Health and Wellbeing Board

Friday 3 October 2025

PRESENT:

Councillor Aspinall, in the Chair.
Councillor Lugger, Vice Chair.
Councillors Laing and P.Nicholson.

Statutory Members: David Haley (Director for Children's Services), Professor Steve Maddern (Director of Public Health), Chris Morley (Locality Director for Plymouth, NHS Devon), Tania Paine (Healthwatch Plymouth), and Gary Walbridge (Strategic Director, Adults Health and Communities).

Co-opted Representatives: Ian Lightley (Chief Operating Officer, Livewell Southwest), Rachel O'Connor (Director for Integrated Care Partnerships and Strategy, UHP), and Rob Smith (Chief Executive, Improving Lives Plymouth).

Also in attendance: Peter Collins (Chief Medical Officer, NHS Devon), Louise Ford (Head of Commissioning), Matthew Jerreat (Regional Chief Dental Officer, South West), Jane Marley (Public Health Specialist), Kamal Patel (Public Health Consultant), Melissa Redmayne (Pharmacy Optometry and Dental Commissioner, NHS Devon), Michael Whitcombe (Deputy Chief Operating Officer, University Hospitals Plymouth), and Elliot Wearne-Gould (Democratic Advisor).

The meeting started at 10.00 am and finished at 12.46 pm.

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.

51. **Declarations of Interest**

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

52. **Chairs Urgent Business**

There were no items of Chair's Urgent Business.

The Chair thanked Jo Beer (Chief Operating Officer, University Hospitals Plymouth) for her collaboration and support to the Board.

53. **Minutes**

The Board agreed the minutes of 12 June 2025 as a correct record.

54. **Questions from the public**

There were no questions from members of the public.

55. **Winter Planning 2025-26**

Chris Morley (Locality Director for Plymouth, NHS Devon ICB) introduced the Winter Planning Update and discussed:

a) Winter planning aimed to ensure robust plans were in place across health and social care to maintain flow and service delivery during the winter period and anticipated pressures;

b) The presentation outlined University Hospitals Plymouth's (UHP) winter plan, noting that this was a collaborative effort across partners, including Livewell Southwest and Plymouth City Council;

c) Headline areas included social care preparations, market resilience, and the vaccination programme.

Michael Whitcombe (Deputy Chief Operating Officer, UHP) added:

d) During winter 2024/25, bed occupancy rates had exceeded 98%, with an average of 40 patients remaining in the Emergency Department awaiting onward beds, and nearly 20% of patients experienced onward delays;

e) Ambulance handover delays had resulted in over 7,500 hours lost, preventing crews from responding effectively in the community;

f) The system was focused on meeting NHS England mandates, including delivering ambulance handovers within 30 minutes, improving Category 2 response times, and reducing 12-hour stays in the Emergency Department;

g) The acute bed gap, if no action was taken, was forecast at 70–90 beds short within the acute trust. Seven workstreams were in place to address this, aiming for a 50% reduction, equating to 39 beds;

h) Reducing length of stay by half a day could close the gap by 22 beds, supported by improved discharge processes and collaboration with community partners;

i) Elective care would be maintained throughout winter and vaccination hubs were operational, aiming for a 5% increase in staff uptake and encouraging patient vaccinations;

j) Current performance showed 72% compliance with the four-hour standard, a 6% improvement on last year, and ambulance handover delays had reduced by two-thirds in the last quarter.

Louise Ford (Head of Commissioning) provided an update on social care preparations and discussed:

k) Work continued to ensure effective flow and commissioned capacity, including collaboration with Advice Plymouth and hospital discharge teams to streamline processes;

l) Infection prevention and control measures were regularly raised with providers, alongside ensuring business continuity plans were in place;

m) Additional work focused on demand and capacity planning, data integration for real-time forecasting, optimisation of brokerage functions, and oversight through the Integrated Commissioning Group;

n) Winter plan actions included promoting vaccinations, supporting unpaid carers, and resilience-building for the care workforce.

Peter Collins (Chief Medical Officer, NHS Devon ICB), Rachel O'Connor (Director of Integrated Care and Partnership, UHP) and Ian Lightley (Chief Operating Officer, Livewell Southwest) added:

o) The Devon-wide campaign went live on 01 October 2025, prioritising older adults and aimed for completion by the end of November 2025, with school programmes continuing until March 2026;

p) Delivery models included GP sites, pharmacies, schools, acute hospitals, and targeted outreach for underserved communities.

In response to questions, the Board discussed:

q) Concerns about ambulance delays and assurance that patients in ambulances received the same level of care as those in the Emergency Department, supported by HALO teams and rapid assessment nurses;

r) The role of NHS 111 in winter preparedness, with improvements in clinical triage and signposting to alternatives to ED admission;

s) Vaccination uptake challenges among health and social care staff, with Livewell reporting 40% uptake in 2024/25 and a target of 60% this year. Public Health confirmed national trends of declining uptake and committed to monitoring and tactical interventions;

t) The need for data collection across providers to monitor vaccination uptake and address gaps, particularly among domiciliary care and voluntary sector workers;

u) Assurance was sought that employers supported staff vaccination and that myths and resistance were being addressed through engagement and education;

Action: Requested that Public Health analyse data on health & social care staff vaccination, including across care markets, and report back to a future meeting;

Action: Requested that future reports include analysis of vaccination uptake and availability for the City's 'looked after children'.

Action: Requested that vaccination access and eligibility for voluntary sector workers (e.g., wellbeing hubs) is considered and reported to a future meeting.

The Board agreed:

1. To review, comment on, and endorse the plans set out in the Winter Planning report;

2. To receive feedback and updated data on vaccination uptake and winter preparedness at a future meeting.

56. **NHS 10 Year Plan & Integrated Neighbourhood Teams**

Chris Morley (Locality Director for Plymouth, NHS Devon ICB) introduced the NHS 10-Year Plan and Integrated Neighbourhood Teams report and discussed:

a) The NHS 10-Year Plan was published on 3 July 2025 and centred on three key shifts: moving from acute to community care, shifting from treatment to prevention, and maximising digital opportunities;

b) The plan emphasised reducing waiting lists, tackling inequalities, and improving convenience for individuals, alongside a new operating model for Integrated Care Boards (ICBs) to act as strategic commissioners and reduce running costs to free up frontline resources;

c) Workforce was highlighted as a central priority, ensuring staff were better treated, motivated, and supported with training and career development;

d) Devon's engagement plan was considered a leading example nationally, with significant feedback from Plymouth, including two well-attended workshops and drop-in sessions. A substantial proportion of national feedback came from Devon;

e) Key feedback themes included valuing the NHS as free at the point of access, prioritising workforce as the most valuable asset, improving access and personalisation, addressing primary care and mental health waiting times, and recognising low satisfaction levels with NHS operations. Funding the NHS sufficiently was seen as a priority;

f) The three shifts outlined in the plan were discussed:

   i. Hospital to community: More investment in frontline services and reduction in management costs;

   ii. Sickness to prevention: Better access to diagnostics and preventative services, and education strategies to build confidence in self-care;

   iii. Analog to digital: Leveraging technology while addressing mistrust of AI, ensuring data safety, and avoiding digital exclusion;

g) Integrated Neighbourhood Teams were identified as a golden thread within the plan, requiring a neighbourhood-focused operating model. Plymouth's Local Care Partnership (LCP) would drive local development, supported by a Devon-wide steering group;

h) Plymouth had submitted an application to join the national Neighbourhood Health Implementation Programme during a three-week summer window, with 25 partners signing up, the highest number in Devon. Although unsuccessful in wave one, discussions with NHS England were ongoing to position Plymouth for wave two in March next year;

i) Partners committed to progressing work regardless, revisiting foundations to define vision, co-produce offers with communities, and pilot initiatives to accelerate learning;

j) The emerging Devon Health and Care Strategy proposed a neighbourhood delivery model for populations of 30,000–50,000, integrating health, social care, and voluntary services, alongside place-level and specialist services where appropriate;

k) Current priorities included defining neighbourhood footprints, implementing risk stratification tools, and aligning governance through the LCP. The ambition was to accelerate progress while maintaining co-design principles.

In response to questions, the Board discussed:

l) The importance of co-designing neighbourhood footprints with all partners, including the Council, Livewell Southwest, UHP, primary care, and the voluntary sector, ensuring alignment with natural communities and insights;

m) The need to temper optimism with reality, recognising that healthcare delivery would change significantly and require clear communication to the public about benefits and implications;

n) Concerns about public dissatisfaction with NHS services and the lack of joined-up IT systems. Assurance was given that digital architecture improvements were underway to enable data sharing and interoperability;

o) The Health and Wellbeing Board's oversight role was confirmed, including responsibility for signing off the neighbourhood health plan as part of the annual operational planning process. Timelines were tight, and additional Board meetings might be required;

p) Alignment with the government's Families First programme for children was discussed, with assurance that local efforts would integrate both agendas to avoid duplication and confusion;

q) Members requested health partners' views on local government reorganisation and its impact on healthcare delivery, with a commitment to share insights directly with all councillors;

r) UHP expressed strong support for integrated neighbourhood teams, noting recent investment of £6–7 million into community care and the need for bold timelines and robust governance to manage shared risk and accountability;

s) The importance of recognising Plymouth's tertiary and specialist care capabilities in the plan was highlighted;

t) Livewell Southwest reiterated support for the neighbourhood model and stressed the need to maintain momentum following the summer bid, accelerate governance, and improve public messaging to avoid alienating communities with technical terminology;

u) Members emphasised the opportunity to align governance with prevention agendas and winter planning priorities, and the need for flexible, hyper-local approaches within larger neighbourhood footprints;

Action: Requested clarification on how young people would be consulted and engaged throughout the development of Neighbourhood planning;

Action: Requested that consultation was shared with all councillors in addition to the relevant committees to ensure that wholistic community views were captured.

The Board agreed:

1. To review, comment on, and debate the content of the report and its implications for Board partners;

2. To be kept informed of progress and convene additional Health and Wellbeing Board meetings if required to meet national timelines.

57. NHS Devon ICB Dental Services Update

Peter Collins (Chief Medical Officer, NHS Devon ICB) introduced the Dental Services Update and discussed:

a) Both primary and secondary dental services were not at the level required to serve the population, which was recognised as a national issue rather than solely local;

b) The Board was assured that all possible options were being explored to provide care and improve access, including new and innovative approaches.

Melissa Redmayne (Senior Primary Care Commissioning Manager, NHS Devon ICB) presented the national position and local response and discussed:

c) The dental contract was a national contract and widely recognised as unfit for purpose. The Government had reiterated its commitment to fundamental reform, but the latest consultation focused on interim measures rather than full

reform. The consultation closed in August 2025, with changes anticipated in April 2026;

d) The current model would remain based on Units of Dental Activity (UDA), but changes aimed to improve attractiveness, prioritise urgent needs, significant dental issues, children, and prevention, and allow better use of skill mix;

e) A national urgent dental care incentive scheme had been announced, but Devon had already introduced a local scheme considered more attractive in terms of finance and operational support;

f) The local dental recovery plan prioritised urgent dental care, commissioning additional stabilisation services to prevent repeat urgent cases, and commissioning access for vulnerable groups to reduce inequalities. Oral health initiatives continued with local authority partners, expanding from children to care homes;

g) Key progress included increasing the minimum UDA rate to £34.66, above the national minimum of £28 and closer to the British Dental Association's recommended £35, following strong feedback from stakeholders;

h) A local urgent care incentive scheme launched in Q1 increased the urgent care rate to £105 (previously £40), representing a £5 million investment in Devon. Six providers were operating in Plymouth;

i) Contract management changes released £2.6 million from under-delivered contracts in Plymouth, enabling commissioning of new services. Additional orthodontic activity was commissioned, including 1,235 units in Plymouth;

j) A new procurement was launched for urgent care, stabilisation, and mandatory services for vulnerable populations. Plymouth had the largest lot, seeking 54,000 units per annum, with a contract value of £18 million over its life and £2.2 million per annum. Contracts were expected to be awarded in January 2026 and mobilised by May 2026;

k) Services for vulnerable groups included provision for people experiencing homelessness and children looked after in Plymouth, with plans to expand to cancer pathways and patients on bone-strengthening medication;

l) Workforce initiatives included a £327,000 Golden Hello scheme, offering £20,000 incentives for dentists committing to NHS activity for three years. Four appointments had been made in Devon, with one pending in Plymouth. A workforce group had agreed six priority areas;

m) Devon held 150 NHS dental contracts and 13 orthodontic contracts. Q1 delivery was 21,000 appointments (87% of target), and Q2 delivery was 91% of target, with data still being finalised. Activity had not bounced back post-COVID, particularly in rural and coastal areas, and reversing this trend would take time;

n) Urgent dental care remained the top priority, with a target of 81,750 appointments (Devon's share of 700,000 nationally) by 2025/26, representing a 42% increase from baseline. Urgent care activity had declined by 24% since 2024/25, but recent performance showed improvement, moving Devon's national ranking from 41st to 31st.

Matthew Jerreat (Regional Chief Dental Officer, South West) added:

o) Fluoride varnish application would only occur after dental assessment and would not mask decay. Preventative measures such as supervised toothbrushing were evidence-based and effective;

p) Workforce challenges were significant, with students often returning to home regions or larger cities. Plans included marketing campaigns, videos promoting Devon, and developing apprenticeships for dental nurses and the wider team. Engagement with MPs and regional leadership was ongoing.

In response to questions, the Board discussed:

q) Recognition of progress and the need for assurance that underspent funds would be reinvested locally. It was confirmed that no value-for-money schemes were being blocked due to lack of resource;

r) Members raised concerns about patient expectations regarding registration with dentists. It was confirmed that reforms in April would address NICE guidance and improve continuity of access;

s) The impact of UDA uplift on urgent care decline and raised technical concerns about fluoride varnish masking decay. It was assured that varnish would only follow assessment and prevention measures were evidence-based;

t) Members emphasised the importance of public messaging to communicate improvements and manage expectations;

u) Questions were raised about increasing hospital slots for children requiring extractions under general anaesthetic. It was confirmed that an internal business case was being developed to increase capacity and meet national standards;

v) The Board discussed recruitment and retention challenges, noting plans for apprenticeships, marketing, and collaboration with the new Postgraduate Dental Dean. Members suggested using Plymouth's branding assets to support recruitment campaigns.

The Board <u>agreed</u>:

1. To review, comment on, and debate the contents of the report, its implications, and next steps for Board partners;

2. To receive updates on procurement outcomes, workforce initiatives, and paediatric dental capacity at future meetings.

58. **Plymouth Drugs Partnership Annual Report**

Kamal Patel (Consultant in Public Health) and Jane Marley (Public Health Specialist) introduced the Plymouth Drugs Partnership Annual Report and discussed:

a) The report outlined the work of the Plymouth Drug Strategic Partnership, which addressed significant individual and societal harm associated with drug and alcohol dependence, including coexisting challenges such as poor physical and mental health, poverty, discrimination, violence, offending, and homelessness;

b) Drug deaths in England had been rising since 2014, leading to the national drug strategy in 2021, which focused on three priorities: breaking supply chains, delivering world-class treatment and recovery, and achieving a generational shift in demand;

c) The partnership comprised multiple members, including Public Health, Devon and Cornwall Police, OHID regional teams, commissioned providers, probation services, the Police and Crime Commissioner, and elected members;

d) National estimates indicated approximately 2,000 people in Plymouth used opiates and/or crack, and 3,500 were alcohol dependent. Plymouth's opiate/crack use rate was 27% higher than England, and alcohol dependency was 21% higher;

e) Main commissioned providers included the Plymouth Alliance for Complex Lives, Harbour, Hamoaze House, and Livewell Southwest for adults, and The Children's Society for young people;

f) Drug treatment capacity had increased by 8% overall, driven by non-opiate and alcohol treatment. A reported 12% reduction in young people's treatment was attributed to a coding error during provider transition, which had since been corrected;

g) Unmet need for opiates and crack was significantly below the national average, placing Plymouth among the top five areas nationally for reaching this cohort. However, unmet need for alcohol remained high at 79%, slightly above the national figure of 76%;

h) Treatment progress showed 47% of adults achieved successful outcomes, matching the England average. Outcomes for young people were similar to national figures, with Plymouth performing better for cannabis and other drugs;

i) Continuity of care for prison leavers with drug treatment needs had improved significantly, now exceeding the England average, reducing risks of harm, death, and reoffending;

j) Drug misuse deaths in Plymouth were 7.5 per 100,000, compared to 5.5 nationally, reflecting higher prevalence. Deaths in treatment had reduced from

2% to 1.5%, approaching the England average of 1.3%, though further improvement was needed;

k) Alcohol-related deaths had increased locally while reducing nationally, though confidence intervals overlapped. Work was ongoing to address this trend;

l) Delivery plan priorities included improving treatment quality and capacity, reducing drug deaths through initiatives such as the Local Drug Information System, synthetic opioid preparedness, peer-to-peer naloxone distribution, the Plymouth Overdose Response Team, and the Avoidable Deaths Review Group;

m) Alcohol-focused work included an alcohol steering group, needs assessment, a new specialist community alcohol treatment team, dedicated training packages, licensing engagement, screening tools, and intramuscular thiamine provision to prevent alcohol-related brain injury;

n) Workforce development was a key priority, with initiatives such as suicide prevention training, trauma-informed approaches, workplace wellbeing champions, and embedding the drug and alcohol capability framework;

o) Integration efforts included co-location of mental health teams within Harbour, MDT contributions, psychological therapy access, and partnerships with homelessness intervention teams, and employment support through Shekinah;

p) Criminal justice work focused on continuity of care, hospital in-reach, alcohol interventions, and probation engagement;

q) Children and young people's work included increasing school referrals, embedding CAMHS workers within services, educational outreach via The Zone, and a partnership group addressing substance misuse and vaping, now expanding to broader needs. Priorities included implementing screening tools, understanding ketamine use, and piloting a virtual team model;

r) Future priorities included strengthening enforcement collaboration across Devon and Cornwall, refreshing the delivery plan, undertaking a substance use health needs assessment, expanding young people's work, continuing synthetic opioid preparedness, and embedding co-production with service users.

In response to questions, the Board discussed:

s) Licensing engagement: Public Health would join licensing panels to assess applications, informed by mapping of alcohol-related hospital admissions against licensed premises. Work would include harm reduction measures and supporting police-led "Reduce the Strength" campaigns;

t) Deaths in treatment: Deaths in treatment had reduced over time, aided by the Avoidable Deaths Review Group, which reviewed two cases every eight weeks and would produce a system-wide learning report;

u) Data accuracy: Members queried corrections to children's treatment data. It was confirmed that the issue was explained narratively in the report and resolved for future reporting.

The Board agreed:

1. To endorse the actions taken by the Plymouth Drugs Partnership for 2024/25;

2. To provide comments and suggested areas of focus for the partnership going forward, including care-experienced young people;

3. To receive updates on delivery plan refresh, enforcement collaboration, and health needs assessment at future meetings.

59. **Partner Updates**

Rachel O'Connor (Director of Integrated Care, Partnerships & Strategy, UHP) provided an update and discussed:

a) The national oversight framework for NHS trusts had been published, ranking trusts from segment one (highest quality) to segment five (special measures). UHP was rated in segment four, an improvement from previous positioning, reflecting progress made in key areas;

b) The rating was influenced by ambulance handover delays, staff survey results, and training experience scores. UHP ranked 109 out of 134 trusts nationally. Financial deficit constraints meant trusts could not score above segment three until recovery was achieved;

c) The framework was publicly accessible, and UHP was committed to transparency and improvement. Quarterly progress reports would be presented to the Trust Board;

d) UHP had been invited to bid for an extension to the Community Diagnostic Centre (CDC) currently under construction in the city centre. The bid, worth £20–25 million, aimed to create a health community hub incorporating diagnostics, cancer pathways, and potential co-location of dental and primary care services. Early co-design discussions were underway with planning teams and partners;

e) Surgery services had been rated "Good" by the CQC, moving up from "Requires Improvement" and "Inadequate" following significant improvement work. New facilities, including the orthopedic centre and REI contributed to this success;

f) Stroke performance had achieved national recognition, with UHP ranked second in the country for thrombectomy outcomes in the 2024/25 SNAP report. Further improvements were planned through consultant expansion and pathway development.

In response to questions, the Board discussed:

g) Concerns about patient drop-off and pick-up points at Derriford Hospital during site development. Members requested consideration of shelter provision for patients waiting outdoors, particularly during winter.

Tanya Payne (Healthwatch Plymouth) presented and update and discussed:

a) The DASH Review, published in July 2025, included nine recommendations accepted by the Government. Recommendation five proposed merging statutory functions of local Healthwatch: health-related functions into ICBs and social care functions into local councils;

b) Legislative changes to the Health and Social Care Act were expected following the King's Speech in spring. The NHS 10-Year Plan proposed closing Healthwatch England or merging it into the Department of Health and Social Care under a new national directorate for patient experience;

c) Local Healthwatch statutory roles would be integrated with NHS and council functions. Until legislation changed, Healthwatch would continue business as usual, with contracts maintained. Plymouth's current contract ran until March 2026;

d) Engagement priorities were under review to ensure patient voice remained central during system changes. Healthwatch continued to support community engagement, including contributions to the NHS 10-Year Plan consultation and securing input from children;

e) Volunteers remained active in care home engagement and place inspections, despite uncertainty about future arrangements.

In response to questions, the Board discussed:

f) The need for assurance that Healthwatch functions and volunteer expertise would be preserved during transition. Members emphasised continuity of engagement and safeguarding local knowledge;

g) Concerns about volunteer morale and the importance of maintaining their involvement in community work during organisational changes.

The Board agreed:

1. To note the updates and monitor legislative developments affecting Healthwatch;

2. To receive further partner updates at future meetings.

60. **Tracking Decisions**

The Board agreed to note the Tracking Decisions Log.

61. **Work Programme**

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

1. Update on flu and COVID vaccination uptake over the Christmas period;
2. Revised Health and Wellbeing Board Terms of Reference;
3. Strategic Plan development;
4. City Brand Strategy;
5. Cultural wellbeing and VCSE organisations.