#healthyplym

Oversight and Governance
Chief Executive's Department
Plymouth City Council
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Health and Wellbeing Board

Thursday 10 January 2019
10.00 am
Warspite Room, Council House

Members:
Councillor Tuffin, Chair
Councillors Mrs Bowyer and McDonald.

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

Non-Statutory Co-opted Members: Representatives of Plymouth Community Homes, Plymouth Community Healthcare, Plymouth NHS Hospitals Trust, Devon Local Pharmaceutical Committee, University of Plymouth, Devon and Cornwall Police, Devon and Cornwall Police and Crime Commissioner 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 Council Chamber, councillors 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.

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Tracey Lee
Chief Executive

Health and Wellbeing Board

1. Appointment of Vice Chair

The Committee will be asked to appoint a Vice Chair.

2. Apologies

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

3. Declarations of Interest

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

4. Chairs urgent business

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

5. Minutes (Pages 1 - 6)

To confirm the minutes of the meeting held on 4 October 2018.

6. 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.

7. Chair's Report: (Pages 7 - 8)

8. STP Update - To follow: (To follow)

9. Aspiring Integrated Care System - Population Health Management: (Verbal)

10. Thrive Plymouth Update - People Connecting through Food: (Verbal)

11. Vaping and E-Cigarettes: (Pages 9 - 14)

12. Avoidable Deaths Approach: (Pages 15 - 36)

13. Work Programme (Pages 37 - 38)

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

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Health and Wellbeing Board

Thursday 4 October 2018

PRESENT:

Councillor Tuffin, in the Chair.
Councillor Mrs Bowyer, Vice Chair.
Councillor McDonald

David Bearman (Devon Local Pharmaceutical Committee), Carole Burgoyne MBE (Strategic Director for People), Ann James (University of Plymouth Hospitals NHS Trust), Dr Adam Morris (Livewell South West), (Sarah Lees Consultant in Public Health substituting for Ruth Harrell Director of Public Health), Alison Botham (Director of Children's Services), Professor Sara Demain University of Plymouth substituting for Professor Bridie Kent (University of Plymouth) and Dr Andy Sant (CCG) substituting for Dr Shelagh McCormick (CCG).

Apologies for absence: Craig McArdle (Director for Integrated Commissioning), Ruth Harrell (Director of Public Health) (Sarah Lees Consultant in Public Health substituting), John Clark (Plymouth Community Homes)(Sue Shaw Plymouth Community Homes Substituting), Judith Harwood (Service Director for Education, Participation and Skills), Nick Pennell (Healthwatch) (Justin Robins Healthwatch Substituting), Chief Superintendent Dave Thorne (Devon and Cornwall Police) and Professor Bridie Kent (University of Plymouth)(Professor Sara Demain University of Plymouth substituting), Dr Shelagh McCormick (CCG).

Also in attendance: Jamie Sheldon (Democratic Advisor), Claire Turbutt (Advanced Public Health Practitioner) and David McAuley (NHS).

The meeting started at 10:00 and finished at 12:30.

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.

49. **Appointment of a Vice Chair**

Councillor Lynda Bowyer was appointed as Vice Chair for this meeting.

50. **Declarations of Interest**

In accordance with the code of conduct, the following declaration of interest was made –

Name	Subject	Reason	Interest
Councillor Lynda Bowyer	Devon Wide Learning Disability Strategy.	Her son has learning disabilities.	Personal.

51. **Chairs urgent business**

There were no items of Chair's Urgent Business.

52. **Minutes**

Agreed that the minutes of 21 June 2018 were confirmed.

53. **Questions from the public**

There were no questions from members of the public.

54. **Chairs Report**

The Chair (Councillor Ian Tuffin) presented this report to the Board highlighting the following key points:

(a) Reminded the board of their role to act as system leaders on the strategic planning and co-ordination of NHS, Public Health, Social Care, Children's and Wellbeing Services;

(b) In August the CQC published their reviews of University Hospital Plymouth and Livewell Southwest. University Hospital Plymouth, was rated as Requires Improvement overall and Livewell Southwest was rated as Good;

(c) Motion of Notice - Motor Neurone Disease was proposed at Full Council on 17th September and Plymouth City Council adopted the MND charter;

(d) Plymouth City Council, Livewell Southwest and University Hospital Plymouth worked in partnership, along with the support of Scott College, to develop the Proud to Care Ambassador Programme in Plymouth. This was launched in June 2018 and to date over 70 workers from across health and social care in Plymouth have signed up to be a Proud to Care Ambassador.

Members noted the report.

55. **Director of Public Health Annual Report 2018**

Sarah Lees (Consultant in Public Health) and Clare Turbutt (Advanced Public Health Practitioner) presented the Director of Public Health Annual Report 2018 to the Board.

The following key points were highlighted to Members:

(a) the Director of Public Health had a duty to publish an independent report on a topic of their choosing;

(b) this year's report was a review of year three of the Thrive Plymouth programme;

(c) Thrive Plymouth was the Council's 10-year programme to improve health and wellbeing and reduce health inequalities in the city;

(d) each year of the campaign had a different focus;

(e) year three (which ran from October 2016 to October 2017) focused on the localisation of the national 'One You' campaign within Plymouth;

(f) One You was the national Public Health England (PHE) campaign to re-engage 40 to 60 year olds with their health.

Members agreed to -

1. making healthy growth a priority for our city and creating environments in our city where the healthy choice is the easy choice and should therefore plan for health impact assessment to be considered in all our developments and strategies.

2. use targeted media to reach those who have not engaged with One You so far and find out what will get them engaged.

3. make the most of our natural environment through low cost and fun activities that will improve health outcomes.

4. to increase the low cost/free options for improving health and wellbeing within the city,making it easier for everyone to engage with activities on their doorstep.

56. **Suicide Audit and Prevention Update**

Sarah Lees (Consultant in Public Health) presented the Suicide Audit and Prevention Update to the Board:

The following key points were highlighted to Members:

(a) the report provided the Health and Wellbeing Board with an update on local suicide prevention action and presented the latest citywide audit on deaths by suicide;

(b) local leadership for suicide prevention was the responsibility of the local authority and was provided by the Office of the Director of Public Health and through a local strategic partnership group;

(c) the Health and Wellbeing Board had previously asked to be receive occasional reports on local activity for suicide prevention and on the annual audit of deaths by suicide undertaken by the Office of the Director of Public Health. The last report was presented to the Board in October 2015.

Members agreed to –

1. Note and accept the latest suicide audit report

2. Note the progress being made by the Plymouth Suicide Prevention Strategic Partnership on delivering the annual action plan

3. Support the proposal of the Plymouth Suicide Prevention Strategic Partnership to review the scope of the citywide audit and to amend it to make it locally more appropriate [in the absence of current national guidance

4. Support the Office of the Director of Public Health in exploring the adoption of an avoidable deaths approach to consider deaths by suicide alongside drug and alcohol related deaths, to widen the scope of future audits and to develop proactive and timely sharing of information and the development of shared learning.

57. **Prevention Concordat for Better Mental Health**

Sarah Lees (Consultant in Public Health) presented the Suicide Audit and Prevention Update to the Board.

The following key points were highlighted to Members:

(a) outlined the background to the development of the Concordat, its aims and ambitions;

(b) the Prevention Concordat aimed to encourage and enable cross-sector action to promote public mental health approaches by promoting good mental health and wellbeing;

(c) the type of resources that have been developed to support the concordat and the 5 areas for collaborative action;

(d) the consensus statement developed to enable organisations to sign up to commit to work together through national and local action to prevent mental health problems and promote good mental health;

(e) opportunity for the Health and Wellbeing Board to sign the consensus statement in support of the Prevention Concordat;

(f) the existing local mechanisms through which the Prevention Concordat can be delivered and summarised some of the existing work that contributed to the aims and ambition of the concordat.

Members agreed to –

1. to sign the Prevention Concordat consensus statement to set a clear direction to the local health and social care system and the constituent parts that all should work towards a tangible increase in the promotion of mental health and wellbeing and the prevention of mental illness.

2. the Public Health team to continue to provide system leadership for the promotion of mental health and wellbeing and the prevention of mental illness.

3. confirm that the existing multi-agency groups and networks should be the basis for taking forward the Prevention Concordat.

4. ask that Public Health oversee the development of a local strategy and action plan for increasing work to promote mental health and wellbeing and prevent mental illness across the system, building on the good work already in place.

5. receive an update on progress in 12 months' time.

58. **Integrated Care System Development**

Sonja Manton (CCG) presented the Integrated Care System Development to the Board.

The following key points were highlighted to Members:

(a) the two-year STP report which has been recently published, providing the opportunity to reflect on the progress across Devon, Plymouth and Torbay over the past two years against our shared ambition;

(b) updated the board on recent national developments in relation to Integrated Care Systems and local work on developing a strategy for our system;

(c) invited members to consider how they can be involved in the system development and design work over the Autumn in relation to the emerging ICS in Devon.

The Health and Wellbeing Board noted the update.

59. **Devon Wide Learning Disability Strategy**

David McAuley (CCG) presented the Devon Wide Learning Disability Strategy to the Board.

The following key points were highlighted to members:

(a) The Health and Wellbeing Board were invited to endorse the adoption of the draft Devon Learning Disability Strategy as it has been developed in partnership with users, carers and key stakeholders.

(b) the draft Devon Learning Disability Strategy was consistent with the Plymouth Corporate Plan ambitions as well as the Plymouth City Council Integrated Commissioning Strategies.

Members agreed to endorse the strategic direction of the draft Devon Learning Disability Strategy.

60. **Work Programme**

The Board noted the work programme and were requested to email Democratic Support to add items to the work programme.

HEALTH AND WELLBEING BOARD CHAIR'S REPORT

THURSDAY 10TH JANUARY 2019

1. NCAS Conference 14-16th November

The President of ADCS, Stuart Gallimore, gave a buoyant but sobering opening address and acknowledged that this year's conference comes at a time when local government has been disproportionally affected by funding cuts when compared with other parts of the public sector. Also at a time when need continues to rise, placing ever more pressure on our services – with a significant rise in child protection activity. He went on to say that whilst historically children's services have been 'expert innovators', there is simply not enough money in the system and that nationally, local authorities needed to spend more than was budgeted in 2018/2019 to meet need.

I would encourage you to read the full speech at:

http://adcs.org.uk/assets/documentation/NCASC18_Presidents_opening_address_web.pdf

Caroline Dinenage MP – Minister of State for Care, Department of Health and Social Care addressed delegates, she was passionate about the need to ensure that the voice of Social Care was strong at a national as well as local level. She shared stories of examples where local systems are innovating with their communities to deliver improved cohesion thus reducing isolation. She discussed the merits of partnership working and the role of leaders across all sectors in working together to address rising demand and complexity of need making particular reference for a need to grow local solutions for local populations.

The conference closed with an inspiring speech from Andy Burnham – Greater Manchester Mayor. He talked about a lateral thinking approach to addressing the homelessness issues in Manchester. He described rough sleeping as one of the most "visible failures of public services" and questioned why things were not working?
He suggested that life has become more precarious with insecure work having an impact on secure housing for a number of different cross- sections of society. He was very clear that in his view Whitehall cannot deliver a solution to address local challenges since it cannot manage multi-faceted complexity therefore he challenged that if you want a 21st century solution then this needs to be community based offer built around individuals with all parties pulling together to same goal. He also suggested that local networks were imperative to improving outcomes particularly when "there will be nothing coming from the top anytime soon".

2. Local System Reviews

This Board has already been briefed on the Local System Review conducted by the Care Quality Commission in December 2017 and has delegated oversight to the monitoring of our local action plan to Scrutiny. Our plan was based around three key areas:

- Commissioning and Market Management
- Staff and Organisational Development
- System Improvement

CQC reviewed 20 local health and care systems and published their report "Beyond Barriers- How older people move between health and social care" in 2018. Their national findings noted that not all local systems were sufficiently mature to deliver fully integrated support to their local populations. It details examples of good practice, high quality care and innovative approaches. It made specific reference to the roles of Health & Wellbeing Boards in driving whole system working. The report also cites our local befriending service in addressing some of the social isolation needs across the City.

3. LGA Publication- Shifting the centre of gravity: Making place-based, person-centred health and care a reality

The LGA launched this publication at NCAS conference in November following the review of "Stepping up to the Place". Local teams met with authorities across the country to gather good practice examples and to test out the impact of funding changes, demand pressures and the impact of a challenges workforce on local areas.

The integration work that we have delivered in Plymouth has been referenced in a number of sections across the publication.

- Community based services in Plymouth- describes the integration health and social care provision delivered by Livewell Southwest.
- Shared Leadership and accountability notes Plymouth's System Leadership approach including the co-location of CCG and LA Commissioning staff
- Workforce- Plymouth's approach to aligning the workforce challenge facing health and social care services with our economic development agenda is cited as ambitious but delivering good benefits
- Funding and Resources- Plymouth's Integrated Fund and risk sharing arrangements is highlighted as a positive approach to managing budgets to deliver better outcomes for people
- Information sharing/IT- the development of our shared service provider DELT is acknowledged as a key enabler for our local system

4. MND Charter

Following on from Plymouth City Council's recent adoption of the Motor Neurone Disease Charter, an awareness session has been arranged for councillors on: Monday the 4th February 2019.

The session will be delivered by Kerry Palmer (Regional Care Development Adviser for Cornwall, Devon & Somerset Motor Neurone Disease Association) and Linda Parry (Motor Neurone Disease Association visitor) and will cover:

- What is MND?
- The impact the disease has on people's lives.
- A carer's perspective
- How charter adoption can make a positive difference and how councillors can help
- How the Motor Neurone Disease Association helps people who are diagnosed with MND and their families

Members can then continue to champion this agenda in their local communities.

PLYMOUTH CITY COUNCIL

Subject:	Vaping and E-Cigarettes
Committee:	Health and Wellbeing Board
Date:	10 January 2019
Cabinet Member:	Councillor Ian Tuffin
CMT Member:	Ruth Harrell (Director of Public Health)
Author:	Dan Preece, Advanced Public Health Practitioner
Contact details	T: 01752 304743 E: Daniel.preece@plymouth.gov.uk
Ref:	Your ref. VAPE
Key Decision:	No
Part:	I

Purpose of the report:
The purpose of the report is to inform the Health and Wellbeing Board of the latest evidence on vaping and e-cigarettes and to consider the opportunities and concerns that vaping presents. To discuss these in the context of smoking prevalence in Plymouth and the part that vaping can play in its reduction. To agree an evidenced based position on vaping that can be consistently promoted in the City.

Corporate Plan
The approach relates to A Caring Council in that it is focussed on reducing health inequality and on prevention.

Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land

There are no additional financial implications.

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

A consistent approach to vaping will support more people to stop smoking tobacco which will have health, social care and economic benefits for those people, their families and communities.

Equality and Diversity

Has an Equality Impact Assessment been undertaken? No

Recommendations and Reasons for recommended action:

That the Health and Wellbeing Board adopt the following position on vaping and e-cigarettes;

1. We recognise that e-cigarettes have a key role in driving down rates of smoking in Plymouth.

2. Vaping with e-cigarettes is estimated to be 95% less harmful than smoking tobacco.

3. Consumers and the public deserve protection from potential harms of vaping and the use of e-cigarettes through restrictions on their sale and marketing to children and controls to ensure safety and quality.
4. Stopping smoking is the best thing a person who smokes can do for their health. Our advice to smokers is to consider switching from smoking tobacco to vaping with e-cigarettes.
5. Ongoing surveillance and research is crucial to detect long-term impacts on individuals and communities. If any new risks emerge, or guidance from Public Health England changes, we will revise our position on e-cigarettes. In the meantime, we have a vital responsibility to communicate the evidence that is emerging and currently that which is sufficiently robust to help guide us.
6. We need clear and consistent messages to the public. There is widespread public confusion about e-cigarettes and research shows people's perceptions have become less accurate. The evidence tells us e-cigarettes are less harmful than tobacco, but a growing number of people believe e-cigarettes are at least as harmful as tobacco, or say they don't know. This inaccurate view could be preventing smokers who have never tried e-cigarettes from quitting. We have a duty to provide clear messages to the public, based on the evidence. E-cigarettes carry a fraction of the risk of smoking and can help even some of the most addicted smokers to quit and smokers who switch to vaping reduce the risks to their health dramatically.

Alternative options considered and rejected:

No agreed position to inform citywide efforts to reduce the prevalence of smoking, which would result in a piecemeal approach and the continued confusion in the minds of the public on the safety and effectiveness of e-cigarettes as a tool to stopping smoking.

Published work / information:

Background papers:

Health Matters: Stopping smoking - what works?

Clearing up some myths around e-cigarettes

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7
Vaping and E-cigarettes Report	x								
Vaping and E-cigarettes Presentation	x								

Sign off:

Fin	djn.18.19.168	Leg	lt 31789/2/2112	Mon Off		HR		Assets		IT		Strat Proc	
Originating SMT Member													
Has the Cabinet Member(s) agreed the contents of the report? Yes													

1.0 Background

Smoking is the primary cause of preventable illness and premature death, accounting for approximately 79,000 deaths a year in England. Smoking rates in both Plymouth and England have been dropping for decades. The current rate in Plymouth [2017] is 18.4% compared to the rate for England of 14.9%. As the rate continues to drop, the challenges of successfully engaging a smaller, more heavily addicted and entrenched group of smokers becomes greater. This group tend to be poorer and live in our most deprived areas. We need new approaches if we are to maintain momentum on driving down rates of smoking.

One of these approaches involves the use of electronic cigarettes [e-cigarettes]. Millions of people are using e-cigarettes to help them stop smoking and the development of e-cigarettes and vaping present a major opportunity to achieve population level reductions in rates of smoking. A public health, evidence based approach involves careful consideration of this relatively new technology to maximise any opportunities, while identifying and mitigating any significant risks.

2.0 Opportunities

E-cigarettes are currently the most popular stop smoking aid, with an estimated 2.5 million users in England. Public Health advice (to the 39,000 people in Plymouth who currently smoke) is that switching from smoking tobacco to vaping with e-cigarettes is a good idea. E-cigarettes can positively engage with people who smoke, in particular with the target group of poorer people living in our most deprived areas, who have tended to be more resistant to traditional alternatives to smoking.

The public generally overestimate the relative risk of vaping compared to smoking and this presents a key opportunity to improve the understanding of the role that vaping can have in helping people to stop smoking and in improving peoples health. Any trusted source of information providing accurate and consistent advice to smokers could increase the numbers of people making a successful quit attempt.

Local stop smoking services have an important role to play in supporting smokers who want to use e-cigarettes in their quit attempt. Yet currently in Plymouth, only around 4% of those using stop smoking services are using an e-cigarette. There is a clear opportunity to combine the most popular quitting method (vaping) with the most effective quitting aid (local stop smoking service), to maximise the numbers of smokers quitting successfully.

3.0 Concerns

As with any new technology that large numbers of people are using, careful consideration of the risks it could pose and the control of risks that are significant is important.

3.1 Use by Children

A significant area of concern relates to the potential impact on children and young people. While it appears that experimentation with vaping is occurring among children, there is no evidence that this is acting as a gateway into smoking. Children may be trying e-cigarettes but the rate of children regularly using e-cigarettes remains very small and their use is almost exclusively by current or ex-smokers. National government have introduced stringent controls on the age of sale (over 18s) to mitigate this risk. This is a dynamic situation and we will continue to review and respond to new evidence as it emerges.

To date, e-cigarettes have not undermined public health efforts to drive down rates of smoking among children. Both in Plymouth and nationally, smoking rates have continued to drop in recent years as e-cigarettes have grown in popularity.

3.2 Regulations and control of E-cigarette marketing

Marketing of e-cigarettes is an extensive, successful and developing field. This presents issues because marketing could potentially mislead people and target children. England has some of the most stringent regulations in the world covering the marketing of e-cigarettes.

3.3 Involvement of the tobacco industry

The e-cigarette market is emerging and many small to medium sized manufacturers are independent of the tobacco industry. However, as with any new industry, these companies are consolidating over time. With conventional tobacco sales in decline in established markets and e-cigarette sales growing, the tobacco industry has begun to launch its own products as well as taking over existing manufacturers. Plymouth City Council have signed the Local Government Declaration on Tobacco Control, which includes a pledge to recognise and apply our responsibilities under the WHO framework convention on Tobacco Control. Plymouth City Council do not have a partnership of any kind with any tobacco company and do not knowingly promote or supply their products.

4.0 Current Activity

Plymouth City Council commission Livewell Southwest to deliver an integrated health improvement service for the local population [One You Plymouth https://www.oneyouplymouth.co.uk/]. This service helps people to stop smoking by providing behavioural and pharmacological support. Clients are encouraged to consider the whole range of options available to help them in their quit attempt, including the use of e-cigarettes. The service also provides training and support for a wide range of health professionals, including nurses, midwives and community based stop smoking advisors working in local GP surgeries. This training includes the established public health position on e-cigarettes.

Plymouth City Council Trading Standards team provide regulatory advice and carry out routine test purchasing operations with shops in Plymouth to test their compliance with the law that prevents the sale of e-cigarettes to anyone aged under 18. They also test the quality and safety of e-cigarettes and e-liquids.

5.0 Frequently Asked Questions

What are electronic cigarettes?

E-cigarettes are battery-powered devices, which heat a solution that typically contains nicotine and propylene glycol or glycerine, producing an inhalable vapour. Unlike tobacco cigarettes, e-cigarettes do not contain cancer-causing tobacco or involve combustion. So there is no smoke, tar or carbon monoxide.

What is "vaping"

The action of using an e-cigarette.

What is the difference between E-cigarettes and tobacco cigarettes?

The key difference between vaping with nicotine e-cigarettes and smoking tobacco cigarettes is in the relative harm they present to people's health. The smoke from tobacco causes the vast majority of harm in cigarettes, not the nicotine. Nicotine is relatively harmless to health. ECs do not contain tobacco. The current best estimate is that e-cigarettes are around 95% less harmful than smoking.

Are e-cigarettes 100% safe?

No. E-cigarettes are not risk free but are safer than smoking tobacco cigarettes because they don't contain tobacco. They do contain nicotine, which is addictive, but isn't responsible for the major health harms from smoking.

People who switch completely from tobacco to e-cigarettes show reduced exposure to the harmful chemicals in tobacco smoke. There remain some questions around long-term safety of these products due to the lack of long-term health studies. Some traces of toxic chemicals have been found in some products, although generally in much lower levels than tobacco cigarettes.

Can ECs help people to stop smoking?
Yes. A study in 2014 showed that those who made quit attempts with e-cigarettes and no other support were around 60% more successful than those who used no aid. In contrast, the same study found that those who use over the counter nicotine replacement therapy [NRT] with no support are no more likely to quit than those who go cold turkey.

E-cigarettes may be particularly effective when combined with behavioural support. The National Centre for Smoking Cessation and Training (NCSCT) has advised Stop Smoking Services to be open to those wishing to use an e-cigarette as an aid to stop smoking, especially those who have tried and failed to quit using licensed stop-smoking medicines.

Are e-cigarettes cheaper than smoking?
Yes. Many people can save hundreds of pounds over the course of a year after making the switch from cigarettes to e-cigarettes. Each person will use their e-cigarette differently, and across a wide range of devices and liquids, so prices can vary. After purchasing a starter kit, e-cigarettes will often work out cheaper over time than smoking.

Are e-cigarettes a gateway to smoking tobacco?
No. There are some concerns that e-cigarettes could act as a gateway to young people taking up smoking cigarettes, but so far, the evidence does not support this view in the UK. Continued use of e-cigarettes by 'never smokers' remains low and coincides with the continuing decline in youth smoking. The rate of current smoking among 15 year olds in Plymouth is at an all-time low (around 6%).

Can e-cigarettes be prescribed?
No. E-cigarettes are currently not available on prescription in the UK, and there are no e-cigarettes licensed as a medicine commercially available in the UK. It is unlikely there will be a medically licensed product that will be available for prescription in the near future.

Do e-cigarettess harm bystanders?
No. Unlike tobacco smoke, there is no good evidence to suggest that second-hand e-cigarette vapour is dangerous to others.

Can pregnant women use them?
Yes. Guidance produced for midwives and other health care professionals states that:
"Little research has been conducted into the safety of electronic cigarettes in pregnancy, however ***they are likely to be significantly less harmful to a pregnant woman and her baby than cigarettes****."*

What controls exist concerning the marketing of e-cigarettes?
Regulations are in place aimed at

- restricting appeals to children
- controlling sales to children (over 18s)
- ensuring minimum standards for the safety and quality of all e-cigarettes and refill containers
- providing information to consumers so that they can make informed choices
- determining where and how they can be advertised

PLYMOUTH CITY COUNCIL

Subject:	Avoidable Deaths Approach
Committee:	Health and Wellbeing Board
Date:	10 January 2019
Cabinet Member:	Councillor Ian Tuffin
CMT Member:	Ruth Harrell (Director of Public Health)
Author:	Gary Wallace Public Health Specialist
Contact details	T: 01752 398615 E: gary.wallace@plymouth.gov.uk
Ref:	Your ref. ADA
Key Decision:	No
Part:	I

Purpose of the report:
The purpose of the report is to outline a new approach to managing audit, scrutiny and review of a range of 'Avoidable Deaths' and seek endorsement of the new approach. To discuss the contents of the new approach with the board and to agree reporting by and scrutiny of the approach by the Health and Wellbeing Board

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Corporate Plan
The approach relates to A Caring Council in that it is focussed on reducing health inequality and on prevention. Additionally the method is co-operative in that it will be delivered with partners in the statutory and voluntary sector

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Implications for Medium Term Financial Plan and Resource Implications: Including finance, human, IT and land

There are no additional financial implications; it is a re-direction of existing staff resources

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

The approach will improve understanding of risks of death and contribute to management of those risks

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Equality and Diversity

Has an Equality Impact Assessment been undertaken? No

Recommendations and Reasons for recommended action:
The Health and Wellbeing Board endorse the new approach because it will significantly improve understanding of the overlaps between avoidable deaths and thereby improve prevention across the system

Alternative options considered and rejected:
To continue to deliver in separate silos of work – this has been rejected because it does not enable disparate partners to easily share informartion, audit and review cases collectively and thereby distribute learning across the system of services in the city.

Published work / information:

ONS Statistical Bulletin (2017) **Avoidable mortality in England and Wales: 2015.** Available: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2015

Background papers:

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7
Avoidable Deaths Discussion Paper	x								
Avoidable Deaths Presentation	x								

Sign off:

Fin	djn 18.19. 166	Leg	lt/31 789/ 2112	Mon Off		HR		Assets		IT		Strat Proc	
Originating SMT Member													
Has the Cabinet Member(s) agreed the contents of the report? Yes													

Published work / information:

Discussion Paper

A Proposal for an 'Avoidable Death' Review Process

Scope and terminology

This discussion paper is focussed on a cluster of different but often related classifications/circumstances of deaths, sometimes referred to as 'preventable' deaths, historically these would have been described as drug related deaths, alcohol related deaths and suicide. However, changes to patterns of drinking and drug use and more awareness around suicide risks, fire deaths and mental health and domestic homicides make these 'traditional' differentiations less relevant for a public health approach informed by the wider social determinants of health and wellbeing.

Our working definition of an 'avoidable death' is those deaths where 'in which modifiable factors may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future deaths could be reduced' (* this is taken from the definition of preventable child deaths). Our working definition is also in line with the official ONS definitions (2017, p4) of amenable, preventable and avoidable mortality (where avoidable mortality is the broadest term):

- *Amenable mortality*: "a death is amenable (treatable) if, in the light of medical knowledge and technology available at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided through good quality healthcare"
- *Preventable mortality*: "a death is preventable if, in the light of understanding of the determinants of health at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense"
- *Avoidable mortality*: "avoidable deaths are all those defined as preventable, amenable (treatable) or both, where each death is counted only once; where a cause of death is both preventable and amenable, all deaths from that cause are counted in both categories when they are presented separately"

For the purposes of this paper, avoidable deaths include:

- ✓ Deaths directly attributable to alcohol

- ✓ Drug related deaths (traditionally this would mean illegal drugs but there is a case that deaths from abuse of prescription drugs should also be included)
- ✓ Suicide
- ✓ Domestic abuse [DA] leading to homicide
- ✓ Homicide by a person with mental health [MH] problems

Current Situation

Currently there is a well-established suicide audit process which feeds into but is separate from the suicide prevention strategy. The local suicide audit follows national guidance; however, there is no agreed scrutiny process for deaths by suicide (especially for deaths where the person was not in touch with local services). Deaths by suicide are included in the PHOF.

There is also a well-established drug related death process that records deaths and undertakes some audit and scrutiny activity but lacks some of the features that would make it a true audit and scrutiny process. Drug related deaths will be included in the PHOF in future years as a response to the unprecedented rises seen nationally and locally. In addition to ‘traditional’ illegal drugs we are seeing shifts in substance misuse with many more people abusing prescription drugs (usually acquired illegally) and PHE report that benzodiazepines, anti-depressants and Z drugs are all appearing post mortem at an increasing level.

Alcohol related deaths have only been recorded and counted in the last calendar year previously there was no process at all, largely because of the difficulty collecting data and the added complexity around deaths where there is a fractional attribution. This year we have been recording alcohol deaths in (or near) treatment, i.e. people on waiting lists, currently in treatment or discharged within the previous twelve months.

Domestic Abuse homicides and Mental Health homicides are not routinely recorded and are only subject to scrutiny if a ‘responsible’ body commissions a serious case review. They are rare events but when they occur they have a very high profile in the media and generate lots of work for involved agencies.

At the moment, Gary Wallace undertakes the audits related to substance misuse and is also been involved in DA homicide reviews. Moira Maconachie runs the suicide

audit process. Carol Harmon, Public Health Analyst has just joined the group to provide additional capacity and expertise.

Over the last year we have stepped up collaboration between us because we have all noted the considerable overlap between the types of deaths discussed above. Several drug deaths might have been classified as suicide, and suicides very often involve substance misuse, either as the method of suicide or in the antecedents prior to suicide. In addition, both DA homicides involved substance misuse by the perpetrators and one included the victim too. Lastly, colleagues from the Fire Service have highlighted the frequency of substance misuse and mental health associated with fire deaths and indicated they are willing to join an Avoidable Deaths Group.

Proposal

Our proposal is to extend the above work (when appropriate) to include a joint review of avoidable deaths. This would involve co-producing a new way of working together with partners so that we share expertise and deepen our understanding of the range of avoidable deaths that occur in the city.

Our local coroner has met with us to discuss this approach and share his ideas, he is fully supportive and has agreed to give us systematic access to information which will significantly improve our ability to review deaths. Our complex needs services have also agreed to participate in a review process and to routinely share SIRI investigations, root cause analysis and other learning points that would feed into and inform different prevention strategies in the city.

With a coordinated approach between our review process and the coroner's office we will be able to routinely offer results of our investigations to the coroner – something which only happens ad hoc currently. This improved access will enable us to carry out audits and reviews more consistently and effectively and to produce results which are directly comparable year on year and with other areas. It will enable us to produce annual reports identifying trends and to collate things like risk factors and correlations that we can feed into risk 'flagging' systems in services.

Finally, should this proposal be implemented we hope to facilitate the establishment of an 'Avoidable Deaths Review Group' (ADRG), comprised of experts

from services including MH, the police and fire service. This group will review those deaths where there is 'system learning' and where there is overlap between multiple factors. The group will not replace or duplicate existing processes, but instead provide an opportunity to review those deaths which cross organisational thresholds and boundaries. The proposed 'Avoidable Deaths Review' has had an initial meeting and partners are supportive of the idea to bring the various audit processes together. The first piece of work is being undertaken by ODPH and is to map all the deaths over the last years in order to develop a better understanding of the size, scope and issues. The aim is for this to be complete by the beginning of April 2019.

We propose that the Health and Wellbeing Board is the strategic body which 'owns' this piece of work and that the ADRG be a sub-group of the H&WBB. This will give the group legitimacy and therefore, any recommendations it makes will have strategic 'reach'.

Summary

1) There is considerable overlap between suicide, substance misuse deaths, fire deaths and domestic homicide deaths
2) There is currently no process that brings reviews together in order to generate learning across our whole system
3) The work currently being done would continue to be done; this proposal suggests we amend our work to include a review process to share learning in order to help reduce the number of avoidable deaths in the city.
4) We propose the Avoidable Deaths Review Group (ADRG) produces an annual report and presents it to the Health and Wellbeing Board.
5) We propose that the ADRG reports to the H&WBB on an exception basis where particular threats, harms or trends require action in year.

<u>Prepared by</u>

Gary Wallace, Moira Maconachie, Carol Harmon and Vikki West

December 2018

Reference

ONS Statistical Bulletin (2017) **Avoidable mortality in England and Wales: 2015.** Available:
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/avoidablemortalityinenglandandwales/2015

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PLYMOUTH CITY COUNCIL

AN AVOIDABLE DEATHS APPROACH FOR PLYMOUTH

PLYMOUTH
CITY COUNCIL

THE BIGGER PICTURE

Integrated Commissioning

Created ONE system:

- Integrated governance arrangements
- Four Strategies
- Commissioning of an integrated health and social care provider for the city

Creating ONE budget:

- Section 75 between NEW Devon CCG and PCC
- Integrated funds £638 million gross (£462 million)
- Risk share and financial framework

People and place:

- Relationships
- Trust
- Co-location in one building

Complex Needs

- Substance misuse, MH, Homelessness, Offending, Domestic Abuse
- 29 services, 5 commissioners working together for 3 years
- Whole system approach, shared risk, integrated care, common confidentiality, common core assessment
- Open agenda, dispersed leadership, transparency, fostering co-operation, mitigating competition
- Must feel to the user like a single system
- Two key structures – System Optimisation Group and the Creative solutions forum

Thresholds and labels

- Thresholds have become barriers
- Labels – diagnostic, behavioural etc – determine what services people get rather than the persons actual presentation
- They drive worker identity – 'specialist X' rather than describing the actual work
- We want to make thresholds permeable, fuzzy and responsive to presenting picture (always a combination of problems and assets)
- We set up a structure to lead and support these culture changes

PLYMOUTH
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HOW DOES THIS APPLY TO DEATHS?

What are avoidable deaths?

Our working definition of an 'avoidable death' is those deaths

'in which modifiable factors may have contributed to the death. These are factors defined as those, where, if actions could be taken through national or local interventions, the risk of future deaths could be reduced'

(* this is taken from the definition of preventable child deaths).

Our working definition is also in line with the official ONS definitions (2017, p4) of amenable, preventable and avoidable mortality (where avoidable mortality is the broadest term):

Working Definition

- Deaths directly attributable to alcohol
- Drug related deaths (traditionally this would mean illegal drugs but there is a case that deaths from abuse of prescription drugs should also be included)
- Suicide
- Domestic abuse [DA] leading to homicide
- Homicide by a person with mental health [MH] problems
- Deaths by fire

Why these deaths?

There is considerable overlap in terms of:

- Polypharmacy – both licit 'grey' and illicit
- Alcohol
- Mental Health problems
- Contact with services
- Common social determinants
- Common localities (excluding suicide)
- Existing (but not joined-up) processes for suicide, DRD and DH which we can build on

Our project

- To develop an integrated approach at both the strategic and operational level
- To adopt methods that consider avoidable deaths within a 'systems' context
- To look both backwards (audit and review) and forwards (risk identification, preventive activities, culture and system change)
- To develop humane 'end of life' pathways for the marginalised
- To develop and protect the workforce
- To provide 'aftercare' for victims

Some things we've done

- Discussion paper produced and approach agreed
- Health and Wellbeing Board informal presentation arranged
- Bereavement training for complex needs staff
- End of life suite in homeless hostel
- Bereavement counselling for staff and relatives
- Identified a staff team in public health to shape the work
- Identified an 'expert' group

Expert Group

- To review cases from a 'systems' perspective
- Identify learning where system and/or service change is required
- Identify training needs
- Develop, prototype and test a risk identification matrix for DRD and ARD (in process)
- Develop a risk management process for cases so identified
- Produce an annual report for the H&WBB

Workforce development

- This is a 'sub-set' of the broader complex needs work
- Develop a knowledge and skills framework for Plymouth workers
- Identify training specific to avoidable deaths – core MH skills, core physical screening skills, risk assessment and risk mitigation skills etc
- Develop a culture of prevention which includes PH messaging about death, dying and grief

Systems Learning

Identified learning goes to

- The System Optimisation Group – a forum of CEO's of 28 services and 5 commissioners meeting monthly specifically to drive high level system and culture change
- The Creative Solutions Forum – meets monthly and made up of practitioners, commissioners and Adult Safeguarding where new practice is modelled and implemented around complex cases

HEALTH AND WELLBEING BOARD

Work Programme 2018 - 2019

Date of meeting	Agenda item	Responsible
12 July 2018	CQC Action Plan	Craig McArdle (Director for Integrated Commissioning)
	Commissioning intentions	Craig McArdle (Director for Integrated Commissioning)
4 October 2018	CQC Action Plan	Craig McArdle (Director for Integrated Commissioning)
	Suicide Prevention	Sarah Lees (Consultant in Public Health)
	Prevention Concordat For Better Mental Health	Sarah Lees (Consultant in Public Health)
	DPH Annual Report	Ruth Harrell (Director for Public Health)
	STP Year 2 Update	
	The Joint Health and Social Care Refreshed LD Strategy for Devon	
	Integrated Care System Strategy	Carole Burgoyne (Strategic Director for People)
	Loneliness and Social Isolation	
10 January 2019	Aspiring Integrated Care System	Ruth Harrell (Director for Public Health)
	Update on Year 5 – People Connecting Through Food	Sarah Ogilvie (Consultant in Public Health)
	Tackling Smoking	Dan Preece (Advanced Public Health Practitioner)
	Avoidable Deaths	Gary Wallace (Public Health Specialist)
7 March 2019	Housing	Ruth Harrell (Director for Public Health)
	Physical Inactivity	Ruth Harrell (Director for Public Health)
	Sexual violence	Ruth Harrell (Director for Public Health)
Items to be scheduled	Integrated sexual health	Laura Juett
	Dementia in Devon	Craig McArdle (Director for Integrated Commissioning)
	Update from Safer Plymouth	

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