Health and Wellbeing Board

Thursday 9 January 2020

PRESENT:

Councillor McDonald, in the Chair.
Dr Shelagh McCormick, Vice Chair.
Councillors James (for Councillor Mrs Bowyer), Laing and Kate Taylor.

Apologies for absence: Councillor Mrs Bowyer and David Bearman

Also in attendance: Professor Sub Banerjee (University of Plymouth), John Clark (Plymouth Community Homes), Ruth Harrell (Director of Public Health), Ch Supt Tamasine Matthews (Devon and Cornwall Police), Craig McArdle (Strategic Director for People), Dr Adam Morris (Livewell SW), Nick Pennell (Healthwatch), Rob Nelder (Plymouth City Council), Zoe Allen (University of Plymouth and Public Health England), Sarah McFarlane (NHS England), Carol Harman (Plymouth City Council) and Rob Witton ((PDSE) - Peninsula Dental Social Enterprise, University of Plymouth and Public Health England), Steve Statham (Chief Executive) and Abenaa Gyamfuah-Assibey (Community Development Worker) from St Luke's Hospice, Lin Walton (NHS Devon Clinical Commissioning Group) Anna Moss and Jackie Kings (Plymouth City Council) and Amelia Boulter (Democratic Advisor).

The meeting started at 10.00 am and finished at 1.02 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.

20. **Declarations of Interest**

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

21. **Chairs urgent business**

There were no items of Chair's urgent business.

22. **Minutes**

Agreed that the minutes of 3 October 2019 were confirmed.

An update was provided on the following minutes:

Minute 14 (1). It was reported that the sign off of the NHS Long Term Plan which was delegated to the Director of Public Health for sign off on behalf of the Health and Wellbeing Board had been delayed. The NHS Plan was still under review with the regulators.

Minute 16. It was reported that a workshop on how to tackle deprivation in the city would be taking place on 12 February 2020. An agenda would be circulated shortly. It was also highlighted that a 10 year review of the Marmot Report would be launched on 25 February 2020.

23. **Questions from the public**

There were no questions from members of the public.

24. **Oral Health Needs Assessment**

Rob Nelder (Plymouth City Council), Zoe Allen (University of Plymouth and Public Health England), Sarah McFarlane (NHS England), Carol Harman (Plymouth City Council) and Rob Witton ((PDSE) - Peninsula Dental Social Enterprise, University of Plymouth and Public Health England) were present for this item and referred to the report in the agenda. The presentation highlighted that:

(a) there was a recognition for the need for an Oral Health Needs Assessment (OHNA) to evidence the issues within Plymouth;

(b) Public Health and Peninsula Dental Social Enterprise (PDSE) worked collaboratively to produce and deliver the OHNA;

(c) the OHNA has been used to support the bid submitted to NHS England for a new City Centre dental practice and to inform conversation between dental leads in Plymouth the Chief Dental Officer;

(d) oral health was an integral part of health and wellbeing and oral diseases were largely preventable;

(e) oral diseases impact negatively on quality of life and imposes a significant social and economic burden on the city;

(f) over 14,000 people in Plymouth on the waiting list for routine NHS dental and 3,000 children in Plymouth on the waiting list;

(g) in conclusion:

- a partnership approach was required to address the wider determinants of health, to prioritise particular groups at higher risk of disease and to develop oral health programmes and services which reduce health inequalities;
- Plymouth would benefit from additional health improvement activity and from increased access to urgent and routine NHS dental care.

In response to questions raised, it was reported that:

(h) they would welcome working with social housing providers such as Plymouth Community Homes to help spread the word within the

communities and reaching the more vulnerable groups within the city;

(i) NHS England reported that the Oral Health Needs Assessment was in place and would inform the commissioning plans and procurement. They were also looking at providing more urgent care to help more patients to receive treatment and improve access whilst trying to provide a more sustainable approach;

(j) with regard to the 623 children having teeth extracted under general anaesthetic, it was reported that Plymouth was 4 times higher than the rest of the peninsula. This was a challenge, however, the key was giving young people the best start in life, first dental steps and were in the process of training midwives, health visitors, school nurses to give the key oral messages to parents and better access to dental care would help address this serious issue;

(k) that with regard to community water fluoridation in Plymouth, it was reported that this was not a straight forward solution. The main water pipe which supplies Plymouth also supplies neighbouring areas which meant that negotiating water fluoridation was made more difficult;

(l) the number of students that have remained in the city following graduation had changed over the years, many factors such as students having to undertake a foundation year in another part of the country as well as students coming to the city to undertake their studies move back to their hometown when qualified had impacted on the number of dentists retained in the city;

(m) also qualified dentists were not choosing to work in NHS Dental services because of the current NHS contracts leading to a shortage of dentist in this field. Currently in Plymouth there were 17 vacancies. The national contract needed to be revised to encourage more dentists to take the NHS route otherwise recruitment issues would persist;

(n) NHS England reported that Plymouth remained a priority area and the current waiting list supports and evidences what was needed to commission and working with our partners to address the issues. There were plans to be part of the primary care networks and would need to be looked at across the patch;

(o) it was highlighted to the Board that Plymouth has the smallest dental school in the country and there was no good reason for this inequity. Plymouth could accommodate more students and we could accommodate more students we would be able to undertake more work within the community and help with retention in the city;

(p) it was reported to the Board that the Child Poverty Action Plan since its inception five years ago included the issues within the city around poor dental health and access to dental care. The Oral Health Needs Assessment helps with the visibility and member's need to consider how to move this great work forward so that we are not sat here in a year's time saying how shocking were children's teeth;

(q) this was such a fundamental issue but what we really need to focus on was poverty and that we're not addressing by picking off single issues and to have the serious conversations around this with communities, with charities, with social enterprises, with people out there trying to address this;

(r) there were established care pathways for looked after children and Livewell SW was one of the service providers within the city, however it was clear that the demand exceeds capacity. The Dental School were also happy to accept children in care but there was a need to have proper structure in place with sustainable services to address all of the needs and looked after children were an important part of the Oral Health Needs assessment;

(s) the Dental School and (PDSE) provide a service to homeless people with an 84 percent re-attendance rate. They started with a pilot to provide ½ day session per week which was increased to 2 days a week and were now at the limit on what they could provide. They put forward a proposal to NHS England 12 months ago based on the oral health needs analysis and were hoping that there would be some progress on commissioning a proper service for this particular group otherwise these individuals would continue to suffer significant health inequality as a result of a lack of dental access;

(t) that the Dental School and the University have two excellent clinical facilities located at the Cumberland Centre and Plymouth Science Park. However these facilities do not provide students with real life experience of working in a general dental practice so they were keen to develop a dental practice for students to rotate through in their final years. A proposal for a city centre practice for students have been made formally with a business case to NHS England seeking ongoing costs of treating the patients and that proposal was with NHS England for the last 12 months;

(u) PCC working closely with PDSE to put the proposal together for the City centre dental practice and can only take the idea so far but need NHS England to take forward this contact, 14,000 on the waiting list which includes 3,000 children and this practice would reduce this number.

The Board agreed:

1. That a letter is sent from Plymouth's Health and Wellbeing Board to the relevant lead person within NHS England to express the Board's support for the initiatives outlined in the presentation and to be kept up to date with progress. The letter to include:

    - lobbying NHS England and Health Education England to increase the capacity at the Dental School in line with other Dental Schools in the country;
    - definitive timeline around the proposals for the city centre dental practice and homeless dental service.

2. To request the Health and Adult Social Care Overview and Scrutiny Committee to undertake a select committee to further scrutinise dental health in Plymouth and to include how to recruit students from Plymouth and support students living in the city to choose dentistry as a career option.

25. **Plymouth as a Compassionate City**

Steve Statham (Chief Executive) and Abenaa Gyamfuah-Assibey (Community Development Worker) from St Luke's Hospice were present for this item and referred to the report in the agenda. The presentation highlighted that:

(a) that Plymouth had been recognised by Public Health Palliative Care International as being the first Compassionate City in England which was a great achievement for the city;

(b) that despite some real progress made around death and dying it still remained a real taboo subject within our society and one that affects every aspect of people's lives;

(c) that there was a real challenge on how we meet those needs around palliative care and that no one in our community should die alone, in distress or in pain. However it was reported that many patients if not supported by St Luke's would have died alone;

(d) it was known that no organisation has the resource or capability to ensure that no one dies alone and feel that it needs a real joined-up approach based on individual organisations working together recognising that loss and bereavement was simply not solely for health and social services but was everybody's responsibility;

(e) the impact of bereavement on young people in terms of their school life and building the resilience in our younger communities so they can transition through life I'm being able to cope with the impacts that death and loss;

(f) have been working on developing compassionate workplaces and asking workplaces and businesses to review their compassionate

policies and to think about their employee's health and well-being at a time when they're caring for someone that might be dying or have been bereaved;

(g) they have developed compassionate cafes and compassionate friends have gone into hubs and social spaces that already exist in Plymouth to help provide a friendly ear to people that might be experiencing bereavement;

(h) more people were dying within a care home setting and how to recognise the good work taking place in care homes supporting people towards the end of their life;

(i) about how we encourage more organisations and workplaces to sign up to the End of Life Compassionate City Charter.

Board members welcomed the presentation and the opportunity to engage with the network and support this work.

In response to questions raised, it was reported that they have limited resources and rely on the support of the community, however if they could get more support at a senior level within organisations would help drive this agenda forward.

1. Note the progress that has already been made against the Compassionate City Charter.

2. Commit to considering what each partner organisation could contribute to the Charter.

26. **Plymouth Mental Health Programme Board**

Lin Walton (NHS Devon Clinical Commissioning Group) was present for this item and referred to the report in the agenda pack. It was highlighted that:

(a) the Plymouth Mental Health Programme Board is a multi-agency board which meets bi-monthly and was established to cover all age groups and to develop plans to meet the needs of the Plymouth population;

(b) sixteen priority areas were identified and the prioritisation reflects the status of service or pathways in the city alongside the importance to people's mental health and wellbeing;

(c) nationally there was a recognition that mental health funding was behind physical health funding and that despite investment were not at the same level of equity.

In response to questions raised, it was reported that:

(c) Plymouth would be involved in the work and input into the

workstreams;

(d) there was a separate workstream addressing autism and the Autism Partnership Board would pick up this area of work. However it was reported that the waiting time for the autism diagnosis in Devon was longer than Plymouth;

(e) there was a challenge around the workforce to support people with mental health, however this was a national problem and not unique to Plymouth. There was a need to think more broadly about what the workforce would look like and the skill mixes rather than just thinking about the specialists roles;

(f) some of the work we need to do in terms of what that third sector capacity needs to needs to look like and the acknowledgement that the third sector need both support and capacity in order to deliver and was something that would need to be addressed for moving forward.

The Board to note Plymouth Mental Health Programme Board Report.

27. **Safer Plymouth Briefing Paper**

Chief Superintendent Tamasine Mathews (Chair of the Safer Plymouth Board), Anna Moss and Jackie Kings (Plymouth City Council) were present for this item and referred to the agenda in the pack. The attached presentation was shared with the board.

Safer Presentation H&WB board.pptx

In response to questions raised, it was reported that:

(a) there was a challenge supporting the workforce with rolling out the trauma informed approach. However, it was reported that training would be freely accessible to anyone but they could only currently train 30 people each month. Since the roll out of the training they have had well over 600 applicants and were looking at other avenues to deliver this training;

(b) the Livewell Training Academy might be able to help and support with rolling the trauma informed approach training.

The Board agreed:

1. To bring greater clarity to the functions of the Safer Board and Safer Executive Group.
2. To reduce the eleven current delivery priorities sub-groups of Safer Plymouth into the following thematic partnerships:

- Safer Families
- Safer Communities
- Safer People

3. That Safer Plymouth activity should significantly increase focus on effective communication and workforce development. This was the overwhelming feedback from our consultation events and will be reflected in the refreshed communication plans and a workforce development plan.

28. **Work Programme**

The Board noted the work programme and delegated to the Chair and the Lead Officer to prioritise the work programme.