for the municipal year 2022/23.

2. To appoint a Vice-Chair

For the Board to appoint a Vice-Chair for the municipal year 2022/23.

3. Apologies

To receive apologies for non-attendance by Health and Wellbeing Board Members.

4. Declarations of Interest

The Board will be asked to make any declarations of interest in respect of items on this agenda.

5. Chairs urgent business

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

6. Minutes **(Pages 1 - 6)**

To confirm the minutes of the meeting held on 03/03/2022.

7. Questions from the public

To receive questions from the public in accordance with the Constitution.

Questions, of no longer than 50 words, can be submitted to the Democratic Support Unit, Plymouth City Council, Ballard House, Plymouth, PL1 3BJ, or email to democraticsupport@plymouth.gov.uk. Any questions must be received at least five clear working days before the date of the meeting.

8. Devon, Cornwall, Isles of Scilly Health Protection Committee Annual Report 2020 - 21: **(Pages 7 - 36)**

9. Director of Public Health Annual Report 2021 Annual Report & Thrive Plymouth Year 7 (2022/23) Listen and Reconnect: **(Pages 37 - 70)**

10. Health and Care Skills Partnership Update: **(Pages 71 - 88)**

11. Integration White Paper Update: **(Pages 89 - 98)**

12. Health and Care Act 2022 Briefing: **(Pages 99 - 104)**

13. Terms of Reference Review **(Pages 105 - 108)**

The Board will review its Terms of Reference in relation to its role and scope, and amend accordingly.

14. Work Programme **(Pages 109 - 110)**

The Board are invited to add items to the work programme.

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Health and Wellbeing Board

Thursday 3 March 2022

PRESENT:

Councillor Nicholson, in the Chair.
Councillor Dr Mahony, Vice Chair.
Councillor Dr Pam Buchan.

Apologies for absence: Councillors Downie, McCormick and Michelle Thomas.

Also in attendance: Ruth Harrell, Alison Botham, Craig McArdle, Tony Gravett MBE, Anna Coles, Louise Higgins, Matt Garrett and Ann James.

The meeting started at 10:00 and finished at 12:02.

Note: At a future meeting, the committee 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.

75. **Declarations of Interest**

There were no declarations of interest made in accordance with the code of conduct.

76. **Chairs urgent business**

There were no items of Chairs urgent business.

77. **Minutes**

Agreed that the minutes of 27 January 2022 were confirmed.

78. **Questions from the public**

There were no questions from members of the public.

79. **The Alliance (Presentation and verbal update)**

Matt Garrett, Service Director for Community Connections delivered a presentation to the Board on Homelessness and highlighted the following key points:

a) There had been an increase in the number of households accommodated in temporary accommodation from 163 in April 2019 to 284 in February 2022. The number of households in a Bed and Breakfast increased from 43 to 113 in the same time period. The number of families in a Bed and Breakfast had increased from 2 to 34;

b) 9,00 households had been recorded on the housing register for alternative accommodation;

c) For the year 2021 – 2022 the Council had been approached by 3,000 households, this increased from 2018 where 2,500 households approached Plymouth City Council for alternative accommodation;

d) Demand had increased due to a number of contributory factors and included; relationship breakdown, impact on physical and mental health, end of furlough, end of the Universal Credit uplift, increased utility costs, end of the eviction moratorium and an increase in private sector rent costs;

e) Plymouth City Council had been working to create a single, structured, multi-agency programme of work with the aim of reducing and preventing homelessness in Plymouth;

f) In recognition of the crisis a taskforce had been created to seek a reduction in the number of households in Bed and Breakfast with a focus on reducing families within this accommodation;

g) The Plymouth Alliance worked alongside Plymouth City Council to provide a range of housing and homelessness prevention and floating support. The Alliance took a whole system approach in supporting people with complex needs and provide support for problematic substance use, mental health and offending;

h) The Plymouth Alliance had been working to reduce the number of people in temporary accommodation by; adding temporary accommodation, working with other accommodation providers; securing and using funds to help people remain in tenancies where they had been at risk or to secure new tenancies, providing additional support to families;

i) Plymouth had been awarded funding from the Department of Levelling up, Homes and Communities and National lottery. The Changing Futures Programme seeked to deliver a whole system transformation for people experiencing multiple disadvantage. The Programme received funding of £2.4 million across three years.

Members of the Board discussed:

a) There had been a range of accommodation for people that Plymouth City Council provided on an emergency basis and then on a longer term basis. The housing market in Plymouth had changed dramatically in the 6-9 months prior to March 2022 which had included an increase in private sector rents, an increase in home ownership and people finding it difficult to access accommodation. There had been a recognition that there were too many people in bed and breakfast accommodation and for too long. Plymouth Alliance had been co-ordinating efforts with the private sector to address the number of families in B&B accommodation;

b) The Board and Officers had not been aware of any national action to reduce the increased costs for those using pre-payment meters. It was acknowledged that the poorest people in the country would be in the majority for using pre-paid metres;

c) The Local Housing Allowance (LHA) which had been paid by the Department for Work and Pensions would not be increasing, however landlords would be able to charge whatever they wanted. This had been decreasing the number of landlords willing to rent to those in receipt of LHA. It was acknowledged that the LHA had not kept up with inflation with National Government not seeking to increase the allowance as it had been believed that this would move the private sector rental market in an upward trend;

d) There needed to be a focus on homelessness for the Board into next year;

80. **Safer Plymouth Partnership (Presentation and verbal update)**

Matt Garrett, Service Director for Community Connections delivered a presentation to the Board on Safer Plymouth and highlighted the following key points:

a) Safer Families which had been led by the NSPCC and Hamoaze had priorities for 2022/23 which included; healthy relationships, substance misuse and hidden harm, reduction in the risk of causing harm and improved alignment through new family hubs and Bright Futures;

b) It had been Safer Plymouth week which stated on 28 February, it had delivered various sessions and groups around the themes for Safer Plymouth;

c) Safer Communities led by Tracey Naismith (PCC) and Inspector Andy Smith had developed a new ASB case review policy. There had been a use of appreciative enquiry to inform understanding of community cohesion. Prevent training would be re-developed for partners. Funding had been received for Safer Street 1 and 3. Safer Plymouth had supported the roll out of the Adolescent Safety Framework;

d) Serious Violence Prevention led by Laura Juett (PCC Public Health) had aimed to; develop local serious violence definition and to establish new partnerships and to develop Safer Plymouth spend plan for the new OPCC serious violence prevention funding.

e) Domestic Abuse and Sexual Violence led by Lyn Gooding (Firstlight) and Hannah Shead (Trevi) had: provided significant support and evidence to the VAWG Q&A session in December 2021 and also to the Violence Against Women and Girls Commission (VAWG); Safer Streets 3 funding provided investment in Bystander Training and work with Beyond Equalities to progress understanding; Developed Domestic Abuse Safe

Accommodation Strategy; A new Peninsula Project 'SPARK' had been funded by the tampon tax and would look to improve system response to working with highly vulnerable women; There had been an increase in the number of Domestic Homicide Review referrals;

f) Youth Justice Service which had been led by Jean Kelly had a Plymouth Youth Justice HMIP inspection and had received a positive performance summary against all 5 key performance indicators; The Impact Project which had been running for 6 months had gained recognition as a model of trauma informed practice; Emerging themes included concern at a lack of parental support available to reduce re-offending in cases of violence, increased reporting of young people carrying knives and a need to look at disproportionally/diversity issues in the Youth Justice caseload.

Members of the Board discussed:

a) The Domestic Abuse, Stalking and Honour Based Violence (DASH) Risk Identification, Assessment and Management Model had been implemented by SAFER Plymouth and most of its organisations;

b) Once the VAWG Commission reports its recommendations, SAFER Plymouth would look to deliver its service based on those recommendations;

c) The Plymouth Children's Safeguarding Partnership had maintained effective links and safeguarding with a Strategic and Operational Group that had been reviewing arrangements and intelligence arrangements around any form of exploitation;

d) There had been no further updates in relation to the Keyham events, however once the report had been published, the SAFER Plymouth partnership would look at those recommendations;

e) The Board noted the improvements from the outcome of the Youth Justice inspection and specifically the improvements in Governance arrangements which had been highlighted as an issue in the Joint Targeted Area Inspection (JTAI).

81. **Admission avoidance services across physical and mental health (CCRT, acute nursing service and First Response)**

Louise Higgins (Livewell Southwest) presented members of the Board with a presentation and members discussed:

a) The Emergency departments should not be used by members of the public to access NHS support in response to mental health and should use other services. This pathway had been regularly communicated to patients in order to prevent an overload on the Emergency Department;

b) There had been concern that there had been a gap in patients being signposted and whether patients had received the service they required after being signposted, this would be taken away by NHS staff and looked at;

c) The CCRT had not been limited to the frail/elderly and would include frail and an inability to cope young people;

d) Livewell Southwest had been less joined up with Cornwall counterparts due to the services provided spanning across the West Devon area and Plymouth. Work had started to reach out to Cornish colleagues and a lot of the work sits under the Western Urgent Care Board;

e) The ARP role function could be used flexibly and those employees go through a robust education and training programme to elevate their senior skills and experience. They have the training and skills in order to use more holistic skills that had been in a physical and mental health crisis. Where there had been issues within Primary Care, the service had been able to use ARP's within the surgery to respond to visits where the GP had been asked to respond initially. This would've been triaged properly to ensure that the ARP's would've been the best person to respond to that patient and would thereafter work closely with GP colleagues for the benefit of the patient;

82. **Transformation in Enhanced Primary Care (community MDT and care home support)**

Louise Higgins (Livewell Southwest) gave a presentation to the Board and Members discussed:

a) The GP surgeries that declined to take part had been due to capacity issues as the programme to set this up would be intense. GP surgeries would need to be able to commit to having clinicians as part of the setup;

b) All care homes are in scope to be a part of this, all care homes are keen to be engaged in this. Patient and client stories would be circulated to members of the Board outside of the meeting to bring to life the feedback that had been received;

83. **Work Programme**

Board members were invited to forward items to populate the work programme. It was agreed to add the following items –

1. The Impact of COVID-19 (as one of the first in the new municipal year)
2 South West Ambulance Service – response times and delivery service
3 Connection between SAFER Plymouth and the Plymouth Safeguarding Board (Efficacy)

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Health and Wellbeing Board

Date of meeting:	30 June 2022
Title of Report:	**Devon, Cornwall, Isles of Scilly Health Protection Committee Annual Report 2020-21**
Lead Member:	Councillor Dr John Mahony
Lead Strategic Director:	Ruth Harrell (Director of Public Health)
Author:	Julie Frier
Contact Email:	julie.frier@plymouth.gov.uk
Your Reference:	JF-DCIHPCAR-30/06/22
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
To present the annual assurance report of the Devon and Cornwall Health Protection Committee 2021/22 for information.

Local authorities, through their Director of Public Health, require assurance that appropriate arrangements are in place to protect the public's health. To this end the Health Protection Committee (HPC) is mandated by the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council, and Cornwall Council and the Council of the Isles of Scilly to provide assurance to the local Health and Wellbeing Boards that adequate arrangements are in place for prevention, surveillance, planning and response to communicable disease and environmental hazards, to protect the public's health.
The HPC produces an annual report to the Health and Wellbeing Boards, which provides a summary of the assurance functions of the Devon, Cornwall and Isles of Scilly Health Protection Committee and reviews performance for the period 1 April 2020 to 31 March 2021, for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council, Cornwall Council and the Council of the Isles of Scilly.

The report considers the following domains of health protection:

- Communicable disease control and environmental hazards
- Immunisation and screening
- Health care associated infections and anti-microbial resistance

For each of these domains the report sets out:

- Assurance arrangements
- Performance and activity during 2020/21
- Actions taken against health protection priorities identified for 2020/21
- Priorities for the current year.

The health protection agenda in 2020/21 was dominated by the COVID-19 pandemic. This report therefore focuses on the response to the pandemic, the impact on wider health protection activity, and work to recover screening and immunisation coverage for our population.
There is a delay between the reporting period and the preparation of the report due to the timetable for publication of annual screening and immunisation performance. Because of this time lag, this year's report contains some information in relation to activities undertaken during 2021/22, to provide a more timely picture of progress.

The format of the report also differs from previous years, with the highlighting of local challenges, innovation and good practice in relation to the pandemic response.

Key points from the report for Plymouth

Management of COVID-19 outbreaks

The report includes numbers of outbreak by setting type dealt with by UKHSA. These numbers in particular for education and businesses settings will be smaller than the actual figures for outbreaks in these settings as local public health management was in place for education and workplace settings. Care settings were managed in collaboration with UKHSA but with local teams taking a far more proactive and supportive role than previously. Rates of non-COVID infectious diseases reported to UKHSA were low during the pandemic.

Local areas of innovation and good practice

COVID-19 testing was coordinated peninsula wide, with Public Health teams managing targeted community testing and outbreak testing at local level. Strong partnership working enabled all areas to support and supplement the national testing programme with local arrangements to speed and increase access during outbreaks in higher risk settings.

COVID-19 and flu vaccination were coordinated under a Devonwide seasonal vaccination programme with local targeting of areas of low uptake and groups with a lack of 'vaccine confidence'.
The new Devonwide Infection Management System was central to the COVID-19 response, working locally as part of a Plymouth multi-agency team supporting care homes throughout the pandemic. This offer included the development of bespoke and care-home specific support via 'virtual infection prevention and control walkrounds'.

Local Outbreak Engagement Boards in all areas helped local authorities to keep in touch with key stakeholders, with Plymouth also setting up a 'Plymouth Community COVID Champions network' which was valuable in shaping communications, and sharing key messages with communities.

Screening & Immunisation programmes

All programmes (except childhood immunisations which continued throughout) were affected by the pandemic, but all have made strenuous efforts to recover and all are due to be back on track by July 2022 if they have not already achieved this. Coverage figures are reported annually almost a year in arrears so will not fully reflect the recovery.

Healthcare associated infections

Reducing the incidence of E.coli is a priority for Devon where case rates are particularly high. This work is part of the Anti-Microbial Resistance programme seeking to prevent and tackle those infections which are resistance to anti-virals, antibiotics, or antifungal treatments. Restarting this programme is a key priority as we move on from the acute phase of the pandemic and need to maintain the important learning around infection prevention and control. Handwashing and ventilation are messages for the long term, not just for COVID.

Health Protection Committee Priority areas

Peninsula wide priorities for action in 2020/21 have been:

1 COVID-19 response including vaccination and targeting areas of inequality
2 Recovery of screening and immunisation delivery, coverage and uptake
3 Strengthening infection prevention and control throughout the community
4 Reducing healthcare associated infections and tackling antimicrobial resistance across
5 Developing health protection pathways for migrant and homeless communities
6 Maintaining a focus on the climate emergency.

Progress against these will be included in the next annual assurance report.

Recommendations and Reasons

The Health and Wellbeing Board notes the contents of the report.

Alternative options considered and rejected

The report is for noting only

Relevance to the Corporate Plan and/or the Plymouth Plan

The role of the Health Protection Committee, along with its annual assurance report, is to provide the structures and arrangements required to assure adequate performance against health protection priorities across communicable disease control and environmental hazards; immunisation and screening; health care associated infections and antimicrobial resistance. All areas of action are designed to protect and support individuals and settings at greatest need or risk.

The function of the Committee and its assurance role helps to deliver against the caring priorities within the Corporate Plan, and particularly with regards to 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.*

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							

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	djn.22.23.36	Leg	EJ/38690	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: Julie Frier

Please confirm the Strategic Director(s) has agreed the report? Yes – (Rob Nelder agreed in Ruth's absence)

Date agreed: 25/05/2022

Cabinet Member approval: *[Cllr Dr John Mahoney - approved by email]*

Date approved: 25/05/2022

Public Health Devon

Devon County Council

Annual Health Protection Assurance Report for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council and Cornwall and the Isles of Scilly Councils

2020/2021

March 2022

PLYMOUTH CITY COUNCIL

TORBAY COUNCIL

CORNWALL COUNCIL

Council of the ISLES OF SCILLY

Contents

1. Introduction

1.1 This report provides a summary of the assurance functions of the Devon, Cornwall and Isles of Scilly Health Protection Committee and reviews performance for the period from 1 April 2020 to 31 March 2021, for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council, Cornwall Council and the Council of the Isles of Scilly.

1.2 Due to the time lag in receiving the annual reporting data for 2020/21, the report contains some information in relation to activities undertaken in 2021/22, to provide a more timely picture of progress.

1.2 The report considers the following key domains of Health Protection:

- Communicable disease control and environmental hazards
- Immunisation and screening
- Health care associated infections and antimicrobial resistance
- Emergency planning and response.

1.3 The report sets out for each of these domains:

- Assurance arrangements
- Performance and activity during 2020/21
- Actions taken to date against health protection priorities identified for 2020/21
- Priorities for 2021/22.

1.5 The health protection agenda in 2020/21 was dominated by the COVID-19 pandemic. This report therefore focuses on the response to the pandemic, the impact on wider health protection activity, and work to recover screening and immunisation coverage for our population.

2. Assurance arrangements

2.1 Local authorities, through their Director of Public Health, have an assurance role to ensure that appropriate arrangements are in place to protect the health of their populations.

2.2 The Devon and Cornwall Health Protection Committee is mandated by the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council, and Cornwall Council and the Council of the Isles of Scilly to provide assurance that adequate arrangements are in place for prevention, surveillance, planning, and response to communicable disease and environmental hazards.

2.4 Summary terms of reference for the Committee and affiliated groups are listed at **Appendix 1**.

2.5 A summary of organisational roles in relation to delivery, surveillance and assurance is included at **Appendix 2**.

2.6 A major organisational change has been the transition from Public Health England (PHE) to the UK Health Security Agency (UKHSA) which took place in October 2021. This is outside the timescale for this annual report but for practical purposes the organisation is referred to as PHE/UKHSA throughout.

3. Prevention and control of infectious disease

3.1 At the end of December 2019, Wuhan Municipal Health Commission, China, reported a cluster of cases of pneumonia. The situation escalated rapidly and on 30 January 2020 the Director-General of the World Health Organisation declared the novel coronavirus outbreak a public health emergency of international concern (PHEIC) as sporadic cases were now being seen across countries outside of China.

3.2 By the end of January 2020 the first two cases of coronavirus (2019-nCoV) in the United Kingdom were confirmed and, over the course of February, single and linked cases were being identified across the UK and outbreaks were being confirmed across Europe, notably Italy, France and Spain.

3.3 By mid-March 2020, as the UK Chief Medical Officers raised the risk to the UK from moderate to high, the first COVID-19 cases and situations in Devon and Cornwall involving single cases, schools and care homes were being identified. On 26 March 2020, the UK went into lockdown with the instruction to Stay at Home, Protect the NHS, Save Lives.

Activity in 2020/21

3.4 PHE/UKHSA, peninsula local authorities and CCGs worked in partnership to support settings with high-risk cases or outbreaks of COVID-19. Common settings where an outbreak response is required include care homes, supported living settings, early year and education settings, health care settings, workplaces (particularly those associated with national infrastructure or are otherwise high risk) prisons and homelessness settings. Table 1 shows the number of COVID-19 situations recorded on HPZone (PHE/UKHSA case management system) by principal context and local authority area in the year 2020-2021. This will be a significant under representation of the number of settings reported as it does not include situations where the local authority led the response. For example, where the local authority led on providing a response to local schools or workplaces these will not be included in the setting figures below.

Table 1 Number of Covid-19 situations recorded on PHE/UKHSA system between 1 April 2020 – 31 March 2021 by Local Authority and setting type

Local Authority	Adult Care Home or Setting	Educational setting (inc residential)	Workplace	Healthcare	Other
Cornwall	225	32	35	6	9
Devon	341	72	42	15	20
Plymouth	133	36	18	5	14
Torbay	96	<5	14	<5	5

3.5 The above includes the first Covid-19 Outbreak in the South West which occurred in Torbay in early March 2020, during the initial containment phase of the national pandemic response.

3.6 PHE/UKHSA regional Health Protection Teams provided the specialist response to other infectious disease and hazard related situations across Devon and Cornwall, supported by local, regional and national expertise. Situations responded to alongside management of COVID-19 have included:

- Gastro-intestinal outbreaks in early years, schools and residential care settings
- Environmental exposures
- Exposure to Brucella Canis from contact with infected canines
- TB in the workplace

Are of response	Detail
Public Health advice	Public health advice was developed and disseminated in relation to the identification and management of symptoms, case and outbreak response, promotional campaigns, and support for all sectors in relation to the pandemic. Proactive support was provided through a suite of assets and communication tools hosted by local authority, CCG and PHE/UKHSA agencies. Examples include early year and education setting regular webinars, care home webinars, flow charts communicating actions to take following possible or confirmed case(s), checklists and risk assessment tools.
Contact tracing	PHE / UKHSA, working with local authority public health teams and NHS Test and Trace, led the process of contact tracing, testing and isolation, interpreting and implementing changing national guidance during the phases of the pandemic
Testing	*Area of local good practice*  Testing was coordinated across Devon and Cornwall by a regional testing strategist, bringing together clinical, commissioning and public health expertise regularly to review latest guidance and manage implementation in the most effective way for a geographically dispersed population. Testing capacity and capability was targeted to ensure all communities were able to access symptomatic and asymptomatic testing services, taking into account the needs of those without easy access to transport, and vulnerable populations. Targeted community testing, including deployment of fixed and mobile PCR and LFD testing sites, was used to maximise testing uptake across the peninsula.
Vaccination	*Area of local good practice* 

	COVID-19 and flu vaccination programmes were co-managed as a seasonal vaccination programme, channelling resource and expertise in the most effective way. A particular focus was the work to identify and target areas of vaccine inequality. Health equity audits were undertaken to identify groups and areas of practice to be addressed. An infection control site toolkit was developed, and bespoke vaccination sessions were organised for people who were homeless, people with a learning disability, and people with complex lives. A community engagement officer, and a vaccine hesitancy nurse, were appointed by the CCG to support this work. Local authorities worked with the CCG to develop the outreach offer, through use of all vaccine partners – CCG, acute trusts, GPs and pharmacies, and use of community settings in areas of high deprivation and low uptake.
Variants of concern	PHE/UKHSA led the response to investigating single cases and outbreaks of variants of concern, working closely with local authorities to ensure containment and, in the case of Delta and Omicron, mitigate spread.
Infection prevention & control	*Area of local good practice 1*  The Devonwide Community Infection Management Service commenced in April 2020 and has been central to the COVID response across the whole of Devon as well as to developments in wider infection prevention and control. The service operates a hub and spoke model with expertise based in each of the four acute hospitals in Devon reaching out to support the care sector. This approach enabled more intensive specialist support for outbreak prevention and control than would be been possible before. One particular area of innovative practice was the development of 'virtual infection control tours' where the team was able to walk round a care home via the Manager's iPAD, and to advise on infection control measures in a much more practical way, for example cleaning, and PPE donning and doffing arrangements. *Area of local good practice 2* 

	A small team of two infection prevention and control nurses was employed by Devon, Plymouth and Torbay local authorities, hosted by Devon, and gave infection control advice to a range of non-NHS settings to support the COVID response. This reached out to settings such as businesses, schools, factories, and homeless hostels. The practitioners developed a range of IPC resources including checklists, posters and guidance documents as well as delivering training and education to these settings to complement national resources. These included: • 'Ready for Anything', a full IPC guide to support workplaces and businesses beyond the pandemic, which was added to the Heart of the South West Growth Hub. • IPC information posters for events • IPC self-assessment checklists to support the COVID-19 vaccination clinics, temporary accommodation for homeless settings, bridging hotels and education settings.
PPE	*Area of local good practice*  The Devon Public Health team took a lead role, in partnership with PHE/UKHSA, in developing South West wide guidance in the use of PPE for non NHS settings. This enabled decisions to be made to protect both staff and residents at a time when national guidance was not yet available to guide local practice.
Settings based prevention & case & outbreak response	Prevention and response programmes were developed for all settings to prevent and control outbreaks: • Schools and early years • Care homes and domiciliary care • Businesses & hospitality • Places of detention • Homelessness settings New and productive relationships were built with all sectors to support them to keep staff, clients and students safe, minimise disruption and keep premises open and functioning.
Communications & engagement	*Area of local good practice*  Local Outbreak Engagement Boards in each local authority brought together stakeholders from health and care, education, business, hospitality, voluntary and community sectors, faith

	groups, police and other sectors to feed into local policy and ensure clear communications to all parts of the community. 'Covid Champions' networks were established to influence communications and share key messages around COVID safe behaviours through professional, social and community networks. THE PLYMOUTH GOOD NEIGHBOURS SCHEME

Surveillance Arrangements

3.8 UKHSA provides a quarterly report to the Committee containing epidemiological information on cases and outbreaks of communicable diseases of public health importance at local authority level.

3.9 Fortnightly bulletins are produced throughout the winter months, providing surveillance information on influenza and influenza-like illness and infectious intestinal disease activity, including norovirus. These bulletins report information for the UKHSA (South West). UKHSA also provides a list of all community outbreaks all year round.

3.10 The Devon Health Protection Advisory Group, led by UKHSA and convened quarterly, provides a forum for stakeholders, including hospital microbiologists, environmental health officers, consultants in public health, water companies and infection control nurses, to share intelligence and any risks identified in local arrangements to manage communicable disease incidence.

4 Screening programmes

4.1 This section summarises some of the key developments for the individual screening programmes during 2020/21.

4.2 All screening programmes suffered from the impact of the COVID-19 pandemic to varying degrees with the focus during 2020/21 to support providers to safely pause programmes where this was necessary or required, for example due to infection, prevention and control reasons, and then to develop and implement detailed recovery plans to safely recommence screening and tackle the backlog that had developed during the pandemic to return programmes back to a business as usual footing. For some programmes, this has required significant investment, both regional and national to increase capacity over and above 100% to be able to deliver screening in a COVID-19 secure manner (for example, longer appointments to follow PPE and IPC procedures) and to offer screening to all those individuals who were affected by the pause in the programmes in as timely a way as possible. As a consequence, this investment has been designed to build in increased capacity to ensure more robust and sustainable services into the future.

4.3 The impact of the COVID pandemic has meant that there have been challenges meeting some national standards (for example, round length and coverage) and for these areas, action plans and improvement plans are in place alongside the recovery plans.

4.4 The following table gives a summary of performance, challenges and developments during 2020/21 and future developments.

Screening programme:	
Bowel	Both routine and surveillance programmes had to be paused at the start of the pandemic due to a number of factors, including IPC concerns at colonoscopy. Invitations were recommenced in a phased way to enable providers to manage flow of patients through the screening pathway and providers increased invitation rates and colonoscopy capacity (compared to pre-Covid) in order to recover backlogs. All providers met the national recovery ambition. As part of the national recovery plan, bowel scope screening was paused and then a decision made to cease this programme. Any individuals who were invited to bowel scope screening but were not able to be screened due to the pause of services were invited to bowel screening. In addition to recovery, nationally, age extension of the bowel cancer screening programme commenced from mid May 2021. This is a 4-year extension programme starting with 56-year olds in 2021-22 to include 50 year olds by 2024-25. All providers have commenced age extension to 56-year olds with a plan to launch age 58 invites in Q1 2022/23 in line with national guidance, subject to regional finance allocations. It has been agreed that screening of individuals with Lynch syndrome will be introduced in 2023/24 with planning around process, IT systems and finance led nationally in 2022/23.
Breast	All services were affected by the pandemic with routine screening paused initially at the start of the pandemic due to a number of factors, including IPC concerns on the mobile screening vans. Screening for those at high-risk continuing throughout. As part of the national recovery plan, the national Age Extension breast screening trial ceased recruiting. The national recovery ambition is for all providers to recover by end March 2022. Based on current trajectories, 2 Devon providers are on track to recover within this timeline, one within a few weeks of this date and the other July 2022. Women waiting longest have been invited first and at the time of this report providers are inviting women within approximately 8 weeks of their due date. Provider recovery plans have required significant new investment, both regional and national, to increase capacity sufficiently above 100% to offer screening to all individuals delayed screening within the national timeline. This has been able to address pre-COVID-19 issues in staffing levels and aging equipment that will ensure more robust and sustainable services into the future. Until the backlog is cleared and round length is fully recovered, it is not possible fully to determine the impact of the pandemic on uptake and coverage. This is being closely monitored and text messaging has been introduced in all programmes as an additional reminder to women and to help to reduce wasted slots. Work also continues with GP practices to encourage ladies to attend when due. A project has been started to see whether an online booking solution can be developed. Providers will be completing the PHE/UKHSA Health Equity Assessment Tool during 2022/23 and developing action plans.

Cervical	At the start of the pandemic, a national decision was made to temporarily pause invitations to cervical screening. All other components of the cervical screening pathway continued throughout albeit at reduced capacity for a short period. Due to social distancing and IPC requirements, local colposcopy teams paused seeing women with low grade referrals for a short period. Letter invitations for Devon and Cornwall recommenced on 05/06/2020 and the programme has been running as expected since that time, with some fluctuation in laboratory turnaround time due to temporary staff sickness/self-isolation throughout the pandemic. This has been a national issue with all labs affected to some degree. Uptake data suggests that this has been stable and a project has been carried out to review GP practice level data and provide support and resources to those with lower uptake. A national pilot of self-sampling has commenced.
Antenatal/ Neonatal	All antenatal screening programmes were maintained throughout COVID as a core part of routine maternity care. All providers continue to provide a full service and are in the main meeting BAU national standards. Newborn and infant examination (NIPE) and Newborn bloodspot screening (NBBS) were also maintained as core part of maternity and neonatal care. An initial impact on the NIPE 6-week hip scan for at risk babies was fully recovered by the Autumn 2020. The enhanced newborn targeted Hepatitis B vaccination programme was successfully implemented on 01/04/2021 in all providers, meeting the national deadline. Non-invasive Perinatal Testing (NIPT) was successfully implemented on 01/06/2021 in all maternity providers, meeting the national deadline. The national evaluative Severe Combined Immunodeficiency (SCID) programme went live on 01/09/2021. The SW is not part of this evaluative roll-out so babies born in the SW will not be screened for SCID and providers only need to be aware of implications for babies that move in at this stage. All the required changes in maternity, the newborn lab, CHIS and BCG providers have been implemented. Key implications are that BCG vaccination will be given around 28 days after checking the SCID result, and GP practices must check for a SCID result before giving Rotavirus vaccination (live vaccine).
New-born Hearing	There was significant disruption from COVID to the delivery of newborn hearing services affecting Devon and Cornwall due to the community model. The backlog due to COVID has been fully recovered. A further NHSP national assurance exercise took place during August 2021 and confirmed that recovery has been maintained. The Devon Local Authority Health Visitor Service gave notice to cease providing the first newborn hearing screen from end March 2022. A new provider has been identified for Devon and enhanced contracts agreed for Plymouth and Torbay providers. Mobilisation work is progressing, led by Devon CCG, to take over the service from the 01/04/2022.
Diabetic Eye	All services were affected by the pandemic as most venues for screening are in the community and GP surgeries, which had to close for long periods

	of time. Routine screening was paused initially, however screening for those at high-risk continued throughout. The national recovery ambition is for all providers to recover by end March 2022 (plus 6 weeks) and all providers are on track to recover within this timeline, and are training their own staff in Slit Lamp Bio-microscopy to ensure these patients are also seen in a timely way by April 2022. Hospital Eye Service capacity is a long-standing issue compounded by the impacts of COVID. Potential programme changes are being considered at a national level to address this including the introduction through Section 7a of Optical Coherence Tomography. National meetings are taking place to discuss extending the screening interval for low-risk patients from one year to two years. All programmes have completed the PHE/UKHSA Health Equity Assessment Tool and action plans are being developed.
Abdominal Aortic Aneurysm (AAA)	All services were affected by the pandemic as most venues for screening are in the community and GP surgeries, which had to close for long periods of time. Routine screening was paused initially and screening for those at high-risk continued throughout. The national recovery ambition is for all eligible men in the 2021/22 cohort to be invited for screening by end March 2022 (+2 months) in line with the national standard and all providers are on track to recover within this timeline. Investment to support recovery has led to increased capacity through funding additional staff, equipment and venue hire. All programmes have tracked the progress of each referral made to vascular surgery and taken action actively to manage any delays to assessment or subsequent treatment. However, meeting national quality targets is challenging due to ongoing pressures in Acute Trusts, including theatre space and ICU beds. All programmes have completed the PHE/UKHSA Health Equity Assessment Tool and action plans are being developed.

5 Immunisation programmes

5.1 This section summarises some of the key developments for the individual immunisation programmes during 2020/21.

5.2 National pandemic guidance prioritised the continuation of all immunisation programmes to ensure that public health protection was maintained and outbreaks of vaccine preventable diseases were prevented.

5.3 The impact of the COVID pandemic has meant that there have been challenges meeting some national standards in some programmes (for example, recommended intervals between doses and coverage) and for these areas, action plans and improvement plans are in place alongside the recovery plans.

5.4 The following table gives a summary of performance, challenges and developments during 2020/21 and future developments.

Immunisation programme:	
Primary childhood immunisations	All practices continued to deliver the routine child immunisation programmes throughout the pandemic. Routine data collections that monitor uptake and coverage (COVER) do not provide timely data so the SW Screening and Immunisation Team worked with the Child Health Information Services to develop new real-time data sets that have enabled close monitoring of the impact of the pandemic. These have shown that uptake of primary immunisations has been maintained. Annual COVER data for 2021/22 is also reassuring. The real-time datasets however do show that for immunisations at 12 months of age and at 3 years 4 months a larger proportion of children are not immunised as close to the age of eligibility as is recommended. Further investigations will be taking place and improvement plans put in place as necessary.
School-aged immunisations	The SAI programme has been severely impacted by the pandemic due to the initial lockdown, the second wave of school closures, and ongoing outbreaks that have prevented immunisation teams attending schools for clinics. These factors prevented the 2019/20 programme being completed in the Spring and Summer terms 2020 and have continued to impact delivery of the 2020/21 programme. In addition, the COVID vaccination programme for 12-15s and the expanded flu vaccination programme has impacted the 2021/22 programme. Both DCIOS providers restarted immunisation clinics during the first COVID lockdown have worked hard to deliver as much of the routine programme as possible as well as catch-up clinics over the summer periods. The aim is to complete the routine programme for those in 2019/20, 2020/21 and 2021/22 cohorts by the end August 2022. The Cornwall programme had nearly completed the routine programme at the time of the first lockdown in 2020 and was able to achieve expected uptake levels for the 2019/20 cohort. Uptake for the 2020/21 cohort are also good. The Devon programme was significantly disrupted by the first lockdown has had large numbers of clinics due in the Spring/Summer 2020 terms and due to the ongoing challenges with delivery of the routine programme and catch-up clinics. The provider was also heavily impacted by involvement in the delivery of the covid programme for 12-15s. Uptake at this stage is therefore lower and it is hoped will improve by the end August 2022. Work is still underway to complete HPV for the 2020/21 cohort, which is the clinical priority and some second doses may extend into the coming academic year. Business cases are being developed to expand the provider workforce to achieve the ambition to complete the routine programme for those in 2019/20, 2020/21 and 2021/22 cohorts by the end August 2022.
Vaccinations in pregnancy	Vaccination has continued throughout the pandemic in maternity and GP setting, however, maternity providers have reported significant challenges in delivering vaccines due to ongoing workforce pressures with staff regularly diverted to cover clinical duties. As a consequence,

	flu vaccines delivered in antenatal settings are below levels in previous years. There are also ongoing challenges with data quality as vaccinations given in maternity need to flow to GP practices so these can be recorded in the medical record and captured in IMMFORM that is the source of routine reporting. Most Trusts are now using NIVS for flu vaccinations that helps with data flows to GPs however this is not the case for pertussis vaccinations. Work to improve data flows is ongoing.
Older people immunisations	Singles and pneumococcal immunisations for older people have been maintained throughout the pandemic. However, as this group was advised to self-isolate (and many will have been in the group recommended to shield) the offer of these vaccinations is likely to have been disrupted. To mitigate against this the eligibility for the vaccination was temporarily extended nationally for those that would have turned 80 during 2020/21 to enable them to access the vaccination. The Screening and Immunisation Team has undertaken work to identify practices with lower uptake, developed a toolkit to support improving uptake and has run a communications campaign to encourage those aged 70-80 years old to attend for vaccination. This work is ongoing. Low levels of pneumococcal vaccinations continue due to global shortages of vaccine, and national prioritisation advice is in place to support GP practices.
Flu immunisations	The flu vaccination programme has continued to be a priority during the 2020/21 and 2021/22 programmes with extension to the eligible groups (2021/22 addition of years 8-11 and those aged 50-64byears) placing pressure on GP practices and Schools immunisation providers at the same time as delivering the COVID vaccination programme. Delivery through community pharmacy has expanded to support the programme. Multi-agency arrangements were established in Devon and Cornwall to manage the delivery of the seasonal vaccination programmes including both COVID-19 and influenza.

6 Health Care Associated Infections

6.1 The following table summarises the key performance position and developments for health care associated infections over 2020/21. Note that targets were relaxed due to the pandemic.

Infection type:	
MRSA	*Devon:* There were 8 cases over 2020/21, for an overall rate of 0.68/100,000. The majority or MRSA cases were community-associated and unlinked. *Cornwall:* There were a total of 5 cases over 2020/21, an overall rate of 0.89/100,000. Two cases were inpatients with previous MRSA history and the remaining three cases were unlinked.

MSSA	*Devon:* There were 312 cases over 2020/21, for an overall rate of 26.4/100,000. MSSA bacteraemia rates continued to be steady, with higher variability in NDHT and TSDFT due to the smaller population in these areas. *Cornwall:* There were a total of 138 cases over 2020/21, with an overall rate of and 24.5/100,000. 11 cases below the incidence of previous year 2019-20.
***C. difficile* Infection**	*Devon:* There were 311 cases over 2020/21, for an overall rate of 26.3/100,000. During 2020/21 there was limited scope for investigation and analysis of community cases, despite the new team set up to do so; this is due to that team having to pivot to offering pandemic support. Cases did not rise significantly during this year. *Cornwall:* There were a total of 192 cases over 2020/21, an overall rate of 34.1/100,000, a total of 44 cases above threshold. Limited scope for investigation due to COVID-19 pandemic pressures, employment of C. diff investigative members of staff started in February 2021.
***E. coli* Bacteraemia**	*Devon:* There were 1009 cases over 2020/21, for an overall rate of 85.0/100,000. Projects for *E. coli* reduction have been limited by the necessities of the pandemic response. *Cornwall:* There were a total of 438 cases over 2020/21, an overall rate of 77.7/100,000. General GNBSI and E. coli reduction were limited due to system pressures and COVID-19 pandemic.
Antimicrobial resistance	*Devon:* AMR group meetings recommenced in the latter half of 2020/21, however the Chair and primary care lead for the group stood down during 2020/21 and this, along with the impact of the pandemic, limited action during the year. *Cornwall:* The AMR planning and delivery group held two meetings in 2020/21, but due to system pressures and COVID-19 pandemic were not held as regularly as hoped. Cornwall Antibiotic Resistance Group (CARG) continued to operate during 2020/21 where possible, as a 'one health' group with representation from human and animal health sectors.

6.2 The key challenges for 2021/22 include strengthening the antimicrobial resistance programme, continuing to support the COVID-19 response, implementing *E. coli & C. difficile* reduction strategies, and ensuring consistent information and analysis from community infections.

7 Emergency planning and response

7.1 Emergency planning was dominated during 2020/21 by the response to the pandemic. This involved a very substantial amount of work during the year and substantially challenged our systems to deliver. In summary the response involved:

- Activation of emergency structures
  - A strategic co-ordinating group was established to manage the local response in support of the UK's response to COVID-19. This SCG structure ensured the effective co-ordination of the Local Resilience Forum and other specialist resources.
  - To maximise co-ordination across the Peninsula, one Tactical Co-ordinating Group for DCIOS was established rather than four across the area.
  - Organisations across DCIOS stood up their incident management structures and held desk-top exercises.
  - With the need for local multi-agency working groups to respond to COVID-19 below the level of the LRF-wide Tactical Co-ordinating Group (TCG), local Operational Incident Cells were also established.
  - Logistical supply chains were set up for obtaining and co-ordinating PPE supplies.
  - The South West Regional Strategic Coordination Group instigated in response to the pandemic will be further developed as a concept post COVID-19.

7.2 In addition to the pandemic response there were a number of other events during 2020/21:
- Large fire in Cornwall which required a health and public health response
- Flash flooding in Barnstaple
- XR day of action event.

7.3 Despite the pandemic, local and regional exercises were held over the period.

7.4 It is safe to say that the year 2020/21 saw unprecedented challenges across health and social care systems. The primary focus was on responding and adapting to the issues and risks that arose, from which substantial learning, improvement and good practice has been, and continues to be, identified. Our EPRR professionals have met this challenge.

8. Work Programme Priorities 2020/21- Progress

8.1 Progress against 2020/21 priorities is set out below.

	Priority	Progress on delivery
1	Continue to support the COVID-19 pandemic through national, regional and local response, preventing disease transmission and responding to situations and outbreaks. Locally this will be delivered through the Local Outbreak Management Plans and associated local Health Protection and Local Engagement Boards.	The whole system worked together to deliver a comprehensive COVID-19 prevention and response programme. Local Outbreak Management Plans were developed and revised through each pandemic phase, guiding local action.
2	Support the implementation of emerging interventions aimed at reducing COVID-19 transmission.	This work has focused on the vaccine roll out programme, ensuring high levels of uptake across the population and specifically in target groups where uptake is traditionally lower. Work has also continued to promote and support delivery of the community testing

		programme, ensuring PCR and LFD testing is available and signposted for symptomatic and asymptomatic individuals. UKHSA and Local Authority public health teams have also supported surveillance initiatives such as waste water testing, and variant response including surge testing.
3	Work with our partners across the system to identify, mitigate and monitor for the effects of COVID-19 on the health protection system and the services it delivers.	Under the Local Authority COVID-19 Health Protection Boards, all partners worked collaboratively to put in place systems for prevention, early identification, advice and guidance, response and engagement. Monitoring of COVID-19 impact has taken place at a number of levels, through daily system business information reporting, identification of trends, and information to monitor impact and inform the pandemic recovery.
4	Work with our partners across the health protection system to support the restoration of key health protection public health services and activities disrupted by COVID-19.	The pandemic continued in acute phase throughout 2020/21, with recovery activities largely postponed into 2022. However the joint work on the COVID response laid foundations for greater post pandemic resilience and effective partnership working to address all areas of health protection. Work to recover screening and immunisation services progressed during the year and all services have returned to normal operation or are on track to do so. New systems to tackle foodborne diseases were put in place via an MoU between UKHSA and Local Authority Environmental Health teams, and new systems to identify and manage infectious disease outbreaks in care homes are being introduced.
5	Work with our partners across the health protection system to support the restoration of the screening programmes disrupted by COVID-19.	NHSEI and the PHE Screening and Immunisation Team worked closely with all screening providers to ensure that backlogs were cleared by the national recovery targets. Apart from a few exceptions this has been achieved ahead of, or will be achieved by, these targets. Progress is being actively monitored and plans are in place.
6	Work with our partners across the health protection system to support the recovery of the immunisation programmes disrupted by COVID-19.	
7	Continue efforts to ensure high uptake of flu vaccinations locally, particularly amongst at risk groups and frontline health and social care	The system ran a very successful flu vaccination programme with higher rates of uptake in all groups in all localities. This sat

	workers, and to support effective roll-out to the Year 7 primary school cohort and other additional cohorts that may be recommended. Efforts will be directed through regional and local flu groups and networks.	alongside the COVID-19 vaccination programme which also achieved high uptake.
8	All members support the ongoing local action following declaration of a climate change emergency.	All areas continued with strong organisational commitment to the delivery of published plans to address climate change, working with statutory, voluntary and commercial partners across local systems.

9. Work Programme Priorities 2021/22

9.1 Priorities agreed by Health Protection Committee members for 2021/22 were to:

1 Maintain response to COVID-19 and ensure preparedness and resilience to respond to future pandemics or health protection emergencies. As part of this, lead efforts to target vaccination inequalities

2 Recover screening and immunisation programme delivery, coverage and uptake

3 Embed and strengthen community infection management services to prevent and respond to infections throughout the community

4 Work to reduce the incidence of healthcare associated infections and to tackle antimicrobial resistance across our communities

5 Focus efforts to address health inequalities, in particular health protection pathways for migrant and homeless communities

6 Maintain a focus on local action to address the climate emergency.

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11. Glossary

AMR	Antimicrobial resistance
CCG	Clinical Commissioning Group
E. coli	Escherichia Coli
HPV	Human papillomavirus testing (for risk of developing cervical cancer)
IPC	Infection Prevention and Control
MMR	Measles, Mumps and Rubella (immunisation)
MRSA	Methicillin resistant Staphylococcus aureus
MSSA	Methicillin sensitive Staphylococcus aureus
NEW Devon CCG	Northern, Eastern and Western Devon Clinical Commissioning Group
NHSEI	NHS England and NHS Improvement
NIPE	New-born Infant Physical Examination
PHE	Public Health England
PPE	Personal Protective Equipment
SCID	Severe Combined Immunodeficiency
UKHSA	UK Health Security Agency

12. Appendices

Appendix 1 Health Protection Committee terms of reference & affiliated groups

Appendix 2 Roles in relation to delivery, surveillance and assurance

Appendix 3 Immunisation performance 2020/21

Appendix 4 Screening performance 2020/21

Appendix 1

Health Protection Committee
Summary terms of reference & affiliated groups

Membership of the Committee:

- Local Authority Public Health
- Public Health England (PHE), now UK Health Security Agency (UKHSA)
- NHS England & Improvement (NHSEI)
- NHS Devon and Cornwall Clinical Commissioning Groups (CCG).

Meetings of the Health Protection Committee are held quarterly.

A number of groups sit alongside the Health Protection Committee with remits for:

- Infection Prevention and Control
- Antimicrobial Stewardship
- Immunisation
- Screening
- Seasonal vaccination
- Emergency planning (including Local Resilience Forums)
- Migrant and Refugee health
- TB & Hepatitis.

All oversight groups have Terms of Reference and clear escalation routes to ensure accountability both within NHS England and Public Health England / UKHSA and into individual partner organisations.

NHSE, PHE / UKHSA and CCG provide quarterly performance, surveillance, and assurance reports to the Health Protection Committee.

The Local Authority lead officers review surveillance and performance monitoring information to identify health protection risks and/or under performance prior to committee meetings. Officers are responsible for liaising with relevant partners to ensure that actions have been agreed to mitigate against any identified risks, or to improve performance. The outcomes of these discussions are formally reported to the Health Protection Committee for consideration and agreement.

Appendix 2

Definition of roles and arrangements in relation to delivery, surveillance and assurance

Prevention and control of infectious disease

Normal working arrangements are described in the paragraphs below. During the pandemic there has been an enhanced response to infectious disease, with additional responsibilities taken on by Local Authority Public Health teams in relation to COVID-19 tracing, isolation and containment, funded in part through the national Contain and Outbreak Management Fund.

Public Health England (now UKHSA) health protection teams lead the epidemiological investigation and the specialist health protection response to public health outbreaks or incidents. They have responsibility for declaring a health protection incident, major or otherwise and are supported by local, regional and national expertise.

NHS England / Improvement is responsible for managing and overseeing the NHS response to any incident that threatens the public's health. They are also responsible for ensuring that their contracted providers deliver an appropriate clinical response.

Clinical Commissioning Groups ensure, through contractual arrangements with provider organisations, that healthcare resources are made available to respond to health protection incidents or outbreaks.

Local Authorities, through the Director of Public Health or their designate, has overall responsibility for strategic oversight of an incident or outbreak which has an impact on their population's health. They should ensure that an appropriate response is put in place by NHSE/I and UKHSA, supported by the local Clinical Commissioning Group. In addition they must be assured that the local health protection system response is robust and that risks have been identified, are mitigated against, and adequately controlled.

Public Health England / UKHSA provides a quarterly report to the Committee containing epidemiological information on cases and outbreaks of communicable diseases of public health importance at local authority level.

Surveillance information on influenza and influenza-like illness and infectious intestinal disease activity, including norovirus, are published during the Winter months. These bulletins report information for the Public Health England Centre geography (Devon, Cornwall and the Isles of Scilly, and Somerset). Public Health England also provides a list of all community outbreaks all year round.

The Devon Health Protection Advisory Group, led by Public Health England and convened quarterly, provides a forum for stakeholders, including hospital microbiologists, environmental health officers, consultants in public health, water companies and infection control nurses, to share intelligence and any risks identified in local arrangements to manage communicable disease incidence.

Screening and Immunisation

Population Screening and Immunisation programmes are commissioned by NHS England and Improvement under what is known as the Section 7A agreement. There are 20 population immunisation programmes and 11 population screening programmes. These programmes cover the whole life course from antenatal to elderly persons and, in any one year, approximately 70% of the population will become eligible for at least one immunisation or screening test. These programmes are a core element of prevention and early diagnosis and offer opportunities for accessing populations to improve wider health and wellbeing.

NHS England is the lead commissioner for all immunisation and screening programmes except the six antenatal and new-born programmes that are part of the CCG Maternity Payment Pathway arrangements, although NHS England remains the accountable commissioner.

Public Health England has been responsible for setting national screening and immunisation policy and standards through expert groups (the National Screening Committee and Joint Committee on Vaccination and Immunisation). At a local level, specialist public health staff in Screening and Immunisation Teams, employed by NHSE/I, work alongside NHS England Public Health Commissioning colleagues to provide accountability for the commissioning of the programmes and system leadership.

Local Authorities, through the Director of Public Health, are responsible for seeking assurance that screening and immunisation services are operating safely whilst maximising coverage and uptake within their local populations. Public Health Teams are responsible for protecting and improving the health of their local population under the leadership of the Director of Public Health, including supporting NHSE/I in efforts to improve programme coverage and uptake.

The South West Screening and Immunisation Team provides quarterly reports to the Health Protection Committee for each of the national screening and immunisation programmes. Reports are considered by lead Local Authority Consultants in Public Health and any risks identified are considered with NHSE/I specialists to agree mitigating activities.

Serious incidents that occur in the delivery of programmes are reported to the Director of Public Health for the Local Authority and to the Health Protection Committee.

Locality Immunisation Group activity was suspended during the pandemic but is being re-introduced from 2022.

Separate planning and oversight groups are in place for seasonal influenza.

There are oversight groups (Programme Boards) for all screening programmes and these form part of the local assurance mechanisms to identify risks and oversee continuous quality improvement. In addition, specific project groups are convened, as necessary, to oversee significant developments in the programmes and the introduction of new programmes.

All the oversight groups have Terms of Reference and clear escalation routes to ensure accountability both within NHS England and Improvement and into individual partners.

Healthcare associated infections

NHS England and NHS Improvement sets out and monitors the NHS Outcomes Framework which includes Domain Five (safety): treating and caring for people in a safe environment and protecting them from avoidable harm. The Area Locality Teams of NHS England and NHS Improvement hold

local Clinical Commissioning Groups to account for performance against indicators under this domain, which includes incidence of healthcare associated methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia and incidence of Clostridium difficile infection (CDI).

Public Health England, through its consultants in communicable disease control, leads the epidemiological investigation and the specialist health protection response to wider community non-hospital outbreaks, and is responsible for declaring a health protection incident.

The Clinical Commissioning Group's role is to ensure, through contractual arrangements with provider organisations, that health care associated infection standard operating procedures are in all provider contracts and are monitored regularly. NHS Devon Clinical Commissioning Group deploys this role through the Nursing and Quality portfolio. In addition, Clinical Commissioning Groups must be assured that the Infection Prevention and Control Teams covering the hospital and NHS community healthcare provided services sector are robust enough to respond appropriately to protect the local population's health, and that risks of health care associated infection have been identified, are mitigated against, and are adequately controlled.

The Local Authority, through the Director of Public Health or their designate, has overall responsibility for the strategic oversight of a health care associated infection incident affecting their population's health. They should ensure that an appropriate response is put in place by NHS England and NHS Improvement and Public Health England, supported by the Clinical Commissioning Group.

The Devon Infection Prevention & Control (IPC) Forum is a forum for all stakeholders working towards the elimination of avoidable health care associated infections (HCAI) for the population of Devon, including the Unitary Authorities of Plymouth and Torbay. The group covers health and social care interventions in clinical, home and residential care environments, identifying risks, sharing best practice and collaborating in system-wide approaches. The group is co-ordinated by NHS Devon Clinical Commissioning Group and is a cross-agency forum involving Acute and Community NHS Trusts, Ambulance and Out of Hours Doctors, Local Authority Public Health, Public Health England, Medicines Optimisation and NHS England and NHS Improvement. The Group meets quarterly with more frequent sub-groups as required.

In Cornwall there is a Directors of Infection Control Group with multi-agency attendance working on a similar agenda, also reporting into the Health Protection Committee. There is cross-attendance between the Devon and Cornwall groups.

Emergency planning and response

Local resilience forums (LRFs) are multi-agency partnerships made up of representatives from local public services, including the emergency services, local authorities, the NHS, the Environment Agency, and others. These agencies are known as Category 1 Responders, as defined by the Civil Contingencies Act. The geographical area the forums cover is based on police areas (Devon, Cornwall and the Isles of Scilly).

The LRFs aim to plan and prepare for localised incidents and catastrophic emergencies. They work to identify potential risks and produce emergency plans to either prevent or mitigate the impact of any incident on their local communities.

The Local Health Resilience Partnership (LHRP) is a strategic forum for organisations in the local health sector. The LHRP facilitates health sector preparedness and planning for emergencies at Local Resilience Forum (LRF) level. It supports the NHS, Public Health England (PHE) and local authority (LA) representatives on the LRF in their role to represent health sector Emergency Planning, Resilience and Response (EPRR) matters.

All Councils continue to engage with the Local Resilience Forum and the Local Health Resilience Partnership in undertaking their local engagement, joint working, annual exercise programme, responding to incidents and undertaking learning as required.

Appendix 3

Immunisation Performance 2020/21

Childhood Immunisations		Devon	Plymouth	Torbay	Cornwall and IoS	South West	England
12M	Cohort	*6,536*	*2,776*	*1,162*	*4,878*	*53,163*	***610,509***
	DTaP/IPV/Hib/HepB %	95.9	94.7	96.4	93.4	94.8	**92.0**
	MenB %	95.7	95.0	96.3	93.3	94.7	**92.1**
	Rota %	93.7	92.4	92.6	91.6	92.8	**90.2**
24M	Cohort	*6,926*	*2,906*	*1,282*	*5,134*	*55,376*	***630,876***
	DTaP/IPV/Hib/HepB %	96.3	97.0	95.9	95.1	95.8	**93.8**
	Hib/MenC %	94.1	94.8	93.4	91.9	93.2	**90.2**
	MenB/booster %	94.1	94.4	92.4	90.7	92.5	**89.0**
	MMR %	94.4	95.2	93.6	92.1	93.3	**90.3**
	PCV %	94.3	94.8	93.4	92.2	93.3	**90.1**
5Y	Cohort	*7,836*	*3,279*	*1,446*	*5,936*	*62,245*	***693,928***
	DTaP/IPV %	89.9	91.6	90.1	87.7	89.7	**85.3**
	DTaP/IPV/Hib %	96.9	98.0	97.4	96.5	96.8	**95.2**
	Hib/MenC %	94.9	96.3	96.1	95.0	95.2	**92.3**
	MMR1 %	96.1	97.4	96.7	95.5	96.0	**94.3**
	MMR2 %	92.4	93.5	91.6	90.2	91.2	**86.6**

Shingles vaccination						
Cohort	**England**	**Local authority**				NHS
		Devon	**Torbay**	**Plymouth**	**Cornwall IoS**	DEVON
Turning 71 and over	4,185,341	91,557	14,690	17,601	**61,413**	123,848
Vaccine coverage (%)	61.4%	61.8%	57.5%	59.8%	**59.1%**	61.0%
Cohort	**England**	**Local authority**				NHS
		Devon	**Torbay**	**Plymouth**	**Cornwall IoS**	DEVON
Turning 71-78 (routine cohort)	3,606,055	78,938	12,703	15,231	**53,431**	106,872
Vaccine coverage (%)	62.7%	63.0%	58.4%	61.3%	**60.1%**	62.2%
Cohort	**England**	**Local authority**				NHS
		Devon	**Torbay**	**Plymouth**	**Cornwall IoS**	DEVON
Turning 79 and 80 (catchup cohort)	579,286	12,619	1,987	2,370	**7,982**	16,976
Vaccine coverage (%)	53.3%	54.7%	52.1%	50.2%	**52.5%**	53.7%

Seasonal flu vaccine uptake 1/9/2020-28/2/2021							
		Devon	**Plymouth**	**Torbay**	**Cornwall IoS**	**South West**	**England**
65+	Cohort	*211,769*	*42,787*	*39,100*	*143,812*	*1,270,751*	***10,448,410***
	Coverage	82.8	81.2	79.8	80.3	82.8	**80.9**
6months -65 years clinical risk groups	Cohort	*109,527*	*37,118*	*21,610*	*80,907*	*794,012*	***8,098,035***
	Coverage	58.1	52.3	54.8	54.2	57.2	**53.0**
Pregnant	Cohort	*6,027*	*2,401*	*1,253*	*3,786*	*52,184*	***606,540***
	Coverage	50.5	45.0	43.8	32.6	46.4	**43.6**

Appendix 4

Screening Performance 2020/21

Cancer screening programmes

Indicator	Lower threshold	Standard	Geography	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
2.20i - Cancer screening coverage - breast cancer (%)	70	80	Devon	79.2	80.4	80.1	80.0	79.1	79.1	78.8	78.3	78.3	78.2	78.1
			England	76.9	77.1	76.9	76.3	75.9	79.2	78.9	78.5	78.3	78.2	77.6
2.20ii - Cancer screening coverage - cervical cancer age 25-49 (%)	75	80	Devon	79.1	78.0	77.0	75.2	75.7	76.1	75.3	74.9	75.1	76.7	77.2
			England	78.0	77.6	77.2	75.2	75.2	74.9	74.4	74.0	73.8	75.0	75.6
2.20ii - Cancer screening coverage - cervical cancer age 50-64 (%)	75	80	Devon	82.6	82.2	81.6	81.1	80.2	80.1	79.8	79.0	78.1	78.2	78.4
			England	81.5	82.3	82.0	81.6	81.1	80.4	80.1	79.4	78.5	78.6	78.8
2.20iii - Cancer screening coverage - bowel cancer (%)*	55	60	Devon						60.5	62.6	64.2	64.2	65.4	69.0
			England						62.0	62.7	63.6	63.4	64.1	67.9

Indicator	Lower threshold	Standard	Geography	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
2.20i - Cancer screening coverage - breast cancer (%)	70	80	Plymouth	79.9	80.6	80.1	78.7	78.4	79.1	79.3	79.0	78.2	78.2	77.4
			England	76.9	77.1	76.9	76.3	75.9	79.2	78.9	78.5	78.3	78.2	77.6
2.20ii - Cancer screening coverage - cervical cancer age 25-49 (%)	75	80	Plymouth	75.2	74.3	74.6	73.5	73.9	73.7	72.6	71.7	71.5	73.1	73.7
			England	78.0	77.6	77.2	75.2	75.2	74.9	74.4	74.0	73.8	75.0	75.6
2.20ii - Cancer screening coverage - cervical cancer age 50-64 (%)	75	80	Plymouth	81.2	80.7	80.9	80.6	80.2	79.3	78.7	77.7	76.2	75.9	76.0
			England	81.5	82.3	82.0	81.6	81.1	80.4	80.1	79.4	78.5	78.6	78.8
2.20iii - Cancer screening coverage - bowel cancer (%)*	55	60	Plymouth						61.3	61.6	61.1	61.6	61.9	66.5
			England						62.0	62.7	63.6	63.4	64.1	67.9

Indicator	Lower threshold	Standard	Geography	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
2.20i - Cancer screening coverage - breast cancer (%)	70	80	Torbay	79.2	78.6	76.9	77.0	76.5	76.7	74.7	74.1	74.4	74.2	77.0
			England	76.9	77.1	76.9	76.3	75.9	79.2	78.9	78.5	78.3	78.2	77.6
2.20ii - Cancer screening coverage - cervical cancer age 25-49 (%)	75	80	Torbay	75.4	75.0	75.1	73.4	74.0	73.9	72.7	71.9	71.5	73.4	74.3
			England	78.0	77.6	77.2	75.2	75.2	74.9	74.4	74.0	73.8	75.0	75.6
2.20ii - Cancer screening coverage - cervical cancer age 50-64 (%)	75	80	Torbay	80.5	79.4	79.5	79.4	79.4	79.1	78.1	76.9	75.2	75.0	75.2
			England	81.5	82.3	82.0	81.6	81.1	80.4	80.1	79.4	78.5	78.6	78.8
2.20iii - Cancer screening coverage - bowel cancer (%)*	55	60	Torbay						62.0	61.4	61.8	61.1	62.1	65.4
			England						62.0	62.7	63.6	63.4	64.1	67.9

Indicator	Lower threshold	Standard	Geography	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
2.20i - Cancer screening coverage - breast cancer (%)	70	80	Cornwall	80.0	79.8	79.3	79.9	80.1	80.3	80.0	79.3	78.4	78.2	78.1
			England	76.9	77.1	76.9	76.3	75.9	79.2	78.9	78.5	78.3	78.2	77.6
2.20ii - Cancer screening coverage - cervical cancer age 25-49 (%)	75	80	Cornwall	76.2	75.4	75.7	74.0	74.8	75.2	74.3	73.4	73.4	75.0	75.9
			England	78.0	77.6	77.2	75.2	75.2	74.9	74.4	74.0	73.8	75.0	75.6
2.20ii - Cancer screening coverage - cervical cancer age 50-64 (%)	75	80	Cornwall	80.0	79.7	80.0	79.4	78.8	78.2	77.8	77.2	76.3	76.1	76.0
			England	81.5	82.3	82.0	81.6	81.1	80.4	80.1	79.4	78.5	78.6	78.8
2.20iii - Cancer screening coverage - bowel cancer (%)*	55	60	Cornwall						58.3	60.5	61.7	61.5	62.7	66.6
			England						62.0	62.7	63.6	63.4	64.1	67.9

Non cancer screening – diabetic eye screening

Standard 7-KPI DE1 Uptake; 75 & 85%

				Quarterly											
				Q2 18-19	Q3 18-19	Q4 18-19	Q1 19-20	Q3 19-20	Q4 19-20	Q1 20-21	Q2 20-21	Q3 20-21	Q4 20-21	Q1 21-22	Q2 21-22
Standard 7-KPI DE1 Uptake; 75 & 85%	CORNWALL AND THE ISLES OF SCILLY HEALTH & SOCIAL CARE PARTNERSHIP (STP)	Cornwall	Numerator	20,893	20,939	21,373	22,528	24,053	24,002	38	2,025	5,692	9,024	13,833	16,934
			Denominator	27,469	27,824	28,427	29,220	30,378	31,225	41	2,480	7,183	11,795	17,594	21,217
			%	76.1%	75.3%	75.2%	77.1%	79.2%	76.9%	92.7%	81.7%	79.2%	76.5%	78.6%	79.8%
	DEVON STP	Devon	Numerator				48,941	51,372	51,841	42,273	30,898	29,663	33,719	48,063	55,708
			Denominator				56,495	59,915	60,776	49,436	35,900	34,522	40,373	56,079	64,489
			%				86.6%	85.7%	85.3%	85.5%	86.1%	85.9%	83.5%	85.7%	86.4%

Health and Wellbeing Board

Date of meeting:	30 June 2022
Title of Report:	**Director of Public Health Annual Report 2021**
Lead Strategic Director:	Ruth Harrell (Director of Public Health)
Author:	Ruth Harrell (Director of Public Health)
Contact Email:	Ruth.harrell@plymouth.gov.uk
Your Reference:	DPH21
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report

The Director of Public Health Annual Report covers the pandemic years. It summarises the pandemic itself and highlights some of the impacts of Covid-19, both direct and indirect, and with a focus on mental health and wellbeing. It also highlights some of the lived experiences of people in the city.

Finally it highlights the focus for Thrive Plymouth this year; to listen, connect and heal. The report, provided in pdf form for the papers, is accessible online as a set of web pages.

Recommendations and Reasons

For the Committee to note the report.

Alternative options considered and rejected

N/A

Relevance to the Corporate Plan and/or the Plymouth Plan

The DPH annual report supports the Plymouth Plan aim to become a Healthy City, reporting on the way in which Covid-19 has and may continue to provide a challenge to this aim.

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	Director of Public Health Annual Report 2021							

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		Leg		Mon Off		HR		Assets		Strat Proc	

Originating Senior Leadership Team member: Ruth Harrell (Director of Public Health)

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

Date agreed: 14/03/2022

DPH ANNUAL REPORT

2021

FOREWORD

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

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

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

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

1 INTRODUCTION

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

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

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

2 THRIVE PLYMOUTH

2.1 What is Thrive Plymouth?

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

So how do we help people to make healthier choices?

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

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

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

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

Thrive Plymouth has three approaches;

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

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

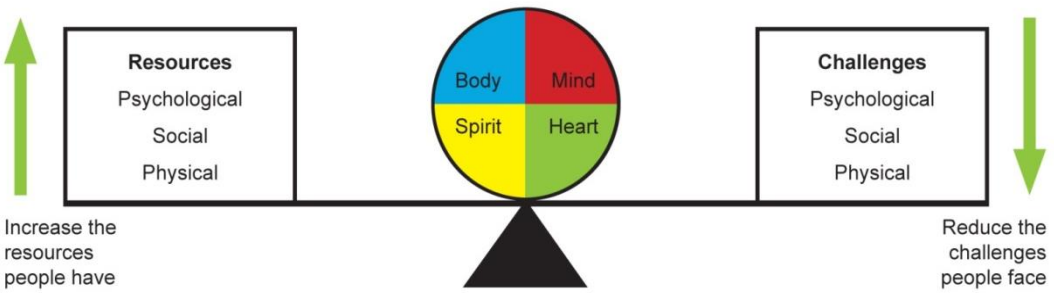
2.2 What are the healthy behaviours?

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

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

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

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



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

2.3 Campaign topics

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

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

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

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

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

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

3 THE COVID-19 PANDEMIC

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

3.1 Timeline and epidemiology

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

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

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

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

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

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

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

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

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

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

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

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

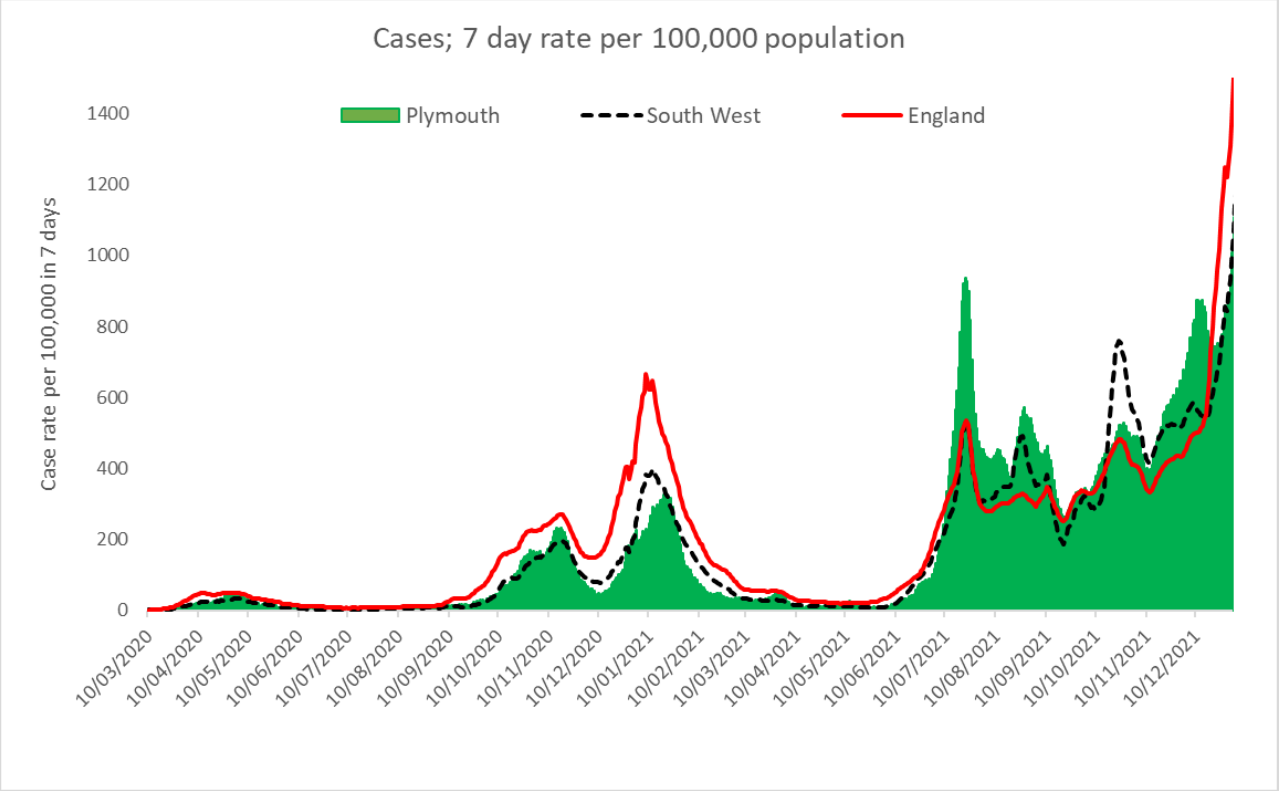


Figure 1. Case rates of COVID-19 from the start of the pandemic. In the early stages, testing was not widely available so the true rates will have been higher. Source; UK Government at https://coronavirus.data.gov.uk/

3.2 Longer term view

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

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

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

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

3.3 The impacts of COVID-19

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

DIRECT IMPACTS

Infection with COVID-19

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

INDIRECT IMPACTS

Impacts on

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

Impacts of changes to

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

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

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

3.3.1 COVID-19-related health inequalities

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

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

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

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

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

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

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

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

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

3.4 A focus on COVID-19 and mental health

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

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

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

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

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

3.4.1 Mental health and wellbeing during COVID-19

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

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

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

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

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

3.4.2 Future mental health needs

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

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

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

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

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

A collated summary of these discussions is presented below:

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

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

3.4.3 Conclusions from evidence and intelligence

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

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

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

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

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

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

3.4.4 Mental Health Concordat

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

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

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

The PHE Prevention Concordat for Better Mental Health consensus statement.

The undersigned organisations agree that:

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

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

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

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

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

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

3.4.5 Ongoing developments

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

4 LIVED EXPERIENCES OF COVID-19

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

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

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

4.1 Good Neighbours Scheme - Supporting Vulnerable and Diverse Communities

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

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

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

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

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

THE PLYMOUTH
GOOD NEIGHBOURS
SCHEME

Coordinating our voluntary response to coronavirus

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

4.2 Young People's concern for others

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

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

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

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

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

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

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

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

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

With thanks to Merafield Care home for sharing this story.

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

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

What impact did that have in the care home?

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

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

4.4 Lived experiences of Long COVID

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

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

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

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

Impact of long COVID – hear from Melanie

Impact of long COVID - hear from Tracey

Impact of long COVID - hear from Tracey's girls

4.5 Pandemic Poetry

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

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

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

Love Letter

By Paula Moore

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

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

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

Reproduced from Poetry and COVID

4.6 The corona files; a journal of the pandemic year

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

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

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

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

5 NEXT STEPS FOR THRIVE PLYMOUTH

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

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

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

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

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

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

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

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Health and Wellbeing Board

Date of meeting:	30 June 2022
Title of Report:	**THRIVE PLYMOUTH YEAR SEVEN (2022/23) LISTEN AND RECONNECT**
Lead Member:	Councillor Dr John Mahony
Lead Strategic Director:	Ruth Harrell (Director of Public Health)
Author:	Abenaa Gyamfuah-Assibey
Contact Email:	Abenaa.gyamfuah-assibey@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 which aims to reduce health inequality in the city. 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.

The COVID-19 pandemic highlighted that the health inequalities persisting in our society affect the things which enable us to live well. 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 and apply to the wider challenges of inequality.

The summary paper provides further details on the rationale behind Year 7 and describes some of the activities that the partnership of Thrive Plymouth has enabled.

Recommendations and Reasons

The Health and Wellbeing Board notes the content of the summary paper.

Alternative options considered and rejected

Not applicable

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.*
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 <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.22.23.47	Leg	EJ/38810	Mon Off	N/A	HR	N/A	Assets	N/A	Strat Proc	N/A
Originating Senior Leadership Team member: Ruth Harrell											
Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 25/05/2022											
Cabinet Member approval: Councillor Mahony approved verbally in briefing meeting Date approved: 15/06/2022											

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THRIVE PLYMOUTH YEAR SEVEN (2022/23) LISTEN AND RECONNECT

Office of the Director of Public Health

1. HEADLINES FOR THRIVE PLYMOUTH YEAR 7 - Update

Through the launch and listen and reconnecting workshops, over 100 people have directly engaged in Thrive Plymouth Year 7 events. This includes over 100 people who attended the launch in May 2022 and 30 in workshop attendees over the last month.

Key achievements have been:

- New Thrive Plymouth Members
- Pandemic reflection stories and enablers of health and wellbeing during the pandemic
- Network members and organisations trained in listening skills and behaviour change tools
- Dissemination of Mental Health Awareness Week Campaign
- Connection between and engagement in projects health and wellbeing projects such as Belong in Plymouth, NHS Health Check review, Compassionate City
- Co-production of city wide training module 'Trauma informed approaches for workplaces' to support wellbeing at work

Network meetings will be planned over the year to continue our efforts to reconnect the Thrive Plymouth Network and as a city. Meetings will provide an opportunity reflect on the impact of pandemic on health inequalities, review progress on previous Thrive Plymouth campaigns, work on this year's actions and consider actions for future years.

1. Background to the Thrive Plymouth programme

People's lifestyles (whether they smoke, how much they drink, what they eat, and whether they take regular exercise) affect their health and wellbeing. Each of these lifestyle risk factors is unequally distributed in the population. Although, the overall proportion of the English population that engages in three or four of these behaviours (to an unhealthy extent) has declined in recent years, these reductions have been unequal as they have been seen mainly among those in higher socio-economic and educational groups. Therefore, although the health of the overall population has improved (as a result of the decline in these behaviours), the poorest, and those with least education, have benefitted least, leading to widening inequalities and avoidable pressure on health and social care services.

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

It is being led by the Office of the Director of Public Health, Plymouth City Council. The campaign 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 campaign will also have a specific annual focus.

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

2. Annual campaigns

As well as the ongoing focus on the four behaviours mentioned above, there is also an annual focus as follows:

- 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

3. Thrive Plymouth Year Seven – Listen and Reconnect

Thrive Plymouth Year 7 (TPY7) will seek 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 name of the campaign for the year is 'Listen and Reconnect'. TPY7 will use this year to focus on listening and reconnecting across the 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 are lifted, 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.

Training workshops will be offered and network meetings will be hosted. Working with partners and the Thrive Plymouth Network we will seek to encourage participation in these workshops which will be held in community spaces and wellbeing hubs across the city.

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.

4. TPY7 Listen and Reconnect in summary

The main programme for the year will focus 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 TPY7 campaign is keen to showcase and support approaches, and projects, used locally to 'listen and connect'. Case studies and our training offer will form the basis for the subsequent Director of Public Health Annual Report.

We co-designed the year's training offer with Livewell Southwest, Theatre Royal Plymouth, Public Health Team and St Luke's Hospice Plymouth.

The offer will 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.

5. TPY7 Listen and Reconnect in detail

Each year the Thrive Plymouth annual focus is launched formally through an event. This launch event took place online via MS Teams on **Monday 11th May from 9.30am-1.00pm**.

Since the pandemic, the number of Thrive Plymouth Network members has decreased due to a large number leaving their organisations. We therefore agreed to extend invitations beyond the Thrive Plymouth Network who are traditionally voluntary organisations and health and social care groups, to grow our reach. This included:

- Schools
- Businesses
- Health and social care
- Voluntary Organisations
- Community Groups
- People who work with children, young people and vulnerable people/complex lives
- Those interested in making a difference to health, wellbeing and/or health inequalities

Our partner's hosted training workshops with over 100 spaces offered in total. This took place following the launch to enable people in developing the tools and skills to meaningfully listen and-reconnect within their organisations and community. These were delivered online and face-to face in order to provide partners and the Thrive Network an opportunity to reconnect, in person, at health and wellbeing hubs across the city. The training workshops are listed below:

- **Appreciative Inquiry** Delivered by Plymouth City Council
  Appreciative Inquiry is a technique used to help understand and facilitate change in complex systems. It starts with understanding how people experience a system and then using this to deliver a real cultural change within their organisation.

- **Compassionate Friends Awareness Session** Delivered by St Luke's Hospice Plymouth
  A Compassionate Friend lends a helping hand, or listening ear, to people who have a life limiting illness or are affected by loss and bereavement. Our awareness session builds compassionate friends' skills and confidence in order to have open, honest and sensitive conversations, while equipping them with skills to think about ways they can help and support their peers, colleagues and communities.

- **Motivational Interviewing** Delivered by Livewell Southwest
  Motivational Interviewing is an approach towards behaviour change across a range of needs which embraces and enhances the person's autonomy to focus on the things that matter to them.

  This seeks to help learners:
  - Gain knowledge of the principles and ethos of Motivational Interviewing
  - Practice using Motivational Interviewing
  - Acquire Motivational Interviewing tools to use at work

- **'Our Space'** Delivered by Theatre Royal Plymouth

'Our Space' is a creative programme that works with adults and young people with lived experience of homelessness, mental health issues, reoffending, or feel socially isolated for other reasons. This workshop allows participants to see what takes place in a typical 'Our Space' session whilst gaining insight from the team about our person-centred approach.

- **Solution Focused Therapy** Delivered by Livewell Southwest
  Solution Focused Therapy is a strengths-based approach to health improvement – supporting clients to reach solutions and achieve their health and wellbeing goals.

6. TPY7 Listen and Reconnect - the 'offer' and the 'ask'

Each year the Thrive Plymouth campaign includes an offer to the city, and an ask from the city. The offer and ask for TPY7 is listed below.

Our Ask:

- Join the Thrive Plymouth network
- Attend training and workshops
- 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
- Attend a Thrive Plymouth network meeting

Our Offer:

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

7. LAUNCH EVENT MAY 2022

We launched Year 7 in May 2022 online to encourage wider participation across the city. Delegates heard reflections on the pandemic from key partners across the city. Partners included primary care, Plymouth Youth Parliament, Trevi House which supports vulnerable and disadvantaged women and mutual aid networks from across the city. Pandemic reflections not only explored the challenges to health and wellbeing but also the positives which enabled it. We set up 'Google Whiteboard' to continue collecting delegate pandemic experiences and what helped enable health and wellbeing. This board is still live to continue to collect reflections. This will be analysed and learning will inform action for future Thrive Plymouth campaigns.

Following this, we heard six, including video footage of introductions, to different models and tools being used locally to listen and reconnect. Case studies were presented to showcase how they are being used successfully to improve health and wellbeing.

We developed a package of training offers and workshops to encourage local action following the launch based on the models that were presented at the launch.

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 campaign. A summary of the pledges made since the launch are below:

- 30 people pledged to listen and connect with their community.
- 10 people pledged to do Appreciative Inquiry
- 16 people pledged to promote safe spaces for conversation, reflection connection
- 24 people pledged to attend Thrive Network Meetings
- 30 people pledged to attend workshops and share practice

8. PROGRESS ON Y7 'ASK'

It has been six weeks since the launch of TY7. Below is progress on our 'Ask' of the city following our training workshops.

Training workshops
Training workshops began on 16th May 2022 and ran over a three week period. Each partner organisation offered two training dates. In person training was held at Theatre Royal Plymouth, Four Greens Health and Wellbeing Hub –Whitleigh and Jan Cuttings Healthy Living Centre. Future workshop dates will be considered to encourage wider participation.

- 30 people attended training workshop
- Voluntary and mutual aid groups valued opportunity as costs can be a barrier to accessing training
- Participants intend use learning to support workplace wellbeing and the populations they work with
- Meeting in person provided an opportunity to connect and network

Conduct an appreciative inquiry (AI) in your community/setting
- Will use AI knowledge to support public health 'Health Checks Project'
- Will use approach to explore work place wellbeing at large employers in Plymouth

Take Compassionate Friends Awareness session into your settings/communities
- 10 made pledges to be Compassionate Friends and engage in local Compassionate Cafes which support those experiencing loss and bereavement.

Share Every Mind Matters tips for lifting people out of loneliness
- 98 impression on twitter over 24hours
- Need to conduct a further review through partners and Thrive Plymouth Network members

Promote safe spaces for conversation, reflection and connection
- In discussions with Horticultural therapy trust to promote space for listening and reconnecting
- Health and Social teams to do pandemic reflection with staff

Attend a Thrive Plymouth network meeting
- The next steps will be to plan the first network meeting taking a hybrid approach as people continue to build their confidence connecting face to face.

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Health and Wellbeing Board

Date of meeting:	30 June 2022
Title of Report:	Health and Care Skills Partnership Update
Lead Member:	Councillor Dr John Mahony
Lead Strategic Director:	Craig McArdle (Strategic Director for People)
Author:	David McAuley (Programme Director)
Contact Email:	david.mcauley@nhs.net
Your Reference:	Click here to enter text.
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
This report provides an update on recent work undertaken to develop a system wide Health and Care Skills Partnership and the subsequent delivery plan that is being co-produced by the group for the health and care system in Plymouth.

Recommendations and Reasons

For the Health and Wellbeing Board to receive the report for information and consideration.

The committee are invited to note the content of the report, acknowledging progress and successes.

To acknowledge the considerable system wide challenges and pressures that exist within Plymouth, noting plans to address workforce challenges in the short, medium and longer term.

Alternative options considered and rejected
Not applicable - report is for information only

Relevance to the Corporate Plan and/or the Plymouth Plan
This document supports the ambitions and strategic direction of the Plymouth Plan 2014-2034 principally "People in Plymouth live in happy, healthy, safe and aspiring communities." It also aligns to other strategic plans such as a Bright Future 2021-2026 and policy HEA2: Delivering the best outcomes for children, young people and families.

The plan will contribute to the delivery of the Corporate Plan priority "Caring for People and Communities".
In addition, it supports delivery of policy GRO2: Delivering skills and talent development

Implications for the Medium Term Financial Plan and Resource Implications:

The plan focuses on key areas of improvement, innovation and efficiency related to the health and care workforce. Delivery of the plan will contribute to improved system working, driving wider efficiencies and flow. It will also support the delivery of the Federated People elements of the Medium Term Financial Plan.

The plan aims to address workforce challenges facing the Plymouth health and care system.

Carbon Footprint (Environmental) Implications:
The plan will look to impact positively on this agenda through supporting low carbon travel initiatives that seeks to ensure travel across the city is more energy efficient and by more efficient deployment of the workforce, travelling should be reduced.

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.*
Delivery of the plan will contribute to our Child Poverty Agenda in supporting children and families to have the best possible start to life and stay well into adulthood. The plan will help build capacity and sustainability across the whole health and care workforce in Plymouth.

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 <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.*						
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Sign off:

Fin	N/A	Leg	N/A	Mon Off	N/A	HR	N/A	Assets	N/A	Strat Proc	N/A
Originating Senior Leadership Team member: Ruth Harrell											

Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 15/06/2022
Cabinet Member approval: Yes (Cllr John Mahony) Date approved: 15/06/2022

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Health and Wellbeing Board
Health and Care Skills Update
June 2022

Together for Plymouth

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1. Introduction	• Risks and needs • Strategic approach
2. Local context	• Priorities identified through local needs analysis • Learning from what works • Local partnerships
3. Programme Outputs	• System leadership • Partnership establishment • Development of plans
4. Outline plans	• Priority 1 – Data and market intelligence • Priority 2 – Recruitment and retention • Priority 3 – Sustainable pipeline of new recruits • Priority 4 – Communication and coordination • Priority 5 – Enabling work – digital, organisational development, estates, finance, performance data

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Introduction and Wider Context

- Workforce recruitment and retention is one of the biggest risks within the Health and Care system currently, both locally and nationally
- Devon wide (Integration Care System) workforce strategy in development. This will identify skills gaps across the system and develop a high-level approach to address these in the short, medium and long term

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Local Context

- The Plymouth Local Care Partnership (LCP); through Plymouth City Council (PCC), have established a multi-agency Health and Care Skills Partnership to bring partners together to develop a system wide solution that promotes Health and Care as a profession of choice and, to attract and train the volume of new entrants required to make the local system sustainable
- The Health and Care Skills Partnership Steering Group plans will sit underneath the Devon wide strategy. The group is developing a local delivery plan.
- The local approach builds on a model of good local practice - the blueprint of the successful PCC led “Building Plymouth skills partnership”, with the construction sector.

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Identified local issues and need

- We know local employers and providers have critical skills gaps and skills shortages, including the urgent need to recruit 500+ care workers and domiciliary support workers. This creates system wide pressures.
- Current real-time Labour Market Intelligence has identified nearly 2,800 new jobs in Plymouth's health and care sector between now and the next 18 months
- We need to be better able to attract, develop and retain a skilled workforce that will be capable of delivering the strategy for health and care – to meet short, medium and long term demand

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Progress to date

- PCC Recruitment campaign – innovative approach to working with recruitment agency to attract staff . Described as “inspirational” in recent LGA review)
- Plymouth City Council (PCC) have invested in 2 Health and Care coordinators to build capacity to deliver local plans (now in post). Over 50 people recruited to health and care roles since February.
- PCC have facilitated the establishment of, and Chair the Health and Care Skills Partnership
- Recruitment via Job Centres and Job Shops with DWP
- System wide recruitment and retention work
- Engaging with the Lighthouse Lab staff at risk of redundancy
- Plymouth Prospectus – harvesting existing material and literature to portray Plymouth as desirable location to live and work

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Programme Outputs

- Provide system leadership to engage partners and develop whole system approach “joining dots” and realising the benefits of systemic working
- Working with partners, develop pathways across the Plymouth system to attract, train, recruit and retain people into Health and Care careers
- Describe agreed proposals in the form of a plan, with clear timelines, milestones and goals
- Monitoring of progress in terms outcomes

Delivery Plans

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Priority 1

To gather data and intelligence that will inform the development of our plan

Understand the current (and on-going) levels of vacancies within the health and care system)

Use the local population profile to understand how levels of need will impact upon workforce requirements

Success Measures

· Plans will be based on best evidence and align with strategic drivers and the needs of the population

Begin scoping the future configuration of the Plymouth health and care system based on best evidence and strategic drivers

Delivery Plans

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Review other identified recruitment issues e.g. pay and conditions and

Using exit interview data and other available intelligence, identify reasons for people leaving

Explore supportive incentives e.g. subsidised housing, flexible career pathways

Create more joint appointments, rotational posts and flexible roles that span systems and pathways.

Priority 2

To attract and retain individuals into health and care careers

Success Measures

· Number of vacancies will decrease
· Sufficient capacity to deliver plans
· Numbers of applicants increase-
- The number of people leaving health and care will decrease

Appointment of 2 Health and Care coordinators

Creating a collaborative training offer

Develop local programme of recruitment campaigns supported by a partnership with a recruitment agency to increase numbers applying for care sector roles

Develop a single health and care prospectus for Plymouth

Recruit internationally into vacancies

Delivery Plans

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Comms programme myth busting perceptions of health and care

Develop and maintain visibility and active recruitment within all schools

Develop a workforce model that articulates the roles required, the predicted numbers for each role and an understanding of the number of recruits required

Priority 3

To develop a sustainable planned pipeline of people who want to work in health & social care, in Plymouth

Create an active recruitment programme for veterans

Every secondary school/college in Plymouth to have a Proud to Care Ambassador

Success Measures

- Adequate flow of recruits into health and care roles
- Full employment across health and care roles

Engage and maximize the private, voluntary sector as equal partners in the system

Sufficient teaching and training capacity

Create opportunities for the long term unemployed and disabled

Delivery Plans

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Priority 4

To effectively coordinate communication across the partnership and to potential applicants

Communicate clearly to potential and existing staff the different roles and training pathways across the system.

Clear points of contact are identified

Success Measures

· Clear lines of communication and leadership are identified
· The number of applicants for health and care careers increase

Myth busting material and comms plan developed to support recruitment

Delivery Plans

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Review rostering systems that allow and enable flexible working

Monitor and review an agreed set of success indicators e.g. vacancies, applications for courses, people leaving etc..

Priority 5

To ensure that enabling work supports the delivery of the health and care skills programme

Success Measures

· The workforce is efficient and effective
- Reduction in leavers from health and care roles
- The Plymouth Health and Care Skills Partnership Delivery Plan is effective

Enable new technology introduction through identification of best practice and provision of training

Prepare staff for change and supporting new technology introduction through removal of barriers to change.

Using leadership programme, identify key issues that representatives from the partnership can focus on as a discreet programme of work

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Summary & Next Steps

Next Steps:

Plymouth LCP have established a system wide Health and Care skills partnership that aims to address the recruitment and retention challenges within the health and care workforce. The LCP are aiming to:

- Build on good practice and partnerships spanning several years.
- Pursue and develop international recruitment campaign
- Codify existing work to develop a “Plymouth Prospectus”.
- Gather data and workforce projections
- Explore and deliver programme of recruitment and retention incentives
- Expand programme architecture, including leads and detailed plan
- Deliver a system wide plan that addresses the workforce challenges across Plymouth

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Health and Wellbeing Board

Date of meeting:	30 June 2022
Title of Report:	Integration White paper Update
Lead Member:	Councillor Dr John Mahony
Lead Strategic Director:	Craig McArdle (Strategic Director for People)
Author:	David McAuley (Programme Director)
Contact Email:	david.mcauley@nhs.net
Your Reference:	Click here to enter text.
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report

This report provides an update and forward plan on the recently published White Paper "Health and Social Care integration: Joining Up Care for People, Places and Population. The paper was published by the HM Government on 9th February 2022.

The aim of the paper is to escalate the scale and pace of health and care integration, to improve access, experience and outcomes for individuals and populations.

The white paper sets out progress on integration and the case that joined up and person-centred care and support is better for people and places; leads to better services and better health and wellbeing outcomes; and makes the best use of NHS and local authority resources. It also emphasises the need for a preventative approach to build health resilience in people and places. It acknowledges the progress that has already been made, including through the Better Care Fund, Sustainability and Transformation Partnerships, health devolution and the joined-up response to support and protect communities through the pandemic.

The white paper is one of a suite of reforms of the health and care system, including the "Build Back Better: Our Plan for Health and Social Care" https://www.local.gov.uk/parliament/briefings-and-responses/lga-response-people-heart-care-adult-social-care-reform-white, the Adult Social Care Reform white paper, People at the Heart of Care ,the Health and Care Act (2022).

Recommendations and Reasons

For the Health and Wellbeing Board to receive the report for information and consideration.

The Health and Wellbeing Board are invited to note the content of the report.

To acknowledge the considerable progress made on the integration agenda in Plymouth already, recognising the strong position Plymouth is placed, moving forwards.

Alternative options considered and rejected

Not applicable - report is for information only

Relevance to the Corporate Plan and/or the Plymouth Plan
This document supports the ambitions and strategic direction of the Plymouth Plan 2014-2034 principally "People in Plymouth live in happy, healthy, safe and aspiring communities." It also aligns to other strategic plans such as a Bright Future 2021-2026 and policy HEA2: Delivering the best outcomes for children, young people and families.

The plan will contribute to the delivery of the Corporate Plan priority "Caring for People and Communities".
In addition, it supports delivery of policy GRO2: Delivering skills and talent development

Implications for the Medium Term Financial Plan and Resource Implications:

The White Paper supports the delivery of the Plymouth LCP Plan (2021-2024) which focuses on key areas of improvement, innovation and efficiency related to the health and care workforce. Delivery of the plan will contribute to improved system working, driving wider efficiencies. It will also support the delivery of the Federated People elements of the Medium Term Financial Plan.

Carbon Footprint (Environmental) Implications:
The plan will look to impact positively on this agenda through supporting low carbon travel initiatives that seeks to ensure energy use across the city is more energy efficient

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.*

Implementation of the proposed changes will mean local leadership taking on delegated responsibility for the delivery of improvement and delivery plans across the City. A process of due diligence and a maturity assessment will be required both locally and by the Integrated Care Board to determine readiness and support required to enable a smooth transition.

Appendices
**Add rows as required to box below*

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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.

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	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
Originating Senior Leadership Team member: Ruth Harrell											
Please confirm the Strategic Director(s) has agreed the report? Yes Date agreed: 15/06/2022											
Cabinet Member approval: Yes (Cllr John Mahony) Date approved: 15/03/2022											

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Local Care Partnership (LCP)

Plymouth Local Care Partnership is one of five Local Care Partnerships across the Devon Integrated care system. "Together for Plymouth" reinforces the collective intent for collaborative working to solve some of the deep-rooted challenges we face and to create a step change in system transformation. The primary purpose of the Partnership is to provide leadership and oversight to our ambition of creating an integrated system, which puts the needs of our population ahead of that of any single organisation.

The overarching aims of the Partnership are:

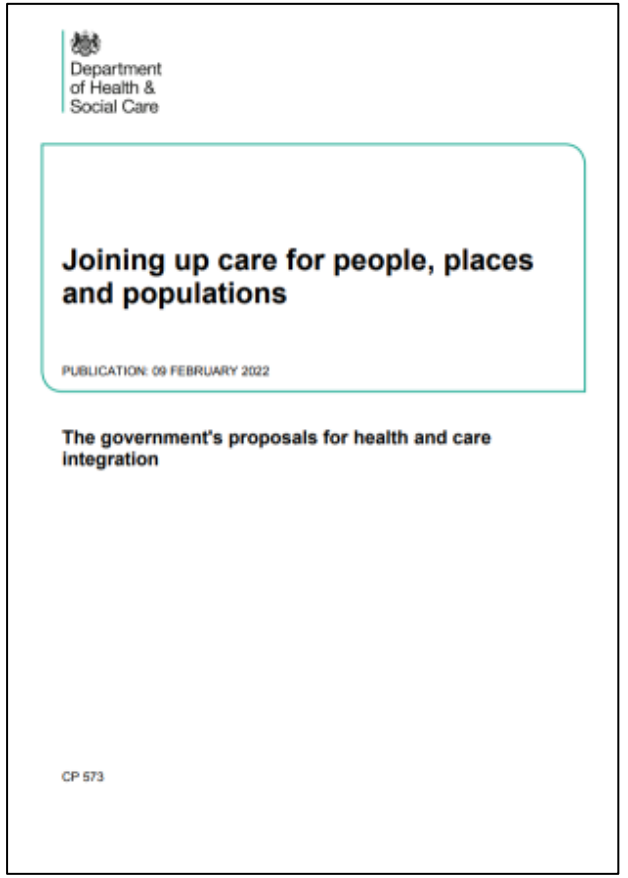
- Improve health and wellbeing outcomes for the local population
- To reduce inequalities in health & wellbeing of the local population
- To improve people's experience of care
- To improve the sustainability of the health and wellbeing system
- To develop into autonomous "place based" partnership with delegated responsibility from the ICB

Overview

The DHSC published a new integration white paper on 9th February 2022, 'Joining up care for people, places and populations'. The paper supports place-based partnerships to develop and mature by setting out a number of key deliverables.

It aims to:

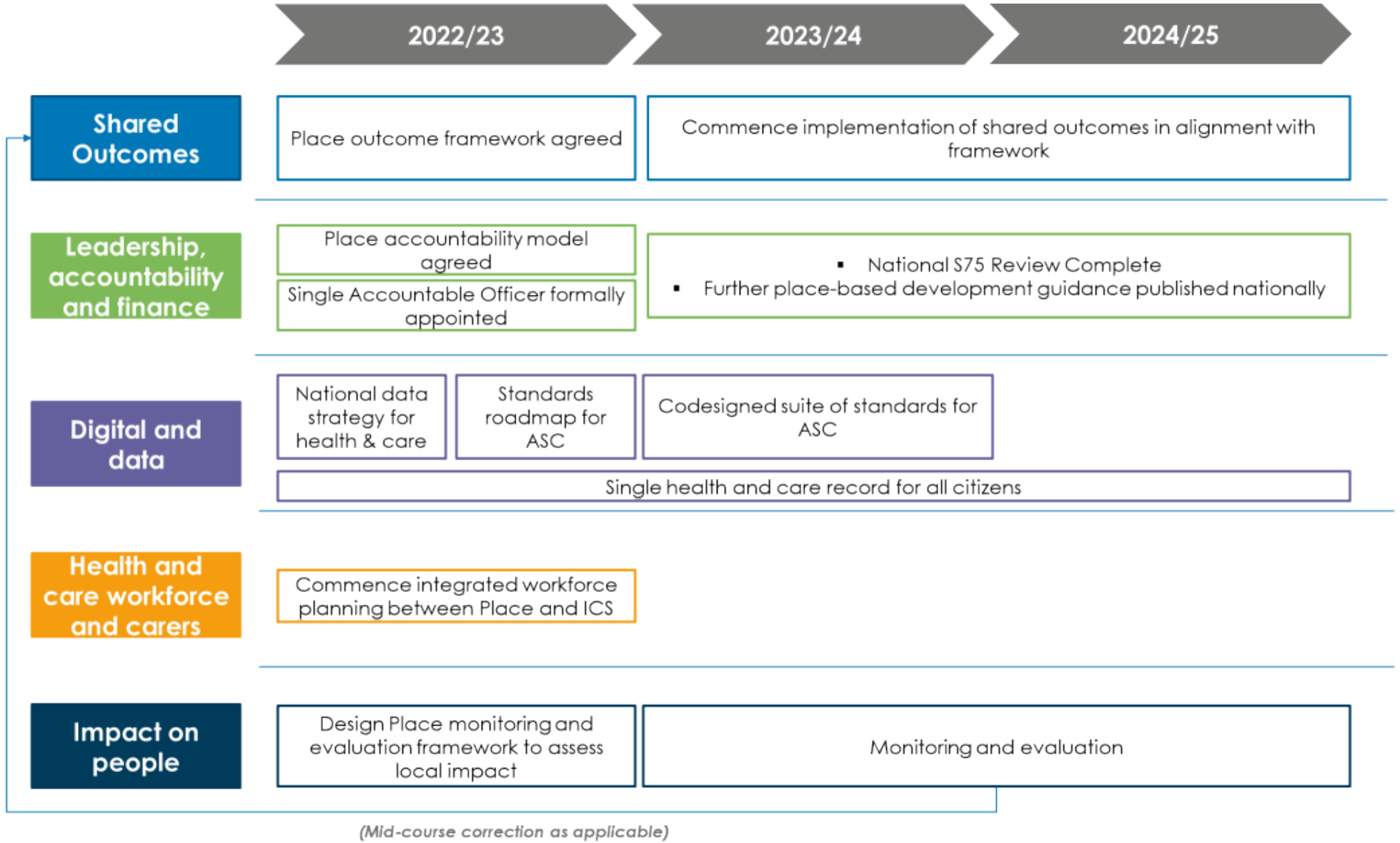
- Accelerate **better integration** across primary care, community health, adult social care, acute, mental health, public health and housing services which relate to health and social care.
- **Children's social care is not included** within the scope of the paper, and it is left to places to consider the integration between and within children and adult health and care services.
- Overall, the document is **not prescriptive. For example: "**To make integration a reality places must consider integration in a way that meets the local needs."



Key areas of focus for place-based development

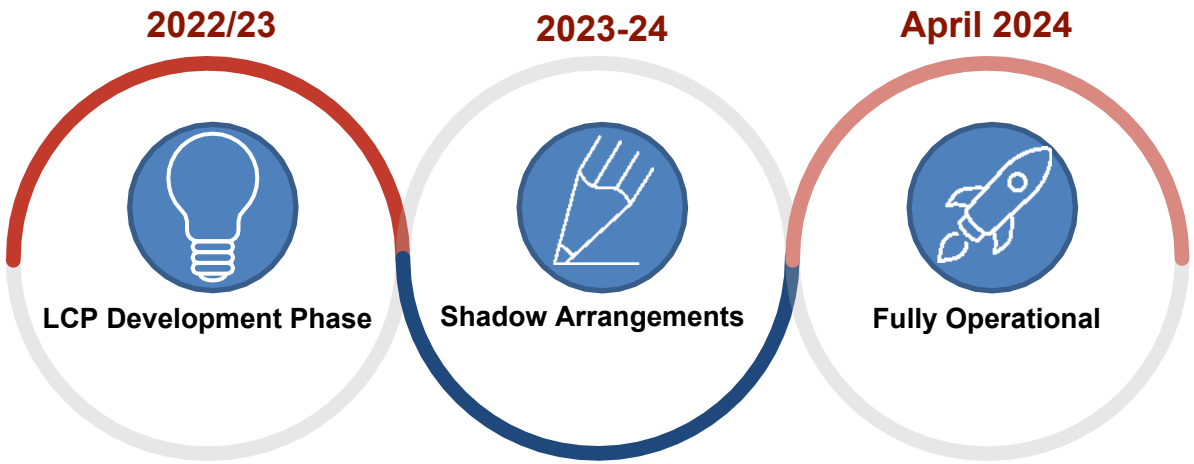
Shared Outcomes	Leadership, accountability and finance	Digital and data	The health and care workforce and carers	Impact on people
▪ Create a **framework with national and local outcomes** by Spring 23 ▪ Alignment will be reviewed with other priority setting exercises and outcomes frameworks across health and social care ▪ Ensure implementation of shared outcomes will begin from April 2023	▪ All Places to **'adopt a governance model'** by 2023. ▪ A **single person, accountable** for the delivery of the shared plan and outcomes for Place ▪ **National leadership programme** will be developed and rolled out for Places ▪ A **model of accountability** and provide clear responsibilities for decision making by Spring 23 ▪ **CQC assessment to align** with new accountabilities ▪ **S75 of the Health Act 2006 will be reviewed and simplified**, followed by guidance to go further & faster on pooled budgets by Spring 23	▪ **Data Strategy for Health and Care** will be published (Winter 21/22) ▪ Ensure every health and adult social care provider within an ICS to reaches a **minimum level of digital maturity** ▪ **Single health and adult social care record** for each citizen (by 2024) ▪ Implement a **population health platform** with care coordination functionality ▪ Develop a standards roadmap (2022) and co-designed **suite of standards for adult social care** (Autumn 2023) ▪ **1m people to be supported by digitally enabled care** at home (by 2022)	▪ **Strengthen the role of workforce planning at ICS and place** levels ▪ **Review barriers** to flexible movement and deployment of health and care staff at place level	▪ **Monitoring and evaluation framework**

Timeline for place development



Development arrangements for Local Care Partnerships – timeline

The Locality Executive Committee will develop over time to undertake more delegated decisions as the scope and functions of the LCPs mature.



The Locality Executive Committee will function as a collaborative forum underpinned by a partnership agreement/MOU.

Decisions are made within current organisational frameworks and in alignment with the ICS Operating Model.

Delegated NHS/Council decisions can be made for specifically agreed service changes aligned to LCP priorities.

Delegated authority is scaled, and the Locality Executive Committee becomes collectively accountable for population health and wellbeing outcomes.

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Health and Wellbeing Board

Date of meeting:	30 June 2022
Title of Report:	**Health and Care Act 2022 Briefing**
Lead Member:	Councillor Dr John Mahoney (Cabinet Member for Health and Adult Social Care)
Lead Strategic Director:	Craig McArdle (Strategic Director for People)
Author:	Sarah Gooding (Policy & Intelligence Advisor)
Contact Email:	Sarah.Gooding@Plymouth.gov.uk
Your Reference:	HWB PB 300622
Key Decision:	No
Confidentiality:	Part I - Official

Purpose of Report
To provide the Health and Wellbeing Board with an overview of the Health and Care Act 2022 and associated new duties.

Recommendations and Reasons
For the Health and Wellbeing Board 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

The health and wellbeing strategy for Plymouth is incorporated into the Plymouth Plan.

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 Care Act 2022 Briefing							

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	N/A	Leg	N/A	Mon Off	N/A	HR	N/A	Assets	N/A	Strat Proc	N/A
Approved by: N/A Date approved: N/A											

HEALTH AND CARE ACT 2022

Policy Briefing – June 2022

Introduction / Background

The Health and Care Act, which received Royal Assent in April 2022, introduces significant reforms to the organisation and delivery of health and care services in England. It builds on proposals for legislative change set out in the NHS England Long Term Plan and will be backed by £36 billion over the next 3 years through the Health and Care Levy. The main purpose of the Health and Care Act is to establish a legislative framework that supports collaboration and partnership-working to integrate services. Among a wide range of other measures, the Act also includes targeted changes to public health, social care and the oversight of quality and safety.

Health and Care Act – Key Measures on Integration

Integrated Care Systems

The Act places Integrated Care Systems (ICS) on a statutory footing and ensures that every part of England will be covered by an ICS. It also introduces Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs) and this will take place on 01 July 2022.

The legislation did not stipulate for a one-size-fits-all approach but aims for flexibility for local areas to determine the best system arrangement for them and build on existing partnerships at place and system level.

Integrated Care Boards

Integrated Care Boards (ICBs) will be responsible for the NHS functions of an ICS. This means that CCGs will be absorbed into their local ICSs. Their commissioning powers and the majority of their staff will become part of the ICS body. These powers will sit within the ICB, which will manage NHS commissioning and funding within ICSs.

Integrated Care Partnerships

Each ICB and 'responsible' local authority in the area must establish an Integrated Care Partnership (ICP). Membership of the ICP must include local authorities in ICS area and local NHS, but wider membership is for local determination. The Chair is to be jointly selected by NHS and local authority and can be same chair as NHS ICS Board. The establishment of ICPs is intended to bring together the NHS, local government and other local partners to support integration.

Integrated Care Strategies

Each ICP is required to produce an integrated care strategy setting out how to meet the needs of the population – as identified in the joint strategic needs assessments from the health and wellbeing boards that fall within the area of the ICB – through the exercise of functions by the ICB, NHSE and the upper tier local authorities. Local Healthwatch must be involved in the strategy, as well as people who live or work in the area. The strategy must address whether the needs could be met more effectively through the use of NHS/local authority section 75 agreements and may include a view on how health and social care could be more closely integrated with health-related services.

Each time an ICP receives a Joint Strategic Needs Assessment (JSNA), it must consider whether the current integrated care strategy should be revised. ICPs must publish their strategy and give a copy to each responsible local authority, and to each partner ICB of those local authorities.

Guidance on integrated care strategies is due in July 2022. DHSC has stated it will[1]:

- include in its guidance, recommendations for ICPs on who to consider engaging in the preparation of their integrated care strategies
- produce guidance setting an expectation that the ICP should consult local children's leadership, and children, young people, and families themselves, on the integrated care strategy
- ensure that guidance for the integrated care strategy is aligned with guidance for ICBs and providers on working with people and communities
- refresh guidance for Health and Wellbeing Boards in light of the wider system changes

Joint Health and Wellbeing Strategies

Joint health and wellbeing strategies will be known as joint local health and wellbeing strategies. When a responsible local authority and each of its partner ICBs receives an integrated care strategy from the ICP, they must consider whether any existing joint local health and wellbeing strategies sufficiently address how needs will be met. If existing strategies do not address this sufficiently, a new joint local health and wellbeing strategy must be prepared. The health and wellbeing strategy for Plymouth is incorporated into the Plymouth Plan.

A responsible local authority and each of its partner ICBs must have regard to:

- Joint strategic needs assessments in responsible local authority areas
- Any integrated care strategy that coincides with or includes the whole or part of a responsible local authority area
- Any joint local health and wellbeing strategy prepared by a responsible local authority and its partner integrated care boards

Other Duties

Triple Aim

Integration will be supported by a broad duty to collaborate across the health and care system and new duties have been introduced to ensure the wider effects of decisions are considered. NHS England must consider the effects of its decisions on:

- people's health and wellbeing
- quality of NHS services
- efficiency and sustainability of NHS resources

Inequalities in health, wellbeing and the quality of services must be considered as part of the triple aim. This duty also applies to ICBs and NHS trusts and foundation trusts. NHS England has the power to produce guidance on this duty, must consult before publishing the guidance, and must have regard to it when it is in place.

Duty to Consult

In its responsibilities for public involvement and consultation under section 13Q of the National Health Service Act 2006, NHS England has a duty to consult individuals to whom services are being or may be provided, in the planning and development of commissioning arrangements for those services. The Act extends this to include "carers and representatives" of people receiving a service or who may do so. The extension of this duty is replicated in an equivalent duty on ICBs.

[1] Integrated care partnership (ICP): engagement summary - GOV.UK (www.gov.uk)

Joint Forward Plans

Before the start of each financial year, each ICB and their partner NHS trusts and foundation trusts must publish a five-year joint forward plan, setting out how they propose to exercise their functions, including proposals for health services, and action on the ICB's general duties and financial duties. Plans must describe any steps taken to implement relevant joint local health and wellbeing strategies, to address the needs of children and young people under 25, and to address the needs of victims of abuse, whether adult or children. The ICB and its partner trusts must have regard to the plan.

The ICB and its partner trusts must consult people for whom the ICB has core responsibility and any others as appropriate and must involve each relevant health and wellbeing board (HWB) in preparing or revising the plan. Each HWB must be given a draft of the plan, or any revised plan, and be consulted on whether it takes proper account of each joint local health and wellbeing strategy. HWBs must respond with their views on this. HWBs may give their views to NHSE, informing the ICB and partners if they do so.

A copy of published plans must be given to the system's ICP, each relevant HWB and NHS England. Published plans must include a summary of views from consultation and how these were taken into account, and the final opinions of each relevant HWB. A HWB may give NHSE its opinion on whether a published plan takes proper account of each joint local health and wellbeing strategy and if it does so, must give the ICB and its partners a copy of this opinion.

Joint Capital Resource Use Plan

Before the start of each financial year, each ICB and its partner trusts must prepare and publish a plan setting out their planned capital resource use covering a period specified in a direction by NHSE. A copy of the plan must be given to the relevant ICP, HWB and to NHSE. Joint capital resource use plans may be revised.

Annual Report and Performance Assessment

Each ICB must produce and publish an annual report on how it has discharged its functions in the previous financial year and this report must also describe performance on the forward plan and on the capital resource use plan. Each ICB must review what has been done to implement any joint local health and wellbeing strategies and consult with relevant HWBs on this review. It must also review the extent to which it has exercised their functions consistently with NHSE's views about how powers in relation to information on inequalities. The annual report must cover information relating to mental health expenditure.

NHSE must conduct a performance assessment and publish a report on each ICB covering every financial year. In doing this they must consult each relevant HWB on its views on what the ICB has done to implement relevant joint local health and wellbeing strategies.

Care Quality Commission (CQC)

The Act introduces new duties that extend the role of the CQC in two areas: integrated care systems and local government adult social care. The CQC will review healthcare and adult social care in each ICB, with reviews covering how partners work together in the integrated care system. Priorities for reviews will be set by the Secretary of State and include leadership, integration, quality and safety. Reviews will assess the provision of the NHS, public health and adult social care, the activities of the ICB, local authorities and provider in relation to the care and the function of the whole system including the ICP.

Health and Care Act - Other Measures

As well as progressing integration, the Act also does a number of other things including formalising the merger of NHS England and NHS Improvement with the resulting body, NHS England, now responsible for providing 'unified, national leadership for the NHS'. The Act also introduces targeted changes to public health such as limiting the advertisement of junk food and to social care by creating a framework for assuring commissioners and sharing data. The Act formalises the role of the Health Services Safety Investigations Body – an independent body to investigate patient safety issues in England.

Legislation to allow a cap on care costs was already in place in the Care Act 2014 but implementation was postponed. The Health and Care Act 2022 amends the Care Act to change the cap-and-floor model of social care funding which will be implemented from October 2023. The changes will mean that local authority contribution towards paying for a person's care would no longer be counted towards the cap on their total costs.

The Health and Care Act is part of a wider range of policy reforms aimed at transforming health, care and wellbeing, supporting better health and care integration, and tackling growing health inequalities.

Other key publications include:

- The health and care integration White Paper 'Joining up care for people, places and populations'
- The adult social care reform White Paper 'People at the heart of care'
- The 'Levelling up the United Kingdom' White Paper
- The Government's plan for healthcare, adult social care, and new funding 'Build Back Better: Our Plan for Health and Social Care'
- A White Paper on health disparities (due later in 2022)

Health and Well Being Board

1. FUNCTIONS

The council's function relating to its Health and Wellbeing Board under Part 5 of the Health and Social Care Act 2012 as amended (2.2 below).

2. RESPONSIBILITIES OF HEALTH AND WELLBEING BOARD

2.1 The purpose of the Board is to promote the health and wellbeing of all citizens in the City of Plymouth. The Board has three principles of working cooperatively which are to:

- Work together with all city partners and with those we serve to take joint ownership of the sustainability agenda
- Ensure systems and processes will be developed and used to make the best use of limited resources, every time
- Ensure partners move resources – both fiscal and human to the prevention and health and wellbeing agenda

2.2 The Board will identify and develop a shared understanding of the needs and priorities of local communities in Plymouth through the development of the Plymouth Joint Strategic Needs Assessment (JSNA). Specifically, the Board will ensure that:

- A Joint Health and Wellbeing Strategy for Plymouth is prepared and published to ensure that the needs identified in the JSNA are delivered in a planned, coordinated and measurable way.
- The Plymouth JSNA is based on the best evidence and data available so that it is fit for purpose and reflects the needs of local people, users and stakeholders
- The JSNA drives the development of the Joint Plymouth Health and Wellbeing Strategy and influences other key plans and strategies across the city
- Plymouth City Council, Devon Clinical Commissioning Group and NHS England Area Teams demonstrate how the JSNA has driven commissioning decisions

2.3 The Board will:

- Develop an agreed set of strategic priorities to focus both collective effort and resources across the city
- Seek assurance that commissioners plans are in place to deliver the Board's strategic priorities and outcomes
- Review the commissioning plans for healthcare, social care and public health to ensure that they have due regard to the Joint Plymouth Health and Wellbeing Strategy and take appropriate action if they do not
- Ensure that appropriate structures and arrangements are in place to ensure the effective engagement and influence of local people and stakeholders
- Represent Plymouth in relation to health and wellbeing issues across the sub regional and at national level
- Work closely with Plymouth Healthwatch ensuring that appropriate engagement and involvement with existing patient and service user involvement groups takes place

- Retain a strategic overview of the work of commissioners in the city

- Support joint commissioning of NHS, social care and public health services and identify those service areas in Plymouth where additional improvements in joint commissioning could achieve the Board's priority outcomes
- Recommend the development of aligned or pooled budgets and encourage partners to share or integrate services where this would lead to efficiencies and improved service delivery

3. MATTERS DELEGATED TO OFFICERS

3.1 The Strategic Director for People, Director of Public Health and Director for Children Services are authorised to carry out all other functions in respect of health and wellbeing in accordance with the officer scheme of delegation of functions.

4. GENERAL

Membership
4.1 The Council's Health and Wellbeing Board is comprised of:
A core membership being -

- The Cabinet Member responsible for Health and Adult Social Care
- The Cabinet Member responsible for Children and Young People
- The opposition member
- Chair of the Local Care Partnership
- The Strategic Director of Public Health
- The Strategic Director for People
- The Service Director for Community Connections
- Director for Children Services
- One representative from the Devon Clinical Commissioning Group
- One representative of the local Healthwatch

Reflecting the approach to engage with customers and other stakeholders over the city's key priorities, the Board will co-opt additional partners which it considers are most likely to be able to work together to deliver the vision. The Board will make recommendations to the city council for appointments to the Board.

4.2 The Health and Wellbeing Board is a committee of the council under the Local Government Act 1972. The Local Authority (Public Health, Health and Wellbeing and Health Scrutiny) Regulations 2013 have dis-applied aspects of the Act which have been incorporated into these terms of reference.

4.3 The Board will act in accordance with the council constitution unless this conflicts with law.

4.4 Meetings

The Health and Wellbeing Board will meet four times per year. The date, time and venue of meetings will be fixed in advance by the Board and an annual schedule of meetings will be agreed by council. Additional meetings may be convened at the request of the Chair. Meetings will be webcast and utilise social media tools to allow real time interaction with the meeting.4.5 Voting
In principle, decisions and recommendations will be reached by consensus. In exceptional circumstances and where decisions cannot be reached by a consensus of opinion and/or there is a need to provide absolute clarity on the will of the Board to executive bodies, voting will take place and decisions will be agreed by a simple majority of all members (councillors and co-opted members) present.
Where there are equal votes the Chair of the meeting will have the casting vote.

4.6 Declaration of Interests
Members of the Health and Wellbeing Board will promote and support high standards of conduct and as such will be subject to the council's code of conduct. Members of the Board must, before the end of 28 days beginning with the day on which they become a member of the Board, notify the authority's monitoring officer of any disclosable pecuniary interests Notification of changes to declared interests must be made to the authority's monitoring officer within 28 days of the change taking effect.

4.7 Quorum
A quorum of one third of all members will apply for meetings of the Health and Wellbeing Board including at least one elected councillor from Plymouth City Council.

4.8 Access to Information/ Freedom of Information
Health and Wellbeing Board meetings will be regarded as a council committee for Access to Information Act purposes and meetings will be open to the press/public. Freedom of Information Act provisions shall apply to all business.

4.9 Papers
The agenda and supporting papers will be in a standard format and circulated at least five clear working days in advance of meetings. The minutes of decisions taken at meetings will be kept and circulated to partner organisations as soon as possible and will be published on the city council web site.

4.10 General Rules
The Health and Wellbeing Board will adhere to the Rules of Debate and General Rules Applying to Committees. Where there are gaps in procedure the Chair will decide what to do.

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HEALTH AND WELLBEING BOARD

Work Programme 2022 - 23

Date of meeting	Agenda item	Responsible
30 June 2022	DC & IOS Health Protection Report	Julie Frier – PCC
	DPH Annual Report & Thrive Plymouth Update	Rob Nelder / Abenaa Gyamfuah-Assibey
	Work Force Health and Skills Care Update	Craig McArdle
	White Paper on Integration	Craig McArdle
	Briefing: Health & Social Care Act 2022	Craig McArdle
	Review of Terms of Reference	Ross Jago
29 September 2022		
26 January 2023		
16 March 2023		
Items to be scheduled	NHS Long Term Plan	NHS Devon CCG
	Food Insecurity	Public Health
	Growth Board/Resurgum Board	
	Pharmaceutical Needs Assessment – Sept 2022	Public Health
	How citizens with learning disabilities and severe mental illness have fared in Covid	Livewell SW
	Projected increases in demand for MH services linked to economy and post Covid	Livewell SW
	Impact of COVID-19 Pandemic	Livewell SW / Public Health
	South West Ambulance Service	
	Safer Plymouth and Plymouth Safeguarding Board	

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