#healthyplym

Oversight and Governance
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HEALTH AND WELLBEING BOARD

Thursday 8 October 2020
10.00 am
Virtual Committee

Members:
Councillor Kate Taylor, Chair
Councillor Laing, Vice Chair
Councillors Allen and Nicholson.

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 virtual meeting to consider the items of business overleaf.

This meeting will be broadcast and available on-line for playback once the meeting has concluded. By joining the meeting, councillors are consenting to being filmed during the meeting and to the use of the recording for the online viewing.

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Tracey Lee
Chief Executive

Health and Wellbeing Board

1. Apologies

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

2. Declarations of Interest

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

3. Chairs urgent business

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

4. Minutes **(Pages 1 - 4)**

To confirm the minutes of the meeting held on 30 July 2020.

5. 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.

6. CQC Collaboration Report **(Pages 5 - 30)**

7. Integrated Care System Update **(Pages 31 - 34)**

8. Transforming Cities - Mobility Hubs **(Pages 35 - 48)**

9. Loneliness Action Plan **(Pages 49 - 52)**

10. Update from Board Members

11. Work Programme **(Pages 53 - 54)**

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

Health and Wellbeing Board

Thursday 30 July 2020

PRESENT:

Councillor Kate Taylor, in the Chair.
Councillor Laing, Vice Chair.
Councillors Allen and Nicholson.

Apologies for absence: Dr Shelagh McCormick (NHS Devon CCG), Ann James (University Hospital Plymouth NHS Trust), Alison Botham (Director of Children's Services) and Dr Adam Morris (Livewell SW).

Also in attendance: Ruth Harrell (Director for Public Health), Craig McArdle (Director for People), Anna Coles (Service Director for Integrated Commissioning), David Brown (University Hospital Plymouth NHS Trust), Judith Harwood (Service Director for Education, Participation and Skills), Michelle Thomas (Livewell SW), Claire Hill (Mannamead Health and Wellbeing Board), Nick Pennell (Healthwatch) and Amelia Boulter (Democratic Advisor).

The meeting started at 10.00 am and finished at 11.40 am.

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.

1. **To note the Appointment of Chair and Vice-Chair**

The Board agreed -

1. the appointment of Councillor Kate Taylor as Chair for the municipal year 2020 – 2021;
2. the appointment of Councillor Laing as the Vice-Chair for the municipal year 2020 -2021.

2. **Declarations of Interest**

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

3. **Chairs urgent business**

The Chair reported the changes to the membership and to the format of the board over the next year as the Health and Wellbeing Boards move towards being at the centre of the Integrated Care System Plans in Devon. Task and finish groups looking at specific issues would enable the wider partnership to drill down into issues that affect the health and wellbeing of our residents, this new approach would allow for a more in-depth discussion from the wider partnership.

4. **Minutes**

Agreed that the minutes of 12 March 2020 were confirmed as a correct record.

5. **Questions from the public**

There were no questions from members of the public.

6. **COVID-19 Update from Board Members**

The Chair invited Board Members to provide an update on COVID-19:

- David Brown (University Hospital Plymouth Trust) shared a presentation on Phase 2 focusing on recovery and Phase 3 dealing with COVID through winter period.

- Claire Hill (Deputy CEO Mannamead WBH) reported that charities quickly responded to lockdown and planning taking place for a second local lockdown.

- Anna Coles (Service Director for Integrated Commissioning) and Craig McArdle (Strategic Director for People) reported on PPE response and co-ordination with the distribution of over half million items. Caring for Plymouth helped 7k people and looked at how they deliver care differently with more services being undertaken remotely. Accommodation support for workers within the care home sector from the hotel sector, shared staffing and great support from the PCC communications team.

- Ruth Harrell (Director for Public Health) reported that this was a new disease and the challenge was understanding the disease. The whole system has pulled together and has been incredible working together as a health and social care system in helping people, supporting each other and the most vulnerable.

- Judith Harwood (Service Director for Education, Skills and Participation) reported on the challenges of suspected cases in schools, working closely with partners on how to respond and keeping abreast of the guidance. Preparations in place for September and deploying large number of staff to ensure families were stable and supported.

- Nick Pennell (Healthwatch) reported that this was a challenging time for Healthwatch. They were adapting to new modes of engagement using zoom, social media/phone calls. However this can also provide a digital divide with a small number of groups that could be excluded. They were currently carrying out a survey responses from people that have been shielding and hope to circulate that report shortly. They have also produced regular updates on advice and guidance.

- Michelle Thomas (Livewell SW) reported that following central guidance, planned services were switched off and they reviewed the waiting the list, worked with the staff to move them around, provided training and discharged people as soon as they became fit. Working with the mental health teams to ensure people feel supported and away from the front door of the hospital by providing a hub for people to visit. They have expanded the 24/7 crisis support for adults and children and need to be mindful of the long term impact on mental health moving forward.

7. **Plymouth COVID-19 Local Outbreak Management Plan**

Ruth Harrell (Director of Public Health) referred to the report within the agenda pack. It was reported that every local authority has to develop a plan on how to contain COVID-19 moving forward. They have taken a coherent approach across the south west to join up responses. Engagement with communities to help prevent the spread of COVID-19 and how to keep themselves, friends and colleagues protected. The plan looks at how to respond to outbreaks and how to use the data to focus on prevention.

The Board noted the Plymouth COVID-19 Local Outbreak Management Plan.

8. **Health Protection Report for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council and Cornwall and the Isles of Scilly Councils 2018-2019**

Ruth Harrell (Director of Public Health) referred to the report in the agenda pack.

The Board noted the Health Protection Report for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council and Cornwall and the Isles of Scilly Councils 2018 – 19.

9. **A Framework for COVID19 Inequalities**

Ruth Harrell (Director of Public Health) referred to the report in the agenda pack which outlines the workshop planned for September.

The Board noted the Framework for COVID-19 Inequalities.

10. **Work Programme**

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

- CQC Collaboration Report
- Dentistry
- Trauma Informed
- Growth Board and Resurgum programme
- Integrated Care System
- Food insecurity

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HEALTH AND WELLBEING BOARD

CQC- Provider Collaboration Reviews

Overview of Collaboration Reviews

During July and August CQC completed reviews in 11 different English localities, to find out how care providers worked together in response to the pandemic. CQC wanted to find out how providers collaborated to improve care for older people, who are most at risk of COVID-19. The 11 reviews focused on the interface between health and social care for people aged 65 and over. In each system CQC carried out a deep dive review of a local authority area and then fed this information back to the Integrated Care System (ICS) or Sustainability and Transformation Partnership (STP) leads.

To get a comprehensive picture, CQC engaged with a wide variety of organisations locally, including primary care networks, local medical committees, adult social care providers, directors of social services, NHS trusts and independent hospitals, urgent care providers, NHS 111, community care providers, integrated care teams, urgent dental services, local Healthwatch and other organisations that represent those who use services, their families and carers.

Tackling the issues related to COVID-19 has required effective strategic planning, good relationships and practical, deliverable solutions. Emerging learning across the reviews so far has included:

- Understanding local population needs, including cultural differences, was especially important.
- The quality of existing relationships between local providers played a major role in the coordination and delivery of joined-up health and social care services that meet the needs of the local population.
- There was an increased focus on shared planning and system wide governance, but pre-existing plans may not have been fit for purpose to cope with COVID-19.
- Staff across health and social care worked above and beyond their roles – we spoke to dedicated, passionate staff, committed to supporting everyone including people aged 65 and over.
- There was a range of initiatives to ensure the safety and wellbeing of staff working both on the front line and in support services.
- The move to digital working accelerated and impacted on access to services, and more generally digital solutions supported data sharing and communication between health and social care partners and within health and social care organisations.

CQC will report their full findings from these first 11 Provider Collaboration Reviews (PCRs) in their State of Care 2019/20 report to Parliament in October 2020.

Devon Provider Collaboration Review

Devon ICS was identified as being one of the 11 areas and this was then focussed down further to the Plymouth System. Attached is a presentation on the feedback from the review of the Plymouth System given recently by CQC to System Leaders.

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Provider Collaboration Review

Devon Team

Alison Giles *Inspection Manager*
Nicola Cliffe *Inspection Manager*
Victoria Marsden *Inspection Manager (oral health)*
Victoria Lea *Pharmacist Specialist*
Jo Johnson *Inspector*
Sue Oulsnam *Inspector*
Kate Dew *Inspector*
Laura Unsworth *Inspector*
Claire Drakeford *Assistant Inspector*

Provider Collaboration Reviews

How have providers worked **collaboratively** as a system in response to the Covid19 pandemic?

The Scope and Objective

- The experience for people over the age of 65 with/without Covid19 across health and social care providers, including the independent sector, local authorities and NHS providers

- The objective is to support providers across systems by sharing learning on the Covid19 period

The Outputs

- Feedback for each local system
- Insight report – September 2020
- Final report – Chapter in CQC State of Care report October 2020

Key Lines of Enquiry

- How have **providers collaborated** to ensure that people moving through health and care services have been seen safely in the right place, at the right time, by the right person?
- Was there a **shared plan** and system wide governance and **leadership** during the Covid19 period?
- Was there a plan for ensuring the **safety of staff**, and sufficient health and care skills across the health and care interface during the Covid19 period?
- What impact have **digital solutions** and technology had on providers and services during the Covid19 period?

How we carried out this Review

- Focused on the local authority area of **Plymouth**
- During the week of 20 July, we spoke with a wide range of frontline health and social care staff, senior managers and executive leaders from across the system
- Carried out 25 interviews with individuals and teams covering providers and networks for adult social care, NHS funded providers (including the ambulance service) a hospice, GPs and primary care networks. We spoke with dental providers and pharmacists, the local authority and clinical commissioning group and we spoke with the local Healthwatch organisation

Provider Collaboration Review

ANALYTICAL DATA
DEVON – PLYMOUTH

Plymouth in context

- Plymouth has a **lower number of older people** compared with the rest of Devon which has many areas with a medium to high proportion of older people
- The south region of Devon has **lower levels of deprivation** when compared to the north of the county – although this is much lower around Barnstaple
- Plymouth has a lot of areas of **high population density**
- **Ethnicity** in Devon is in the lowest 20% nationally
- Plymouth shows a low **small area vulnerability index** (SAVI) to Covid19. Almost the whole county scores around the lowest 20% nationally on this vulnerability index. Rises (although still only low to medium) in an area between Axmouth and the border with Dorset, and some of the more rural areas (*University of Liverpool*)

Plymouth in context – life expectancy

- In Plymouth, both total life expectancy and healthy life expectancy at age 65 for females are below the England average
- For males in Plymouth, total life expectancy is also below average, but healthy life expectancy is above average
- Across the system, life expectancy is worst in Plymouth for both females and males, and healthy life expectancy for females is also the lowest. However, healthy life expectancy for males is lower in Torbay than in Plymouth
- **In Devon, older people in Torbay and Plymouth live the longest in poor health**

Provider Collaboration Review

KEY LINE OF ENQUIRY FINDINGS

Key Findings – How have providers **collaborated to** ensure that people were seen safely in the right place, at the right time, by the right person?

What we were told went well:

- Fast removal of **barriers**
- Strong and quick uptake of **cooperation and leadership**
- Great **links** forged – special relationships
- New **respect** for each other and different provisions of care, particularly for older and vulnerable people
- **Faith** in people being able to deliver
- Support from **independent health** sector
- Local authority and commissioner support particularly for adult social care – **knowing the system**
- Safeguarding was supported to be strong and enhanced to **react** to new threats

Key Findings – How have providers **collaborated** to ensure that people were seen safely in the right place, at the right time by the right person?

Future focus:

- Early issue with **treatment escalation** plans – anxiety
- **Mixed messages** around shielding
- PPE differences in guidance – led to **fear**
- Creation of the right type of **capacity** - ensure others consulted when changing service provision
- Care homes **anxious** about being assertive to protect people
- **Overwhelming** support for care homes hard to manage at times
- Cessation of **visiting** – impact has been hard on so many
- **Asymptomatic** patients and atypical symptom recognition
- **Impact** on patients from this pandemic still to be understood

Key Findings – Was there a **shared plan** and system wide governance and **leadership**?

What we were told went well:

- Major providers/stakeholders were quick to agree **roles and responsibilities**
- Systems established for managing **outbreaks**
- Systems let **experienced** communities take the lead
- Command and control became **nuanced** – only where necessary
- Key people coming together under **shared direction and plans**
- **Learning** was shared widely. Confidence to **speak-up**
- Changes will be made for the future from **new ways** of working
- Governance was **scaled back** to enable pace and innovation but remained active

Key Findings – Was there a **shared plan** and system wide governance and **leadership**?

Future focus:

- Guidance for some staff was **overwhelming**
- **Impact** on GPs and their services not always recognised
- Some ASC providers felt **on their own**. Those who were confident took decisions, but not clear what was right or wrong
- ASC turned to their **own networks** in the early days – not all providers were involved in local response
- A lot of **quality surveillance** stood down
- GPs and OOH services worried about missing **face-to-face** contact from regular rounds. Impact remains to be understood
- Demand **predictions**, which did not materialise, caused major anxiety
- Pandemic **plans** did not all stand up – some worked in part

Key Findings – Was there a strategy for ensuring the **safety of staff** and sufficient health and care skills across the health and care interface?

What we were told went well:

- Care staff described as "**amazing**"
- Staff felt care was **not compromised** as it was delivered
- Impressive **redeployment** of staff where they were needed
- **Major support** to ASC home on edge of collapse from Livewell
- Major effort in staff **safety and wellbeing**
- Early **innovative** practices emerging for staff health and wellbeing
- Staff gained new skills and new **confidence** – strong future
- **Visible** leadership in all sectors – executives and senior staff were on duty

Key Findings – Was there a strategy for ensuring the **safety of staff** and sufficient health and care skills across the health and care interface?

Future focus:

- Recognising the **exhaustion** of all staff across the system
- Building **staff confidence** in new systems and ways of working – ensure all experts are given a voice
- Helping with **reducing the fear** among staff – and recognise it's there. Understand how providers might not all work the same way
- Supporting **smaller providers** where senior staff are sick or unable to work
- Rapid **consistent guidance** around PPE and staff safety needed for ASC
- **Testing** was unclear for too long – and still uncertainty
- More local input from **volunteers** – national scheme did not work for everyone

Key Findings – What impact have **digital solutions** and technology had on providers and services?

What we were told went well:

- Busting of some of the **digital myths** in all disciplines
- Fantastic virtual support which built up for ASC with **multidisciplinary input** into care and treatment
- **Transformed** so many ways of working together
- Given patients **vital time** with their families and friends
- Larger providers **helped** smaller services with equipment
- Virtual **clinician-to-clinician** time seen as great support
- Valuable work with **admissions avoidance** and support of GPs
- “Never felt **closer** to each other”
- Potential for **savings** in so many areas

Key Findings – What impact have **digital solutions** and technology had on providers and services?

Future focus:

- Systems **not talking** to each other – information in early days from overwhelmed 111 limited on detail – left risks
- Not all staff confident as yet with **new ways** of working
- **Impact** on patients and their treatment from virtual working is yet to be fully understood. Some GPs anxious **not crossing** the threshold
- Temporary relaxation of GDPR has helped, but needs to be reconsidered to support ongoing **sharing** of key information
- Home-working or remote working has implications for some staff around **wellbeing and loneliness**
- Virtual contact in ASC does **not replace** the hands-on experience and skills of health and social care staff

Medicines Optimisation

- Good collaboration helped arrangements for pharmacies to hold and supply medicines for end of life care during extended hours
- Had a medicines optimisation control centre – helped on a range of issues including supply of medicines
- More dialogue between local pharmacy professionals around support for care homes. CCG continued GP support remotely
- Collective problem solving and sharing good ideas/innovations
- CCG currently advancing timing for blood tests for drug monitoring to help avoid this in winter pressure period
- Devon already a high user of NHS prescription App – helped
- Consensus around building relationships in the locality between different people, organisations and sectors

Oral Health

- Limited dental provision. Urgent services set up. System restoring gradually. Still low patient numbers, but ¾ urgent cases seen
- Managers followed national guidance and implemented changes. Local dental council supportive with guidance, referrals, local contact, and for urgent care
- Dental staff in bubble teams – enabled good coverage of staff. Extra care for shielding patients
- Support for wellbeing of staff – holidays encouraged
- Work needed for online prescribing – some good innovations
- Some staff able to work remotely but took time to set-up due to national demand for equipment
- Great digital support from Livewell with IT and remote training

Reflections

Future focus:

- The **speed and pace** of reorganisation and change was at times overwhelming
- Volume of national and local messaging made **coordination** of guidance a full-time occupation
- Organisations had a **huge task** with managing their own services, staff and patients, as well as contributing to system support
- This period has been **exhausting** for staff and many older people and they have to continue for an unknown length of time

Reflections

More of the same please:

- The system **understood** its older population and what was needed to keep them safe
- Providers were **partners** and ensured each voice was heard
- Ambulance trust was **included**
- **Local** communication was key for local success
- Decision-makers **were always there**
- Many providers keeping a record of **innovations and learning**
- The **future will be different** – need to build-up networks further

Your questions please

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Together for Plymouth

Health and care working in partnership with local communities in Plymouth and the rest of the Devon

Devon Integrated Care System- Plymouth Local Care Partnership

"Together for Plymouth"

Introduction

This paper provides for the Health and Wellbeing Board an overview of the, outcomes, functions priorities and governance arrangements of the Shadow Plymouth Local Care Partnership and our relationship to the Wider Devon Integrated Care System.

Outcomes

The shadow Devon ICS Board has set down the following aims for each of the LCPs:

1. Deliver Devon system strategies at local level
2. Improve health and wellbeing outcomes for the local population
3. Reduce inequalities
4. Improve people's experience of care
5. Improve the sustainability of the health and care system
6. Support local engagement including with PCNs

Functions of Place

As thinking on ICS develops so too does the understanding on the functions of Place with a recent Kings Fund presentation setting out the following:

1. Developing an in-depth understanding of local communities and neighbourhoods
2. Working in partnership across multiple agencies to coordinate service delivery
3. Driving service transformation, particularly for community-based services
4. Mobilising the local community and building community leadership capacity
5. Making use of local assets
6. Enabling local organisations to use all of their resources to support health, social and economic development

Locally the Devon ICS has set down the following activities that each of Local Care Partnerships should focus on:

- Coproduce plan with ICS Partnership Board which will deliver improved health and care services at population level
- Develop integrated services
- Create conditions for healthy living
- Manage resources within available budget
- Plan services through engagement with citizens
- Develop community assets

Together for Plymouth
Health and care working in partnership with local communities in Plymouth and the rest of the Devon

Local Priorities

The Plymouth Plan remains the City's overarching Strategic Plan setting the vision, ambition and our direction until 2034. These priorities align to this plan and represent the Local Care Partnerships first tranche of priorities emerging from our COVID-19 response phase towards reset and restoration. They will form the focus of our joint endeavor whilst we develop our wider framework for tackling inequalities.

1. Building on Caring for Plymouth develop a single front door for care and support
2. Develop enhanced support for care homes
3. Strengthening out of hospital care through the Integrated Care Model with a focus on:
    a. Admissions Avoidance- provision of additional multi-disciplinary community crisis response to provide wraparound support for individuals in crisis.
    b. Improved access to step down provision to support hospital discharge arrangements including provision of additional beds with on-site therapy offer
    c. Further development of placed based Mental Health Support aligned to community multi-disciplinary offer wrapped around individual PCN's and supported by the voluntary sector.
4. Ensuring homeless people are housed in appropriate accommodation, have their needs fully met and as few people return to the streets as possible.
5. Working with Primary Care to build on learning from "Hot Hub" approach to ensure sustainable multi-disciplinary provision for COVID and non COVID residents.
6. Collectively and pro-actively support the City's *Resurgam* Programme, with a specific focus on the Health and Care Sector Plan, Skills, Building Plymouth, Spend-4-Plymouth and City Centre Renaissance.
7. Locally support a number of enabling programmes such as digital, workforce and infrastructure and estates. An initial priority in relation to estates will be seeking to maximise the HIP2 and One Public Estate Programmes to facilitate service change and develop new opportunities.

Our Role in System Working

In order to develop care and support services around people and communities the ask of the wider system is:

- ❑ The new system should be built up from place
- ❑ The ICS to play an underpinning rather than overseeing role enabling place to develop
- ❑ ICS STP to recognise that places will start from different places and evolve at different paces

Recognising this place in the wider Devon system and our relationship with neighbouring partners we will:

- ❑ Play an active place based role in the developing Devon Integrated Care System
- ❑ Recognising the ICS role in performance improvement we will work to ensure place makes the best contributor it can to system performance
- ❑ As leaders of place set down a clarity of purpose- make it simple and articulate why it matters

- ❑ Facilitate local mobilisation empowering others to act- and declutter if necessary
- ❑ Planning and delivery will be seamless and will utilise strengths across the system
- ❑ Be governance light and delivery heavy with rapid decision making (within Frameworks)
- ❑ Work in close partnership to align plans with our neighbouring systems in South East Cornwall and Western Devon.

Governance arrangements

The Shadow governance arrangements are set out in Appendix One. In designing these the following principles were adopted:

- ➢ Arrangements should support our Placed Based Health and Wellbeing Agenda
- ➢ Arrangements should be an enabler for us to deliver at pace for our population
- ➢ Arrangements should build on existing partnerships

System Resources

The establishment of the Local Care Partnership has consciously been built into business as usual processes of the main statutory partners. Locally Boards and Executives are already deployed to this agenda with Place being considered the day job. As such partners are already bringing in extensive Accountable/Senior Officer Commitment with dedicated and scheduled time to deliver the Together for Plymouth priorities.

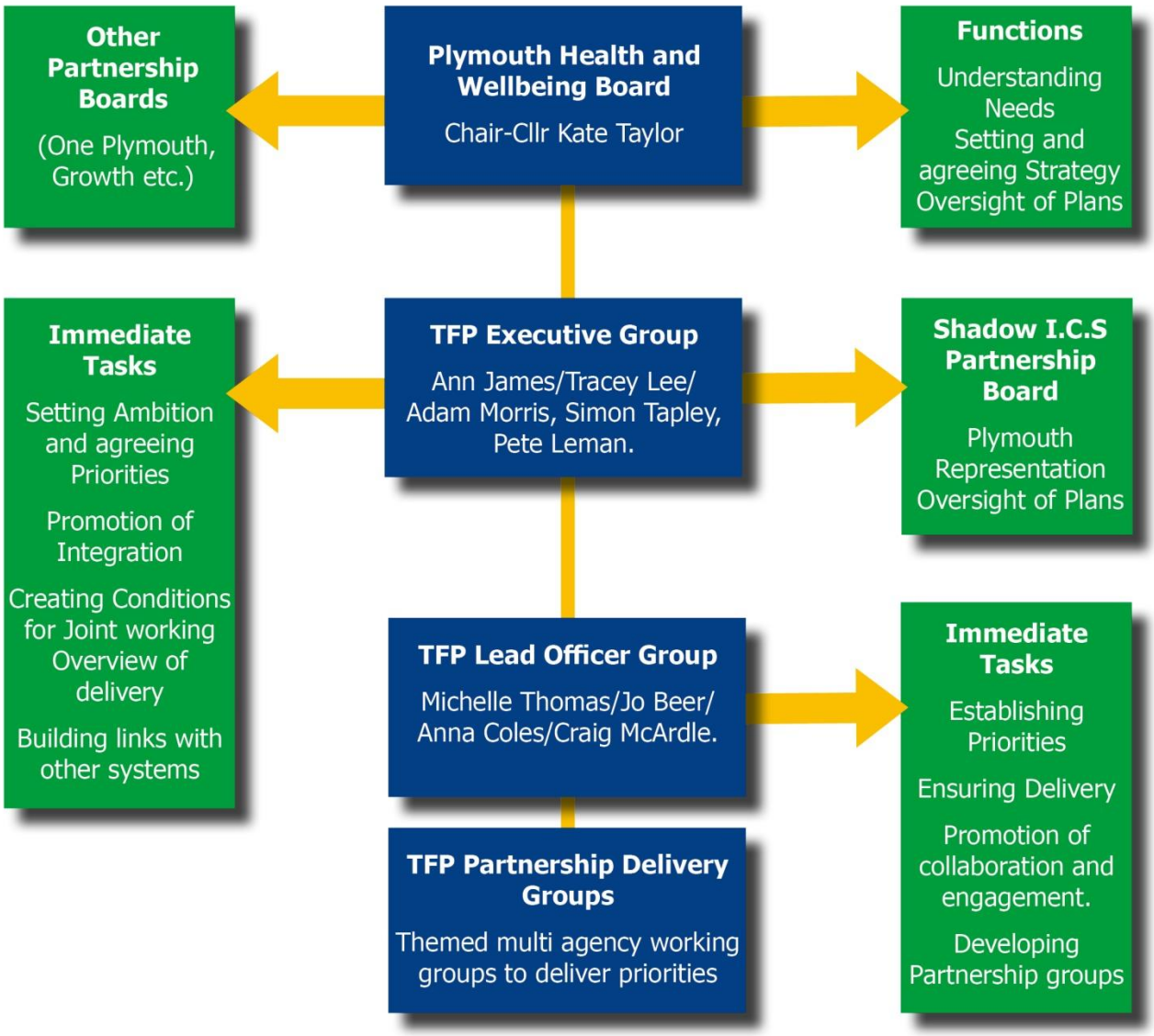
In addition, further resources have been allocated such as Business Support, Communications and Organisational Development. Should additional resources be required to facilitate the development or running of the Local Care Partnerships the then partners have committed to finding additional resources.

Next steps

As we continue to develop the Plymouth Local Care Partnership there will be a focus on developing the architecture and workings of the LCP and on developing a programme of works that will drive service change, promote integration and improve performance and quality.

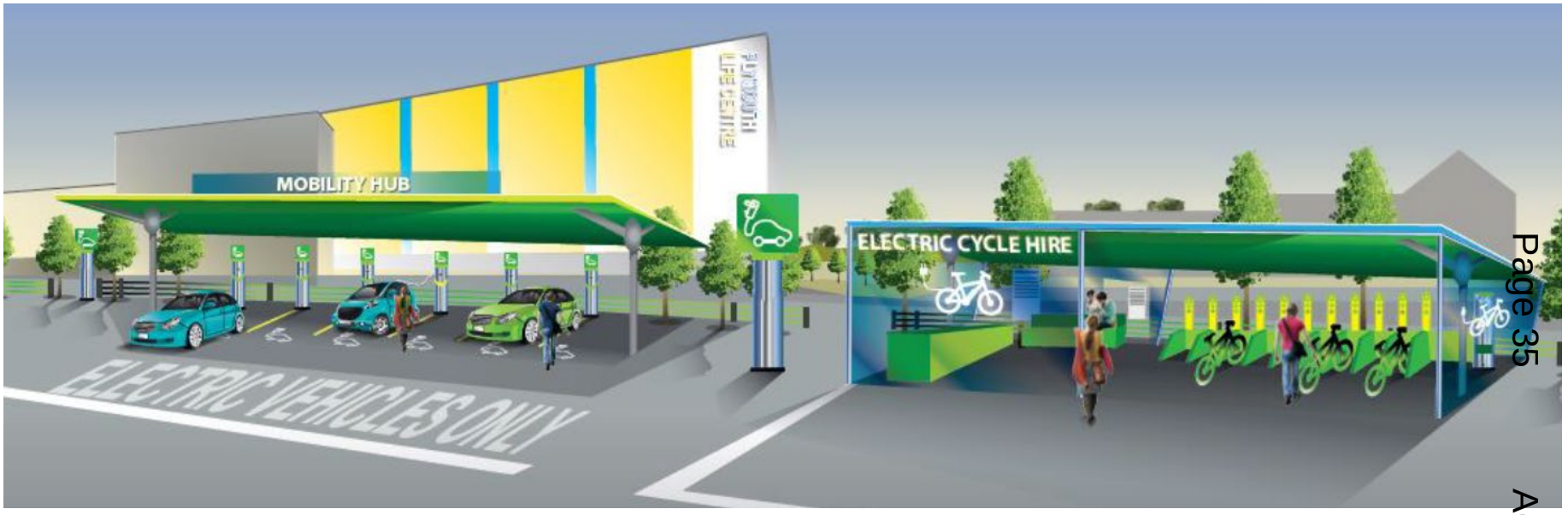
Together for Plymouth

Health and care working in partnership with local communities in Plymouth and the rest of the Devon



Decision making of each of the governance layers are through individual officer's decision making authorities and organisationsown boards.

Mobility Hubs



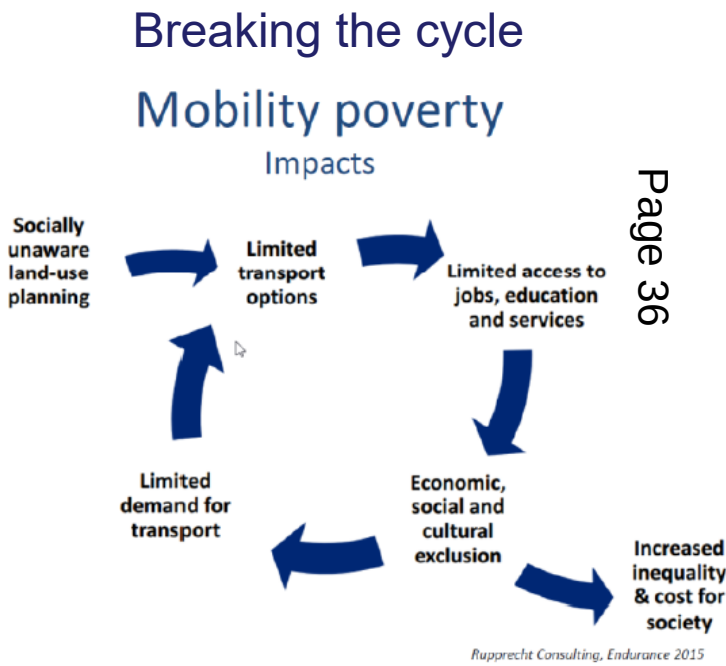
Delivering up to 50 multi-modal mobility hubs across Plymouth including:

- Electric bikes
- Electric cargo bikes
- Electric vehicle car club
- Electric vehicle charging points

Supported via the Transforming Cities Fund

Objectives

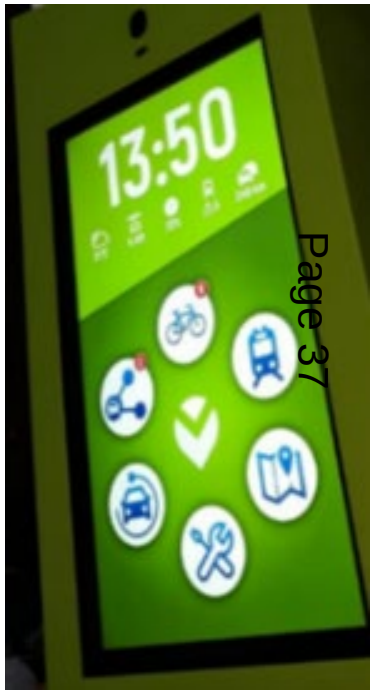
- Improve air quality
- Encourage active travel
- Reduce congestion
- Reduce carbon dioxide emissions
- Improve mobility opportunities in low income neighbourhoods
- Improve access and connectivity to employment, education, health and leisure facilities



Social prescriptions enabling GPs to offer patients electric bike hire membership for 6 months to help improve their health and fitness

Visibility & accessibility

- A unified look throughout the network
- Clear signage
- Disabled access
- Safe
- Open visible areas
- Well lit
- CCTV



Mobility As A Service

- Mobility As A Service app
- Journey planning information
- Ticketing
- Ease of switching modes
- Including public transport

Stakeholder input

- Internal discussions with all departments and officers who will have an interest in the design and functioning of the mobility hubs
- Engagement with residents, businesses and other local stakeholders will commence in February 2021

Principles of Universal Design

We are considering using the following principles to help guide the design of the Mobility Hubs and the Mobility As A Service app.

Principle 1: Equitable Use

The design is useful and marketable to people with diverse abilities:

- 1a. Provide the same means of use for all users: identical whenever possible; equivalent when not.
- 1b. Avoid segregating or stigmatizing any users.
- 1c. Provisions for privacy, security, and safety should be equally available to all users.
- 1d. Make the design appealing to all users.

Principles of Universal Design

Principle 2: Flexibility in Use

The design accommodates a wide range of individual preferences and abilities:

- 2a. Provide choice in methods of use.
- 2b. Accommodate right- or left-handed access and use.
- 2c. Facilitate the user's accuracy and precision.
- 2d. Provide adaptability to the user's pace.

Principles of Universal Design

PLYMOUTH CITY COUNCIL

Principle 3: Simple and Intuitive Use

Use of the design is easy to understand, regardless of the user's experience, knowledge, language skills, or current concentration level:

- 3a. Eliminate unnecessary complexity.
- 3b. Be consistent with user expectations and intuition.
- 3c. Accommodate a wide range of literacy and language skills.
- 3d. Arrange information consistent with its importance.
- 3e. Provide effective prompting and feedback during and after task completion.

Principles of Universal Design

Principle 4: Perceptible Information

The design communicates necessary information effectively to the user, regardless of ambient conditions or the user's sensory abilities:

- 4a. Use different modes (pictorial, verbal, tactile) for redundant presentation of essential information.
- 4b. Provide adequate contrast between essential information and its surroundings.
- 4c. Maximize "legibility" of essential information.
- 4d. Differentiate elements in ways that can be described (i.e., make it easy to give instructions or directions).
- 4e. Provide compatibility with a variety of techniques or devices used by people with sensory limitations.

Principles of Universal Design

Principle 5: Tolerance for Error

The design minimizes hazards and the adverse consequences of accidental or unintended actions:

- 5a. Arrange elements to minimize hazards and errors: most used elements, most accessible; hazardous elements eliminated, isolated, or shielded.
- 5b. Provide warnings of hazards and errors.
- 5c. Provide fail safe features.
- 5d. Discourage unconscious action in tasks that require vigilance.

Principles of Universal Design

Principle 6: Low Physical Effort

The design can be used efficiently and comfortably and with a minimum of fatigue:

- 6a. Allow user to maintain a neutral body position.
- 6b. Use reasonable operating forces.
- 6c. Minimize repetitive actions.
- 6d. Minimize sustained physical effort.

Principles of Universal Design

PLYMOUTH CITY COUNCIL

Principle 7: Size and Space for Approach and Use

Appropriate size and space is provided for approach, reach, manipulation, and use regardless of user's body size, posture, or mobility:

- 7a. Provide a clear line of sight to important elements for any seated or standing user.
- 7b. Make reach to all components comfortable for any seated or standing user.
- 7c. Accommodate variations in hand and grip size.
- 7d. Provide adequate space for the use of assistive devices or personal assistance.

Next steps

- Concept design
- Site selection
- Mobility As A Service app scoping
- Engagement with residents, businesses and other local stakeholders will commence in February 2021

If there is someone that you think we need to involve in the design, construction, or operation of the Mobility Hubs, please check with them that they know about the initiative and if needed put them in touch with: john.green@plymouth.gov.uk

Questions

- Thank you

PLYMOUTH CITY COUNCIL

Subject:	Loneliness Action Plan
Committee:	Health and Wellbeing Board
Date:	8 October 2020
Cabinet Member:	Councillor Kate Taylor
CMT Member:	**Ruth Harrell (Director of Public Health)**
Author:	Rachel Silcock (Strategic Commissioning Manager)
Contact details	Tel: 01752 307176 email: rachel.silcock@plymouth.gov.uk
Ref:	
Key Decision:	No
Part:	I

Purpose of the report:

The purpose of this report is to inform the Board about the work taking place on addressing loneliness and the work of the Loneliness Action Group and seeks the support of the Board. The Health and Wellbeing Board adopted the Loneliness Action Plan (Pledge 55 of the Council's Pledges) in March 2019. This report updates the Board on progress with this. Loneliness is a growing problem, and its effects have been recognised nationally and internationally. In Plymouth services and activities exist to support people to create and sustain new and existing relationships with others. However, we do need to do more work on this area, including awareness raising and reducing the stigma attached to loneliness; the aforementioned Loneliness Action Group will work with charities, social care providers, NHS, local employers, businesses, and others on delivering action plan to ease loneliness.

The Corporate Plan 2018 - 2022:

This Loneliness action plan will support the Corporate Vision through:

- Helping to deliver the priority of a Caring Council in adopting a whole society approach to loneliness to make a real difference to the health and well-being of the residents of Plymouth through challenging times.
- Putting citizens at the heart of their communities and work together with our partners to serve the best interests of our City in a co-operative way. We will achieve this together by developing strong and resilient individuals and communities, destigmatising loneliness and providing opportunities for people to take part

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

All resource implications have been considered and incorporated within the MTFS and Business
Plans.

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

The work described in this report complements the Council's existing policy framework with respect to the above.

Equality and Diversity

Has an Equality Impact Assessment been undertaken? Where potential equality and diversity implications are identified from the implementation of any new activities arising from the pledge completion, assessments will be undertaken in line with the Council's policies.

Not yet, this will be developed as part of the work of the Loneliness Action Group.

Recommendations and Reasons for recommended action:

Health and Wellbeing Board adopt the updated Loneliness Action Plan. Further updates will be provided to the Health & Wellbeing Board on progress.

Alternative options considered and rejected:

The Loneliness Action Plan is not adopted.

Published work / information:

Background papers:

Title	Part I	Part II	Exemption Paragraph Number						
			1	2	3	4	5	6	7
Council Pledges	X								

Sign off:

Fin djn. 20. 21. 95	**Djn.**	Leg MS/ 29.0 9.20	It	Mon Off		HR		Assets		IT		Strat Proc	
Originating SMT Member Ruth Harrell, Director for Public Health													
Has the Cabinet Member(s) agreed the contents of the report? Yes													

The Impact of Loneliness

The vast majority of us will feel lonely at some point in our lives, it is a natural human emotion which can mean different things to different people. However, sustained feelings of loneliness can have negative impacts on a whole host of aspects of our lives, including our health, wellbeing, productivity, and self-esteem. Frequently feeling lonely has been linked to early deaths and an increased risk of coronary heart disease, stroke, depression, cognitive decline and Alzheimer's. Certain cohorts of people in society may be more susceptible to experiencing loneliness and there are also certain times in people's lives when they are more susceptible to experiencing it: bereavement, losing job, moving to a new place. Office for National Statistics recently analysed how various factors affect the likelihood of feeling lonely, those who reported being lonely more often were likely to have at least one of several specific characteristics, including being aged 16 to 24, being widowed, having poor health, having a long-term illness or disability. The current lockdown situation has exacerbated this all of this, and affected a broader swathe of society.

The Work at National and Local Level So Far:

Central government appointed a Minister for tackling loneliness and created a strategy for tackling it in late 2018. The three key areas and some of the gains made so far are below; this is an ongoing piece of work and has particularly been relevant during the lockdown to deal with the pandemic:

- reduce stigma – talking about it, a national conversation, the latest related to this is the # Let's Talk Loneliness campaign
- ensure that it is considered in all areas of government policy making
- Improving the evidence base, creation of new measures including a new public health outcomes framework measure, ONS measures.

Locally in Plymouth are many services and activities to support people to create and sustain new and existing relationships with others. New services have been set up since the start of the lockdown such as Caring for Plymouth and Good Neighbours and services and organisations have adapted to work in different ways including use of volunteers. We do need to do more work on this area, and the aforementioned Loneliness Action Group will work with charities, social care providers, local employers, businesses, and others on delivering a whole society action plan to ease loneliness.

Vision:

Plymouth to be a place where we can all have strong social relationships. Where families, friends and communities support each other, especially at vulnerable points where people are at greater risk of loneliness. And where loneliness is recognised and acted on without stigma or shame, so that we all look out for one another.

Aims of the work of the Loneliness Action Group:

- Channel and share good practice,

- Raise awareness to tackle the stigma associated with loneliness encouraging people to talk about how they feel and be more comfortable about asking for support (the Let's Talk Loneliness toolkit may be used for this at https://letstalkloneliness.co.uk)
- Use measurement tools and the knowledge of group members to determine prevalence and where people are in City who have the characteristics more likely to often experiencing loneliness
- Consider what the different agencies and organisations represented in the group can do as there needs to be a whole society approach that involves civil society - neighbours, small groups volunteers local and national charities, public-sector NHS local government libraries schools colleges housing organisations
- Link and learn from other areas good practice including keeping abreast of the work of central government in this area
- Think about how we tackle loneliness through place strengthening community infrastructure and assets
- Consider how we provide support such as transport and technology to help sustain connections

Recommendation to Health and Wellbeing Board

To adopt the updated attached action plan which contains proposals for ways in which the national strategy areas for action can be implemented locally, to provide support and encouragement for implementation

HEALTH AND WELLBEING BOARD

Work Programme 2020 - 2021

Date of meeting	Agenda item	Responsible
30 July 2020	COVID-19 Update from Board Members	All Board Members
	Plymouth COVID-19 Local Outbreak Management Plan	Ruth Harrell
	Health Protection Report for the Health and Wellbeing Boards of Devon County Council, Plymouth City Council, Torbay Council and Cornwall and the Isles of Scilly Councils 2018-2019	Julie Frier
	A Framework for COVID19 Inequalities	Ruth Harrell
8 October 2020	CQC Collaboration Report	Craig McArdle
	Transforming Cities – Mobility Hubs	John Green
	Update from Board Members	All Board Members
	Integrated Care System Update	Craig McArdle
	Loneliness Action Plan	Rachel Silcock
7 January 2021	Update from Board Members	All Board Members
4 March 2021	Update from Board Members	All Board Members
Items to be scheduled	Dental Health	
	Food Insecurity	
	Growth Board/Resurgum Board	
	Trauma Informed	

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