Health and Adult Social Care Scrutiny Panel

Friday 21 November 2025

PRESENT:

Councillor Murphy, in the Chair.
Councillor Ney, Vice Chair.
Councillors Lawson, Lugger, Moore, Morton, Noble, Penrose, Simpson and Tuohy.

Also in attendance: Julia Brown (Service Director for Adult Social Care), Louise Ford (Head of Commissioning), Ed Garvey (Head of Locality Commissioning, NHS Devon), Ian Lightley (Chief Operating Officer, Livewell Southwest), Anjula Mehta (Joint Chief Medical Officer, University Hospitals Plymouth), Gill Nicholson (Head of Innovation and Delivery), Rachel O'Connor (Director for Integrated Care, Partnerships and Strategy, University Hospitals Plymouth), Helen Slater (Lead Accountancy Manager), Gary Walbridge (Strategic Director for Adults, Health and Communities), Andy Williams (Lead for Adult Social Care, Livewell Southwest), Michael Whitcombe (Deputy Chief Operating Officer, University Hospitals Plymouth), and Elliot Wearne-Gould (Democratic Advisor).

The meeting started at 2.00 pm and finished at 4.35 pm.

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

100. **Declarations of Interest**

There were three declarations of interest made.

Councillor	Interest	Description
Lawson	Personal	Employee at University Hospitals Plymouth, NHS Trust,
Noble	Personal	Employee at University Hospitals Plymouth, NHS Trust,
Morton	Personal	Employee at University Hospitals Plymouth, NHS Trust,

101. **Minutes**

The minutes of the meeting held on 15 July 2025 were agreed as a correct record.

102. **Chair's Urgent Business**

There were no items of Chair's Urgent Business.

103. **Adult Social Care Finance Report, Month 6 - 25/26**

Helen Slater (Lead Accountancy Manager) delivered the Adult Social Care Finance Report, Month 6- 25/26 report and discussed:

a) At Month 6, the Adult Health and Communities Directorate reported a financial pressure of just over £3 million, of which £2.243 million related specifically to Adult Social Care;

b) £824,000 of the pressure was within domiciliary care, driven by increased demand for intermediate care to support hospital discharge;

c) The largest element of pressure, £3.519 million, related to bedded care (residential and nursing care) across all pathways;

d) A further £477,000 pressure was attributed to other care packages, linked to reduced waiting lists which had a financial impact;

e) There was a direct correlation between increased expenditure and income through joint funding and client contributions, which helped offset pressures by £2.310 million;

f) A new Joint Funding Panel had been established to maximise contributions for clients with shared health and social care needs, which commenced the previous week;

g) A Director's Budget Containment Group had been set up to review high-risk areas, including domiciliary care analysis, fee levels, pipeline demand, timescales, and planning for increases in client direct payments;

h) Work was ongoing to address short-term residential clients and identify barriers to transitioning to long-term care;

i) 75% of the in-year savings target (£2.074 million) had been achieved, with the remainder flagged as amber for delivery by year-end;

j) Budget planning for 2026/27 was underway, with assumptions being made on the National Living Wage (modelled at £12.80 per hour) and inflation, pending confirmation. There remained significant uncertainty regarding overall PCC funding following the recent policy statement, which was being analysed and modelled.

In response to questions, the Panel discussed:

k) Confidence in meeting savings targets, with assurance given that progress was positive at 75% achieved and risks were being managed throughout the year;

l) Contingency planning for potential increases in the National Living Wage, noting that sensitivity analysis was undertaken as part of the Medium-Term Financial Plan (MTFP) and various scenarios were modelled, although there was no specific contingency line for this;

m) The importance of continued scrutiny, with budget scrutiny scheduled for January.

The Panel agreed:

1. To note the Month 6 Finance Report for Adult Social Care and the actions being taken to manage financial pressures;

2. To receive further updates as part of the upcoming budget scrutiny process.

104. **Adult Social Care Activity and Performance Report**

Andy Williams (Lead for Adult Social Care, Livewell Southwest), Gill Nicholson (Head of Innovation and Delivery), Julia Brown (Service Director for Health and Adult Social Care), Gary Walbridge (Strategic Director for Adults, Health and Communities), and Ian Lightley (Chief Operating Officer, Livewell Southwest) delivered the Adult Social Care Activity and Performance Report and discussed:

a) The report was structured into four sections: Care Act Assessments, Care Act Reviews, Occupational Therapy (including minor adaptations), and Commissioned Services, with additional updates on domiciliary care, reablement, direct payments, and hospital discharge performance;

b) Significant progress had been made in reducing the Care Act assessment waiting list, which stood at 301 in September against a target of 200, compared to 800 eighteen months ago;

c) The average time to complete an assessment from allocation was 16.9 days, and 178 assessments had been completed in the reporting period;

d) A more targeted approach was being adopted to support the system, recognising that clearing backlogs had increased demand for domiciliary and residential care. This work was linked to the Council's Budget Containment Plan, including reviewing whether needs had changed and adjusting priorities accordingly;

e) The sustainable waiting list target of 200 was based on modelling that assumed processing within 28 days, though this would be reviewed once achieved;

f) The percentage of long-term service users with an assessment within the last year had risen to 57.4%, approaching the national target of 60.7%. Productivity remained strong despite added responsibilities, and the most long-standing reviews were complete;

g) Further efficiencies were limited, but focus remained on reviewing new cases promptly, reducing waiting lists, and delivering timely responses. Review waiting times were improving in line with assessment work;

h) Local stretch targets were set annually based on comparator authorities and national performance;

i) Increased costs following reviews were attributed to increased need rather than inflation. Data on reviews resulting in reduced or ceased care packages would be added to future reports;

j) The number of people waiting for Section 2 occupational therapy assessments had reduced, but further work was needed to bring waiting lists down. The average waiting time was 192 days, which was acknowledged as too high;

k) Livewell had initiated an improvement programme aligned to wider transformation, focusing on early intervention, community-based support, and initiatives such as encouraging private equipment purchases, reintroducing care and repair services, and better use of community hubs;

l) Plans included raising the minor adaptation budget threshold, streamlining access to basic equipment through self-referral, and partnerships with local suppliers to release capacity within the team;

m) Challenges included historic data issues between systems, which had now been resolved, and workforce pressures. A phased recovery plan was in place to reduce waiting times over 12 months, applying learning from Care Act assessment improvements;

n) There had been an increase in residential and nursing care placements for adults over 65, rising from 368 in October last year to 391 currently, creating budget pressures;

o) Work was ongoing to review care packages and ensure appropriate step-down from hospital discharge to home where possible. Individuals discharged into residential care were contacted within 24 hours and seen within 48 hours, with a target of resolving Pathway Two cases within 42 days;

p) Increased demand for domiciliary care was noted, with work ongoing with Independence at Home and internal brokerage teams to increase capacity and ensure timely, person-centred support;

q) Reablement performance was positive, with 81.6% of individuals remaining at home after 91 days, above regional benchmarks. Average length of stay in reablement was 4.7 weeks against a six-week target. Plans were in place to expand reablement services citywide;

r) Uptake of direct payments had returned above target, with 635 individuals (over 20% of current users) now using this option. The banking service had been brought in-house, and work continued to promote direct payments through Livewell social workers;

s) While "No Criteria to Reside" figures had deteriorated earlier in the year, recent weeks had seen improvement, with Plymouth's position benchmarking well nationally. Collective work continued with Devon and Cornwall colleagues to maintain performance through winter.

In response to questions, the Panel discussed:

t) The Panel suggested exploring whether housing associations could undertake simple adaptations, such as installing handrails, without requiring a full occupational therapy assessment. Officers agreed this was a practical idea and confirmed it would be investigated further;

u) The Panel requested year-on-year data to identify seasonal trends and asked for distribution analysis of waiting times, including banding and prioritisation methods. Officers confirmed that historic data could be provided, noting that previous methodology changes might affect comparability;

v) The Panel expressed concern about the availability of care staff to meet increasing demand for home-based care and reablement services. Officers confirmed that recruitment had improved post-pandemic, market capacity was currently stable, and work continued to ensure continuity of care and effective workforce deployment;

w) The Panel emphasised the importance of maintaining independence for individuals discharged from hospital and ensuring they were placed in appropriate settings. Officers outlined commissioning work to embed reablement approaches in care homes and confirmed efforts to match individuals to suitable environments, including consideration of cognitive needs;

x) The Panel raised concerns about individuals without dementia being placed in homes where most residents had dementia, potentially leading to isolation. Officers acknowledged this challenge and confirmed that placement decisions aimed to match individuals to appropriate settings wherever possible;

y) The Panel queried whether early discharge from hospital contributed to increased residential placements. Officers confirmed that collaborative work was underway with hospital teams to ensure least restrictive options were considered and that individuals were supported to return home wherever possible;

z) The Panel queried challenges with the uptake of direct payments. Officers advised that Plymouth performed well compared to other authorities but aimed to further improve figures next year, promoting choice and control for service users;

aa) The Panel asked whether individuals were being signposted to private occupational therapy assessments and how many had taken this route. Officers confirmed that while advice was given, data on private assessments was not routinely captured.

1. **Action:** Officers to explore opportunities for housing associations to undertake minor adaptations without requiring a full occupational therapy assessment;

2. **Action:** Officers to provide year-on-year data to identify seasonal trends and include distribution analysis of waiting times, including banding and prioritisation methods;

3. **Action:** Data on reviews resulting in reduced or ceased care packages to be added to future reports;

4. **Action:** Officers to provide data on the proportion of community-based assessments resulting in a formal package of care at the next meeting.

The Panel agreed:

1. To note the Adult Social Care Activity and Performance Report and the progress made across all areas.

105. **Winter Planning**

Michael Whitcombe (Deputy Chief Operating Officer, University Hospitals Plymouth), Louise Ford (Head of Commissioning), Chris Morley (Plymouth Locality Director, NHS Devon) and Ed Garvey (Head of Locality Commissioning, NHS Devon) presented the Winter Planning update and discussed:

a) Winter planning was an annual process undertaken collectively across University Hospitals Plymouth (UHP), Livewell Southwest, Plymouth City Council, and wider system partners, guided by national expectations and NHS England returns;

b) The approach was informed by predictive modelling based on previous winter demand and analysis of flu season trends in the southern hemisphere, particularly Australia, to anticipate pressures such as respiratory illness surges, high bed occupancy, long emergency department waits, and ambulance handover delays;

c) The hospital's operational picture indicated that without mitigations, there would be a gap of 70–90 beds against demand. Strategic actions had reduced this gap to approximately 33–40 beds, supported by seven key workstreams focusing on infection prevention and control, surge response, timely discharge, workforce resilience, and community services;

d) Ambulance handover performance had deteriorated in October but improved significantly, with less than 1,000 hours lost and an average handover time of 16 minutes, against a mandatory target of 45 minutes and an aspiration of 30 minutes. The national standard remained 15 minutes;

e) Key assumptions included a 1.5% increase in non-elective demand and peak flu and COVID pressures occurring in the second week after Christmas. The hospital aimed to maintain elective services and utilise virtual wards and community support to ensure timely discharge;

f) Vaccination uptake was critical to reducing bed occupancy pressures. UHP had achieved approximately 38% staff uptake for flu vaccination, with targeted campaigns and outreach to hard-to-reach areas. Vaccinations had improved uptake compared to previous years;

g) The hospital lost around 120 beds last winter due to flu, COVID, and norovirus, with approximately 10% of these occupied by care home residents. Actions were being taken to provide care within residential settings to avoid hospital admissions and associated risks;

h) Virtual ward capacity included 75 acute beds (respiratory and cardiology) and 68 frailty beds, with plans to increase to 95 beds before winter. Occupancy had dropped but improvement work was underway to raise awareness and streamline onboarding processes;

i) Additional pathway one capacity had been commissioned to support home-based care and prevent destabilisation of the local workforce, including agency support for PCC's Independence at Home service;

j) Brokerage processes were being strengthened to ensure timely access to domiciliary care for hospital discharge and community step-up support, alongside measures to prevent hospital admissions through wraparound services;

k) Workshops with domiciliary care providers had secured commitments to increase workforce capacity before Christmas, supporting the system's "Home First" approach. Approximately 66% of complex discharges now resulted in home-based care, compared to 24–25% two years ago;

l) For pathway two (bedded care), work was ongoing with PCC to ensure capacity and reablement support, including projects to utilise additional pathway one capacity for individuals leaving bedded settings;

m) Integrated working was supported through daily system escalation calls, weekly commissioning oversight meetings, and governance processes to monitor pressures and take rapid action where necessary;

n) Measures to maintain market resilience included promoting vaccinations and infection prevention across care settings, monitoring demand and capacity for bedded and domiciliary care, supporting access to household support funding, and addressing staff training needs for timely discharge planning;

o) The autumn/winter campaign was underway, targeting eligible cohorts through GP practices, pharmacies, schools, hospitals, and outreach clinics for housebound individuals and underserved communities. Uptake for flu

vaccination across Devon was higher than last year, with targeted actions for areas of lower uptake;

p) Communications focused on encouraging early protection, with messages such as "Don't give the gift of flu for Christmas." Booking options included the NHS website and 119 telephone service.

In response to questions, the Panel discussed:

q) Assurance that vulnerable groups, including those in drug and alcohol rehabilitation and homeless services, were being offered vaccinations, with officers confirming eligibility and targeted outreach;

r) Clarification on whether additional winter capacity involved new staff or existing personnel taking on extra tasks. Officers confirmed that additional care capacity was sourced externally to avoid destabilising the local workforce, while integrated working across health, social care, and providers was key to resilience;

s) The importance of flow through capacity as well as increasing numbers, with officers highlighting daily escalation calls and governance processes to manage discharge and commissioning decisions;

t) Uptake of vaccinations among hospital staff, which had improved compared to previous years but remained below desired levels;

u) Emergency preparedness for future pandemics, with officers confirming that disaster plans, national escalation frameworks, and scenario modelling were in place, supported by a Devon-wide command centre;

v) Ambulance handover times, with officers confirming an average of 16 minutes currently, significant improvement from previous delays, and assurance that patients received continuous care during any waiting period;

w) Virtual ward capacity and challenges, noting reduced occupancy and recruitment delays but plans to increase frailty beds and improve onboarding processes;

x) Concerns about temporary escalation spaces and corridor care, with officers confirming that the Trust did not tolerate corridor care and had measures to prevent its use except in extreme circumstances, with rapid de-escalation when required;

y) Uptake of vaccinations in care homes, with officers confirming improved rates this year;

z) Cultural and personal barriers to vaccination uptake, with officers noting ongoing monitoring and targeted education to address resistance.

The Panel agreed:

1. To note the Winter Planning update and the actions being taken across health and social care to manage seasonal pressures;

2. To receive data on vaccination uptake in care homes and across staff groups at a future meeting.

106. **Readmissions at UHP**

Anjula Mehta (Joint Chief Medical Officer, University Hospitals Plymouth) and Rachel O'Connor (Director of Integrated Care, Partnerships and Strategy) presented the Hospital Readmissions update and discussed:

a) NHS England defined a readmission as a patient being readmitted to hospital as an emergency within 30 days of their previous stay. This definition did not require a clinical link to the previous condition, meaning some readmissions were unrelated to the original admission;

b) It was highlighted that readmissions needed to be considered through multiple lenses:

   i. Whether the readmission was clinically related to the index admission or a new condition;

   ii. Whether discharge processes contributed to the readmission, including poor coordination or unclear communication;

   iii. Operational pressures during winter months that could impact discharge quality;

   iv. Patient-specific factors such as social care breakdown or environmental issues;

   v. Data quality and coding inconsistencies, which could misclassify planned follow-ups as readmissions;

c) The risks of prolonged hospital stays were emphasised, particularly for frail elderly patients. Evidence showed:

   i. Average length of stay for complex patients was up to 21 days;

   ii. 30% of older patients developed hospital-acquired disabilities, which could include muscle loss, functional decline, and mental health deterioration;

   iii. Muscle loss of 2–5% per day during immobility, leading to significant deconditioning over 10–21 days;

   iv. Increased risk of falls (50% higher for older patients), delirium (20–30% increase), depressive symptoms (up to 60%), infections, and pressure injuries;

d) Data analysis indicated:

   i. Total readmissions had increased in absolute numbers, but the readmission rate remained stable at 7.2%, below the national average;

   ii. Overall discharges had increased, meaning the proportion of readmissions had not risen significantly;

   iii. Complex discharges had not seen an increase in readmissions, which was reassuring and suggested discharge processes for these patients were effective;

e) A deep dive into 100 readmission cases revealed that only 43% were true unplanned readmissions. Many were incorrectly coded as readmissions when they were planned follow-ups, such as:

   i. Surgical patients admitted for diagnosis on day one and returning for a procedure the next day;

   ii. Patients in same-day emergency care returning for blood tests or reviews;

   iii. These cases should have been coded differently, highlighting the need for improved data quality;

f) Patient safety assurance was sought through incident reporting, which showed:

   i. A reduction in harm incidents related to discharge and readmissions;

   ii. A reduction in incidents where readmission was a cause of concern;

   iii. A reduction in ED delay-related harm, attributed to improved patient flow;

g) Patient experience data indicated that over 50% of surveyed patients were unclear about their discharge plan and felt poorly supported when returning to the community. Concerns included:

   i. Inconsistent communication, with different staff giving conflicting information;

   ii. Poor coordination of discharge processes, leaving patients uncertain about what would happen next and where to seek help;

h) While patient safety concerns had reduced, the lack of clarity and confidence among patients remained unacceptable and required urgent improvement;

i) Next steps included:

i. Conducting an audit focused on patient voice to understand reasons for readmissions and whether they were clinically necessary or due to lack of support;

ii. Improving data quality and coding accuracy to distinguish planned follow-ups from true readmissions;

iii. Implementing quality improvement work to strengthen discharge processes, including early and consistent communication with patients and families;

iv. Ensuring staff across wards adopt cultural changes through initiatives such as the "Building Brilliance" programme, which asks patients daily: "Do you know what is happening today? Do you know when you are going home? Do you know what to expect next?";

v. Enhancing system-wide collaboration to connect hospital and community pathways, particularly for frail elderly patients;

vi. Expanding use of community-based services such as virtual wards, which provided multidisciplinary care in patients' homes to reduce readmissions and support confidence post-discharge;

In response to questions, the Panel discussed:

j) The importance of clear communication with patients throughout their hospital stay and at discharge. Members noted that lack of information caused distress and confusion, with patients often unaware of why they were being moved or discharged. It was explained that communication was a cultural issue requiring consistent improvement. The Building Brilliance programme was a key initiative to ensure patients understood their care plan and discharge arrangements;

k) Concerns raised by care homes about patients being discharged too early and subsequently readmitted. Robust clinical handovers to care homes were essential and details of any specific cases would be addressed;

l) The Panel welcomed plans to improve discharge processes and requested a future update on progress, particularly regarding patient experience and communication improvements;

m) UHP was committed to cultural change and quality improvement, and that patient voice audits and pathway reviews would inform future actions.

1. **Action:** Officers to return to a future meeting with an update on patient experience improvements, discharge process changes, and outcomes of the patient voice audit.

The Panel agreed:

1. To note the update on hospital readmissions and the actions being taken to improve discharge processes, patient experience, and data quality;

2. To receive a future report on progress with the Building Brilliance programme and discharge quality improvement work;

3. To provide details of any care homes reporting concerns about early discharge to support targeted improvements.

107. **Action Log**

The Panel agreed to note the progress of the Action Log.

108. **Work Programme**

The Panel agreed to add the following items to the Work Programme:

1. Care Quality Commission (CQC) Outcome report;
2. Armed Forces Care Update;
3. PCC Carers Strategy;
4. Wellbeing Hubs;
5. Social Prescribing.

109. **Exempt Business**

There were no items of Exempt Business.