Health and Adult Social Care Scrutiny Panel

Tuesday 27 January 2026

PRESENT:

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

Also in attendance: Councillor Mary Aspinall (Cabinet Member for Health and Adult Social Care), Julia Brown (Service Director for Adult Social Care), Mark Collings (Strategic Commissioning Manager), Louise Ford (Service Director for Integrated Commissioning), Viktor Keaty-Korycan (Manager of Caring for Carers, Improving Lives Plymouth), Kate Lattimore (Commissioning Officer), Ian Lightley (Livewell Southwest), Amanda Nash (Head of Communications, University Hospitals Plymouth), Gill Nicholson (Head of Innovation and Delivery, Adult Social Care), Rebecca Sampson (Lead Account), Gary Walbridge (Strategic Director for Adults, Health and Communities), Elliot Wearne-Gould (Principle Democratic, Governance and Scrutiny Officer), and Michael Whitcombe (Deputy Chief Operating Officer, University Hospitals Plymouth).

The meeting started at 2.00 pm and finished at 4.27 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.

110. **Declarations of Interest**

There were three declarations of interest made:

Minute No.	Councillor	Interest	Description
All	Lawson	Personal	Employee at University Hospitals Plymouth
All	Noble	Personal	Employee at University Hospitals Plymouth
All	Morton	Personal	Employee at University Hospitals Plymouth

111. **Minutes**

The Panel agreed the minutes of the meeting held on 21 November 2025 as a correct record, subject to the following amendment:

1. Addition to 'Also in attendance': Councillor Mary Aspinall

112. **Chair's Urgent Business**

There were no items of Chair's Urgent Business.

113. **Finance Monitoring Report for H&ASC**

Councillor Mary Aspinall (Cabinet Member for Health and Adult Social Care) introduced the Adult Social Care Finance Report, Month 8 24/25 and discussed:

a) The Adults, Health and Communities directorate had reported an in-year overspend of £4.4 million at Month 8, of which £2.4 million related specifically to Adult Social Care, reflecting sustained financial pressure within care services;

b) The main pressures remained consistent with the pattern seen throughout the year, particularly a rise in demand for domiciliary care, with increased activity flowing through as waiting lists were reduced and more people entered the system;

c) The service had been able to offset a proportion of these pressures through additional joint funding and client income, which helped to reduce net expenditure against budget;

d) Inflationary pressures had arisen following the collapse of the Council's previous Community Equipment Service provider, and additional funding had been required to stabilise and sustain delivery of that service under new arrangements;

e) A Budget Containment Group had been activated from the beginning of the financial year, supported by a series of focused work-streams, to identify high-risk budget areas and develop mitigations, including: targeted package reviews, cost-containment activity, and opportunities to increase appropriate income;

f) Approximately £800,000 additional income from health partners had been identified by reviewing domiciliary care packages;

g) Despite the mitigations, some risks remained: £500,000 of delivery plans carried forward from previous years were still in progress and required continued oversight to ensure full delivery;

h) Delivery plans for 2025/26 had generated £2.7 million of savings at the time of reporting. The remainder of the programme continuing to be monitored through the Budget Containment Group;

i) The Adult Social Care budget for the following financial year was being developed in parallel, with planned growth of £11.1 million in 2026/27 to address National Living Wage increases, wider inflationary pressures and demand growth across the system, recognising that the demand patterns evident in the current year were expected to continue.

Rebecca Sampson (Lead Account) added:

j) The approach taken sought to distinguish clearly between unavoidable demand-led pressures and those areas where management action, joint working and improved processes could reasonably be expected to mitigate costs;

k) Work was ongoing with health partners to ensure joint funding arrangements were robust, transparent and consistently applied, so that Adult Social Care did not bear costs that were more appropriately attributable to NHS responsibilities;

l) The growth of £11.1 million for 2026/27 had been modelled to reflect the confirmed National Living Wage rate, inflation on commissioned care, and known changes in client numbers and complexity, to minimise the risk of in-year volatility;

m) Lessons learned from previous years' income forecasts, particularly around client contributions, had been factored into the new budget assumptions, with a view to improving income accuracy and reducing the likelihood of future income-related pressures.

In response to questions, the Panel discussed:

n) Appreciation for the work undertaken to contain the overspend and concern regarding the sustainability of relying on recharging additional elements of domiciliary care to the Integrated Care Board (ICB), noting the view that there was limited scope to pass further costs to health partners on a recurring basis;

o) The importance of ensuring that the "right service paid for the right care", with Adult Social Care budgets funding social care needs and NHS budgets funding health care needs, and that this principle underpinned the realignment of costs identified through recent reviews of domiciliary care packages;

p) The specific example of one-to-one support provided to people in the initial days following discharge from hospital, where recent analysis had demonstrated that some support previously funded as social care properly met health needs and had therefore been reclassified and recharged to health partners;

q) Assurance given by officers that while there remained some further potential to refine and improve joint funding arrangements, the objective was not to shift unreasonable levels of cost to the NHS, but to ensure that funding responsibilities were allocated fairly and consistently in line with national guidance and local agreements;

r) The expectation that the practice changes underway, including clearer decision-making about the appropriate funding route at the point of discharge

and improved governance around joint panels would, over time, reduce large swings in financial responsibility between organisations and provide greater stability for both the Council and health partners, while supporting better outcomes for individuals;

The Panel agreed:

1. To note the Adult Social Care Finance Report, Month 8 24/25 and the forecast overspend position for the Adults, Health and Communities directorate, including the specific pressures within Adult Social Care.

114. **Performance Monitoring Report for H&ASC**

Councillor Aspinall (Cabinet Member for Health and Adult Social Care) introduced the Adult Social Care Performance Monitoring Report and discussed:

a) The report provided a performance update for Adult Social Care, including demand levels, waiting times, outcomes for people, and key system pressures and improvements;

b) The report followed the recent Care Quality Commission (CQC) inspection of Adult Social Care, with Plymouth receiving an overall rating of 'Good', which was a significant achievement;

c) Performance information was presented thematically, including front door and triage, Care Act assessment activity, review activity, occupational therapy (OT) waiting times, care-home demand, domiciliary care capacity, reablement outcomes and hospital flow indicators including "No Criteria To Reside".

Julia Brown (Service Director for Adult Social Care), Gill Nicholson (Head of Innovation and Delivery, Adult Social Care) and Ian Lightley (Livewell Southwest) added:

d) At the 'front door', no-one waited more than five days for an initial triage decision. This ensured everyone contacting the service received a timely first response and a clear decision on whether a full Care Act assessment was required, enabling earlier advice, information and signposting;

e) Significant progress had been made on Care Act assessments. The average number of days to complete an assessment had reduced from over 200 days earlier in the year towards the 100-day target, and the very long waits of over 500 days had reduced substantially;

f) The 'waiting well' arrangements had been fully implemented, including:

   i. proactive contact with people on the waiting list and clear updates on expected timescales;

   ii. established contact routes so people could notify the service if needs changed or risk increased;

iii. risk-based prioritisation that enabled higher-risk people to be brought forward sooner;

g) Review activity had shown a slight reduction in total reviews completed, reflecting a deliberate shift toward targeted, proportionate reviews that:

i. focused on those at highest risk rather than solely on length of wait;

ii. ensured reviews were proportionate, avoiding unnecessary full reassessments;

iii. supported safe reductions in care packages where people no longer required the same level of support;

h) Targeted reviews had identified individuals whose needs were more appropriately funded through NHS Continuing Health Care or other health budgets. This contributed to a realignment of funding responsibilities, ensuring the correct service funded the correct level and type of care and supporting budget sustainability across health and social care;

i) OT waiting times remained a priority, with the waiting list including both Adult Social Care and health referrals;

j) The overall picture for OT had improved, although around 18% of people were still waiting more than 300 days, which officers acknowledged remained too long;

k) To address OT delays, Adult Social Care and Livewell Southwest had initiated a significant review of OT activity, including:

i. development of a clearer shared definition of Adult Social Care OT, distinguishing longer-term care and independence-focused interventions from health rehabilitation;

ii. review of pathways, demand and prioritisation for Section 2 and Section 9 activity to ensure referrals entered the correct pathway;

iii. expansion of "waiting well" approaches within OT so people waiting were kept safe, informed and supported;

l) Residential and nursing care placements remained broadly stable through November and December 2025, although short-term and step-down placements fluctuated as expected;

m) The Council's new care-home framework had gone live at the start of January with strong provider engagement;

n) The care-home framework aimed to:

i. support greater collaboration with the provider market;

ii. stabilise and contain fee levels while recognising inflationary and complexity pressures;

iii. better align the cost of care with need and outcomes for residents;

o) Domiciliary care data for December showed a slight reduction in total people receiving domiciliary care, though new packages continued to fluctuate month to month;

p) Officers were working closely with the domiciliary care market to ensure sufficient capacity to meet current and forecast demand, particularly in the context of winter pressures and hospital discharge;

q) Reablement performance remained strong, with over 81.8% of people remaining at home 91 days after discharge, above the 80% historic target;

r) The national benchmark for this measure had increased to 83.9%, which would apply from April 2026;

s) Although the future target would be more challenging, officers were confident in the reablement service's effectiveness and its contribution to keeping people well at home;

t) Direct payments continued to show positive progress, with:

i. an in-house payroll function strengthening control, resilience and value for money;

ii. increasing numbers of people choosing to manage their own care following a temporary dip in the summer;

iii. additional staff training so direct payments were routinely offered as a first-line option;

u) The NCTR metric reflected the proportion of inpatients who no longer met criteria to remain in hospital. Plymouth's NCTR figure had been hovering slightly above the 9% target at around 10% during the reporting period, although it fluctuated daily;

v) At present, the NCTR position had improved to approximately 5%, demonstrating the system's ability to restore performance rapidly. Keeping NCTR close to or below the target reduced the risk of unnecessary hospital stays, which could contribute to deconditioning and poorer outcomes;

w) A key reason for delays for people with NCTR status involved arranging care-home placements, which took longer due to the need for care-home assessments;

x) The system therefore prioritised a "home first" approach where appropriate, as discharge home with support could be arranged more quickly than care-home admission.

In response to questions, the Panel discussed:

y) The Panel welcomed the reduction in the OT waiting list from around 742 to 652 and queried how "waiting well" and operational expectations would deliver benefits for residents. It was confirmed that the focus remained on maximising staff time spent on assessments and direct work, removing non-essential tasks and enabling clearer prioritisation;

z) The Panel commended progress on Care Act assessment times and queried when the 100-day target might be reached and what the next ambition would be. Officers clarified that around 11% of people were still waiting more than 200 days and roughly 108 people were waiting over 101 days at the time of reporting. There would be a continued focus over the next four to five months to reduce very long waits. Once the 100-day average was sustained, the next ambition would be to move toward most assessments being completed within six weeks;

aa) Members expressed concern that rising demand pressures could squeeze preventative work despite the emphasis on early intervention during Budget Scrutiny. Officers acknowledged the risk but emphasised protected time for preventative activity and noted that backlog reduction had freed capacity for prevention;

bb) Members queried the drop in monthly Care Act assessment completions after a peak earlier in the year and asked what resilience would support a consistent level of around 180 completions per month. Officers explained that:

i. winter pressures, sickness, annual leave and vacancies had affected capacity;

ii. earlier high completion levels reflected a greater proportion of less complex cases in the backlog;

iii. remaining cases were more complex, naturally lowering throughput;

iv. activity levels would stabilise as backlog and complexity reduced;

cc) Members queried the NCTR figure and asked where the main discharge challenges remained. Officers advised that day-to-day variation was significant but current performance at around 5% was positive. Complex pathways, especially into care homes, created longer waits due to assessment and matching. Daily multi-agency calls reviewed individual delays and resolved issues. Supporting more people home first remained the most effective approach;

dd) **Action:** Members requested that future reports include data on reviews resulting in reduced or ceased care packages. Officers agreed to include this information in future reporting;

ee) It was confirmed that 38 care homes had signed up to the framework and participation was expected to increase, particularly through the innovation lot. Incentives included clearer commissioning intentions and a more stable fee environment;

ff) The Panel reiterated its appreciation of the work undertaken to improve waiting times, reduce long waits and respond to winter pressures, and noted the continued focus on prevention, market sustainability and system flow.

The Panel agreed:

1. To note the Adult Social Care Performance Monitoring Report;

2. **Action:** Officers to analyse the spike in the percentage of reviews with increased costs in August and report back to the Panel;

3. **Action:** Officers to include data on reviews resulting in reduced or ceased care packages in future performance reports.

115. **Adult Social Care CQC Outcome Update**

Gary Walbridge (Strategic Director for Adults, Health and Communities), Julia Brown (Service Director for Adult Social Care) and Louise Ford (Service Director for Integrated Commissioning) presented the Adult Social Care CQC Outcome Update and discussed:

a) The inspection outcome had been received following a significant assessment process which began in January of the previous year, during which the Council had submitted over 300 documents and 50 anonymised cases to the Care Quality Commission (CQC);

b) The on-site inspection had taken place over three and a half days in June and had involved approximately 45 formal interviews with staff, partners and people receiving services, including around 180 individuals in total;

c) The service had been awarded an overall rating of Good, and the presenters expressed strong pride in the outcome, noting the extensive work undertaken by staff, Livewell Southwest, wider Council teams, partner organisations and voluntary and community sector networks;

d) Plymouth had achieved an Outstanding rating for the domain of 'equity, experience and outcomes', one of only a very small number of councils nationally to achieve Outstanding in this area;

e) The Outstanding rating recognised Plymouth's proactive approach to identifying and listening to people most likely to experience inequity in

services and reflected extensive partnership work across directorates and sectors;

f) The presenters emphasised the importance of acknowledging the success achieved while also recognising that not everyone experienced services positively, and the report identified clear areas for improvement which would form the basis of ongoing work with Scrutiny;

g) Inspection documentation, including the full report, had been published on the CQC website and was available for partners and the public;

h) Assessing People's Needs had scored 50%, with strengths including person-centred assessments and 90% of callers having their situation resolved at first contact;

i) Strong examples of joint working and positive feedback on carer assessments had been noted;

j) Improvements were required in communication with people and carers and in strengthening strength-based practice, with the Principal Social Worker leading training to address this;

k) Supporting People to Live Healthier Lives had scored 63%, with strong preventative work, effective reablement and strong partnership working across the council and the voluntary sector;

l) Improvement areas included occupational therapy (OT) pressures and outcomes for those receiving short-term support, though some progress had already been made since the inspection period;

m) Equity in Experience and Outcomes had scored 88%, reflecting embedded co-production and strong engagement with seldom-heard groups, with further work planned on cultural competency and data quality;

n) Care Provision, Integration and Continuity, had scored 57%, with strong recognition of the Council's use of the Joint Strategic Needs Assessment to shape commissioning and the strategic direction provided by the Plymouth Plan;

o) Strong partnership working with the voluntary and community sector and commissioned providers had been noted, alongside positive examples of how people were offered choice in their care;

p) Market-shaping work and the co-production commissioning toolkit had been well received, though further work was needed regarding younger adults, transition pathways with children's services and the development of a dementia commissioning plan including technology-enabled care;

q) Work on domiciliary care market development remained a priority;

r) Integration and Partnership Working had scored 82%, reflecting strong strategic working across the Local Care Partnership, effective use of well-being hubs and community groups and strong integration between health and social care;

s) Improvements were needed to strengthen engagement and feedback loops within partnership structures;

t) Safe Systems, Pathways and Transitions had highlighted a strong Home First discharge model, with 70% of people returning home, strong crisis support responses and improvements in waiting-list oversight;

u) Positive multidisciplinary practice in learning disability pathways had been noted, though mixed experiences remained for young people transitioning to adult services, with a joint plan in development and a joint Select Committee session scheduled;

v) Safeguarding arrangements were strong, with people generally feeling safe, timely reporting and review systems, and high levels of Mental Capacity Act training, though significant pressures remained in Deprivation of Liberty Safeguards;

w) Improvements were required in documenting how safeguarding was made personal to individuals, with work already underway;

x) Governance, Management and Sustainability had shown stability in leadership roles, clear oversight and effective use of data to inform decision-making;

y) Strong organisational culture, learning and improvement, staff development pathways and active partnership working were recognised;

z) Improvements were required in standardising audit processes and addressing workforce capacity challenges in some areas, with work underway locally and regionally;

aa) Learning, Improvement and Innovation had scored strongly, with well-regarded workforce development including the ASYE programme for new social workers, effective use of co-production and a strong culture of continuous improvement.

In response to questions, the Panel discussed:

bb) Clarification of how Deprivation of Liberty Safeguards (DoLS) protected people lacking mental capacity by ensuring any restrictions were in their best interests, proportionate and legally authorised through specialist assessment and medical advice;

cc) The inspection visits had taken place primarily at Crown Hill Court, with additional visits to Mount Gould and to a well-being hub to meet voluntary-sector representatives;

dd) Members asked whether DoLS waiting-list data could be reported regularly, expressing concern about high numbers waiting in residential care. Officers reassured the Panel that people were safe and offered to provide focused reporting in future;

ee) Discussion took place regarding Theme 1 scoring and whether sufficient budget allocation was available to support improvements, with officers advising that performance had progressed since the inspection and that proportional assessment of need was key for financial sustainability;

ff) Members raised concerns relating to emergency respite care for unpaid carers, asking whether urgent placements were available when carers were struggling. Officers confirmed that residential respite could be accessed quickly when appropriate and emphasised the importance of ensuring the right support option was identified based on need;

gg) Members offered congratulations for the achievement of a Good overall rating and acknowledged the intensity of the inspection interviews;

hh) Members suggested that the next inspection, which historically occurred on long cycles, might be less daunting given the strong current performance.

The Panel agreed:

1. To note the Adult Social Care CQC Outcome Update.

116. **Plymouth City-wide All-age Unpaid Carers Strategy 2025 – 2027**

Kate Lattimore (Commissioning Officer), Mark Collings (Strategic Commissioning Manager) and Viktor Keaty-Korycan (Manager of Caring for Carers, Improving Lives Plymouth) presented the Plymouth Citywide All-Age Unpaid Carers Strategy 2025–2027 and discussed:

a) The strategy had been co-produced across the Plymouth health and social care system, including Plymouth City Council, Livewell Southwest, University Hospitals Plymouth, St Luke's Hospice, Time 4 U Partnership and Improving Lives Plymouth, and was supported by a detailed implementation plan intended to ensure promises made to carers translated into practice;

b) Census data from 2021 identified approximately 24,000 unpaid carers in Plymouth, with national estimates of 5.7 million unpaid carers. The school census had identified 730 young carers, although further work with youth services indicated the true figure locally was closer to 1,300;

c) Unpaid caring was recognised as widespread, with around three in five people becoming carers during their lives. 70% of carers reported long-term physical or mental-health conditions compared to 59% of non-carers;

d) Young carers faced significant challenges, including reduced school attendance and attainment. National research suggested young carers lost an average of 23 school days per year due to caring responsibilities;

e) Population change, increasing complexity of need and continuing workforce shortages meant unpaid carers played an increasingly essential role in the wider system;

f) Development of the strategy had involved extensive engagement with carers, with carers identifying what worked well, what did not and what support they needed. Six priorities had been developed from this engagement:

   i. access to support services that worked for carers;

   ii. enhanced financial support;

   iii. improved health, safety and wellbeing;

   iv. early identification and recognition of carers;

   v. improved information, advice and communication;

   vi. support when caring roles changed, including transition and bereavement;

g) A cross-partnership implementation group met regularly to oversee delivery of the action plan, with progress reported to the Carers Strategic Partnership Board;

h) Adult Social Care had introduced a RAG-rated waiting-well tool that ensured people waiting for assessments were supported, informed and signposted appropriately, including checks on carer wellbeing and risk of carer breakdown;

i) Livewell Southwest had undertaken work to strengthen carer involvement in assessments and decision-making, including reviewing carer support plans and undertaking focus groups;

j) A cross-system survey had been issued to understand communication gaps between agencies and identify improvements for carers;

k) Mental-health inpatient units were reviewing discharge processes to ensure carers were included appropriately;

l) Virtual wards and discharge-to-assess models supported care at home but could increase pressure on carers, so systems were working to ensure

appropriate support and communication with carers involved in home-based care;

m) Adult Social Care teams were piloting the Triangle of Care, a national quality framework, to ensure a therapeutic alliance between services, the cared-for person and the carer;

n) A programme called Carer Money Matters, funded by Carers Trust, supported income maximisation, benefits navigation and fuel-poverty reduction. More than 500 carers had been supported, with total financial gains exceeding £1 million;

o) Entitlement reviews were carried out because many carers were unaware of the financial support available to them;

p) Improving Lives Plymouth administered grants including Household Support Fund allocations, which provided direct help to carers in financial hardship;

q) Links had been established with the national Connect to Work scheme, providing employment-related support for carers wanting to return to work;

r) An enhanced sitting service had been established, offering between two and eight hours of regulated respite per week to support carers;

s) A pilot programme across Devon provided carers with discounted hotel stays, days out and wellbeing offers via a carer passport scheme;

t) Counselling was available for carers via commissioned counselling partners;

u) Work was underway to launch Bridgit Care, a digital self-help tool offering personalised advice, guidance and signposting based on carers' circumstances;

v) Work was taking place to raise awareness of young carers, including promoting the No Wrong Doors approach across partners to ensure any professional encountering a carer could identify and signpost appropriately;

w) Targeted work was being undertaken to reach carers within under-represented communities, including refugee and asylum-seeker communities and Gypsy, Roma and Traveller groups;

x) Support for working carers was being promoted through employer toolkits and the city's membership of the Employers for Carers scheme;

y) Young carers were working with the Department for Work and Pensions to improve awareness of carers allowance eligibility from age 16, due to low take-up;

z) The forthcoming Bridgit Care digital tool would give carers access to high-quality and personalised information, aligned with updates to the Plymouth Online Directory;

aa) Work with St Luke's Hospice and other partners supported carers experiencing bereavement and change in caring circumstances;

bb) The Health Determinants Research Collaborative (HDRC) was supporting research and evaluation work focused on young-carer transitions into adulthood;

cc) Caring for Carers extended its support offer to six months after a caring role ended, recognising the need for ongoing emotional and practical support;

dd) The development of a comprehensive evaluation framework combining quantitative and qualitative measures, including increases in carers on the carers register, improved response times and increased participation in community activities. HDRC research support was being utilised to strengthen evaluation methods and embed learning across the partnership.

In response to questions, the Panel discussed:

ee) Clarification of whether individuals drawing a state pension could access carers allowance. Officers explained that state pension receipt affected eligibility and that carers allowance remained one of the lowest benefits;

ff) Members raised concern at the principle that older carers, who formed a significant proportion of the caring population, could be disadvantaged by benefit rules;

gg) Members supported writing to government expressing concerns about inequities between private-pension and state-pension recipients;

hh) Confirmation that Carer Money Matters had no minimum-hours requirement, unlike carers allowance, and was accessible to anyone recognised as an unpaid carer;

ii) Discussion regarding how young-carer numbers were identified, including through school census returns, social-care involvement and youth-service engagement. Officers explained that sibling carers were often identified by social workers and family-support staff;

jj) Concerns regarding very young carers and distinction between caring and safeguarding thresholds. Officers explained that very young carers were identified when asked to undertake tasks beyond what was age-appropriate, with social-care oversight ensuring safeguarding concerns were acted upon;

kk) Members emphasised the importance of early identification, noting research indicating carers often took years to recognise themselves as carers. Officers described ongoing work across primary care, hospitals, youth services, employers and national awareness campaigns to improve recognition;

ll) The Panel welcomed updates on digital tools such as Bridgit Care and recognised the importance of reaching carers who did not access formal services.

The Panel agreed:

1. To endorse the Plymouth Citywide All-Age Unpaid Carers Strategy 2025–2027 and ongoing activity to support unpaid carers in Plymouth;

2. To recommend that the Cabinet Member for Health and Adult Social Care writes to the relevant Government Minister expressing concern about inequity in carers-allowance eligibility for people in receipt of the state pension.

3. To request that officers return to the Panel in six months with a progress update;

4. **Action:** To request clarification from officers on carers allowance eligibility in relation to state pension and private pension receipt;

117. **Winter Pressures Update**

Michael Whitcombe (Deputy Chief Operating Officer, University Hospitals Plymouth), Amanda Nash (Head of Communications, University Hospitals Plymouth), Gary Walbridge (Strategic Director for Adults, Health and Communities) and Louise Ford (Service Director for Integrated Commissioning) presented the Winter Pressures Update and discussed:

a) Winter planning had remained challenging, with the One Plan objective of reducing the number of patients with No Criteria to Reside (NCTR) only partially achieved. Approximately 50% of the intended improvement had been delivered;

b) University Hospitals Plymouth (UHP) had operated under escalation, with a net loss of 54 beds from the beginning of October due to NCTR-related pressures, compared with an anticipated loss of 8 beds after mitigations. The position had stabilised at around 40 beds lost in December and January;

c) Ambulance handover delays had shown significant improvement, with 2,000 hours lost in December 2025, compared to 6,344 hours lost in December the previous year. Although performance remained below desired levels, meaningful progress had been made, resulting from joint acute and community system working;

d) The four-hour emergency department standard had deteriorated more than anticipated against the planned recovery trajectory, with actions underway to improve patient flow and movement through pathways;

e) Vaccination uptake among staff had improved, with UHP exceeding the 5% increase expected across Devon. Particular success was attributed to peer

vaccinators and targeted internal communications, with a further rise in uptake immediately before Christmas in response to rising flu cases;

f) Infection-prevention benefits were evident, with flu and RSV impacts being more controlled and less severe than in the previous winter due to preventative measures and vaccinations;

g) The winter communications campaign had included a major public awareness initiative for the Urgent Treatment Centre (UTC), which had involved social media, radio, Spotify advertising and physical banners;

h) Since the start of the campaign, Urgent Treatment Centre (UTC) attendances had risen significantly, with 11 January 2026 recording the highest number of UTC attendances to date. The campaign had helped reduce emergency-department redirects by encouraging patients with minor illness and injury to present directly to the UTC;

i) Members of the Panel had visited the UTC in November 2025, and positive feedback had been received, with several councillors independently promoting the service following their visit;

j) The presenters emphasised the importance of ensuring the public understood when and how to use the UTC as a safe alternative to the Emergency Department, which supported improved flow through the hospital;

k) UHP highlighted positive results from out-of-hospital services showcased during the BBC NHS Day, including the X-ray car, which had supported over 400 patients, with over 95% avoiding hospital conveyance as a result;

l) Admission-avoidance services remained a priority, with national policy continuing to promote home-based care. Patients typically recovered better in their own environments and were less exposed to infection during winter;

m) Livewell Southwest continued to develop the community virtual ward, with 55 people on the caseload out of a capacity of 95, alongside the acute virtual ward. Onboarding processes were being strengthened, including reviewing patients 48 hours before predicted discharge;

n) Winter-system working between Plymouth City Council, NHS Devon, Livewell Southwest and UHP continued daily, with escalation calls and multi-agency oversight used to manage complex discharges and maintain safe system flow;

o) Capacity in care-home and domiciliary-care markets had remained stable so far during winter, with no significant shortages reported;

p) Norovirus and flu remained active across the system, with norovirus levels 47% higher in the first two weeks of the year compared to the same period the previous year; however, strong infection-control practice and PPE use in care-home settings had helped prevent major outbreaks locally;

q) The presenters reiterated public-health messages encouraging people who were unwell to stay away from vulnerable settings and maintain good hygiene;

r) A more detailed winter review would be brought to a future Panel meeting once the season had concluded.

In response to questions, the Panel discussed:

s) Members queried the increase in staff vaccination uptake and were informed that targeted communications, peer vaccinators and pre-Christmas risk awareness had driven strong engagement;

t) Members sought clarification on RSV vaccination figures. UHP confirmed the data shown related to staff uptake within the Trust, not community-wide population uptake;

u) Members raised public perceptions arising from national NHS coverage and asked about the importance of highlighting out-of-hospital care models. Presenters reiterated that alternatives such as the UTC, X-ray car, virtual wards and lung-screening services were critical in demand management and helped ensure care was provided in the right setting;

v) Members welcomed the evidence of same-day emergency care and virtual-ward performance;

w) Members shared positive personal experiences of virtual-ward provision and asked whether expansion was planned. UHP confirmed further development would be supported alongside the new electronic patient-record system launching in July;

x) Members requested a future session on the Electronic Patient Record (EPR) rollout (Epic), including implications for Adult Social Care and system partners;

y) Questions were raised regarding norovirus prevalence and whether additional proactive measures beyond PPE and hygiene were feasible. It was advised that eradication was not possible, and public-health messaging remained the best mitigation.

The Panel agreed:

1. To note the Winter Pressures Update;

2. To request that an item on the introduction of the Electronic Patient Record (Epic) was brought to the Panel prior to its launch in July 2026.

118. **Armed Forces Care**

The Chair introduced the item and discussed:

a) This was the second occasion the Panel had requested an update on Armed Forces Care, and significant concerns were raised about the quality and appropriateness of the information provided;

b) The Chair expressed disappointment and frustration that no representatives from the Integrated Care Board (ICB) or NHS partners had attended the meeting to present the report;

c) There was a need to clarify information on the final page of the submitted papers, which stated that "there are no special provisions for the (Armed Forces) population to be seen faster than the rest of the population". This appeared to contradict the Armed Forces Covenant, which provided for priority treatment for serving personnel, veterans and their families for service-related conditions, subject to clinical need;

d) The Panel would revisit the matter at the March meeting, where attendance from the ICB and NHS representatives would be required to provide a full, accurate and Plymouth-specific report.

In response to questions, the Panel discussed:

e) Members expressed support for the Chair's comments and noted that the absence of local information undermined the purpose of scrutiny;

f) Members emphasised the importance of recognising the Armed Forces community in Plymouth, given the city's significant military presence.

The Panel agreed:

1. To request a full Plymouth-specific report at the March 2026 meeting, with attendance from the ICB and NHS.

119. **Action Log**

The Panel agreed to note the Action Log.

120. **Work Programme**

The Panel agreed:

1. To note the Work Programme;

2. To move the next scheduled meeting due to a scheduling clash with Taxi Licensing Committee;

3. To request the following reports for the next meeting:

    i. Armed Forces Care;

ii. ICB Reforms and Restructures

iii. Electronic Patient Record (EPIC).

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