Health and Wellbeing Board

Thursday 15 January 2026

PRESENT:

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

Statutory Members: Ed Garvey (Senior Locality Commissioning Manager, NHS Devon), Tony Gravett (Healthwatch), David Haley (Director of Children's Services), Professor Steve Maddern (Director of Public Health), and Gary Walbridge (Strategic Director for Adults, Health and Communities).

Co-opted Representatives: Laura Alexander (University of Plymouth), Neil Macdonald (Chief Executive, University Hospitals Plymouth), Rachel O'Connor (Director for Integrated Care Partnerships and Strategy, University Hospitals Plymouth), Karen Pilkington (VCSE Representative), and Rob Smith (Chief Executive, Improving Lives Plymouth; Wellbeing Hubs Representative).

Also in attendance: Ruth Harrell (Consultant in Public Health), Amanda Lumley (Chief Executive, Destination Plymouth), Ellie Pullen (Population Health Intelligence Apprentice), and Elliot Wearne-Gould (Principal Democratic, Governance and Scrutiny Officer).

Apologies for absence: Matt Garrett (Service Director, Community Connections), Michelle Thomas (Livewell Southwest), and Tracey Lee (Chief Executive; LCP Representative).

The meeting started at 10.00 am and finished at 12.23 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.

62. **Declarations of Interest**

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

63. **Chairs Urgent Business**

There were no items of Chair's Urgent Business.

64. **Minutes**

The Board agreed the minutes of 03 October 2025 as a correct record.

65. **Questions from the public**

There were no questions from members of the public.

66. **The Director of Public Health Annual Report: The Health and Wellbeing of Women in Plymouth**

Councillor Mary Aspinall (Cabinet Member for Health and Adult Social Care) introduced the Director of Public Health Annual Report: The Health and Wellbeing of Women in Plymouth and discussed:

a) That Directors of Public Health had a statutory duty to produce an annual independent report on the health of the communities they served, and that this year's report focused specifically on the health and wellbeing of women and girls in Plymouth;

b) That the report set out clear evidence that, whilst women in Plymouth generally lived longer than men, they spent a significantly greater proportion of those years in poor health, with healthy life expectancy locally being markedly below the England average;

c) That behind the statistics were the lived experiences of real women in the city, many of whom had contributed their voices and insights to the report, and that the report therefore represented both quantitative data and qualitative community insight;

d) That the report highlighted the multiple roles women played in society, often leading them to place their own needs last, and that this had profound implications for their physical and mental health;

e) That the report emphasised the wider determinants of health, including income, education, housing, feelings of safety in public spaces and access to green and blue spaces, and that these factors collectively shaped the health outcomes of women and girls in Plymouth;

f) That the report had been designed to prompt action and progress, showcasing work already under way in the city and setting out a call to action for partners to improve outcomes for women and girls;

g) That the recommendations invited Board members and their organisations to note the content of the report, reflect on how they could support its findings, acknowledge the contribution of women and the organisations supporting them, and commit to considering what more could be done to improve health and wellbeing for women and girls across the city.

Professor Steve Maddern (Director of Public Health) presented the report and discussed:

h) That it was his first statutory report for Plymouth, and that the decision had been taken to focus on women and girls in response to evidence that women

in Plymouth had one of the worst healthy life expectancies compared with similar areas;

i) That, while average life expectancy for women in Plymouth was well into the 80s, healthy life expectancy was 55.7 years, almost six years lower than the England average, meaning women in the city were likely to live for approximately 26–27 years in relatively poor health;

j) That this disparity was not just a health issue but one of equity, dignity and opportunity. Women who faced barriers to basic health care often felt unheard and unsupported, and this undermined their ability to thrive;

k) That the report described how the wider determinants of health, such as income, education, housing, safety, and access to green and blue spaces, shaped women's health, and that these determinants were critical to understanding and addressing inequalities;

l) That the report highlighted positive work already taking place in Plymouth, including the Thrive Plymouth programme with its holistic and trauma-informed framework of 'Healthy Body, Healthy Mind, Healthy Places and Healthy Communities', which sought to ensure lived experience shaped service design and delivery;

m) That examples of targeted initiatives included cancer champions working in communities to improve screening uptake and tackle inequalities, investment by NHS Devon in a dedicated menopause pathway and GP training, and the work of organisations such as Improving Lives Plymouth, Trevi and Gifted Women in providing safe spaces and support for women facing multiple disadvantage;

n) That trauma-informed practice was increasingly being embedded across citywide services, alongside strengthened partnerships to address violence against women and girls, recognised as a national emergency with significant local impact;

o) That, despite progress, major challenges remained, including that around one in five women in Plymouth would be considered disabled under the Equality Act, that approximately 36,000 women were estimated to experience at least one incident of harassment each year, and that HPV vaccination rates among girls were below the national average at around 66%, with concerns about the long-term impact on cancer outcomes;

p) That economic inequality was a key concern, with around 80% of women employed in Plymouth earning below the national median salary, and that access to good education and employment was known to be vital to health and wellbeing;

q) That the report called for a focus on improving access to health care (from contraception through to menopause care and cancer screening), ensuring safer public spaces and tackling online harms, addressing economic inequality,

and supporting women into education and employment in settings that actively supported their wellbeing;

r) That the voices in the report, including women describing difficulties in accessing GP appointments, fear of walking alone at night and the exhaustion of navigating complex systems, underlined that improving outcomes would require concerted and collective action across organisations, not just from public health;

s) That the report should therefore be seen as a citywide call to action to build a Plymouth in which every woman and girl could live not only longer but healthier, safer, more independent and more fulfilling lives.

In response to questions, the Panel discussed:

t) The role of community builders in capturing women's voices, and concern that the report appeared to reference a community builder post for men but not explicitly for women and girls. It was clarified that community builders had been used to bring women's voices into the report and that this would be confirmed;

u) The significantly below-average uptake of HPV vaccination among girls in Plymouth, and concern that young women in the city were missing out on life-long protection against cervical cancer. Members questioned what specific best practice, interventions or campaigns could be pursued to increase uptake;

v) The importance of ensuring HPV vaccination was accessible through the school-based vaccination programme and via primary care recall for girls who had missed their initial opportunity. It was noted that HPV would be a core priority within the wider "Protect Plymouth" vaccination campaign, which aimed to address vaccinations across the life course, and that further communications work would be undertaken to understand why girls were not being vaccinated;

w) Opportunities for collaboration with the University of Plymouth and further education providers, including the potential for vaccination clinics linked to the university's Faculty of Health to communicate with young women, including those not engaged in higher education but in further education. It was confirmed that the Protect Plymouth campaign had historically focused "get ready for university" messaging on meningitis, and that there was an opportunity to broaden this to maximise exposure to HPV vaccination messaging for young women;

x) The need to communicate that HPV vaccination could still be accessed after leaving school and that protection could still be gained, even if the vaccination had not been taken up when first offered;

y) The value of identifying areas of the country with significantly higher-than-average HPV uptake, learning from their best practice and considering how those approaches could be adapted for Plymouth;

z) The high levels of harassment reported in the city and a request for further breakdown of the harassment figures (for example, domestic, external or workplace). It was noted that the figures had been drawn from a Plymouth survey, which captured women who had experienced at least one incident of harassment, and that harassment was often subjective, but further detail would be sought where available and shared with the Board;

aa) The position of women veterans in Plymouth and the reference in the report to a women's veterans "listening circle". It was noted that this aspect of the report had attracted significant interest, reflecting that people often did not automatically think of women when they considered veterans, and that more work was required with military partners to understand and support women veterans' needs;

bb) The potential for the city's major employers to act as a lever for communications, hosting programmes or interventions and amplifying key messages about women's health, vaccines and support services. It was noted that reducing inequalities for women and girls would be of particular interest to the 'anchor' collaboration;

cc) How the findings and themes of the report should be connected into wider strategic work, including developing NHS neighbourhoods and commissioning of services, to ensure that the report's insights informed priority setting and service design rather than sitting in isolation;

dd) The importance of celebrating the value and contribution of women in the city, to avoid the report being framed purely as a deficit narrative. Members emphasised that recognising women's strengths and contributions was essential to shaping positive, asset-based responses;

ee) The need to link the report into forthcoming discussions about Health and Wellbeing Board strategic priorities and the governance arrangements for neighbourhood teams, with an emphasis on using the Board's position to drive and oversee progress on women's health;

ff) Whether the annual report's focus on women meant that there would be reduced visibility of overall population health trends and men's health. It was explained that the broader state of health in Plymouth continued to be monitored through the Joint Strategic Needs Assessment, and that a separate, light-touch piece of work was being planned to respond to the Government's men's health strategy and consider men's health in Plymouth, with an intention to bring this back to a future Health and Wellbeing Board;

gg) The balance between targeting multiple issues and focusing on a smaller number of areas for maximum health gain. It was noted that, at whole-population level, cardiovascular disease remained the primary driver of

mortality and morbidity in Plymouth, and that considering this within future Board priorities could allow the city to align multiple interventions (for example, smoking cessation and lifestyle changes) towards a common goal;

hh) Issues of safety and violence against women and girls, including the experience of women feeling inherently more at risk in public spaces simply by virtue of being female, and the impact this had on decisions such as whether to exercise outside or wear headphones;

ii) A recent local 'Lift the Curfew' event, linked to the 'This Girl Can' campaign and organised by women's running groups, which had highlighted concerns about harassment, catcalling and women's experiences of running and exercising in public, and the intersection between physical activity, health and feeling safe in the city;

jj) The wider question of how well understood it was, particularly by men, that women and girls often perceived a baseline level of risk when moving through public spaces, and that this implicit sense of unsafety was not acceptable. Members noted that while safe, protected spaces for women were important, the longer-term goal must be that all spaces were safe;

kk) The role of schools in shaping safer experiences for girls and young women, and the value of engaging with headteachers and senior leaders, including at primary level, to raise awareness of the report's findings and discuss how schools could contribute to improving safety, confidence and health outcomes for girls;

ll) The existence of current programmes in schools addressing safety, relationships and behaviour, and the need to raise the profile of women and girls' safety issues further, including through presentations of the report at headteacher and senior leader conferences;

mm) The links between domestic abuse, women's safety and public health, and the need to treat domestic abuse as a public health issue as well as a criminal justice matter. Members discussed the recent award of the city's domestic abuse service tender to a new partnership and the importance of ensuring that the partnership engaged effectively with the wider health system;

nn) The need to strengthen the ability of health and voluntary sector services to respond to disclosures of domestic abuse, including building staff competence and confidence to identify and support victims much earlier, rather than after multiple incidents;

oo) The value of aligning domestic abuse work with community-based approaches, including the wellbeing hubs and community connections work, and ensuring that training and support were available across the system;

pp) The opportunity to share the report with Plymouth's Youth Parliament and to develop a more accessible summary version for young people, so that

young people were aware of issues such as HPV vaccination and could make informed choices as they became able to decide for themselves.

Action: The Director of Public Health would clarify the position on community builder arrangements for women and girls;

Action: The University of Plymouth would explore, through the Faculty of Health and the wider anchor collaboration, how the university and further education partners could support HPV vaccination uptake and broader women's health messaging, including options for hosting clinics and joint communications;

Action: The Director of Public Health would seek further breakdown and context for harassment statistics used in the report and share clarifications with Board members (for example, domestic, external or workplace);

Action: The Director of Public Health, working with the Director of Children's Services, would consider presenting the annual report and its key messages to a headteacher and senior leader conference, and explore how schools could further support the safety, health and wellbeing of girls and young women, including reinforcing HPV vaccination messaging;

Action: The Director of Public Health would work with Youth Parliament representatives to develop and share an accessible version of the report, with particular emphasis on HPV vaccination and other preventative measures relevant to young women and girls;

Action: The Director of Public Health would bring an update on Men's Health to a future meeting of the Health and Wellbeing Board, in order to provide visibility of overall population health trends and ensure that the Board maintained oversight of emerging priorities affecting men's health alongside the thematic focus on women and girls.

The Panel agreed:

1. To note the content of the Director of Public Health Annual Report: The Health and Wellbeing of Women in Plymouth;

2. To acknowledge the contribution from women in the city and the organisations that supported them, whose experiences and insights had shaped the report;

3. To commit to considering what more could be done, individually and collectively, to improve the health and wellbeing of women and girls across the city;

4. To recommend that the Director of Public Health collaborates with city partners to ensure HPV vaccine uptake amongst young women in Plymouth increases towards and beyond the national average, and brings an update report to a future meeting of the Health and Wellbeing Board for consideration.

67. **Public Health Intelligence: IMD2025**

Ruth Harrell (Consultant in Public Health) introduced the Index of Multiple Deprivation (IMD) 2025 Update and discussed:

a) That the Index of Multiple Deprivation (IMD) was a core dataset used across the health and wellbeing system, noting that multiple health indicators across Plymouth mapped closely onto deprivation patterns, such as childhood obesity and long-term health conditions;

b) That IMD was periodically reviewed and updated, and although the city's relative position usually remained stable, the 2025 release contained methodological changes which had prompted additional analytical work;

c) That the IMD was composed of seven weighted domains: Income, Employment, Education, Health, Crime, Barriers to Housing and Services, and Living Environment. These domains had changed significantly since 2019, meaning the datasets were not directly comparable;

d) That several indicators had been updated, including the inclusion of persistent school absence post-pandemic, changes to indoor environment metrics (where EPC ratings now constituted 70% of the domain), and removal of central heating access as an indicator due to near-universal coverage;

e) That these changes materially affected Plymouth's apparent level of deprivation, requiring cautious interpretation of the results.

Ellie Pullin (Population Health Intelligence Apprentice) presented the analytical findings and discussed:

f) That Plymouth had moved from 64th most deprived (of 317 authorities) in 2019 to 87th (of 296 authorities) in 2025, appearing to show a significant improvement in ranking;

g) That Plymouth's most deprived Lower Super Output Area (LSOA) remained in St Peter and the Waterfront, which had stayed in the 1% most deprived nationally for over ten years, with a population of 1,843 residents;

h) That Plymouth's least deprived LSOA remained in Plymstock Dunstone and had done so consistently for the past decade;

i) That 11.7% of Plymouth's LSOAs were within the most deprived 10% nationally, representing approximately 32,000 residents, a reduction from 17.4% in 2019;

j) That six LSOAs sat within the most deprived 5%, and 42 LSOAs were within the most deprived 20%, which were areas that could easily shift into more severe deprivation or might improve over time;

k) That Plymouth had made one of the most substantial relative improvements among the Key Cities group, and similar gains were observed when benchmarked against the SIGMA Group of comparable urban authorities;

l) That improvements in the Living Environment domain were strongly influenced by methodological changes, especially the reduced weighting given to access to private outdoor space.

Ruth Harrell (Consultant in Public Health) added:

m) That despite Plymouth's improved ranking, poverty had not reduced, and in some cases had worsened, particularly affecting children;

n) That updated data on absolute and relative child poverty showed increases in both measures over recent years, with Plymouth's rates consistently above the England average;

o) That the Board should remain cautious. While the IMD ranking improved, the lived reality for families did not align with this shift, and it was important not to misinterpret the data as an indication of substantive socioeconomic improvement;

p) That multiple datasets, including ward-level poverty, continued to map onto historical patterns of deprivation, including high deprivation in St Peter and the Waterfront, Ham, Devonport, Honicknowle and St Budeaux.

In response to questions, the Board discussed:

q) That methodological changes in the IMD had contributed to improved rankings, including the national rollout of Universal Credit affecting the Income domain;

r) Concern over the external messaging. If IMD figures were misinterpreted, Plymouth risked appearing less in need of funding and support, despite increasing child poverty and worsening financial hardship;

s) Members sought clarity over what messaging should be shared locally and nationally, noting the potential impact on resource allocation;

t) Members wished to emphasise that any "improvement" was statistical rather than experiential, and should not reduce focus on tackling inequalities;

u) That there was a need to identify genuine areas where improvements had occurred over the last six years, alongside areas where circumstances had worsened;

v) That comparative analysis with Exeter demonstrated clear differences in deprivation trajectories between the two cities;

w) That the 'State of the City' report was currently being prepared and would take a broader look across living conditions, health, and wellbeing, with a draft expected mid-February for future HWB consideration;

x) That wellbeing hubs were working to enhance their data reporting however, data systems varied widely across hubs and agencies, making unified analysis challenging;

y) That councillors required improved access to ward-level deprivation data and maps to support local leadership, and that updated mapping on the council website would support ward-level interpretation;

z) That the potential removal of the two-child limit would positively impact child poverty rates in Plymouth, given the high number of affected families;

aa) Members raised the importance of connecting with relevant academic expertise to explore whether IMD changes aligned with health outcomes or undermined accurate representation of deprivation;

bb) Members noted significant concerns arising from BMI data for children aged 4–11, particularly the high proportion of reception-aged children entering school at unhealthy weight levels, and the importance of continued work with schools to address this;

cc) That despite the concerns, Plymouth performed marginally better than England in flow from healthy to unhealthy weight, though overall levels remained concerning.

Action: The Public Health Intelligence Team would explore mechanisms for improved dissemination of updated ward-level IMD and poverty data to councillors, including through refreshed online mapping tools;

Action: The Public Health Intelligence Team would incorporate IMD 2025 analysis into the forthcoming State of the City report and bring this to a future meeting of the Health and Wellbeing Board.

The Board agreed:

1. To note the IMD 2025 report and, in particular, that the apparent improvement in deprivation ranking reflected methodological changes rather than a reduction in underlying poverty in Plymouth.

68. **City Brand Strategy**

Amanda Lumley (Chief Executive, Destination Plymouth) presented the City Brand Strategy and discussed:

a) That the Brand Strategy work had begun approximately two years earlier following recognition by the Destination Plymouth Board, including representatives from key city organisations, that Plymouth was entering a

major growth trajectory over the next decade and required a clearer, stronger, more competitive city positioning;

b) That the work had been driven by the need to attract people to live, work, study and invest in Plymouth, and to change long-standing external perceptions of the city, noting that many people outside the region knew little about Plymouth or viewed it only as a naval base, a distant location, or a place with limited cultural offer;

c) That early aims of the project included: shifting external perceptions, raising aspirations and civic pride among residents, particularly inspiring young people, increasing awareness of Plymouth's strengths, and creating a narrative rooted in authentic community identity and lived experience;

d) That extensive national perception research had been carried out, including general perception surveys, talent-attraction analysis, sector-specific research (including health, nuclear and defence), and growth-sector insights in collaboration with city partners such as the NHS and University of Plymouth;

e) That the research identified Plymouth's most compelling strengths, including:

   i. The ocean and waterfront as unique and internationally significant assets;

   ii. The UK's first National Marine Park;

   iii. The city's high quality of life when compared to regional competitor cities such as Southampton, Portsmouth, Bristol and Norwich;

   iv. Strong happiness and activity indicators;

   v. A growing cultural offer;

   vi. A friendly, welcoming community;

   vii. Increasing opportunities linked to innovation, marine autonomy, defence, creative industries and health technologies;

f) That talent attraction research revealed people looked for career ecosystems rather than single-job opportunities, meaning Plymouth needed to communicate the breadth of opportunities, progression pathways and family-friendly attributes of the city;

g) That the city's cultural profile remained low nationally despite significant local activity, and that the recent success of Plymouth Culture and the City of Culture announcement created a major opportunity for repositioning the city;

h) That the city possessed over 25,000 anticipated new job opportunities in the coming decade, a substantial investment pipeline now estimated between £8–

9 billion, and a long heritage of innovation stretching back more than 500 years, including modern scientific leadership in areas such as marine microplastics research;

i) That the new overarching narrative, "Make Life an Adventure," reflected the city's unique geography between Dartmoor National Park and the National Marine Park, its emphasis on nature, its environmental credentials and its strengths in community connectedness;

j) That the community-derived city values were:

   i. Go boldly (innovation, doing things first);

   ii. Go together (collaboration and support);

   iii. Go far (global impact and ambition);

k) That the new Brand Toolkit and Media Hub were fully accessible online to all partners, containing narrative statements, facts, case studies, imagery, video content and assets to support recruitment, investment, education engagement and communications across the city;

l) That partners had already begun using the materials, most notably Plymouth Culture for the City of Culture announcement, as well as city centre hoardings, electric bus branding and other public-facing assets;

m) Organisations were encouraged to consistently use the narrative, share the brand across networks and communities, and to "invest in promoting the city," using the brand to support recruitment, outreach and civic pride.

(A video was played at this time - Plymouth, Britain's Ocean City Brand Film)

In response to questions, the Board discussed:

n) That the Strategy had been well-received, with Members commenting that the work was uplifting and long overdue given historic negative perceptions from neighbouring areas in Devon and Cornwall;

o) Members emphasised the importance of the Council and all partners amplifying the Strategy across the UK and internationally, noting the need for a coordinated approach to reach audiences unfamiliar with Plymouth;

p) Opportunities linked to defence recruitment, national defence campaigns, and global talent attraction were highlighted, including discussions around a potential "talent attraction accelerator" and funding avenues such as the Towns Fund;

q) That neighbouring areas, particularly parts of Cornwall and South Hams, often held entrenched negative perceptions of Plymouth despite frequently

using Plymouth's cultural facilities, theatre and retail, signalling the importance of strong regional advocacy;

r) Members reiterated this was a "whole-city" initiative involving partners across all sectors, funded collaboratively and delivered through a highly inclusive process;

s) Members offered personal reflections on how the brand narrative and film captured Plymouth's strengths, noting that even long-term residents often forgot the exceptional environment around them until it was shown through a fresh lens;

t) Members raised that pride in place contributed positively to wellbeing, and that a strong sense of local identity supported the wider health and wellbeing agenda;

u) Newer members of the city workforce, including senior NHS staff recently relocated, described entering the city with limited or outdated perceptions, and commented that the Strategy had the potential to significantly support recruitment and staff retention across the health system;

v) Practical concerns were raised regarding city access during redevelopment, the impact of roadworks on visitor experience, and the importance of minimising disruption during major events. Members also noted that city centre footfall was up by around 6% compared to a national average of 1.8%, and broader data from the city's Data Hub also showed year-on-year increases across the wider central area;

w) That while the visitor economy overall had experienced national declines, Plymouth had performed better than Devon and Cornwall, which reported steeper drops in day-visitor numbers. Collaboration with neighbouring authorities remained essential;

x) Concerns about Christmas trading and temporary disruption were valid, but most city centre works were due to be completed by Christmas 2026, after which benefits to footfall and public space were expected to increase;

y) Members wished to consider showing the brand film at the next Full Council meeting so that all councillors could view and understand the Strategy and its potential benefits.

The Board <u>agreed</u>:

1. To align with the City Brand Strategy and new narratives to position Plymouth as a place to live, work, study and visit;

2. To align with the key components of the branding work, including narratives and visuals, and to mainstream these where appropriate into key delivery programmes requiring citywide messaging;

3. To recognise Destination Plymouth as the citywide marketing organisation with strategic responsibility for leading the brand strategy and implementation, positioning the city's place-brand and continuing to lead the Visitor Plan;

4. To recognise the support of key city partners in funding and driving this work forward.

69. **Neighbourhood Health Plans**

Ed Garvey (Senior Locality Commissioning Manager, NHS Devon ICB) presented a verbal update on the development of the Neighbourhood Health Plan and discussed:

a) That NHS England had published its Operational Planning Guidance late in the previous year, requiring Integrated Care Boards and NHS Trusts to produce and submit a Neighbourhood Health Plan as part of the national planning cycle;

b) That the Neighbourhood Health Plan would need to set out how the NHS, local authority, social care providers and the voluntary and community sector would work together to design and deliver neighbourhood-level health services;

c) That national guidance from the Department of Health and Social Care had not yet been published, and therefore the specific requirements for plan development were still unknown however, guidance was expected imminently;

d) That the purpose of the update was to ensure the Health and Wellbeing Board (HWB) was aware of the upcoming requirement, and that support and approval would be sought once guidance was available;

e) That Plymouth had recently been successful in securing enhanced support from the national Better Care Fund (BCF) Improvement Support Programme, following a bid submitted shortly before Christmas, and that this support would assist in preparing the Neighbourhood Health Plan;

f) That contact from the BCF national team was expected shortly, with a call already scheduled at 1pm on the day of the meeting to confirm next steps, timeframes and expectations;

g) That the ICB and Plymouth City Council intended to develop the plan jointly, and would ensure the Health and Wellbeing Board was fully engaged in its development and sign-off process as required;

h) That previous work across health, social care and the voluntary and community sector, particularly around integrated neighbourhood teams, would sit beneath and feed into the emerging plan, and that national priorities placed significant focus on neighbourhood-based preventative and community care models;

i) That a Local Care Partnership (LCP) meeting had taken place in December where partners had committed to continuing collaborative work. An action agreed at the meeting was to map all relevant workstreams and develop a joined-up strategy and governance framework to drive neighbourhood work forward;

j) That although Plymouth had not been selected for the national Neighbourhood Health Implementation Programme earlier in the year, the bidding process had generated substantial enthusiasm and cross-sector engagement, with a series of workshops continuing to explore co-production and neighbourhood service redesign.

In response to questions, the Board discussed:

k) That Local Government Reorganisation (LGR) would have implications for neighbourhood arrangements and should be considered early in the planning process, even while details remained uncertain;

l) That the HWB may need to convene an extraordinary meeting if required to meet tight national timescales associated with the plan and BCF governance, noting that timely HWB approval was likely to be necessary;

m) That Healthwatch had not yet received significant public interest or awareness around neighbourhood health work. Members noted the importance of public communication and ensuring people understood proposed changes, especially regarding integrated teams and local wellbeing services;

n) That concerns existed regarding potential duplication or postcode inconsistencies unless community involvement, co-production and transparency were built into the planning process from the outset;

o) That Plymouth already had strong community-based models and good practice, and that this should be evidenced clearly in the plan, with the neighbourhood model seen as an opportunity to reinforce existing strengths;

p) That national guidance was needed to shape priorities and provide a framework, but in the meantime local partners should continue preparing foundations through the Local Care Partnership and other integrated governance structures;

q) That children's social care national reforms also emphasised local, multi-disciplinary, co-located models, and that alignment between adults' and children's neighbourhood work would be important to avoid fragmentation;

r) That transitions between children's and adults' services, particularly regarding neurodiversity and mental health, should be considered within the neighbourhood model to improve continuity for young people;

s) Voluntary and community sector partners emphasised the importance of bottom-up, person-centred, trauma-informed service redesign. Members cautioned against top-down rollout that risked embedding system-designed rather than people-designed pathways;

t) That significant cultural change across all organisations would be required to deliver neighbourhood-based care successfully, including challenging long-standing professional silos, organisational protectionism and system-driven metrics that did not reflect people's lived experiences;

u) That the Changing Futures programme had demonstrated strong methodologies for deep community engagement and co-production which could be used to shape the neighbourhood approach;

v) That neighbourhood models may need to develop at different speeds across the city, reflecting the varying needs, strengths and characteristics of individual communities.

The Board agreed:

1. To note the verbal update on the Neighbourhood Health Plan;

2. To note Plymouth H&WB's successful bid for enhanced national BCF support;

3. To review national guidance once published and to consider the development timeline for the Plan at a future meeting.

70. **Revised Terms of Reference**

Elliot Wearne-Gould (Principal Democratic, Governance and Scrutiny Officer) presented the Revised Terms of Reference and discussed:

a) That in Spring 2025 the Board had participated in Development Workshops to review whether the existing Terms of Reference and membership remained fit for purpose;

b) That a subsequent report had been submitted to the Board in April 2025, where Members agreed to explore widening membership to improve representation, particularly by clarifying the distinction between core and co-opted members and how this related to quorum and voting rights;

c) That the revised Terms of Reference included updated partner organisation names, refreshed membership lists, revised role profiles and the incorporation of Neighbourhood Health guidance to reflect emerging national requirements;

d) That a significant proposed change was an amendment to the quorum rules, removing co-opted members from the quorum count to ensure meetings

remained functional as the Board expanded its co-opted membership, noting that co-opted members were not mandated to attend all meetings;

e) That, subject to HWB approval, the revised Terms of Reference would be submitted to City Council for adoption.

Ruth Harrell (Consultant in Public Health) added:

f) That the Plymouth Plan, which also served as the city's statutory Health and Wellbeing Strategy, was in the process of being refreshed and updated;

g) That Public Health requested a workshop be scheduled in late February for HWB Members to review the health and wellbeing elements of the Plymouth Plan and consider any amendments;

h) That the workshop would also include a draft of the new State of the City (health and wellbeing) report to support the Board in identifying priorities for the forthcoming year.

In response to questions, the Board discussed:

i) Members supported setting up a workshop to review the strategy and identify priorities;

j) That further amendments would be made to the Board membership once additional partner organisations had been contacted and confirmed acceptance to Join the Board;

k) That the term "statutory members" had been clarified to remove previous ambiguity around additional/co-opted membership. Statutory members were those required by legislation, while co-opted members were appointed at the Board's discretion.

The Board agreed:

1. To review, comment, and endorse the draft updated Terms of Reference;

2. To submit the revised Terms of Reference to City Council for approval, subject to clarification of additional co-opted partners.

71. Tracking Decisions Log

The Board agreed to note the progress of the Tracking Decisions Log.

72. Work Programme

Elliot Wearne-Gould provided an update on the Work Programme and discussed:

a) That the agenda for 12 March 2026 was currently clear;

b) That the February workshop would generate draft Board priorities for 2026/27 which would then inform agenda planning for the March meeting and beyond;

c) Substantive items would be scheduled once the Board had agreed its revised focus areas flowing from the Plymouth Plan refresh.

The Board agreed to note the Work Programme.