NHS Devon

NHS Devon Integrated Care Board (ICB) Meeting

The Board Room, Aperture House, Pynes Hill, Exeter, EX2 5AZ
and via Microsoft Teams

28 November 2024

09.30 – 13.30

One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Agenda for meeting in public

The quorum for meetings of the Board is:
a) Chair or Vice Chair
b) At least two Executive Directors
c) At least two additional independent members
d) At least one Partner Member
e) At least one of the members must be a registered clinician.

To Note: *Members to be in attendance from 09.20am for welcomes and introductions.*

1.		Introductory Items	Lead	Action	Time
1.1	ICB24-073	Welcome, introduction and apologies for absence	Kevin Orford, Chair	Discussion	09:30
1.2	ICB24-074	Declarations of interest	Kevin Orford, Chair	Information	
1.3	ICB24-075	Minutes of the meeting held on 18 September 2024	Kevin Orford, Chair	Approval	
1.4	ICB24-076	Action Register	Kevin Orford, Chair	Approval	09:35
1.5	ICB24-077	Our People and Communities: Experiences of Health and Social Care	Ginny Snaith, Director of Population Health	Discussion	09:40
2.		**Leadership Reports**	**Lead**	**Action**	**Time**
2.1	ICB24-078	Chair's Report	Kevin Orford, Chair	Information	09:55
2.2	ICB24-079	Chief Executive's Report	Steve Moore, Chief Executive	Information	10:15
3.		**National Oversight Framework Segment 4**	**Lead**	**Action**	**Time**
3.1	ICB24-080	NHS Oversight Framework – progress against Segment 4 exit criteria	Bill Shields, Chief Finance Officer Anthony Fitzgerald, Chief Operating Officer	Assurance	10:30
4.		**For Approval or Endorsement**	**Lead**	**Action**	**Time**
4.1	ICB24-081	2024/25 System Winter Plan	Anthony Fitzgerald, Chief Operating Officer	Approval	10:50
4.2	ICB24-082	Intensive and Assertive Outreach Review (Mental Health)	Peter Collins, Chief Medical Officer	Approval	11:15
4.3	ICB24-083	Adoption of the Safe Learning Environment Charter	Piers Tetley, Chief People Officer	Approval	11:30
		BREAK			**11:40**

5.		Governance, Performance and Assurance Reports	Lead	Action	Time
5.1	ICB24-084	Quality Report	Penny Smith, Chief Nursing Officer	Assurance	11:50
5.2	ICB24-085	Finance Reports – Month 6 i. NHS Devon Finance Report ii. One Devon Finance Report	Bill Shields, Chief Finance Officer	Assurance	12:05
5.3	ICB24-086	NHS Devon Annual Plan – Delivery Assurance	Sam Wadham-Sharpe, Director of Planning and Performance	Assurance	12:20
5.4	ICB24-087	Board Assurance Framework	Philippa Harding, Company Secretary and Interim Chief Communications and Corporate Affairs Officer		12:35
6.		**Partnership Working**	**Lead**	**Action**	
6.1	ICB24-088	Cornwall and Isles of Scilly ICB Update	Terry Willows, Company Secretary, Cornwall and Isles of Scilly ICB	Information	12:50
5.		**Committee Chair Reports**	**Lead**	**Action**	**Time**
5.1	ICB24-089	Quality and Patient Experience Committee – 14 November 2024	Thandiwe Hara, Independent Non-Executive Member	Assurance	13:00
5.2	ICB24-090	Finance and Performance Committee – 10 October and 14 November 2024	Kevin Orford, Acting Chair	Assurance	13:05
5.3	ICB24-091	Primary Care Commissioning Transition Committee – 21 November 2024	Judy Hargadon, Independent Non-Executive Member	Assurance	13:10
5.4	ICB24-092	People and Organisational Development Committee – 7 November 2024	Judy Hargadon, Independent Non-Executive Member	Assurance	13:15
6.		**Closing Items**	**Lead**	**Action**	**Time**
6.1	ICB24-093	Questions from Members of the Public	Kevin Orford, Chair	Discussion	13:20
6.2	ICB24-094	Any Other Business	Kevin Orford, Chair	Discussion	13:25
		Close			**13:30**

NHS Devon Integrated Care Board 28 November 2024

Employee	Role	Interest Type	Active/Date Ended	Interest Description (Abbreviated)	Interest Category	Mitigating Actions
Kevin Orford	Non-Executive Member	Declaration of Interest	Active	Advisor to the Board of Parental Minds C.I.C. (non-remunerated)	Non-Financial Professional	Should there be any issue relating to Parental Minds, there will be a discussion with the Director of Governance and the Chief Executive to ensure that no conflict of interest ensues.
Allison Williams	Contractor (part of SOF4 Mandated support via NHSE Intensive Support Team)	Nil Declaration	Active			
Anthony Fitzgerald	ICB Chief Operating Officer	Declaration of Interest	Active	Director Hamilton Green LtD	Financial	No current or likely interests in the South West
Donna Manson	Partner Member - NHS Devon Board	Declaration of Interest	Active	CEO Of Devon County Council	Financial	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.
Francis O'Kelly	Partner Member NHS Devon Board	Declaration of Interest	Active	GP Partner at Amicus Health	Financial	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
				Blundell's School Lead Doctor		
				Member of the National Armed Forces Reference Group		
				Attends Tiverton High School Welfare Meeting fortnightly		
				Contributor to FASD Forum		
				5 adopted children, 2 with recognised learning difficulties both recieving PIP and with residential or supported living in Devon		
				Wife is a book-keeper for STEER Eduction		
				Wife registered Carer for Adopted Child with Learning Difficulties		
				I attend a monthly online meeting of Primary Care Partner Members, which is organised and Chaired by the NHS Confederation	Non-Financial Professional	Will be declare on Conflict of Interests at meetings.
				My GP practice (Amicus Health) is in advanced talks to merge with the Mid Devon Medical Practice - Dr.Alex Degan (Medical Director for Primary Care at NHS Devon) is a partner in Mid Devon Medical Practice	Indirect	I have declared the business of Amicus Health Group and will declare it at the start of any meeting where a conflict arises
Judith Hargadon	Non-Executive Member	Nil Declaration	Active			
Lincoln Sargeant	Partner Member - NHS Devon Board	Nil Declaration	Active			
Liz Davenport	Partner Member - NHS Devon Board	Declaration of Interest	Active	Chief Executive Officer, Torbay and South Devon NHS Foundation Trust	Financial	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.
Mark Cooke	Managing Director (Strategy, Oversight & Regulation), NHS England South West	Declaration of Interest	Active	Non paid Director	Non-Financial Professional	Declare when necessary
				Director non-paid	Non-Financial Personal	Declaration when appropraite
				Director/trustee	Non-Financial Personal	Declare when appropriate
Penny Smith	Chief Nursing Officer	Nil Declaration	Active			
Peter Collins	Chief Medical Officer	Declaration of Interest	Active	Trustee for Orchestras Live (charity promoting widening participation and community engagement within the orchestral sector)	Non-Financial Personal	To be managed in line with the Conflicts of Interest Policy
Philippa Harding	Company Secretary	Declaration of Interest	Active	Founding Director of Harding Advisory Ltd, a professional services company providing corporate governance expertise.		The company is currently dormant. Should any conflicts relating to NHS Devon be identified they will be managed as they arise in line with the NHS Devon Standards of Business Conduct Policy
Piers Tetley	Chief People Officer	Nil Declaration	Active			
Phillip Mantay	Partner Member - NHS Devon Board	Declaration of Interest	Active	Chief Executive Officer, Devon Partnership NHS Trust	Financial	Declaration of relationship prior to offering opinion or recommendation.
Sam Higginson	Partner Member Designate - NHS Devon Board	Declaration of Interest	Active	Chair of Enfield Unity Primary Care Network	Non-Financial Professional	To be managed in line with the Standards of Business Conduct and Conflicts of Interest Policies
				Committee Member		
				Chief Executive Officer	Financial	
Samuel Wadham-Sharpe	Director of Performance and Assurance	Nil Declaration	Active			
Steve Moore	Chief Executive Officer	Nil Declaration	Active			
Thandiwe Hara	Non-Executive Member	Declaration of Interest	Active	Trustee of Plymouth and District Racial Equality Council, a voluntary organisation that work to promote race equality.	Financial	There should be no conflict of interest in current circumstances, but this may arise if, they became a provider during the course of time. I will declare my
				Member on the NIHR SW Clinical Research Network Board.		
William Shields	ICB Chief Finance Officer	Declaration of Interest	Active	Member HMFA Digital Council	Financial	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
				Deputy Chair, HMFA ICB CFO Forum	Financial	
				Co Chair, NHSE Integrated Finance Board	Financial	
				Occasional presentations for HMFA, EY, KPMG, Channel 3 Consulting and Deloitte	Financial	
				Anthony Fitzgerald (Chief Delivery Officer) and I have a longstanding friendship which could result in a perceived conflict of	Indirect	Any decisions relating to appointments following organisational change
				Undertaking turnaround work in Torbay and South Devon NHS Foundation Trust	Non-Financial Professional	To be managed in line with the Conflict of Interest Policy
			11/18/2024	Director of Shields Health Advisory Limited (Dormant)	Financial	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
			11/26/2024	Chair, HFMA Financial Recovery Group	Financial	
			5/30/2024	Writes a blog for HMFA	Financial	
Virginia Snaith	Director of Population Health, NHS Devon	Nil Declaration	Active			

DRAFT Minutes of a meeting of NHS Devon Integrated Care Board held in public at the Boardroom, Aperture House, Pynes Hill, Exeter, EX2 5AZ and via Microsoft Teams on Wednesday 18 September between 09:30 and 12:45	
Name	*Title and organisation*
Board Members:	
Kevin Orford	Acting Chair, NHS Devon
Steve Moore	Chief Executive Officer, NHS Devon
Graham Clarke	Non-Executive Member, Audit and Risk, NHS Devon
Liz Davenport	Partner Member for NHS Trusts and Foundation Trusts, Chief Executive, Torbay & South Devon NHS Foundation Trust
Dr Thandiwe Hara	Non-Executive Member, Citizen and Community Involvement, NHS Devon
Judy Hargadon	Non-Executive Member, Primary Care, NHS Devon
Donna Manson	Partner Member for Local Authorities, Chief Executive, Devon County Council
Dr Frank O'Kelly	Partner Member for Primary Care, GP Partner, Amicus Health
Dr Lincoln Sargeant	Partner Member, Local Authorities (Population Health and Prevention), Director of Public Health for Torbay
Penny Smith	Chief Nursing Officer
Also in attendance:	
Helen Braid	Head of Governance, NHS Devon
Dr Alex Degan	Primary Care Medical Director, NHS Devon
Kirsty Denwood	Deputy Chief Finance Officer, NHS Devon
Anthony Fitzgerald	Chief Delivery Officer, NHS Devon
Hisham Khalil	Co-Opted Member of the NHS Devon Audit and Risk Committee
Richard Schofield	Director of System Coordination & NHS Greener SW SRO
Piers Tetley	Interim Chief People Officer, NHS Devon
Sam Wadham-Sharpe	Director of Planning and Performance, NHS Devon
Apologies for absence	
Professor Sheena Asthana	Non-Executive Member, Health Inequalities and Population Health, NHS Devon
Mark Cooke	Managing Director, NHS England South West
Philippa Harding	Company Secretary and Interim Chief Communications & Corporate Affairs Officer, NHS Devon
Bill Shields	Chief Finance Officer, NHS Devon
Kate Shields	Chief Executive Officer, NHS Cornwall & Isles of Scilly
Allison Williams	System Improvement Director, NHS England

Item	Ref	Discussion
1.		**Introductory Items**
1.1	ICB24 - 051	**Welcome, Introductions and Apologies** The Chair welcomed Board members to the meeting. Apologies for absence had been received from Bill Shields, Allison Williams, Mark Cooke, Philippa Harding, Kate Shields and Sheena Asthana. It was noted that Kirsty Denwood would be deputising for Bill Shields, Helen Braid for Philippa Harding and that Richard Schofield was attending on behalf of the NHS England South West Regional Team. The Chair welcomed Lincoln Sargeant, Director of Public Health at Torbay Council, who had taken up the role on the Board as Partner Member for Local Authorities (Population Health and Prevention). Alex Degan introduced Becky Randall, a GP trainee who would be observing the meeting as part of her ongoing professional development. It was noted that a meeting in private would be held later in the day when items commercial in confidence would be considered, together with the draft Medium Term Financial Plan. The meeting was deemed quorate.
1.2	ICB24 - 052	**Declarations of Interest** The Board **noted** the Register of Interests. In addition it was noted that Kirsty Denwood had made a “nil” declaration.
1.3	ICB24 - 053	**Minutes of Previous Meeting** It was noted that the question from the public that had been submitted to the July meeting had been appended to the minutes, together with the response provided by the Chief Executive Officer. The Chief Nursing Officer, Penny Smith (PS) referred the meeting to Minute ICB24-037 in respect of Children and Young People’s Services Recovery and the review that had been requested regarding the impact of a patient’s right to choose upon costs and waiting lists. The meeting noted that all the providers involved had now been identified; however, the data included a mix of adults and children who were proving challenging to separate out. The team was working to a deadline of the end of September to complete this work. The minutes of the meeting in public held on 25 July 2024 were **approved** as a correct record.
1.4	ICB24 –054	**NHS Devon: 2023/24** The Chair introduced a short film which highlighted some of the key themes for NHS Devon during 2023/24 and featured members of staff talking about their area of work and also Kevin Dixon, the Chair of Healthwatch in Devon, Torbay and Plymouth, who explained how NHS Devon had worked with Healthwatch to better understand the needs of local people and communities. The film was **noted.**

1.5	ICB24 - 055	**2023/24 Annual Report and Accounts** The Chief Executive, Steve Moore (SM), introduced a report which presented the Board with the final Annual Report and Accounts for NHS Devon for the period 1 April 2023 to 31 March 2024. This report also formally presented the outcome of the 2023/24 Annual Assessment of NHS Devon undertaken by NHS England (NHSE). Issues highlighted during consideration of this item included: • NHS Devon had met all financial duties as required and had received an unqualified audit opinion for the accounts. • NHSE had confirmed that NHS Devon was compliant with its statutory duties. • The Annual Assessment letter clearly set out the challenges that had been faced by NHS Devon during 2023/24 and it was evident from the Board papers being considered at the meeting that those challenges were being addressed. • Areas of improvement required were clear and the development of the Medium Term Financial Plan being considered at the meeting in private later in the day would support the progress required to achieve financial and clinical stability. • Whilst challenges remained, collaboration had now become a way of working and NHS Devon staff were commended for the support that had been given to providers in meeting those challenges. • Chair of the Audit and Risk Committee, Graham Clarke (GC) confirmed the view of that Committee that the documents provided a balanced view of the 2023-24 year. • The Annual Report and Accounts did not reference the savings made across the system and what levels of system savings would be required in future years. System finances would be picked up through the Medium Term Financial Plan. • A formal response would be made to the 2023/24 Annual Assessment Letter, which would be provided to the Audit and Risk Committee. Thanks were extended to the teams who had contributed to the production of the 2023/24 Annual Report and Accounts. **Action:** • The formal response to the 2023/24 Annual Assessment letter to be provided to the Audit and Risk Committee, with a progress report in respect of implementation to be presented to that Committee in six months time. The Board: • **Noted** the final NHS Devon 2023/24 Annual Report and Accounts • **Noted** the Annual Assessment for 2023/24 of NHS Devon by NHS England
2.		**Leadership Reports**
2.1	ICB24 - 056	**Chair's Report** The Chair introduced the report which provided his thoughts in respect of the 2023/24 Annual Report and Accounts and also updated the Board of the visits undertaken as part of his continuing induction as Acting Chair of the NHS Devon Integrated Care Board. The Board **noted** the content of the Chair's report.

2.2	ICB24 - 057	**Chief Executive Officer's Report** The Chief Executive introduced his report which provided an update in respect of the organisational change staff consultation, general practice collective action and children and young people's autism services recovery. It was noted that over 800 pieces of feedback had been received and responded to during the staff consultation and thanks were extended to Human Resources team who had managed the process. The report also presented an amended Ambulance Partnership Board Delegation Agreement for approval, with it being noted that the changes in the Agreement were to ensure there was a good governance process to support the way in which issues were being captured and addressed. Challenge was raised as to whether as a region wide organisation, South Western Ambulance Service NHS Foundation Trust (SWASFT) was able to focus at a locality level. It was noted that agendas needed to be clear as to what was happening at a system level and the work that was required at locality level, with the example of the Devon Task and Finish Group that was currently reviewing Category 2 response times. The Board • **Noted** the content of the report. • **Approved** the amended Ambulance Partnership Board Delegation Agreement.
3.		**National Oversight Framework Segment 4**
3.1	ICB24 - 058	**Recovery Support Programme (RSP) assessment of NHS Devon progress towards delivery of exit criteria for NOF4 in 2023/24** The Chief Executive introduced the report that provided the high-level assessment undertaken by the System Improvement Director of progress made against the criteria required for NHS Devon to exit Segment 4 of the NHS Oversight Framework (NOF4), leading up to the June 2024 reset. It represented a point in time and where further progress has been made since the reset, this was reflected in the final section of this report. The following points were highlighted: • Whilst significant progress had been made, more work was required and there was pressure on all sectors to maintain momentum and energy. The learning to date was being carried forward with conversations taking place to support senior teams and ensuring that the right people were in place to deliver the improvements required. • A balance had to be struck around supporting long term sustainable change and doing what was needed in the short term; as, for example, provider collaboratives would require some 5-7 years to deliver sustainable change, but additional capacity could be brought into the system now to support the fragile services programme. • The role of NHS Devon in respect of Population Health Management was to convene partners across the system rather than delivering programme of work. There was a need to articulate the nature of the strategic challenges being faced, with the delivery to address these challenges being de-centralised to localities with the Local Care Partnerships playing a key role in that delivery.

		• Staff should be commended on the progress that had been made towards achieving an exit from NOF4, particularly in terms of financial savings, with it being acknowledged that the significant impact resulting from this constant pressure should not be underestimated. • Reference was made in the report to the need for a clear clinical strategy supported by robust plans to deliver the performance improvements and service transformation to enable Devon to be clinically and financially sustainable and whether this should be articulated as a Board Assurance Framework (BAF) risk. • Whilst detail had been provided as to how the issues raised in the report were being addressed, would it be possible to pick out a line on one of the plan and Chief Officers be assured that what it was assumed was happening was actually happening or not. It was noted that the Locality Planning and Delivery Meetings (LPDMs) were based upon honesty and being clear with each other that the focus was improvement, and that support would be provided if trajectories were not being met. In addition, there was the performance information that was being produced which would highlight success or where there was an issue that needed to be clearly understood and addressed. • One of the areas of progress had been to develop a common understanding of issues rather than externalising issues or trying to address the wrong drivers of problems. • The Board was fully supportive of the work being undertaken and the position did feel tangibly different than in previous years; however, should there be problematic issues these should be raised with the Board as soon as possible to enable the support required to be identified. • The output of the first round of LPDMs was currently being analysed prior to letters being written to each of the NHS provider Chief Executive Officers setting out what needed to be delivered during the next six months to ensure that the system remained on trajectory to exit NOF4 in the first quarter of 2025/26. • Whether there was any contention between the role of sovereign Boards versus the System Leadership Group and that the role for NHS Devon was to take ownership to ensure that there was the right balance between the two elements. The starting point would be clear and consistent reporting to all Boards, followed by all Boards understanding the importance of their contribution to the system plan and being fully engaged with its delivery. This structural approach would also be complemented by the relationships that had been built over the past year. • A Clinical Strategy was required that would drive the system's agenda, which addressed the total need of the population and dealt with the underlying root causes of the challenges that had to be addressed. This development of the strategy needed to start with a Board conversation around the nature of the challenges which would then enable a broader system discussion which in turn would lead to the plans that would flow from the strategy. • Clarification was awaited as to the detail of the future RSP funding and this would form part of the discussion at the RSP Escalation meeting with NHSE on 17 October 2024. • There was no specific communications plan in respect of NOF4, but rather there being ongoing messages around planned care, waiting times and receiving treatment as those were the concerns of staff and patients. Board members expressed their thanks to Allison Williams for her report.

		Action: • The letters to provider CEOs regarding delivery for the next six months to be circulated to Board members. The Board **noted** the report from the System Improvement Director.
3.2	ICB24-059	**NHS Oversight Framework – progress against Segment 4 exit criteria** The Director of Planning and Performance, Sam Wadham-Sharpe (SWS) introduced the report which sought to provide the necessary assurance to the Board on progress against the agreed criteria and metrics required to exit Segment 4 of the NHS Oversight Framework (NOF4) in Q1 of 2025/26. The report detailed the system position on the criteria for strategy, leadership, Urgent and Emergency Care (UEC), elective and finance recovery, accompanied by a locality position on delivery against trajectory and the key actions to either maintain or improve performance. It was noted that the detailed performance data supporting the report had been scrutinised by the Finance and Performance Committee at its meeting on 12 September 2024, who had subsequently accepted the report recommendations with regard to assurance levels. The following points were highlighted: • It was anticipated that the assurance rating for elective care would move to limited assurance during the month. • Whilst there were variances in performance, situations and relationships were changing and the key was continuing to learn from experience. • The trajectories at the beginning of the year had been ambitious; however, improvements were being made and interventions were considered at planning and delivery meetings to see where improvement could be pushed further. In addition, there were interventions already built into the trajectories such as new urgent treatment centres which together with experience, increased capability and any additional funding would result in improved performance. • The challenge remained around sustainability and providers were learning from each other, best practice and innovation. The right people, process and infrastructure needed to be aligned to ensure credibility and sustainability, all of which required investment. • Winter planning was now part of the annual planning process for the system and not treated as a separate issue; however, specific reporting and process was required in respect of mitigating actions throughout the winter period. • Increased demand could undermine increased provision significantly. The detail in the 2024/25 planning was much higher than in previous years and that had enabled a clear articulation of what level of demand providers could consume which when combined with the work being undertaken around the levels of growth that might be seen across the system was leading to a greater understanding of what was driving that growth. • The impact of GP collective action upon finance and UEC was an unknown quantity at present; however, intelligence gathering was underway with primary care beginning to see some evidence around mental health and prescribing impacts. • To exit NOF4 by the target date of quarter one of 2025/26 would require the system to achieve trajectory in October 2024 and to sustain that performance for the remainder of the financial 2024/25 financial year.

		• The assurance ratings in the report were around performance against trajectory to date and it was accepted that the Board's committees needed to be forward looking and considering the risks that were being faced. • That the report would benefit from a section highlighting risks to meeting targets for example due to changes in demand. On behalf of the Board, the Chair thanked the NHS provider Executive Teams across the system and SWS for their work on the recovery programme. **Action:** • An update report on the current incident management process in place to mitigate the GP Collective Action together with the current level of intelligence around the impact of the action to be brought to the next Board meeting. • A corporate approach to assurance descriptors to be developed. • A section regarding risk to be included in future reports. The Board • **Agreed** the overall assurance level relating to progress against the NOF4 exit criteria as satisfactory. • **Agreed** that adequate plans were in place to mitigate the risks relating to the delivery of NOF4 exit criteria identified in the Locality Planning and Delivery Meetings and the System Leadership Group.
4.		**Governance, Performance and Assurance Reports**
4.1	ICB24 - 060	**Quality Report** The Chief Nursing Officer, Penny Smith (PS), introduced a report which aimed to summarise and provide assurance to the Board regarding patient safety and quality issues, the actions NHS Devon was taking to address these and how assurance on a sustained improved position was being sought. The report sought to evidence the triangulation of quality information around key issues identified through the quality governance process. Issues discussed during consideration of this item included: • All providers had now transitioned to the Patient Safety Incident Response Framework (PSIRF) and work was now underway with primary care colleagues. • There had been a key focus on never events with assurance being taken from the rigour around this from providers and it being noted that Torbay & South Devon NHS Foundation Trust (TSD) was taking learning from the Royal Devon University Healthcare NHS Foundation Trust (RDUH). • There had been some challenges around the governance of infection management which had now been addressed to good effect. • All three maternity providers in the system were subject to the National Maternity Improvement Plan and whilst diagnostic work was still being undertaken there were some emerging themes which would be presented to a joint strategic meeting during November. • There had previously been challenges in displaying the total waiting list size, including waiting time issues within mental health and within children and young people's services. A request had recently been received from the NHSE regional team for a data set which would see NHS Devon working with providers to gain a much better understanding of waiting which would be

		incorporated into the NHS Devon Annual Plan reporting as quickly as possible. • NHSE had developed a national quality framework and going forward the Quality Report would give assurance against delivery of that framework. • There had been concerns around the availability and supply of medication for young people, particularly in respect of ADHD medication. This had resulted in some GPs being required to take decisions which should be under secondary care advice. The issue of medication might also be a concern when considering the right to choose which could result in patients moving between the public and private sector and whether GPs would be required to pick up private sector prescribing. • Risks and incidents around water pollution were increasing and work was ongoing with public health colleagues around the learning from the recent episode in Torbay and to strengthen partnership working across all sectors. **Action:** • The implications of the right to choose for patient pathways to be considered at a future meeting of the Quality and Patient Experience Committee. The Board **noted** the overall assurance level relating to the quality position of NHS Devon as satisfactory and **supported** the position that adequate plans were in place to mitigate and improve quality risks.
4.2	ICB24 - 061	**Finance Reports** The Deputy Chief Finance Officer, Kirsty Denwood (KD), introduced the Month 4 Finance Reports for NHS Devon and for the One Devon Integrated Care System. The following points were highlighted: • The Finance and Performance Committee had scrutinised the reports at its meeting on 12 September 2024 and supported the recommendations relating to the levels of assurance for each section in the reports. • Overall NHS Devon was in plan in terms of forecast and year to date position; however, there was limited assurance around the savings and efficiencies due in part to the confirmation that any unspent dental funding would be clawed back. • There was no longer any unidentified Cost Improvement Plans (CIP) across the system and there was a target to reduce the high risk level of CIP to less than 20% by month 5. • It had been indicated that an element of the costs incurred in respect of industrial action would be provided which would mitigate the risk position, but there did remain unmitigated risk in the plan. The Board **agreed** the overall assurance level relating to the financial position of NHS Devon and of the One Devon Integrated Care System was satisfactory and that adequate plans were in place to mitigate the risks relating to the delivery of planned saving and efficiencies and to the management of the risks identified at the plan stage.
4.3	ICB24 - 062	**Performance Report** The Chief Operating Officer, Anthony Fitzgerald (AF), introduced the report which provided the NHS Devon Board with assurance on key areas of performance in relation to a range of internally and externally set Key Performance Indicators (KPIs) that were not covered in other assurance reporting presented elsewhere on the agenda for this meeting.

		The following points were highlighted: • Work had been undertaken with providers to understand what sat within community waiting lists which presented a complex picture of at least 28 individual domains. It appeared that there had been an increase in waiting lists for children and young people and for muscular skeletal services and work would now be undertaken to validate this. • Community waiting lists would form part of the discussion at the next round of Local Planning and Delivery Meetings (LPDMs) so that this area would be brought into the wider consideration around performance improvement. • The lack of accuracy of the primary care data being fed into the National Workforce Reporting System. • That 30% of the primary care workforce was over the age of 55 and it would be a significant challenge to replace that level of workforce. • There were certain periods in the life cycle when waiting times had more impact and this was the case for speech and language in two to four year olds where delayed intervention could result in ongoing challenges throughout childhood and into adulthood. • The datasets for ADHD and autism needed to be reviewed together with those for speech and language therapy as it was often unclear as to why particular pathways had been chosen for patients. **Action:** • Early detailed work should be undertaken as to the issues that should be taken into the 2025-26 planning round. The Board **agreed** the individual assurance levels relating to the performance criteria contained in the report.
4.4	ICB24 - 063	**Delivery of the 2024/25 Annual Plan – Assurance** The Chief Executive introduced the report which set out oversight and assurance for the delivery of each NHS Devon Directorate's 2024/25 Annual Plan objectives. The report provided details of the objectives where the Programme Management Office (PMO) and Performance team had either no or only partial assurance with respect to progress being made to deliver the Plan. The following issues were highlighted: • The content of the report was created through the detail provided by each Directorate in their highlight reports and the outputs of the review and assurance process with these reviews being chaired by the Director of Performance and Planning. • Further improvements in the delivery of the Plan were anticipated as the 2025/26 planning round commenced as objectives would be clear, there would be direct executive ownership of actions and individual objectives would be assigned to the relevant Assurance Committee. • The Chief Finance Officer objective around procurement was now fully in place. • The report contained areas that were "red" rated and yet were marked as fully assured which was due to the approach of where 50% of priorities were fully assured it received an overall rating as such. That the current approach would be reviewed moving forward. • There was unknown assurance for one or two areas due to capacity and a statement on that would be included within the next report. Other issues leading to an unknown assurance rating included work not having

		commenced yet due to the timing of the objective or that there was not the ability to track the metric as yet. • Understanding why data was not available for some metrics would be important as would the prioritisation of what data it was important to collect first. Looking outwards to identify where similar issues had been solved was an approach that was being adopted with the Business Intelligence team working across other systems to learn how other systems measured their progress and performance. • There needed to be a clear articulation of what success looked like for all of the objectives so progress could be accurately measured. **Action:** • A statement around where capacity was impacting on the ability to rate assurance levels to be included in the next iteration of the report. . The Board: • **Noted** the assurance report summary and assurance levels for each Directorate. • **Approved** the proposed amendment of the Annual Plan to include: "The ICB will address significantly poorer outcomes for care-experienced children and young people by tackling access and equity issues in care delivery."
4.5	ICB24-064	**Winter Plan 2024/25 – Process and Principles** AF introduced the report which described a collective, system wide approach to winter planning in Devon for 2024/25. The following points were highlighted: • The system wide Winter Plan would be presented to the Unscheduled Care Board at its September meeting. • The work being undertaken to develop the plan was based on the assumption that there would be no additional funding available; however, there was ongoing engagement with primary care to establish what could be achieved in terms of admission and attendance avoidance. • Work was also being undertaken with the NHSE regional team in terms of impact change analysis and their work in respect of standardising the ambulance offer across the South West. • The approach being taken was that planning for winter was part of business as usual rather than a separate process with the plans being put in place being those that were being used to manage effective urgent and emergency services. • The right people had been involved in the planning and would be involved in the operational delivery of the plans including SWASFT and the providers of the NHS111 service in Devon. It would be important to maintain engagement, particularly during testing times. • The success of the planning was based upon the expectation that providers would continue to meet their elective care targets and so it was essential that elective pathways were protected. • That a peer to peer review would add value to the process and the possibility of system level event was currently being investigated. • Whether primary care collective action should be incorporated within demand and capacity modelling. • The Business Intelligence team was currently developing work in respect of using the data from winter to inform prevention activities and were also looking at what was happening in other areas for scenario modelling. • The Single Health Resilience Early Warning Dashboard (SHREWD) was now in place which was an electronic system that monitored system

		pressures and also had a predictive element. Work was ongoing to improve feeds into the system which included data from local authorities, SWASFT and mental health services. • The impact that the removal of the winter fuel allowance combined with the increase in energy prices would have upon falls and respiratory problems and that a cross sector communications plan around this would be beneficial. • There was work to be undertaken around reviewing criteria for success to ensure that these aligned with the principles of the Darzi Report. **Actions:** • A joined up communications plan to be developed providing messaging from all sectors around winter. • A report be brought to the November Board meeting setting out the detail of the winter plan for the system including bed equivalent deficit numbers; out of hospital areas of focus; the communications plan and the approach to process and co-ordination throughout the winter period. . The Board **took assurance** from the approach that the One Devon Integrated Care System was taking to winter planning.
4.6	ICB24-065	**Board Assurance Framework** The Head of Governance, Helen Braid (HB), introduced the report which provided an update on the high-level strategic risks that might impact on the achievement of NHS Devon's strategic objectives in the current financial year. The Board was referred to its request to the Finance and Performance Committee to review the residual risk score relating to the Finance and Use of Resources BAF risk to establish whether it remained appropriate. The Committee had agreed that no change was needed to the residual risk score at the present time but that it may revisit this. . The Board **agreed** the third iteration of the 2024/25 BAF.
5.		**Committee Chair Reports**
7.1	ICB24 - 066	**Committee Chair's Reports: Quality and Patient Experience Committee – 11 September 2024** The Chair of the Quality and Patient Experience Committee, Independent Non-Executive Member, Thandiwe Hara (TH), introduced the report which provided the Board with an overview of the issues considered by the Committee at its meeting on 11 September 2024. TH referred the Board to the Committee's concern about assurance levels and data quality regarding the number of S117 cases on the Devon Partnership NHS Trust register set against recorded evidence of S117 updates on the Trust's electronic systems. It was noted that further information gathering would take place and that detail on levels of assurance and mitigation would be reported to the next meeting of the Quality and Patient Experience Committee. Reference was also made to the recommendation from the Committee in respect of responsibilities around patient and public engagement. The Board: • **Noted** the Committee's concern regarding S117 cases and the further work to be undertaken in respect of this.

		• **Approved** the proposal to transfer responsibility for oversight of Patient and Public Engagement from the Quality and Patient Experience Committee to the Population Health Improvement Committee, subject to comments and endorsement by the latter Committee at its first meeting.
7.2	ICB24 - 067	**Committee Chair's Report: Finance and Performance Committee – 11 July, 8 August and 12 September 2024** The Chair of the Finance and Performance Committee, the Acting Chair of NHS Devon, introduced the report which provided the Board with an overview of the issues considered by the Committee at its meetings on 11 July, 8 August and 12 September 2024. The Board was referred to the escalations to the Board for noting in respect of the level of assurance around NOF4 exit criteria and the limited assurance taken in respect of year end positions, with it being noted that both of these issues had been considered during the course of the Board meeting. The Board: • **Noted** the levels of assurance taken by the Finance and Performance Committee around the NOF4 exit criteria at its meeting on 11 July 2024. • **Noted** the limited assurance taken by the Finance and Performance Committee regarding the achievement of agreed year-end positions for UEC, Elective Care and finance at its meeting on 8 August 2024.
7.3	ICB24 - 068	**Committee Chair's Report: Primary Care Commissioning Transition Committee – 18 July and 15 August 2024** The Chair of the Primary Care Commissioning Transition Committee, Independent Non-Executive Member for Primary Care, Judy Hargadon (JH) introduced the reports which provided the Board with an overview of the issues considered by the Committee at its meetings on 18 July 2024 and 15 August 2024. JH referred the meeting to the escalation from the Committee dated 18 July 2024 expressing concern that the primary care sector was being expected to contribute towards the system's CIPs when the sector was still funded below its national level and funding had been cut relatively in recent years. SM agreed that there was a need for the system to be balanced and to focus on primary care, community care and population health as much as the other parts of the system and there was a commitment that as the 2025-26 Annual Plan was developed that there would be a considered debate regarding the allocation of resources despite the challenges of being in deficit. The Committee had also made two recommendations to the Quality and Patient Experience Committee which JH confirmed she would discuss in detail with the Chair of that Committee. The Board: • **Noted** the escalation to the Board of the Primary Care Commissioning Transition Committee's concern as to primary care being expected to contribute to cost improvement plans when it was still funded below its national level, together with the response of the Chief Executive. • **Noted** the recommendations made to the Quality and Patient Experience Committee that they consider the ICB's position on GPs being asked to work above what the British Medical Association state are the safe working limits

		and the concern regarding the length of time it is taking to embed the new patient safety framework.
7.4	ICB24 - 069	**Committee Chair's Report: Audit and Risk Committee – 2 September 2024** The Chair of the Audit and Risk Committee, Independent Non-Executive Member for Audit and Risk, Graham Clarke (GC) introduced a report which provided the Board with an overview of the issues considered by the Committee at its meeting on 2 September 2024. It was noted that discussions were being undertaken with provider organisations around system-wide audit reviews, one of which was in respect of CIPs, the interim findings of which it was hoped would be available ahead of the RSP Escalation Meeting with NHSE on 17 October 2024. Other system wide reviews were currently in development and would focus upon ambulance handovers and another on maternity standards. Assurance was also taken that the 2024/25 Internal Audit Plan was on track for in-year completion. The Board **took assurance** from the Committee Chair's Report of the Audit and Risk Committee meeting held on 2 September 2024.
8.		**Closing Items**
8.1	ICB24 - 070	**Action Register** The Board: • **Agreed** the closure of Actions 59, 61, 62 and ICB24 8a, 12, 29, 32, 33, 36, 37 and 40. • **Noted** the updates in respect of Actions 68, 69, 71 and ICB24 9, 37c, 38 and 38. • **Noted** the update in respect of Action ICB24 037b that had been received earlier in the meeting.
8.2	ICB24 - 071	**Questions from Members of the Public** None.
8.3	ICB24 - 072	**Any Other Business** It was noted that the next meeting of the Board in public would be on 28 November 2024.
		Meeting Closed: 12:45

NHS Devon

Integrated Care Board Meetings in Public - Action Log						
Action Reference	**Date of Meeting**	**Action - issue to be addressed**	**Target Date**	**Lead**	**Progress on action**	**Status**
ICB24 037c	25.07.2024	The Quality and Patient Experience Committee to undertake a deep dive into the "waiting well" offer for children awaiting an autism diagnosis.	30.09.2024	Su Smart	20.11.2024 - Deep dive undertaken at QPEC on 14.11.2024 Propose to close.	**Propose to close**
ICB24 058i	18.09.2024	The letter to provider CEOs regarding delivery for the next six months to be circulated to Board members.	28.11.2024	Steve Moore	21.11.2024 - Shared with Board members via correspondence. Propose to close.	**Propose to close**
ICB24 059i	18.09.2024	An update report on the current incident management process in place to mitigate the GP Collective Action together with the current level of intelligence around the impact of the action to be brought to the next Board meeting.	28.11.2024	Alex Degan	18.11.2024 Update on GP Collective Action included within CEO's Report. Propose to close.	**Propose to close**
ICB24 059iii	18.09.2024	A section regarding risk to be included in future NOF4 progress reports.	28.11.2024	Sam Wadham-Sharpe	18.11.2024 Risk referred to throughout the NOF4 cover report. Propose to close.	**Propose to close**
ICB24 062	18.09.2024	Early detailed work should be undertaken as to the issues that should be take into the 2025-26 planning round.	28.11.2024	Steve Moore / Sam Wadham-Sharpe	22.11.2024 - This has commenced with directorate reviews being held through November alongside Executives and Directors engagement sessions.	**Propose to close**
ICB24 063	18.09.2024	A statement around where capacity was impacting on the ability to rate assurance levels to be included in the next iteration of the 2024/25 Annual Plan delivery report.	28.11.2024	Sam Wadham-Sharpe / Philippa Harding	20.11.2024 - Capacity concerns have been discussed through the Delivery Room process. Propose to close.	**Propose to close**
ICB24 064ii	18.09.2024	A joined up communications plan to be developed providing messaging from all sectors around winter.	28.11.2024	Anthony Fitzgerald	09.10.2024 - Communications section included within 2024-25 Winter Plan. Propose to close.	**Propose to close**
ICB24 064ii	18.09.2024	A report be brought to the November Board meeting setting out the detail of the winter plan for the system including bed equivalent deficit numbers; out of hospital areas of focus; the communications plan and the approach to process and co-ordination throughout the winter period.	28.11.2024	Anthony Fitzgerald	04.11.2024 - Included on agenda for 28.11.2024. Propose to close.	**Propose to close**
68	07.02.2024	Primary Care representation on the Urgent and Emergency Care Board be considered when its Terms of Reference were being reviewed and an update be provided.	30.09.2024	Philippa Harding	17.07.2024 - UEC Group due to review its terms of reference by the end of September as part of work on system structures. The princple of primary care representation has been incorporated into all of this work. 14.03.24 - The systems and frameworks sitting below the System Recovery Board are currently being reviewed and this will be incorporated into that review. To be completed by April 2024.	In progress

Integrated Care Board Meetings in Public - Action Log						
Action Reference	**Date of Meeting**	**Action - issue to be addressed**	**Target Date**	**Lead**	**Progress on action**	**Status**
69	07.02.2024	An update on the outcome of the review being undertaken by the Executive Team in respect of end of life commissioning and equitable funding for adult hospices in Devon to be reported to the Board.	30.09.2024	Anthony Fitzgerald	09.10.2024 - Proposed way forward to be presented to **Board in January 2025** to enable consideration ahead of changes in April 2025. 09.09.2024 - Initial update included in CEO's report. Further update to be scheduled. 15.07.24 – Task and finish work underway and multi-organisation group established; NHS development sessions have taken place. Board item scheduled for September 2024. 24.05.2024 - A meeting with North Devon Hospice has taken place and Steve Moore has commissioned a Task and Finish Group led by Lou Higgins and sponsored by the Chief Medical Officer, to: 1. Rapidly develop a Devon-wide prospective medium-term commissioning plan for End of Life care. 2. Establish a Palliative and End of Life Care Collaborative to provide system-wide co-ordination of change and transformation and advise the ICB on future long-term commissioning plans. The Group will review evidence and guidance, assess Devon's position against this, and make recommendations on a future commissioning model. This replaces the previous action of merely levelling up hospice funding, but instead, going back to commissioning services equitably based on need. The ToR and scoping document for this group will be shared for approval at the next Executive Committee and a report will be made to the Board in September 2024 as scheduled.	In progress
71	26.03.2024	A Board Development Session to be held in respect of the longer term strategy for Primary Care across Devon.	31.10.2024	Peter Collins / Philippa Harding	09.09.2024 - This will now be considered at the **Development Session on 19.12.2024** following on the from the meeting with the Collaboratives on 31.10.2024. 17.07.2024 - Session moved to October 2024 in light of request from primary care collaborative colleagues. 02.05.2024 - Scheduled for August 2024.	In progress
ICB24 009	30.05.2024	Decision-making structures in respect of commissioning to be clarified.	30.09.2024	Steve Moore / Philippa Harding	21.11.2024 - Proposed ToR of executive Commissionig Group have been drafted and circulated. To be considered alongside a revised operational scheme of delegation by the NHS Devon Executive meeting on 03 December 2024. 09.09.2024 - Work on operational scheme of delegation ongoing. Position to be presented to the Board in November 2024. 17.07.2024 - Being picked up as part of work on operational scheme of delegation. Position to be presented to the Board in September 2024.	In progress
ICB24 037b	25.07.2024	A review of the impact of a patient's right to chose upon costs, waiting lists and the private sector's involvement in the area of children and young people's services to be undertaken.	30.09.2024	Bill Shields / Penny Smith	18.09.2024 - All providers involved had now been identified, but that the data included a mix of adult and children and that this was proving challenging to separate out. The team was working to a deadline of the end of September to complete this work. Progress update reminder sent on 20/11/2024	In progress
ICB24 038	25.07.2024	A report to be brought to a future meeting of QPEC in respect of the merger between the Devon and the Cornwall LMNS.	31.01.2025	Hannah Pugliese	09.09.2024 - Scheduled for January 2025.	In progress
ICB24 039	25.07.2024	The Quality and Patient Experience Committee to seek assurance around the work being undertaken to improve data quality and whether the current data highlighted any patient experience or clinical effectiveness issues.	30.09.2024	Penny Smith	09.09.2024 - Scheduled for January 2025.	In progress
ICB24 055	18.09.2024	The formal response to the 2023/24 Annual Assessment letter to be provided to the Audit & Risk Committee, with a progress report in respect of implementation to be presented to that Committee in six months time.	31.03.2025	Steve Moore	20.11.2024 - Scheduled for January 2025.	In progress
ICB24 059iii	18.09.2024	A corporate approach to assurance descriptors to be developed.	28.11.2024	Sam Wadham-Sharpe	22.11.2024 - This is being addressed through the development of the 2025/26 version of the Annual Plan. The CEO has set out some principles for development and aligning assurance scoring.	**In progress**
ICB24 060	18.09.2024	The implications of the right to choose for patient pathways to be considered at a future meeting of the Quality and Patient Experience Committee.	28.11.2024	Penny Smith	20.11.2024 - Scheduled for March 2025.	**In progress**

NHS Devon Integrated Care Board

Chair's report

Date of meeting	Date report produced
28 November 2024	15 November 2024

Author(s)		Report approved by	
Name and title:	Sam Cush, Communications Manager Philippa Harding, Company Secretary and Interim Chief Communications and Corporate Affairs Officer	**Name and title:**	Kevin Orford, Acting Chair
Phone:		**Date:**	21 November 2024
Email:			

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
N/A

Executive summary
This report provides an update from the Chair.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
N/A

Key recommendations and actions requested
1. **NOTE** the contents of the report. 2. **NOTE** the petition relating to stroke services. 3. **AGREE** the proposed amendments to the Terms of Reference of the Board Assurance Committees and the membership of these Committees.

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	N/A
Improve services and reduced unwarranted variation	
Make more efficient use of our resources	
Develop our culture and how we operate	

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	N/A
Health inequalities	
Workforce	
Resources and finance	
Legal	
Digital and Data	
Involvement, Engagement and consultation	

Chair's report

NHS Devon Board appointments

Independent Non-Executive Members (INEMs)

1. As Board members will be aware, the INEM recruitment campaign went live at the beginning of November and will run until 01 December 2024 (further information is available online: NHS Jobs). The appointments panel will be meeting candidates before Christmas and I hope to be able to confirm new appointments early in the New Year.

2. In the meantime, I have decided that we also need some interim INEM capacity. Martin Sykes, Non-Executive Member and Senior Independent Director at NHS Cornwall and the Isles of Scilly Integrated Care Board has agreed to join the Board on an interim basis until the end of March 2025. Martin has extensive NHS experience, previously as the Frimley Health NHS Foundation Trust Director of Finance and Deputy Chief Executive. More recently he has been Vice Chair and Non-Executive Director of University Hospital Bristol and Weston NHS Foundation Trust, where he chairs its finance and digital committee and sits on its audit committee.

Mental Health

3. I am pleased to welcome Phill Mantay, Chief Executive Officer of Devon Partnership NHS Trust, to our Board as the Member charged with representing Mental Health. Phill's appointment comes following an open and competitive appointment process and will bring invaluable expertise and knowledge to the Board as the Chief Executive Officer of the NHS Trust responsible for providing services to people with mental health, learning disability and neurodiversity needs across Devon.

NHS Trusts and/or Foundation Trusts

4. Liz Davenport, Chief Executive Officer of Torbay and South Devon NHS Foundation Trust was appointed for a second term of office as the Member representing NHS Trusts and/or Foundation Trusts in July 2024. In September 2024 Liz announced that she would be retiring from the NHS at the end of 2024. It is with sadness that we wish Liz farewell; she has made a significant contribution to the development of system working through her role on out Board and as senior responsible officer for the Peninsula Acute Sustainability Programme, where she has set the direction for increased collaboration in the provision of acute services across Devon, Cornwall and the Isles of Scilly. She will be greatly missed.

5. I am pleased to welcome Sam Higginson, Chief Executive Officer of Royal Devon University Healthcare NHS Foundation Trust who has been appointed to replace Liz Davenport. I look forward to working more closely with Sam to

continue to strengthen our working relationships with our NHS acute provider partners within the Devon system.

Committee Membership and Terms of Reference

6. Board members will recall that revised membership of our Board Assurance Committees was approved at the Board meeting on 15 July 2024. In light of changes to our Board membership and a number of issues that have come to light since July, I am putting forward the following proposed amendments to our Board Assurance Committee membership and the Terms of Reference (ToR) of a number of our Board Assurance Committees, as follows:

Committee	Proposed membership	Attendance
NHS Devon Audit and Risk Committee	• Independent Non-Executive Member (Chair): **Graham Clarke** • Independent Non-Executive Member: (Vice Chair) **Thandiwe Hara** • Independent Non-Executive Member: **Martin Sykes** • Co-opted Member: **Hisham Khalil**	• Chief Finance Officer: **Bill Shields** • Chief Communications and Corporate Affairs Officer: **Philippa Harding (interim)** • Director of Governance: **Philippa Harding** • Representatives of both internal and external audit • Individuals who lead on counter fraud matters
NHS Devon Remuneration and Internal ICB Workforce Committee	• Independent Non-Executive Member (Chair): **Judy Hargadon** • Independent Non-Executive Member (Vice Chair): **Martin Sykes** • Independent Non-Executive Member: **vacant** • NHS Devon Chair: **Kevin Orford** • Partner Member - Providers of Primary Medical Services: **Frank O'Kelly** • Co-opted Member: **Chair of the ICP**	• Chief Executive Officer: **Steve Moore** • Chief People Officer: **Piers Tetley** • Director of Governance: **Philippa Harding**
NHS Devon Population Health Improvement Committee	• Independent Non-Executive Member (Chair): **Thandiwe Hara** • Independent Non-Executive Member (Vice Chair): **Judy Hargadon** • Independent Non-Executive Member: **vacant**	• Director of Population Health Management and Improvement: **Ginny Snaith** • Director of Governance: **Philippa Harding**

Committee	Proposed membership	Attendance
	• Partner Member - Providers of Primary Medical Services: **Frank O'Kelly** • Partner Member – Director of Public Health: **Lincoln Sergeant** • Chief Medical Officer (Lead Executive): **Peter Collins** • Chief Operating Officer: **Anthony Fitzgerald**	
NHS Devon People and Organisational Development Committee	• Independent Non-Executive Member (Chair): **Judy Hargadon** • Independent Non-Executive Member (Vice Chair): **Thandiwe Hara** • Independent Non-Executive Member: **vacant** • Partner Member – NHS Trusts and NHS Foundation Trusts: **Sam Higginson** • Chief People Officer (Lead Executive): **Piers Tetley** • Chief Finance Officer: **Bill Shields** • A Chief People Officer from one of the NHS Trusts/Foundation Trusts within the One Devon Integrated Care System: **TBC**	• Director of System Workforce: **Mark Sowden** • Deputy Chief Nurse (interim): **Natasha Goswell** • Director of Governance: **Philippa Harding**
NHS Devon Quality and Patient Experience Committee	• Independent Non-Executive Member (Chair): **Thandiwe Hara** • NHS Devon Chair: **Kevin Orford** • Independent Non-Executive Member: **vacant** • Partner Member – Providers of Primary Medical Services: **Frank O'Kelly** • Chief Nursing Officer (Lead Executive): **Penny Smith** • Chief Medical Officer: **Peter Collins**	• Deputy Chief Nursing Officer: **John Trevains** • Director of Governance: **Philippa Harding**

Committee	Proposed membership	Attendance
NHS Devon Finance and Performance Committee	• Independent Non-Executive Member (Chair): **Martin Sykes** • NHS Devon Chair: **Kevin Orford** • Independent Non-Executive Member: **Judy Hargadon** • Chief Financial Officer (Lead Executive): **Bill Shields** • Chief Nursing Officer: **Penny Smith** • Chief Operating Officer: **Anthony Fitzgerald**	• Chair of Audit and Risk Committee: **Graham Clarke** • Deputy Chief Finance Officer: **Kirsty Denwood** • Director of Planning and Performance: **Sam Wadham-Sharpe** • Director of Governance: **Philippa Harding**

7. I am also proposing that the following amendments (highlighted) are made to the ToR of each Committee:

- NHS Devon **Remuneration and Internal ICB Workforce Committee** quorum should be amended as follows - *For a meeting of the Committee to be quorate a minimum of 50% members (i.e., 3 members) is required, including the Chair or Vice Chair of the Committee and either the Chair of the NHS Devon Board or another Independent Non-Executive Member of the NHS Devon Board (unless they are disqualified from participating on that item in the agenda, by reason of a declaration of conflicts of interest).*

- NHS Devon **Population Health Improvement Committee** ToR should be amended as follows - *The membership of the Committee shall be constituted as follows:*
  - *Independent Non-Executive Member (Chair)*
  - *Independent Non-Executive Member*
  - *Independent Non-Executive Member*
  - *Partner Member - Providers of Primary Medical Services*
  - *Partner Member – Director of Public Health*
  - *Chief Medical Officer (Lead Executive)*
  - *Chief Operating Officer*

- NHS Devon **People and Organisational Development Committee** ToR should be amended as follows - *The membership of the Committee shall be constituted as follows:*
  - *Independent Non-Executive Member (Chair)*
  - *Independent Non-Executive Member*
  - *Independent Non-Executive Member*
  - *Partner Member – NHS Trusts and NHS Foundation Trusts*
  - *Chief People Officer (Lead Executive)*
  - *Chief Finance Officer*
  - *A Chief People Officer from one of the NHS Trusts/Foundation Trusts within the One Devon Integrated Care System*

- NHS Devon **Quality and Patient Experience Committee** ToR should be amended as follows -
  The membership of the Committee shall be constituted as follows:
  - *Independent Non-Executive Member (Chair)*
  - *Independent Non-Executive Member*
  - *Either NHS Devon Chair or Independent Non-Executive Member*
  - *Partner Member – Providers of Primary Medical Services*
  - *Chief Nursing Officer (Lead Executive)*
  - *~~Chief Communications and Corporate Affairs Officer~~ Chief Medical Officer*

  For a meeting of the Committee to be quorate a minimum of 50% members (i.e., 3 members) is required, including the Chair or Vice Chair of the Committee (unless they are disqualified from participating on that item in the agenda, by reason of a declaration of conflicts of interest) and either the Chair of the NHS Devon Board or and another Independent Non-Executive Member of the NHS Devon Board.

- NHS Devon **Finance and Performance Committee** ToR should be amended as follows –
  The membership of the Committee shall be constituted as follows:
  - *Independent Non-Executive Member (Chair)*
  - *Independent Non-Executive Member*
  - *Either NHS Devon Chair or Independent Non-Executive Member*
  - *Chief Financial Officer (Lead Executive)*
  - *Chief Nursing Officer*
  - *Chief Operating Officer*

  For a meeting of the Committee to be quorate a minimum of 50% members (i.e., 3 members) is required, including the Chair or Vice Chair of the Committee (unless they are disqualified from participating on that item in the agenda, by reason of a declaration of conflicts of interest) and either the Chair of the NHS Devon Board or and another Independent Non-Executive Member of the NHS Devon Board.

The Board is recommended to agree the proposed amendments to the Terms of Reference of the Board Assurance Committees and the membership of these Committees.

Stroke Association petition

8. NHS Devon received a petition on 7 November 2024 regarding the Stroke Association Recovery Service, signed by 2,550 people (as at 15 November 2024), following our decision to not recommission the Stroke Association's contract for non-clinical services in the county.

9. The wording of the petition read:

"The Stroke Association's Devon Stroke Recovery Service is being forced to close because NHS Devon and Plymouth City Council have said they will no longer fund it. The service has given incredible support to thousands of stroke survivors in our county and the decision to axe funding will be disastrous for the many more thousands of people who will be unfortunate enough to have a stroke in coming years."

10. John Finn, our Deputy Chief Operating Officer, Nicola Bonas, our Deputy Director of Communications and Engagement, and I were pleased to have met with the Stroke Association and several stroke survivors and their carers from across Devon on 20 November 2024 to hear their experiences and concerns.

11. We all really valued the time that they gave to come and speak to us about their experiences of the Life After Stroke Service. Some of the things they talked about included:

    - Individual experiences after having a stroke
    - The support the service gives to them and their carer's
    - The challenge sometimes of navigating the NHS – between GPs and hospital stroke services
    - They recognise that NHS services are stretched and challenged – but where does that leave them when this service goes?

12. During the meeting, we explained that in the context of an £80 million deficit plan, we have to focus on prioritising clinical care, which does impact non-clinical services such as those provided by the Stroke Association.

13. We also outlined that we are increasing investment in clinical stroke services across Devon, specifically:

    - Establishing equitable access to senior stroke decision-makers across the peninsula
    - Delivering a 24/7 microsurgical thrombectomy technic (MST) rota for the peninsula to optimise referrals
    - Optimising the stroke imaging pathway
    - Increasing stroke care reablement service
    - Introducing a test of change for a new workforce model for post-stroke psychological care

14. Stroke services are a priority for NHS Devon, and through our Peninsula Acute Sustainability Programme, we will be look at how we can improve stroke services across Devon, Cornwall and Isles of Scilly.

15. We know we could have handled this situation better, and that we should have given more notice and involved the Stroke Association earlier to agree how we worked together to ensure the right people were involved in discussions.

16. We have taken the learning from this and in future, we will ensure the following two key points are in place:

- Ensure there is a six month notice period for any contracts we do not intend to renew or extend
- A clear plan for involving stakeholders in any decisions to not renew a contract will be required for anything going to the Devon Investment Group for consideration - for example, we acknowledged we should have spoken to the Stroke Association earlier about this and involved them in looking for alternative solutions.

17. The decision to not recommission the service relates solely to the two non-clinical stroke recovery services commissioned from the Stoke Association. These services provide support such as cover providing reassurance and guidance on understanding the effects of stroke and fatigue.

18. Clinical stroke services provided by the NHS and other providers will also continue to be offered to patients throughout Devon.

19. There are a number of services across Devon that will continue to support the population with their post-stroke needs, many of which the Stroke Association refer to.

20. The Devon system is subject to the highest tier of oversight and scrutiny by NHS England (Segment Four of the NHS Oversight Framework [NOF4]), which requires addressing a financial deficit plan of £80 million in 2024/25.

21. As a result of this, we are having to take difficult decisions in some non-clinical services, including those provided by the Stroke Association.

22. An assessment of not re-awarding the contract was undertaken and NHS Devon is working with the provider to mitigate risks as far as possible throughout the close-down period.

23. To ensure people who currently access these services are properly supported we have agreed with the Stroke Association a three-month extension of their service, until 31 December 2024.

Visits

24. It was great to have attended a recent GP fellowship training day, alongside Dr Frank O'Kelly, our primary care partner member. The session focused on health inequalities and population, which is the topic of the "Our People and Communities: Their Experiences of Health and Social Care" video this month.

25. I was pleased to have met with Kevin Dixon, chair of Healthwatch in Devon, Plymouth and Torbay, who gave me an insightful tour of Torquay to highlight some of the health and social care priorities of the town. Many thanks to Kevin for hosting me.

Conclusion

26. The NHS Devon Board is asked to:

- **NOTE** the report.
- **NOTE** the petition relating to stroke services
- **AGREE** the proposed amendments to the Terms of Reference of the Board Assurance Committees and the membership of these Committees.

NHS Devon

NHS Devon Integrated Care Board

Chief Executive's report

Date of meeting	Date report produced
28 November 2024	15 November 2024

Author(s)		Report approved by	
Name and title:	Steve Moore, Chief Executive	**Name and title:**	Steve Moore, Chief Executive
Phone:		**Date:**	21 November 2024
Email:			

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
N/A

Executive summary
This report provides an update from the Chief Executive.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
N/A

Key recommendations and actions requested
NOTE the contents of the report

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	N/A
Improve services and reduced unwarranted variation	
Make more efficient use of our resources	
Develop our culture and how we operate	

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	N/A
Health inequalities	
Workforce	
Resources and finance	
Legal	
Digital and Data	
Involvement, Engagement and consultation	

Chief Executive's report

Executive team changes

1. Earlier this month, we made a temporary and informal change to our Executive team to enable us to support one of our partners in the One Devon Integrated Care System to deliver the best outcomes for the people and communities we serve.

2. As colleagues will be aware, Liz Davenport, Torbay and South Devon NHS Foundation Trust's (TSD) chief executive, is retiring at the end of this year. The search for their new chief executive is underway, with interviews to take place later this month. TSD – like our system – is in the highest level (Segment Four) of the NHS Oversight Framework (NOF4) and is not on track to deliver its 2024/25 operating plan – currently off plan by around £15 million. The Trust needs to take action now to reduce its overspend while making further improvements to the length of time that people are waiting for treatment and care, both in planned care and urgent and emergency care services. We have therefore worked with TSD and the NHS England South West Regional Team to agree some additional capacity and leadership support over the next few months to strengthen their leadership, support the transition to their new Chief Executive and improve performance.

3. With this in mind, as of 11 November 2024, Bill Shields, our Deputy Chief Executive and Chief Finance Officer, is working with TSD to provide system support on a part time basis, until the end of December 2024. Bill will remain as NHS Devon's Deputy Chief Executive and Chief Finance Officer, but Kirsty Denwood, Deputy Chief Finance Officer, will step up to provide leadership to the Finance and Deputy Chief Executive directorate during this period.

4. Sharing resources across our system is nothing new for us, and this is another good example of how we are increasingly working collectively to plan and deliver the best services for our population. I know that Bill's experience, knowledge, and leadership will be of great benefit to Torbay and our wider system.

5. Other, more permanent, Executive team changes that I am pleased to confirm formally to the Board are the appointment of Penny Smith as our Chief Nursing Officer and Piers Tetley as our Chief People Officer. Both have been successfully acting in these roles on an interim basis for some time and their appointment on a substantive basis is a welcome move towards increased stability within the Executive team.

6. Finally, our new Chief Medical Officer, Peter Collins, also joined the organisation in October 2024 and so this will be his first formal Board meeting. Peter is an experienced and skilled chief medical officer and secondary care consultant who has operated at a senior level in the south west for almost two decades.

10 Year Plan engagement

7. A period of extensive national engagement with staff, patients, public and partners launched on 21 October 2024 to support the development of the government's 10-year plan for the NHS.

8. The public engagement exercise will help shape the government's 10 Year Health Plan, which will be published in spring 2025 and will be underlined by three big shifts in healthcare:
    - From hospital to community
    - From analogue to digital
    - From sickness to prevention

9. Alongside, and supporting, the national programme, One Devon partners are working together to engage a wide-range of local people, communities, staff and stakeholders.

10. Members of the public, as well as NHS staff and experts, are being invited to share their experiences, views and ideas for fixing the NHS via a dedicated webpage on the One Devon website.

11. We are pleased to be supported by Healthwatch Devon, Plymouth and Torbay, and we will also be working with the voluntary, community and social enterprise (VCSE) sector.

12. For people who are unable to submit their feedback online, Healthwatch are offering to collate feedback over the phone (0800 520 0640).

13. A series of face-to-face events and engagement opportunities will also take place across the county from next month and into the new year.

14. Outputs from the engagement will help Devon to shape future services, as well as where to focus future involvement.

Procurement of audiology services

15. Audiology services in East Devon have been provided by CHIME Social Enterprise CiC, under a pilot service model since June 2019. Under the pilot, an integrated specialist and routine service was let (following competitive procurement) to test the hypothesis that a single provider would bring benefits in terms of quality and cost.

16. This contract model means that other providers of audiology services are unable to see an NHS patient who is registered with an East Devon GP practice.

17. Significant concerns have been raised with us about the growing waiting times, both for diagnostic assessment and hearing aid fittings, and the lack of choice for

patients. Other anticipated benefits of a sole provider – for example financial – have not been demonstrated.

18. The review of the pilot was considered in early 2024 to assess whether to continue with the pilot model, or to revert to a service delivery model like that in place in the rest of the county of Devon and in most areas of England. As the pilot evaluation had not demonstrated any of the expected outcomes it was agreed to adopt the model that has continued to be successfully used in the other parts of Devon, and indeed throughout much of the country, by separating specialist and routine services.

19. We recently took the decision to separate specialist services from routine audiology services for re-procurement. This decision was made by NHS Devon's Executive Committee following a discussion in April 2024, and was latterly noted at our Board in May 2024.

20. We have been contacted several times by CHIME, regarding the procurement approach for specialist and routine audiology services.

21. It was hoped that the procurement for the specialist services would have been competed by now. However, due to the significant number of clarification questions that were raised during the initial procurement from potential bidders, NHS Devon felt it had no choice but to abandon the procurement while it fully considered the queries raised and to make any necessary amendments to the service specification and funding envelope. These queries needed thorough review before the any procurement could recommence.

22. NHS Devon has advertised the opportunity for routine community audiology services to the market to gauge interest and feedback on our intentions. Providers have fed into this process and all feedback will be considered prior to any further formal process commencing. A procurement is expected to be undertaken in Autumn/Winter 2024, with a view to services starting from April 2025.

ReSound - Strategic Partnering Agreement Renewal

23. NHS LIFT Companies (Local Improvement Finance Trusts) were established in many NHS areas shortly after the formation of Primary Care Trusts (PCTs) at a similar time to the introduction of Private Finance Initiatives (PFI) to provide a private sector line of credit to PCTs for the development of the estate during this era. The NHS in Devon utilised this framework and facility to enable the development of four LIFT buildings in Plymouth, facilitated and developed by strategic partner ReSound (Health) Ltd and owned by Community Health Partnerships (CHP) which is a property company wholly owned by the Department of Health and Social Care (DHSC).

24. Each LIFT scheme typically involves an owner, private funder, bank lender, strategic partner, occupier and commissioner under the framework. CHP own all four of the LIFT schemes in Devon with ReSound as the strategic partner.

25. As a part of the strategic partnership with ReSound who have multiple roles under the agreement for undertakings such as arranging loan facilities, building design and delivery of facilities management services etc, a provision for partnering services was included for consultancy and advisory services which reached the end of its 20 year term in October 2024.

26. In 2023 CHP sought approval from DHSC as parent company to offer each NHS area that has a LIFT scheme to extend the partnering agreement provision for an additional 5-year term to October 2029. The agreement now operates entirely independent of any other agreements or provisions in relation to the management of assets. The original partnering agreement with Resound (Health) Ltd was signed by the following legacy organisations:

    - Plymouth Teaching Primary Care Trust
    - Plymouth Hospitals NHS Trust
    - The Council of the City of Plymouth

27. There are no direct or indirect costs involved in extending or using this agreement. The system has taken advantage of this agreement multiple times over the years and also provides for an effective relationship and productive work where the commissioner has often commissioned CHP to undertake work directly when DHSC/NHSE pass funds through the LIFT for specific pieces of work, for example the PCN work which was funded by NHSE and offered to systems through CHP and their subcontractors GB Partnerships.

28. The NHS Devon Executive agreed in October 2004 that the Lift Joint Venture Strategic Partnering Agreement between Resound (Health) Limited and NHS Devon should be extended for an additional five-year term to October 2029.

GP collective action

29. On 01 August 2024 the British Medical Association (BMA) confirmed the outcome of the ballot on GP collective action. Turnout was 67.7% and 98.3% of members voted in support of GP collective action. Collective action is more than a one-off time-limited action. The intention is that this could result in a resetting of what primary care can and should provide and a move towards a “new normal”. At the time of writing there is no additional national funding to support mitigations linked to GP collective action (e.g. expansion of 111/MIU/UTC capacity).

30. With 118 GP providers in Devon there is a significant level of complexity in terms of which action(s) each provider may individually decide to take or not take, and when, and to what extent. Therefore, quantifying impacts and agreeing mitigations to collective action is similarly complex.

31. In light of this NHS Devon has moved from weekly Incident Management calls to weekly Collective Action System Response Group meetings, with Terms of Reference and system representation recently agreed and signed off with partners. The Communications team has also developed a local communications plan aligned to the national communications toolkit.

Identified impacts to date

32. There was a slight rise in the number of Emergency Department (ED) attendances in September, but in more recent weeks the number of attendances across providers have been similar to or slightly lower than pre-August. Since the start of October, the 7-day average number of ED attendances has been similar to the same time last year.

33. There was a rise in MIU attendances with chief complaint of 'wound care' at the Walk In Centre (noting that data for this site has only been available since June) and Cumberland Centre (noting this is very small numbers) at times since August. However, in more recent weeks, the number of these attendances has reduced.

34. GP Appointment Data for August:

- A total of **698k** appointments were completed in August, **down 2.2%** vs last year. There were fewer working days in August 2024 which had 21 in total, compared to 22 in 2023.
- This equates to **33,237** appointments on average per working day, which is **up 2.5%** compared to August 2023.
- This equates to **540 appointments per 1,000 people in Devon**, nationally this figure is **434 appointments per 1,000 people in England.**
- Appointments are **14%** above pre pandemic levels

35. The reasons for changes in data are complex and multi-factorial. We need to be very careful that we are not drawing conclusions about cause and effect too early and to be mindful of confirmation bias. Seasonality and previous year trends are also going to be important to consider. Whilst seasons, e.g. Winter, are the same defined dates (Dec, Jan, Feb) each year, the weather/temperature etc are not the same each year. We also need to be careful that data isn't skewed by changes to how services are configured and how data is captured / reported.

Known and Anticipated Impacts and Mitigations from System Returns/Information Gathering

36. NHS Devon was required to coordinate and submit a system intelligence return to NHS England at the end of September 2024, summarising known and anticipated impacts and mitigations across a range of service areas and providers. The expectation is that regular updates will be requested to this return on an ongoing basis and will need to form the basis of local impact monitoring and system mitigation planning.

37. The main areas of action across Devon to date are (in no particular order of scale/uptake):

- Implementation of BMA Safe Working Limits guidance

- Cessation of Physical Health monitor of patients with eating disorders/disordered eating (not commissioned from primary care)
- Cessation of Physical Health checks of patients receiving antipsychotic medication (not commissioned from primary care)
- Ceasing transfer of unfunded work relating to primary/secondary care interface
- Reduction in post operative Dressings/Wound Care activity
- Withdrawing from Community Phlebotomy Local Enhanced service in East
- Reduction in Advice and Guidance requests
- Stopping use of standard referral forms for Childrens and Young Peoples referrals
- Refusing requests for GPs to prescribe on behalf of midwives, bladder and bowel nurses, heart failure nurses (not commissioned from primary care)
- Turning off/reducing use of Scriptswitch Medicines Optimisation Software
- Some practices not agreeing to data sharing agreements eg Brave AI (Digital Neighbourhood Vanguard pilot) and One Devon Dataset

38. Practices will need to continue to deliver against all national and local contractual requirements throughout any period of collective action. The Primary Care team is working through the assurance process for ensuring that requirements continue to be met if service delivery changes.

39. Where practices have ceased activity that is commissioned through another provider, providers are considering whether, and then if/how, that activity is prioritised and redirect resource accordingly.

40. Where previously (known or unknown) pathway gaps have been highlighted through collective action, NHS Devon will give consideration to the relative risk of those gaps and where they sit in terms of priority compared to other currently unfunded/non-commissioned areas of work.

Freedom to Speak Up Guardian

41. NHS Devon has an obligation to provide arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Freedom to Speak Up (FTSU) Policy sets out the responsibilities of individuals in relation to speaking up, how to raise concerns, what to expect when raising a concern and the advice and support available to those who speak up. This Policy was approved by the Board at its meeting on 04 October 2023 and is available on the NHS Devon intranet and on its external website.

42. The organisation has appointed two Freedom to Speak Up Guardians (FTSUGs):

    - Alastair Harlow
    - Marina Junaram

43. Until September 2023 there was also a Lead FTSUG, Alison Wilkinson, Associate Director of Transformation. Alison retired in September 2023 and the decision was taken to delay the recruitment of a new Lead FTSUG until the completion of Phase 1 of the Organisational Change Programme. In the meantime, additional support has been provided to the FTSUGs by our Director of Governance. I am pleased to be able to confirm that the recruitment of the new Lead FTSUG has now been completed and that Siobhan Cambridge has been appointed to this role. Siobhan will be attending the next meeting of the Audit and Risk Committee to provide an update on her plans for this important work.

44. FTSUGs should be supported in their roles by a named Executive and Non-Executive. Kevin Orford, Independent Non-Executive Member Remuneration and Finance and Chair of the NHS Devon Remuneration and ICB Workforce Committee, previously provided non-executive leadership in this area. In light of his move to become Acting Chair, this role is now being undertaken by Judy Hargadon, Non-Executive Member for Primary Care. The Chief Nursing Officer, Penny Smith, is the Executive lead for FTSU.

NHS Devon Executive meeting business

45. The NHS Devon Executive's Terms of Reference require a report to be provided at each NHS Devon Board meeting, to demonstrate how the Committee has discharged its responsibilities (since the last meeting of the NHS Devon Board).

46. The NHS Devon Executive met on 01 October 2024 and 05 November 2024. Set out below is a summary of the business that was transacted.

01 October 2024

47. The Executive reviewed the following performance assurance reports:

- Progress towards NOF4 exit
- Integrated Quality and Performance Report (IQPR)
- NHS Devon Integrated Care Board and One Devon Integrated Care System Finance Reports
- An oral update on quality-related activities
- The Corporate Risk Register

48. The Executive also discussed the following reports that can be found elsewhere on the agenda for this meeting of the Board:

- Primary Care Access Recovery Plan (PCARP)
- Proposal to adopt a Safe Learning Environment Charter
- Winter Plan 2024/25

49. The Executive also discussed the following issues at this meeting:

- ReSound Partnering Agreement Extension – see earlier in this report for more information about this.
- Hub Visits and Knowledge Sharing Programme – information about a knowledge sharing and hub visit programme facilitated by the NHS Devon Estates team, funded through a joint bid with Devon County Council made to the Cabinet Office.
- Better Care Fund (BCF) s75 Agreements - a summary of the background, purpose and requirements of the BCF, financial values of each BCF and proposed changes to s75 agreements.
- Urgent and Emergency Care (UEC) Implementation Plan - an update on the development of a UEC Programme Implementation Plan for 2024/25.
- Hospiscare Financial Sustainability and Update on the End of Life Care (EoLC) Work – a briefing on the outcomes of the EoLC review and the development of a Core Clinical Model for Devon and proposed next steps in terms of hospice commissioning.
- CYP Community Contract Decision - proposed revised arrangements for the commissioning of children's community health services.
- Managing Conflicts of Interest - an update on corporate compliance with current NHS Devon policies in relation to the declaration of interests, gifts, hospitality and sponsorship.
- Internal Audit Update - an update on the progress of the 2023/24 internal audit programme and the closure of actions in response to internal audit recommendations.
- Draft Internal Audit Report: Business Continuity Management – proposed management responses to internal audit findings.
- Devon Investment Group (DIG) outcomes - the investments discussed and decisions made at the meeting on 30 August 2024.
- Health and Safety Report 2023/24. This will be presented to the Audit and Risk Committee meeting on 06 January 2024.
- Quality and Patient Experience Committee – minutes of September meeting and draft agenda for November meeting
- Finance and Performance Committee – minutes of September meeting and draft agendas October and November meetings.
- The draft minutes of and actions arising from the Audit and Risk Committee meeting held on 02 September 2024 and the draft agenda for the meeting of the Committee due to be held on 06 January 2025.
- The draft minutes and actions arising from the meetings of the Board on 28 September 2024 meeting and draft agenda for its November meeting.
- National Recovery Support Funding. The report was subsequently presented to the Finance and Performance Committee meeting on 10 October 2024.
- Eating Disorders Physical Health Monitoring

05 November 2024

50. The Executive reviewed the following performance assurance reports, which appear elsewhere on the agenda for this meeting of the Board:

- Progress towards NOF4 exit

- 2024/25 Annual Plan Delivery Assurance
- NHS Devon Integrated Care Board and One Devon Integrated Care System Finance Reports
- Quality Report
- Board Assurance Framework (BAF)

51. The Executive also discussed the following reports that can be found elsewhere on the agenda for this meeting of the Board:

- Ability to provide intensive and assertive mental health care and treatment
- 2024/25 Winter Plan
- NHS Devon Finances - Equity

52. The following additional issues were also considered:

- Teignmouth Health and Wellbeing Centre – next steps. Further information about this is being presented to the Board meeting in private.
- Outcome of Recovery Support Programme (RSP) Escalation meeting on 17 October 2024. This was discussed further at the Finance and Performance Committee meeting on 14 November 2024 and will be the subject of discussion at the Board Development Session in December.
- Ten Year Health Plan Engagement – how to ensure that the One Devon Integrated Care System is appropriately supported to respond to the Government's consultation.
- GP Collective Action – a briefing on potential issues and mitigating actions – see earlier in this report for more information about this.
- Same Day Primary Care Hub Model – an update on the development of alternative Urgent Primary Care provision models.
- All Age Continuing Care restructuring.
- MPOX FFP3 issues in Primary Care
- Internal Audit: Clinical Governance – Section 117 / IPP Review – proposed management responses to internal audit findings.
- Policy Framework Update - an update on the status of NHS Devon's non-clinical policies.
- Devon Investment Group (DIG) outcomes - the investments discussed and decisions made at the meeting on 03 October 2024.
- Action plan - National Primary Care Commissioning Assurance Framework submission 2024.

Conclusion

53. The Board is asked to **NOTE** the report.

NHS Devon

NHS Devon Integrated Care Board

Progress Report on the Requirements of the NHS Oversight Framework – Segment 4

Date of meeting	Date report produced
28 November 2024	30 October 2024 2024

Author(s)		Report approved by	
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Phone:		**Date:**	30 October 2024
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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
N/A

Executive summary
The presentation of the Progress Report on the Requirements of the NHS Oversight Framework – Segment 4 (NOF4) seeks to provide the necessary assurance to the NHS Devon Board on progress against the agreed criteria and metrics required to exit NOF4 in Q1 of 2025/26. The report details the system position on the criteria for strategy, leadership, urgent and emergency care (UEC), elective and finance recovery, accompanied by

a locality position on delivery against trajectory and the key actions to either maintain or improve performance.

This report is presented in a format that seeks to provide an improved assurance-based review and is accompanied the data packs and key lines of enquiry discussed at the Locality Planning and Delivery Meetings.

NHS Devon carried out progress assurance reviews with all Trusts in October 2024

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance	Trend from previous month
Strategy	Satisfactory	Improved from limited
Leadership	Satisfactory	No change
UEC	Limited	No change
Elective	Limited	No change
Finance	Satisfactory	No change

Committees that have previously discussed/agreed the report, and outcomes of that discussion

NHS Devon Executive reviewed this report on 05 November 2024. The Finance and Performance Committee and the Quality and Patient Experience Committee also reviewed this report at their meetings on 14 November 2024.

Key recommendations and actions requested

AGREE the assurance ratings relating to each of the NOF4 progress position of the One Devon Integrated Care System of **satisfactory** and **TAKE ASSURANCE that** adequate plans are in place to mitigate the risks relating to the delivery NOF4 exit identified in Locality Planning and Delivery Meetings, and System Leadership Group.

Impact on NHS Devon objectives

Objective	Impact
Improve population health	All
Improve services and reduced unwarranted variation	
Make more efficient use of our resources	
Develop our culture and how we operate	

Outline the implications of matters covered in this report for the following areas	
Area	
Quality of services	Delivery of access standards
Health inequalities	None
Workforce	None
Resources and finance	Delivery of financial sustainability
Legal	None
Digital and Data	None
Engagement and consultation	None

Progress Report on the Requirements of the NHS Oversight Framework – Segment 4

Introduction and background

1. NHS Devon is currently in Segment 4 of the National Oversight Framework (NOF4) and in receipt of mandated support from NHS England (NHSE) as set out in the national Recovery Support Programme (RSP). The criteria to move from Segment 4 to Segment 3 have been agreed and require robust recovery and improvement plans to be in place with clear oversight via NHS Devon's governance framework.

2. The expectation is that when NHS Devon's Board considers that the NOF4 exit criteria have been met, with the associated evidence, a proposal will be presented for evaluation by the NHSE South West Regional Team, and a recommendation made to the national team for a change in segmentation. The same applies to all NHS provider trusts within Devon, who would also require NHS Devon's support of their assessment.

3. NHS Devon did not meet its original timeline for NOF4 exit of Q1 of 2024/25 and as such, all NOF4 exit criteria and exit measures have been refreshed for the new financial year.

Leadership (see detail in slide 3 and slide 9 of the NOF4 Assurance Report)

4. Progress continues to be made against the leadership exit criteria and measures. Progress is being made in line with expectations in terms of embedding the new system compact and agreeing the approach to organisational development.

5. A Board development session was scheduled for 17 October 2024 to discuss and agree key priorities and aspirations for 2025/26, as well as key decision points for the operational and joint forward planning processes. A further Board development session was scheduled for 31 October 2024 to enable a first review of NHS Devon and system priorities for 2025/26 prior to in depth plans being created.

6. It is recognised that it will take time to enable an accurate assessment of the impact of the governance and assurance structures on enabling the system to meet its NOF4 exit requirements.

7. The Committee can take **satisfactory assurance** that the current plans place and assurance provided from providers will enable the meeting of the leadership NOF4 criteria.

Strategy (see detail in slide 4 and slide 10 of the NOF4 Assurance Report)

8. Overall progress in line with expectations however the case for change will be delayed due to national direction following publication of the Darzi report. Public engagement on the case for change was planned for September to November this year but this will now be delayed.

9. While the public engagement on the case for change will be delayed, progress continues to be made in other elements of the programme such as, including maternity services within the scope of the programme, delivery of the solutions for the 6 fragile services and identification for the first cohort of specialised services.

10. The Committee can take **satisfactory assurance** that the current plans place and assurance provided from providers will enable the meeting of the strategy NOF4 criteria despite to the national directive to pause the process. It is expected that the exit measures for the strategy exit criteria will be amended to reflect the national directive and therefore the committee can take assurance that plans are in place to progress the work that is able to be progressed.

Urgent and Emergency Care (UEC) (see detail in slide 5, 11 and 12 of the NOF4 Assurance Report)

11. The system position for urgent care has worsened in most performance metrics in September 2024 and is not currently meeting trajectory against any key indicators. It should be noted that while performance against these metrics worsened in September, performance remains better than it did in months 1-4 this year.

12. University Hospitals Plymouth NHS Trust (UHP) confirmed that the actions detailed within the One UHP plan were still on track despite 4 hour performance narrowly missing trajectory in September. UHP confirmed a commitment to returning to and remaining on trajectory. In the locality planning and delivery meeting in October UHP raised a risk to a potential delay in the opening of the new urgent treatment centre (UTC) at Derriford hospital. It should be noted that a performance uplift of ~6% is forecasted based on the opening of the UTC in December 2024. Further assurance will be sought in November with the expectations for performance mitigations of any delay to opening of the UTC.

13. Torbay and South Devon NHS Foundation Trust (TSD) performance worsened by more than 5% in September down to 65.43%, which is 11% below the submitted trajectory. A specific action plan has been requested from TSD with the detail that will improve performance to 71% in October, which was the performance level forecast at the October Locality Planning and Delivery Meeting.

14. Royal Devon University Healthcare Foundation Trust (RDUH) performance improved by 0.42% between August and September; however it remains behind the trajectory of 76.7%. Additional GP streaming has supported an improvement to performance and further improvement opportunities in minors pathways at RDUHE has been requested in November. Issues with complex discharge have been discussed at length and a joint funding proposal for additional P1 discharge capacity is planned between RDUH and NHS Devon.

15. There is currently therefore only **limited assurance** regarding the meeting of the UEC exit criteria based on current performance being behind trajectory and the risks identified by the system as they remain significant. Confidence will need to be gained in NHS Devon's delivery of the demand management schemes to support the performance improvements required through winter to enable further assurance on recovery of trajectories.

Elective Care (see detail in slide 6,13 and 14 of the NOF4 Assurance Report)

16. While improvements have been made on long waiting patients, the finalised August 24 position shows that NHS Devon did not achieve its submitted trajectories for 78 week waiters or 65 week waiters. There was one 104 ww patient in the Devon system in August 24 which is an improved position from July.

17. All providers have re-forecast their elective long wait trajectories for the remainder of the year, including identification of when they will reach zero. All providers have outlined plans to clear 78ww by the end of December 2024 and 65ww by the end of March 25. These re-forecasts have been discussed with region.

18. Within the re-forecasted trajectories, risks have been identified in certain specialities and these will continue to be monitored through the monthly locality planning and delivery meetings. These meetings are also seeking assurance that providers are undertaking the levels of activity detailed within their operating plans to deliver the required performance and financial improvements. Over the summer period there was under delivery at both RDUH and TSD against the plan and while assurance has been gained on activity and productivity levels from RDUH, further assurance is being sought from TSD, particularly the use of their new TIF theatres and assurances on levels of elective activity being performed over 'holiday' periods.

19. Elective activity and productivity have increased over the course of 2024/25. As of M5, NHS Devon has performed cost weighted activity growth of 11.3% with an implied productivity growth of 7.6%. The Devon growth exceeds both the regional position (8.2% activity growth and 4.1% productivity) and the national position (6% activity growth and 2% productivity). This has largely been driven by RDUH and UHP who have both increased activity by over 13% with productivity of 10% and 7.6% respectively.

20. During the Recovery Support Programme (RSP) national escalation meeting on 17 October 2024 a recommendation was made to remove Devon providers from the Tier 1 monitoring and oversight process in recognition of the progress made with reduce waiting times. While this will support the review of elective NOF4 exit, the requirement to meet the re-forecasted trajectories will remain key, and NHS Devon is leading a discussion about the oversight requirements to ensure progress will be maintained in the absence of Tier 1.

21. The Committee can take **limited assurance** that the elective NOF4 criteria will be met. The recommendation to remove Devon from elective Tier 1 oversight is a positive step that will support exit from NOF4, however the only way to guarantee exit remains the meeting of agreed trajectories in line with the exit criteria.

Finance (see detail in the Finance Report M4, and slide 7, 15 and 16 of NOF4 Assurance Report)

22. As part of the 2024/25 planning round, the One Devon Integrated Care System (ICS) initially submitted a deficit plan of £85.4m. This position was revised to a deficit plan of £80.0m, against which finances have been monitored since month 2, with the £5.4m improvement being managed through a system risk share. In month 6 the receipt of £80m non-recurrent deficit funding, phased in the second half of the year, has enabled the ICS to forecast delivery of a balanced outturn for 2024/25.

23. As at month 6 the One Devon ICS is reporting a year to date £15.9m deficit against an plan deficit of £15.2m. The cumulative position at month 6 is adverse by £0.7m, reflecting the financial impact of the proportion of industrial action that was unfunded. The forecast for the year is currently at breakeven.

24. The One Devon ICS is reporting £66.6m efficiency achievement in the first 6 months of the year. This is £5.7m above plan. The forecast is to achieve the plan of £213.3m. None of the efficiencies target remains unidentified at month 6 with scheme maturity progressing. 71% of schemes are rated as fully developed (57% M5) and high-risk schemes have reduced from 18% to 10%.

25. At the planning stage risks of £88m were identified of which £17m were mitigated, resulting in a net risk of £71m. Gross risks by month 6 have reduced to £94m, driven in majority by risks relating to the efficiencies programme, resulting in a net risk of £35m which is an improvement of £6.1m on month 5.

26. The Committee can take **satisfactory assurance** that the plan to date is delivering, subject to the unforeseen impact of industrial action and that mitigations are in place to address the risks to the plan. The NOF4 highlight report will continue to forecast the RAG status of the finance programme as red based on external review conversations although the committee can continue to take satisfactory assurance on the year to date progress.

Assurance and Recommendations

27. Based on the discussions held with NHS partners across Devon and review of the performance and finance highlight reports from each organisation it is recommended that the overall level of assurance that the One Devon ICS will achieve the planned NOF4 exit for 2024/25 as at Month 6 is as follows:

Section	Assurance	Trend from previous month
Strategy	Satisfactory	Improved from limited
Leadership	Satisfactory	No change
UEC	Limited	No change
Elective	Limited	No change
Finance	Satisfactory	No change

28. The NHS Devon Board is requested to **AGREE** the individual assurance levels relating to the achievement of the NOF4 exit criteria and **TAKE ASSURANCE that** adequate plans are in place to mitigate the risks relating to the delivery of planned progress to deliver NOF4 exit and to the management of the risks identified at plan stage.

NHS Devon

NHS Oversight Framework – progress against Segment 4 exit criteria

October 2024

One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

NOF4 exit criteria and self-assessment ratings (M6)

Key to Ratings:
On track and with clear evidence to meet the exit criteria by the planned date
Emerging risk of inability, or no clear evidence of ability to meet exit criteria by the planned exit date
Off track with high risks of inability to meet exit criteria by planned date
Exit criteria achieved and embedded
Resources just deployed, too early to tell

NHS Oversight Framework Domain	NOF 4 exit criteria theme	NOF 4 exit criteria	Rating (M6)	NOF4 Exit Forecast (Q1 25/26)
Local Strategic Priorities	Strategy	Delivery of Phase 2 of the Acute Services Sustainability Programme		
		Develop and commence implementation of a plan to eliminate unwarranted duplication of specialist DGH services across Devon		
Leadership and Capability	Leadership	Demonstrate collaborative decision-making in delivering all the RSP exit criteria at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system		
People	-	-	-	-
Quality of Care, Access and Outcomes	Urgent and Emergency Care (UEC)	Make demonstrable progress towards achieving national UEC objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement.		
	Elective Care	Make demonstrable progress towards achieving national elective and cancer objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement		
Preventing Ill Health and Reducing Inequalities	-	-	-	-
Finance and Use of Resources	Finance	Develop and deliver a short-term financial plan (2024/25) that is signed off regionally and nationally		
		Deliver reductions in the run rate for each consecutive quarter		
		To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones		

Exit Criteria Measures - Leadership

Exit Measure	Progress update	
Review of the **ICS strategy** (developed by the ICS Board) and Joint Forward Plan (developed by the ICB) during 2024/25 and agree priorities and timelines for delivery	NHS Devon Board discussion of role of Collaboratives in strategy taking place 31 October 2024. Process for development of an ICB strategy also being addressed at same session, as well as approach to planning for 2025/26. Joint Forward Plan (JFP) review to commence in November, following Medium Term Financial Plan (MTFP) completion.	
Revised NOF4 **system architecture** to reflect learning from 2023/24 RSP process. This will need to include effective governance arrangements for making collective decisions which have financial implications across organisational boundaries including control of workforce, service investments, cost reductions and productivity improvements.	New system governance and delivery architecture becoming embedded. This has been created with input and oversight of Recovery Support Programme (RSP). A new System Leadership Group (SLG) has commenced to oversee delivery of the 2024/25 Operating Plan, development of the MTFP and to enable system wide decision making. Review of operation to be undertaken in November to inform discussion of any changes required to improve effectiveness in December.	
Development and delivery of organisational and system **improvement plans** with clear trajectories aligned to the exit criteria and 2024/25 operational plan to include: ○ Named SROs for organisational and system programmes ○ Clear accountability and reporting arrangements	System improvement plans in place for Urgent and Emergency Care (UEC) and Elective Care, as well as strategic programmes for system wide Cost Improvement Programme (CIP). ICB out of hospital plan agreed in October. Winter plan to be shared with system partners for approval in November.	
Agree which services will be delivered as part of a system-wide 'shared-services' programme and ensure realistic but stretching delivery plans are developed and progressed.	Corporate shared services programme agreed by SLG.	
Review and adapt **Devon Operating Model** and Governance Architecture in response to ICB governance review and the restructure aligned to reduced management costs	System OD Plan development launched with system OD leads in October.	
Develop, agree and deliver specific improvement plans to address quality and performance issues raised by regulators. This will include any **CQC notices and requirements of MSSP.**	Improvement plans for quality issues raised by regulators including CQC notices and requirements of the Maternity Safety Support Programme are reviewed through the NHS Devon Quality and Patient Experience Committee, with escalation levels agreed through the system quality group which has provider and regulator membership. .	
Summary rating	Overall progress in line with expectations; however new governance and oversight architecture is embedding and will require time to ensure it is having the required impact	

Exit Criteria Measures - Strategy

Exit Measure	Progress update	
Phase 2 to be launched in May 2024. Maternity services to be brought into the Programme with workshops complete before end July	Phase 2 launched on time and Boards agreed to bring Maternity in scope. Maternity workshops and scenarios developed. Complete	
Detailed modelling of the scenarios already developed for paediatric, medicine and surgical assessment services to be completed by September 2024 and Maternity by end November 2024	Scenario refinement took place in July and signed-off by Peninsula Acute Provider Collaborative (PAPC) on 12 August 2024. Data agreements in place and data submitted to modelers. Clinical Reference Groups arranged for October, November and December to support detailed modelling of activity, workforce and transport. On track for completion by end December 2024	
Draft Case for Change developed and socialised with key stakeholders during the summer of 2024	Draft Case for Change approved by PAPC in June. Public engagement was planned for September – November. Following publication of the Darzi Report and the national engagement planned on the NHS 10-year plan, the public engagement on the Peninsula Acute Sustainability Programme (PASP) Case for Change was delayed to align with the national engagement. The engagement activity is now planned for mid November as part of the local engagement on the NHS 10-year plan.	
Final Case for Change agreed and signed off by Boards by November 2024	Due to the delay in the stakeholder engagement, the draft case for change will not be updated and signed off in November as required and therefore this criteria will not be met due to external factors.	
Options appraisal to be undertaken in advance of public consultation process being activated (date TBC before end Q4 2024/25)	Options will be generated following conclusion of modelling. On-track for conclusion by end of Q4	
Integrated solutions developed, agreed and in progress for a minimum 6 Fragile services	Stroke and OMFS projects have moved into the approval and implementation stage. Next set of services to prioritise have been agreed: dermatology, microbiology, interventional radiology and cardiology – scope agreed	
Proposal for elimination of unwarranted duplication of ‘specialised services’ agreed, and implementation plans underway	The Specialist DGH workstream has completed its deep dive into 3 services: Head & Neck/Endocrine cancer; Gynae Cancer and Sarcoma to identify whether there is potential benefit from consolidation. Analysis shows high level of duplication with other workstreams and therefore it is agreed that we will develop a collaborative programme delivery model.	
Public consultation process and timeline agreed with Region	For discussion with Region in Q4 when modelling complete and case for change approved by Boards.	
Summary rating	Overall progress in line with internal expectations however case for change will be delayed as per update above. Following previous SIAG, expect the measures to be changed in line with work that can be completed in year.	

Exit Criteria Measures - UEC

Exit Measure	Progress update	
Improvements in line with agreed baseline and plan, over two quarters, in ambulance handover delays (>15 minutes & > 3 hours)	Ambulance handovers within 15 minutes worsened from M5 to M6, however the performance of 18% of ambulances handed over within 15 minutes exceeded the levels achieved in M1-M4. Ambulances waiting longer than 3 hours also worsened between M5 and M6, however this performance on 10.21% also exceeded the M1-M4 performance.	
Improvements in line with agreed baseline and plan, over two quarters, in ambulance response times for Category 2 incidents to 30 minutes on average	Category 2 response times worsened to 44 minutes in M6. In line with ambulance handover performance Category 2 M6 performance exceeded that seen in M1-M4.	
Improvements in line with agreed baseline and plan, over two quarters, in 4 hour performance & 12-hour breaches	4-hour performance worsened in M6 to 69.39% and missed the trajectory of 73.3%. Focus is on continuing to improve performance over the winter and ensuring meeting the M12 position. 12-hour breaches worsened in M6 from the M5 position but exceeded performance from M1 –M4.	
Month on month improvements, over one quarter, in pre-midday Discharges against agreed baseline and trajectories	The system is not currently meeting its internal trajectory of 33% with performance fluctuating between 14% and 16% through the year so far, however performance improved to 15.4% in M6.	
Achieve and sustain a reduction in number of patients who no longer meet the “criteria to reside in hospital"	The system has met trajectory in each month of 24/25 so far although NCTR numbers have risen through M6.	
CQC confirmation of UHP compliance with Conditions on the trust’s Licence	CQC reinspected March 24, conditions were not reissued. UHP One Plan in place to address section 29a conditions and expecting further unannounced inspection by end of 2024.	
Meet and maintain the exit criteria for national Tier 1 for UEC.	The M6 position has seen a worsening in performance from M5 however performance in all areas exceeds performance from M1-M4 and FY23/24, except in 4-hour performance which is stagnant at 69%-70% but exceeds the FY23/24 position.	
Summary rating	Progress has been made on UEC performance from this point in last year, although the position remains fragile, and performance can fluctuate.	

Exit Criteria Measures – Elective care

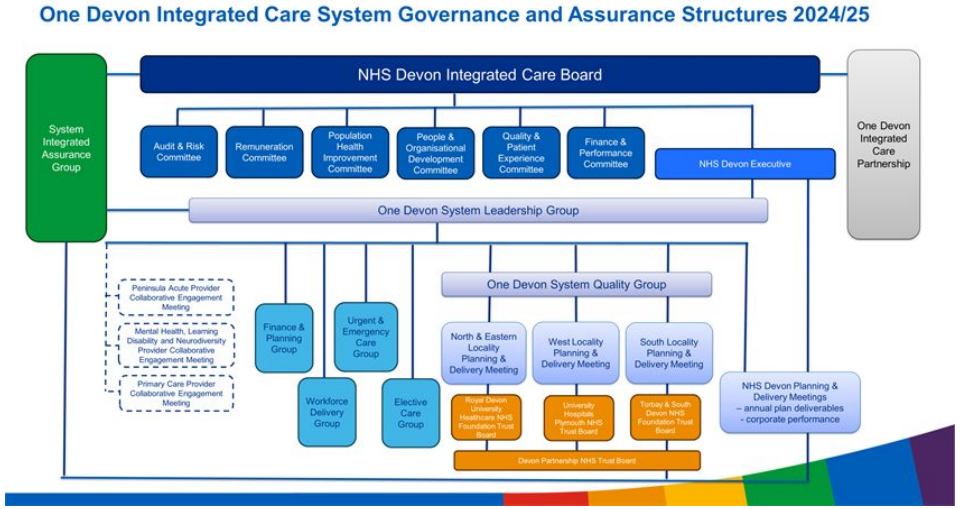
Exit Measure	Progress update	
Elimination of waits over 104 weeks and 78 weeks, in line with agreed plan and operational planning guidance.	System did not meet trajectory in M5 with no provider meeting their individual trajectory. All providers have re-forecasted trajectories and are forecasting clearance of 78ww by end of December 24.	
Virtually eliminate waits over 65 weeks for elective care in line with agreed plan and operational planning guidance.	System did not meet trajectory in M5 with no provider meeting their individual trajectory. All providers have re-forecasted trajectories and are forecasting clearance of 65ww by financial year end.	
Meet and maintain the exit criteria for national Tier 1 for Elective, by all trusts	Conversations at the recent national review described a plan to de-escalate the system out of Tier 1 for elective care. Internal discussions now underway to identify the internal scrutiny mechanisms that will replace Tier 1 and ensure progress on elective recovery continues.	
Summary rating	Progress has been made on long waiter trajectories; however, system is currently not meeting the agreed trajectories and will not return to these in M6. All providers are forecasting clearance of 78ww by December 24 and 65ww by financial year end. Risk remains in certain specialties and will continue to de discussed and mitigated at each Locality Planning and Delivery Meeting.	

Exit Criteria Measures – Finance

Exit Measure	Progress update	
Develop and deliver a financial plan for 2024/25 that is signed off regionally and nationally. This will include, but not limited to: • Confirmation of the exit underlying run rate from 2023/24 and an improvement in the actual recurrent run rate in the 2024/25 plan (Q1 24/25) • The 2024/25 plan shows an improvement in productivity compared to 2023/24 (Q1 24/25) as agreed with NHS England • A system-wide shared services programme is developed that has all appropriate back-office functions within scope and includes accompanying timelines and delivery plans • The system delivers the financial plan for 2024/25 recurrently for two successive quarters (Q4 24/25) • The system delivers improvements in productivity for two successive quarters compared to [baseline year to be determined] (Q4 24/25).	• The underlying run rate is improving as planned, and all organisations in the system have agreed and committed to the underlying position set out in 24/25 plans. • 24/25 productivity metrics up to M4 have been published. The data showed Devon had an implied productivity growth of 7% in comparison to M1-4 23/24. • A system wide shared services programme is in development with Angela Hibbard nominated as SRO. There is a timeframe to realise a single CSS across the 9 service functions by FY27/28. This programme is being reviewed as part of the MTFP submission. • The financial 24/25 plan was delivered through H1 and FOT is at plan.	
To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones	The system has updated the Medium-Term Financial Plan, which clearly articulates the recurrent and non recurrent trajectories to financial balance over the next five years, with breakeven achieved in 2027/28 (excluding convergence and debt repayment). This plan will be underpinned by the Financial Improvements delivered by the strategic signature moves as well as business as usual Cost Improvements. This plan was presented at the Exec-to-Exec meeting in October.	
Develop and agree a Capital Plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.	A system wide prioritised estate exercise has been undertaken and this is currently being extended to include digital and equipment. The system is also undertaking an analysis of any risks due to a reduced capital allocation and identifying future schemes with no current funding scheme identified. A full report will be completed by the end of November. Within the reduced allocation we will determine the optimal split of strategic capital requirements and ongoing equipment and building maintenance. This will be used to inform capital allocations from 25/26 onwards.	
Develop and agree a workforce plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.	24/25 plan WTE reduction is currently on plan at M6, however pay expenditure above plan. Workforce plan aligned to strategic priorities in development as part of MTFP and on schedule for October completion. Significant risk remains in the TSD position and while assurance gained on grip and control measures, further interventions required to meet the plan.	
Summary rating	The system has been delivering the financial plan as at M6. Risk to the year end position has been reducing. All organisations continue to forecast delivery to agreed plan.	

Oversight and Assurance mechanisms

- The first round of the new Locality Planning and Delivery Meetings (LPDMs) took place w/c 12 August 2024.
- Actions identified in these meetings were refined at the System Leadership Group (SLG) meeting w/c 19 August 2024.
- This report reflects the outcomes of the SLG meeting. It has been signed off by the Chief Executives of each organisation. It is intended to provide the System Integrated Assurance Group (SIAG), as well as the individual Boards of each organisation within the system with a “single version of the truth” in respect of assurance about the overall delivery of the NOF4 exit criteria and each individual organisation’s contribution to this.
- The report is supported by Locality Planning and Delivery packs, which contain local level performance data and the key lines of enquiry for performance improvement. These packs also include an outline of the key discussion points and the actions due to completed within the next month.
- The focus in the first round of initial LPDMs and the SLG has been on the identification of specific actions to enable a return to agreed trajectory (where necessary); the next round of meetings will address the delivery of these actions and their anticipated impacts.



The data packs supporting each Locality Planning and Delivery Meeting and reports of issues considered at those meetings can be found in the adjacent table:

	South	West	North and East
Data pack	Microsoft werPoint Presentat	Microsoft werPoint Presentat	Microsoft werPoint Presentat
Report of meeting	Microsoft Word Document	Microsoft Word Document	Microsoft Word Document

Leadership

Exit criteria	Assessment
Demonstrate collaborative decision-making in delivering all the RSP exit criteria at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system	

System OD leads were given the task of codesigning and embedding of the system compact in October and November. Further half day session with system CEOs at the beginning of December will lead to a final version to be presented to system partners' boards for approval in December/January.

System OD leads have also been tasked with the development of a system organisational development plan.

An NHS Devon Board development session on 31 October 2024 considered and agreed key priorities and aspirations for 2025/26. Key decision points for the operational and joint forward planning processes were agreed by the NHS Devon Board in a development session on 17 October 2024.

The draft MTFP was shared at the RSP Escalation meeting on 17 October 2024 with reference to the Transforming Devon Programme which outlines the key system-wide projects which Boards are committed to delivering together. CEOs are now in the process of ensuring that the appropriate governance and delivery mechanisms are in place to deliver at pace with further work to be done to operationalise impact at organisational level. It was acknowledged in the national meeting that Devon is much further ahead in its MTFP than in previous years with the ambition for early sign-off of the 2025/26 plan.

SLG Escalations and Responses		
Area of plan identified as off track by system	Actions agreed by system to return to plan	System's anticipated impact of action
N/A	N/A	N/A

Strategy

Exit criteria	Assessment
Delivery of Phase 2 of the Acute Services Sustainability Programme	
Develop and commence implementation of a plan to eliminate unwarranted duplication of specialist DGH services across Devon	

Fragile services:

- Agreed next set of services to prioritise alongside continuation of stroke/OMFS projects – dermatology, microbiology, interventional radiology and cardiology
- CMO, strategy lead and project support identified for each project
- Developed a clear, agreed mandate for each project

DGH Specialist Services

- Monthly meetings with lead clinicians
- Data reviewed for gynae cancer, complex head and neck cancer and sarcoma
- Analysis of these reviews illustrate that clinical networks, fragile services and speciality improvement workstreams are already involved in work on many specialist services.
- Peninsula Acute Provider Collaborative approved plan to adopt of more collaborative approach to programme management to avoid duplication.

Strategic Service Change

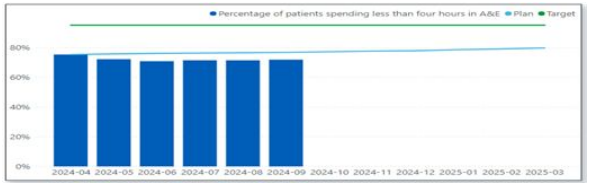
- Public engagement to further develop Case for Change will start mid-November, aligned with national engagement and as part of the local system engagement on the NHS 10-year plan.
- Modelling underway for all clinical scenarios (including maternity) including activity, workforce and transport implications for each scenario.
- First set of Clinical reference groups (CRGs) for surgical, medical, paediatrics and maternity held in October, with good clinical engagement.
- CRGs planned for November and December to work with lead clinicians to develop options from clinical scenarios.

SLG Escalations and Responses		
Area of plan identified as off track by system	Actions agreed by system to return to plan	System's anticipated impact of action
PASP programme, particularly LVHC a) Need for CMO and Directors of strategy to commit to numerating opportunity b) Fragile Services further focus	Liz Davenport to convene a meeting of CEOs to enable refocus of priorities of fragile services and requirements to move work forward by first week in October	Understanding of what work can be continued despite external delays to case for change and clear actions for remainder of the year to progress this.

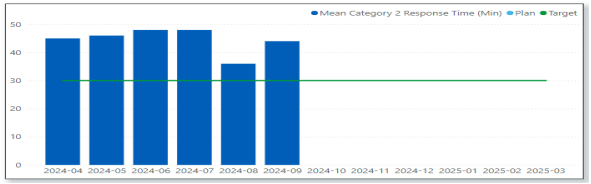
Urgent and Emergency Care (UEC) - System

Exit criteria	Assessment
Make demonstrable progress towards achieving national UEC objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement.	

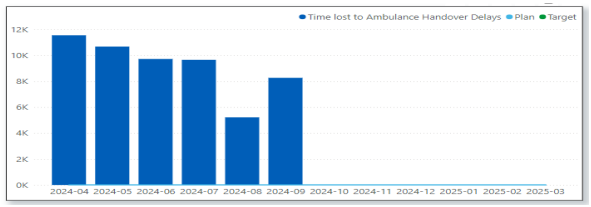
The system 4 hour performance position worsened from 70.89% in August to 69.39% in September. While performance remains stable at system level, the system did not meet its submitted trajectory (73.3%) for the fifth consecutive month.



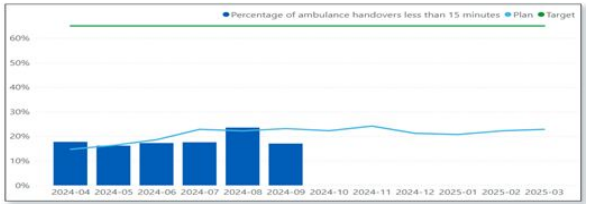
Category 2 response times worsened from 36 mins in August to 44 mins per response in September. 44 mins exceeded performance in M1-M4, however did not meet the standard of 30 minutes.



Time lost due to ambulance handovers worsened in September to 8266 hours lost from 5218 in August, however exceeded performance in M1-M4

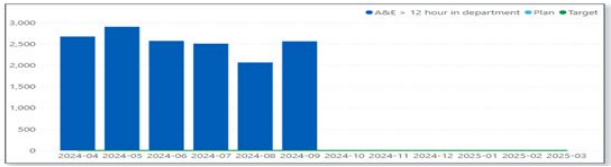


There was a deterioration in the % of ambulances handed over within 15 minutes in September to 18% from 23.5% in August, although this exceeds the performance from M1-M4.



The Locality Planning and Delivery packs contain the local level performance data and the key lines of enquiry for performance improvement. These packs also include an outline of the key discussion points and the actions due to completed within the next month.

The number of patients spending more than 12 hours within emergency departments worsened to 2563 in September.



SLG Escalations and Responses

Area of plan identified as off track by system	Actions agreed by system to return to plan	System's anticipated impact of action
3.All Trusts have identified the need for a system-wide solution for caring for the small number of complex mental health patients who are waiting in ED or in a bed on an acute site for prolonged periods pending an appropriate placement. This includes young people with eating disorders. a) Identify scope of project b) Clear timelines for project c) What is required to enable this work	Warwick Heale presented current work in progress and next steps to SLG. Key actions agreed are • MEN-SAT data and recommendation presented to UEC Board on 5th November • Addition of mental health key UE actions added to winter plan as 7th workstream • Present mental health winter plan to next SLG • Use the mental health urgent care report as primary data source. • Set up agreed points of contact between mental health collaborative and acute providers to support an mental health patients in ED.	One coherent plan to manage mental health impacts on emergency departments and improve patient's outcomes and experiences from being admitted to incorrect environment. Clear metrics to monitor improvement expected as part of winter plan inclusion.

Urgent and Emergency Care (UEC) - Providers

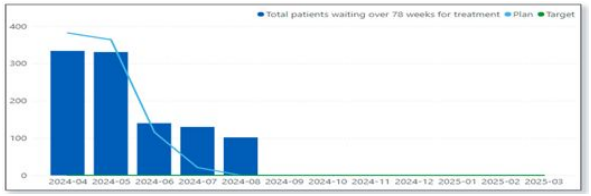
Outcomes of Locality Planning and Delivery Meetings				
	South	**West**	**North and East**	**NHS Devon**
Areas of underperformance identified	4-hour performance **65.43%** v trajectory of **76%** in M6. **9.9%** of ambulances handed over within 15 mins v trajectory of **32%,** and **3331** hours lost which is a deterioration from M5.	4-hour performance **66.31%** v trajectory of **66.66%** in M6. **16.1%** of ambulances handed over within 15 mins v trajectory of **14.21%,** and **3777** hours lost which is deterioration from M5 but remains an improvement on M1-M4.	4-hour performance **71.79%** v trajectory of **76.70%** in M6. **21.4%** of ambulances handed over within 15 mins v trajectory of **25%,** and **1158** hours lost which is deterioration on the previous month.	ICB has committed to supporting UEC performance through a range of schemes to manage demand. The commencement of this work is currently behind schedule
Actions agreed to address underperformance	• To identify and feedback on the process to support junior members of staff who have been requesting ambulance diverts **– Arun Chandran** • To share the specific actions of the plan to bring performance back to 71% in month **– Arun Chandran** • To discuss what support is required from mutual aid on the two fragile services – **Penny Smith/Nicola McMinn** • To discuss TSDs revised trajectories, which NOF4 exit criteria is now based on and how to manage UEC and Elective at TSD **– Sam Wadham-Sharpe/Allison Williams**	• To present the diagnostic and discovery phase of the additional demand work including impacts and progress on implementation to the November meeting **- Chris Morley** • To bring assurance on the overall NCTR trajectory and how this will impact on UHP's trajectory **– Jo Beer** • To update on actions being taken to continue4 hour performance improvements prior to the UTC go live **– Jo Beer** • To circulate the NCTR briefing paper and develop a bed tracker as discussed during the October meeting. **– Tryphaena Doyle**	• To provide an assessment on the minor's flow, GP streaming, and additional ANP and shop floor managers shifts, and the impact seen for the November meeting **– John Palmer** • Provide a clear plan for improving minors performance in East, including addressing cultural issues previously identified **– John Palmer** • To provide assurance and an agreement that the £400k funding request will reconcile pathways 1 & 2 and send to Steve Moore **– John Palmer** • Convene a process to investigate further cardiology support with ICB and present a go- or no-go option at next meeting **– John Palmer** • To provide an update report on the initial 6 Out of Hospital programmes and send to Steve Moore **– John Palmer**	• To present the diagnostic and discovery phase of the additional demand work including impacts and progress on implementation to the November meeting **– Lou Higgins** • Continued delivery of the 6 out of hospital programmes **– James Wenman** • Addition of Mental Health UEC as a 7th strand to the winter plan – **Warwick Heale**
Anticipated impact of agreed actions	Expected improvement to 70% 4-hour performance in M7.	UHP remain committed to returning to trajectory and improving on ambulance position.	RDUH have forecasted a return to 4-hour trajectory in the financial year and meet the M12 position	Impact analysis required for out of hospital plans but expectation of maintaining unscheduled care demand in line with operating plan growth levels
Any unmitigated risks remaining		Any delay to the build and opening of the new UTC and the link to the increase in performance levels built into trajectories.	Mental health pressures as per SLG discussion	

All actions to be completed in next 4 weeks unless otherwise stated

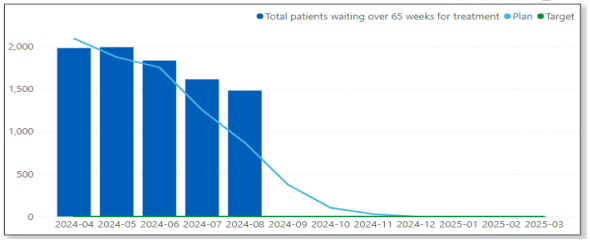
Elective Care - System

Exit criteria	Assessment
Make demonstrable progress towards achieving national elective and cancer objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement	

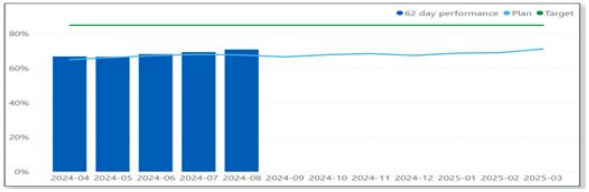
The number of patients waiting beyond 78 weeks for treatment decreased from 130 in July to 102 in August, however, did not meet the system trajectory (0), with no provider meeting their individual trajectory.



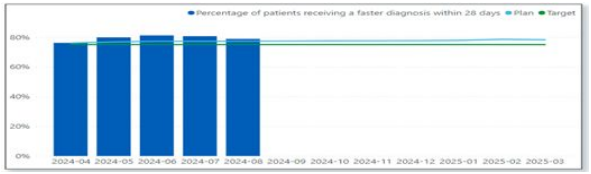
The number of patients waiting longer than 65 weeks for treatment improved to 1482 in August from 1614 in July. The system trajectory of 867 was not met with no individual provider meeting their trajectory.



The system met its 62-day trajectory with a performance of 70.9% v trajectory of 67.7%. This represents a further improvement from the 69.4% in July and means this trajectory has been exceeded in each month this year.



The system continues to exceed both the trajectory and national standard for 28-day faster diagnosis standards. Performance was 78.8% in August which was a deterioration from 80.7% in July. All providers exceeded their trajectory.



The Locality Planning and Delivery packs contain the local level performance data and the key lines of enquiry for performance improvement. These packs also include an outline of the key discussion points and the actions due to completed within the next month.

SLG Escalations and Responses

Area of plan identified as off track by system	Actions agreed by system to return to plan	System's anticipated impact of action
UHP raised risk of independent sector providers not willing to take long waiting patients and not treating in chronological order to support performance position a) What can ICB do to support contractual position with IS providers? b) Can IS provider waiting list be scrutinised in system elective performance meetings to eliminate long wait issues?	John Finn to present a clear position to next SLG on IS providers and any issues impacting performance	Clear understanding of how IS providers can support long waiter clearance and how this will be overseen
With potential move out of Tier 1 for elective but challenges remaining for NOF 4, how do we want to continue to oversee our performance v trajectories?	System agreement to maintain elective performance oversight through locality planning and delivery meetings and also fortnightly through the tactical delivery group.	Maintain performance against trajectories despite removal of tier 1 oversight.

Elective Care - Providers

Outcomes of Locality Planning and Delivery Meetings				
	South	**West**	**North and East**	**NHS Devon**
Areas of underperformance identified	78ww performance was **11** v trajectory of **0**. 65ww performance was **373** v trajectory of **224**	104ww performance was **1** v trajectory of **0** 78 ww performance was **55** v trajectory of **0**, and 65ww performance was **511** v trajectory of **302**	78 ww performance was **36** v trajectory of **0**, and 65ww performance was **598** v trajectory of **341** after meeting all trajectories for Q1.	ICB has committed to supporting elective performance through a range of schemes to support agreed productivity improvements and manage demand. This work is currently behind schedule.
Actions agreed to address underperformance	• To confirm the 78ww forecasted position – **Arun Chandran** • To share the TIF theatre utilisation plan and update on progress **– Arun Chandran** • To outline the specific specialty long waiter recovery plan, mitigation plan, and actions being taken with these specialties to get back on track with trajectories and update at the November meeting. – **Arun Chandran** • To discuss the submission of future booked elective cases – **Sam Wadham-Sharpe/Liz Davenport** • To confirm annual leave and activity arrangements for future 'holiday' periods **– Arun Chandran/Kate Lissett** • To provide an update on the 60-day cycle **– Kate Lissett**	• To provide updated long waiter figures and any additional actions being taken to reduce risks in month **– Jo Beer** • To confirm if the issue with PPG has been resolved for the next meeting and PPG will treat long waiters **– John Finn** • To feedback on the design of a systematic programme for Elective Care at the next meeting **– John Finn** • To outline the escalation process of protecting elective bed over winter for the November meeting **– Jo Beer**	• Review the theatre utilisation data to identify opportunities to boost productivity through winter and mitigate any winter pressures – **John Palmer** • Share updated long waiter performance trajectories with ICB – **John Palmer**	• Review of IS provider opportunities – John Finn • Continuation of market share work in Ophthalmology – John Finn • Continuation of repatriation and productivity programme in line with MTFP – John Finn
Anticipated impact of agreed actions	Expectation of clearance of 78ww by end of December 24 Expectation of clearance of 65ww by end of March 25			
Any unmitigated risks remaining	Dermatology is currently a risk to the 65-week waiters position due to capacity shortfall.	There are significant financial implications to clearing 65wws by end of march due to outsourcing external providers.		.

All actions to be completed in next 4 weeks unless otherwise stated

Finance - System

Exit criteria	Assessment
Develop and deliver a short-term financial plan (2024/25) that is signed off regionally and nationally	
Deliver reductions in the run rate for each consecutive quarter	
To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones	

The year-to-date position at month 6 is adverse by £0.7m, reflecting the residual unfunded element of industrial action. In month 6 the receipt of £80m non-recurrent deficit funding, phased in the second half of the year, has enabled the ICS to forecast delivery of a balanced outturn for 2024/25.

Organisation	Year to date			Forecast		
	Plan surplus / (deficit) £000	Actual surplus / (deficit) £000	Variance favourable / (adverse) £000	Plan for the year surplus / (deficit) £000	Forecast surplus / (deficit) £000	Variance favourable / (adverse) £000
Devon ICB	14,210	14,210	(0)	28,419	28,419	0
Devon Partnership NHS Trust	1,974	1,974	0	3,591	3,591	0
Royal Devon University NHS FT	(11,059)	(11,051)	8	(2,790)	(2,790)	0
Torbay and South Devon NHS FT	(9,622)	(9,622)	0	(13,624)	(13,624)	0
University Hospitals Plymouth NHST	(10,701)	(11,404)	(703)	(15,596)	(15,596)	(0)
Total	**(15,198)**	**(15,894)**	**(696)**	**(0)**	**0**	**0**

The ICS is reporting £66.6m efficiency achievement in the first 6 months of the year. This is £5.7m above plan. The forecast is to achieve the plan of £213.3m.

Organisation	Year to date			Forecast		
	Plan CIP delivery £000	Actual CIP delivery £000	Variance fav / (adv) £000	Plan for the year £000	Forecast £000	Variance fav / (adv) £000
Devon ICB	4,645	4,722	77	37,228	37,228	(0)
Devon Partnership NHS Trust	7,408	7,030	(378)	15,739	15,730	(9)
Royal Devon University NHS FT	21,187	22,484	1,297	63,610	63,610	0
Torbay and South Devon NHS FT	10,648	10,663	15	39,900	39,900	0
University Hospitals Plymouth NHS Trust	16,994	21,677	4,683	56,801	56,802	1
Total	**60,882**	**66,576**	**5,694**	**213,278**	**213,270**	**(8)**

The 24/25 plan is that 70% of savings as recurrent and is on forecast to deliver. At month 6, 56% of year to date efficiency was recurrent (59% M5), against a plan of 75%. At month 6, there is a shortfall in recurrent savings of £6.3m, which has been offset by delivery of non-recurrent savings £12m ahead of the plan at this point in the year. Providers expect all but £1.8m of efficiencies to return to the planned proportions of recurrent and non-recurrent savings by the year-end as schemes mature.

	Year to date			Forecast		
	Plan CIP delivery £000	Actual CIP delivery £000	Variance benefit / (adverse) £000	Plan for the year £000	Forecast £000	Variance benefit / (adverse) £000
Recurrent efficiencies	45,985	39,727	(6,258)	150,076	148,234	(1,842)
Non-recurrent efficiencies	14,897	26,849	11,952	63,202	65,034	1,832
Total	**60,882**	**66,576**	**5,694**	**213,278**	**213,268**	**(10)**
Recurrent %	75.5%	59.7%		70.4%	69.5%	
Non-recurrent %	24.5%	40.3%		29.6%	30.5%	

None of the efficiencies target remains unidentified at month 6 with scheme maturity progressing. 71% of schemes are rated as fully developed (57% M5) and high-risk schemes have reduced from 18% to 10%.

The Locality Planning and Delivery packs and the ICS M6 finance pack contain the local level data and the key lines of enquiry for improvement. These packs also include an outline of the key discussion points and the actions due to completed within the next month.

Class	Year to date (excl capitalised)			Full Year (excl capitalised)			WTE current month		
	Plan £000	Actual £000	Variance fav/(adv) £000	Full Year Plan £000	Forecast £000	Variance fav/(adv) £000	Plan wte	Actual wte (per PWR)	Variance fav/(adv)
Substantive	838,059	841,972	-3,913	1,669,041	1,675,146	-6,105	32,157	31,830	327
Bank	42,129	46,169	-4,040	76,062	86,010	-9,948	1,195	1,372	-177
Agency	20,212	21,004	-792	37,566	38,558	-992	448	572	-123
	900,400	909,145	-8,745	1,782,669	1,799,714	-17,045	33,800	33,774	26

The ICS is reporting a less than 0.1% (£8.7m) adverse expenditure against plan at month 6. Of this total, additional income to offset pay costs above the plan of £7.3m has been received, resulting in an unfunded variance of £1.4m. The forecast indicates a £17m adverse expenditure, which is offset in part by additional funding receipts such as externally funded posts and packages of care which were not in place at planning stage.

SLG/System Escalations and Responses

Area of plan identified as off track by system	Actions agreed by system to return to plan	System's anticipated impact of action
• System net risk is £35m which is an overall improvement of £6m on the previous month. • Year to date CIP delivery on plan but recurrent CIP delivery trajectory behind in both TSD and UHP thereby putting underlying exit position at risk. • Workforce costs ytd over plan, but mostly offset by additional income. Main area of concern is TSD with high levels of agency and bank usage.	• Determine level of unfunded pay award to understand level of mitigation required. • TSD to undertake further work on the risk position and confirm any additional balance sheet flexibility. • Determine what further actions can be undertaken within TSD to improve position and complete review by Kaye Bentley • Review of workforce controls audit outcome to determine any additional actions required particularly by TSD.	• Full understanding of risk to position to enable mitigating actions to be taken to support system to meet the year end plan. • Development of key recovery actions for TSD

Finance - Providers

Outcomes of Locality Planning and Delivery Meetings				
	South	**West**	**North and East**	**NHS Devon**
Areas of underperformance identified	Financial position is **(9,622)** v plan of **(9,622)** Recurrent CIP YTD worsened to **30%** in M6 Workforce YTD expenditure **£4.9m** adverse to plan	Financial position is **(11,404)** v plan of **(10,701)** CIP delivery is **£4.7m** ahead of plan Workforce YTD expenditure **£1.1m** adverse to plan.	Financial position is **(11,051)** v plan of **(11,059)** CIP delivery to date is **£1.3m** ahead of plan Substantive workforce cost over plan by **£1.2m** but offset by £3.0m additional pay related income	
Actions agreed to address underperformance	• To confirm whether the forecast outturn £9.2m will be derisked or reduced – **Mark Brice** • To confirm to outputs of the PMO CIP review **– Mark Brice** • Confirm the amount of balance sheet flexibility identified to support the position **– Mark Brice** • To share the outputs of the month 6 run rate review and the run rate trajectory with Bill Shields and Kirsty Denwood by w/e 25th October **– Mark Brice** • To confirm the non-recurrent and recurrent exit process **– Mark Brice**	• To discuss & identify where bed reduction savings will be made and ensure an understand on core v surge/super surge beds **– Allison Williams/Jo Beer** • To update on the opportunities identified internally to drive the 156 beds – **Jo Beer**	• Update next month on progress in removing costs to mitigate the ERF position- **Angela Hibbard**	• To share the recommendations of the grip and control measure audit for the November meetings – **Piers Tetley** • To discuss a support meeting with Senior teams to discuss 2025/26 planning – **Steve Moore/Liz Davenport**
Anticipated impact of agreed actions	• Identification of further CIP to improve deficit position • Improving risk to position through balance sheet opportunities	• Expectation to remain on plan	• Expectation to remain on plan • Commitment to move toward break even in 25/26	
Any unmitigated risks remaining	There remains risk to the TSD financial position. The outcome of the Kay Bentley review is expected shortly and any impact on forecast will be included in the M7 position. An update can be provided in November SIAG.	Impacts of continued increase in UEC demand	• Cost of mental health 'specialling' • Assumptions on ERF income built into plan • Any further industrial action and impacts on elective activity	

All actions to be completed in next 4 weeks unless otherwise stated

NHS Devon

NHS Devon Integrated Care Board

2024/25 System Winter Plan

Date of meeting	Date report produced
28 November 2024	13 November 2024

Author(s)		Report approved by	
Name and title:	Colin Bradbury, UEC Programme Director.	**Name and title:**	Anthony Fitzgerald, Chief Operating Officer.
Phone:	07825 724206	**Date:**	18 November 2024
Email:	colin.bradbury@nhs.net		

If this paper needs to be presented at a private meeting, please state why
N/A

Executive summary

The attached 2024/25 Winter Plan provides the latest iteration of NHS Devon's arrangements for this winter, developed by senior representatives of partners from across the system. The plan seeks to:

- identify the key causes of pressure during winter, set against locality and individual provider plans' focus on mitigating these known factors.
- summarise our system communications plan for winter.
- set out an approach to collectively managing both day-to-day and strategic winter pressures and risks.
- put forward a process to recommend the allocation of non-recurrent winter monies (should any become available).
- define a process whereby success criteria can be monitored in real time.
- sit alongside the NHS Devon System Surge and Escalation Framework, which underpins the Winter Plan (attached).

Committees that have previously discussed/agreed the report

The following groups were engaged in the development process and iterations of the Winter Plan, culminating in the final draft enclosed with this paper:

- Unscheduled Care Board: 06 August, 01 October and 11 November 2024.
- NHS Devon Board: 18 September 2024.
- NHS Devon Executive: 08 October and 05 November 2024.
- System Leadership Group: 24 September and 22 October 2024.
- System Integrated Assurance Group: 06 November 2024.

Key recommendations and actions requested

TAKE ASSURANCE that the 2024/25 Winter Plan is compliant with national requirements, that adequate escalation frameworks are in place and that the remaining risks are understood, with appropriate mitigations are in place.

AGREE that the Finance and Performance Committee should undertake a detailed review of the system co-ordination arrangements in place for winter 2024/25.

Impact on NHS Devon objectives

Objective	Impact
Improve population health	The plan focuses on the sections of our population that are most affected during winter.
Improve services and reduced unwarranted variation	Implementing best practice is likely to improve performance.
Make more efficient use of our resources	More effective, timely care will contribute to financial sustainability e.g. by reducing LoS.
Develop our culture and how we operate	Building a system-wide evidence based consensus.

Outline the implications of matters covered in this report for the following areas (if none, please state)

Area	
Quality of services	Avoiding non elective admissions, especially within elderly pts will reduce the harm of deconditioning.
Health inequalities	Health inequalities vary across the Localities, and local planning is tailored to population need.
Workforce	The winter plan includes an assessment of workforce readiness by provider and locality.
Resources and finance	No additional winter money is currently available. If any were to be released, the Winter Plan makes recommendations about how to approach allocation.

Legal	No specific legal issues have been identified or raised in the preparation of this paper.
Digital and Data	The plan has received comprehensive BI input.
Involvement, Engagement and consultation	The Winter Plan includes a comprehensive section on system comms during winter.

2024/25 System Winter Plan

Introduction and Background

1. In August this year the Devon Unscheduled Care Board commenced the process to develop the 2024/25 System Winter Plan. To facilitate this, a Winter Planning Team was set up comprising of senior representatives from our healthcare providers (acute, community, mental health, ambulance and primary care), Local Authorities and the voluntary, community and social enterprise (VCSE) sector.

2. The Winter Planning Team has collectively developed the attached draft Winter Plan. The plan seeks to:

    - identify the key causes of pressure during winter, set against locality and individual provider plans' focus on mitigating these known factors.
    - learn lessons from last year's system Winter Plan.
    - assess the projected demand and capacity gap at times of peak pressure.
    - summarise our system communications plan for winter.
    - set out an approach to collectively managing both day-to-day and strategic winter pressures and risks.
    - put forward a process to recommend the allocation of any non-recurrent winter monies (should any become available).
    - define a process whereby success criteria can be monitored in real time.
    - Sit alongside the NHS Devon Surge & Escalation Framework (attached).

3. The Winter Plan is designed to be a live document, to enable it to be responsive, and consider potential additions for the next iteration which are set out in the Next Steps section of this covering paper.

4. In light of the detailed nature of the Annexes to the Winter Plan, these have not been included in its submission to the Board. They are being made available to Board members separately and, will be scrutinised by the Finance and Performance Committee in order to secure full assurance that the NHS Devon system has in place adequate coordination and escalation processes to navigate a challenging winter.

5. The Opel actions defined in the supporting NHS Devon Surge & Escalation Framework are Nationally defined actions. We are currently working with our providers to review the existing local escalation plans and actions, and these will be reflected in the final version of the Framework.

Mitigating winter bed pressures

6. Business Intelligence colleagues are developing waterfalls to set out the projected shortfall in beds throughout the winter months. A full breakdown of these bed model waterfalls is currently being completed and will be included in the next iteration of the Winter Plan. The mitigations quantified and to be

included within the bed models currently rely entirely on the 6 focus areas within the 2024/25 UEC recovery plan.

7. Further mitigations are also being assessed for inclusion within the bed models, whilst at the same time monitoring delivery against the assumptions agreed at the start of the year within the 2024/25 Devon Operational Plan. The additional mitigations being explored:

    - The 5 NHSE Regionally led ambulance task & finish group outputs
    - Additional actions following locality diagnostics to reduce ED demand pressures
    - Additional PCN funding
    - Additional DIG investment in UEC
    - Winter funding (should any become available)

System Coordination Centre

8. The System Coordination Centre (SCC) will be the first point of contact at a Tactical level, ensuring Trusts and Providers enact the plans they have submitted and agreed, but also to act as an additional tier of support, guidance and escalation whenever required.

9. The NHS Devon SCC is situated at Aperture House in Exeter and ensures there is robust oversight of all system pressures. The SCC is operational 08:00-18:00, 7 days a week reporting to the Winter Director. Out of hours NHS Devon operates a manager and director on call rota with the director on call assuming responsibility for overseeing system pressures out of hours. A robust handover process occurs at 08:00 and 17:00 to ensure full visibility of pressures and risk going into any out of hours period. On call managers and directors chair any out of hours escalation call as required in line with the NHS Devon SCC Standard Operating Procedure (SOP) and the NHS Devon Surge and Escalation SOP which can be viewed in the attached link.

10. Within operating hours, the SCC utilises the SHREWD resilience dashboard and SWASFT ambulance monitoring to ensure constant monitoring of pressures within the system. The SCC will lead on the managing of pressure, demand and capacity within the system as follows.

- Collation of information from providers at to enable accurate system Opel level score at 10:00 daily. This is automated within SHREWD and reviewed in advance of each system call.
- Leading daily system calls at 11:00 and 16:30 each day. These calls enable early identification of potential issues and manage actions to rectify.
- Manage ambulance handover delays in line with the regional standard operating procedure.
- Attendance at regional and national reporting and escalation calls as required.
- Initiating additional escalation calls, including GOLD escalation, in line with the surge and escalation SOP as required.

Escalations and Triggers

11. All providers have been asked to share their internal escalation processes and trigger points for additional actions with NHS Devon so that a single escalation framework can be put in place for the winter period and beyond. Each has been asked to include “early warning” triggers that will allow the system to take positive action before pressures result in unacceptable ambulance delays through our winter Gold Command arrangements. At time of writing details of these early triggers were awaiting from some providers.

Next steps

12. Focus is on the following next steps:

a) Produce a single SCC on-call pack that sets out:

- System Meeting Cadence Attendees
- Escalation triggers and actions
- Escalation and de-escalation processes and actions

c) Produce monthly bed pressure and mitigation waterfalls for each provider

d) Add additional mitigations to the bed pressure waterfalls (with a target of ensuring modelled bed pressure never rises above 450), including:

- The 5 NHSE led ambulance task & finish groups
- Additional actions following locality diagnostics to reduce ED pressure
- Additional PCN funding
- Additional investment in UEC

Conclusion

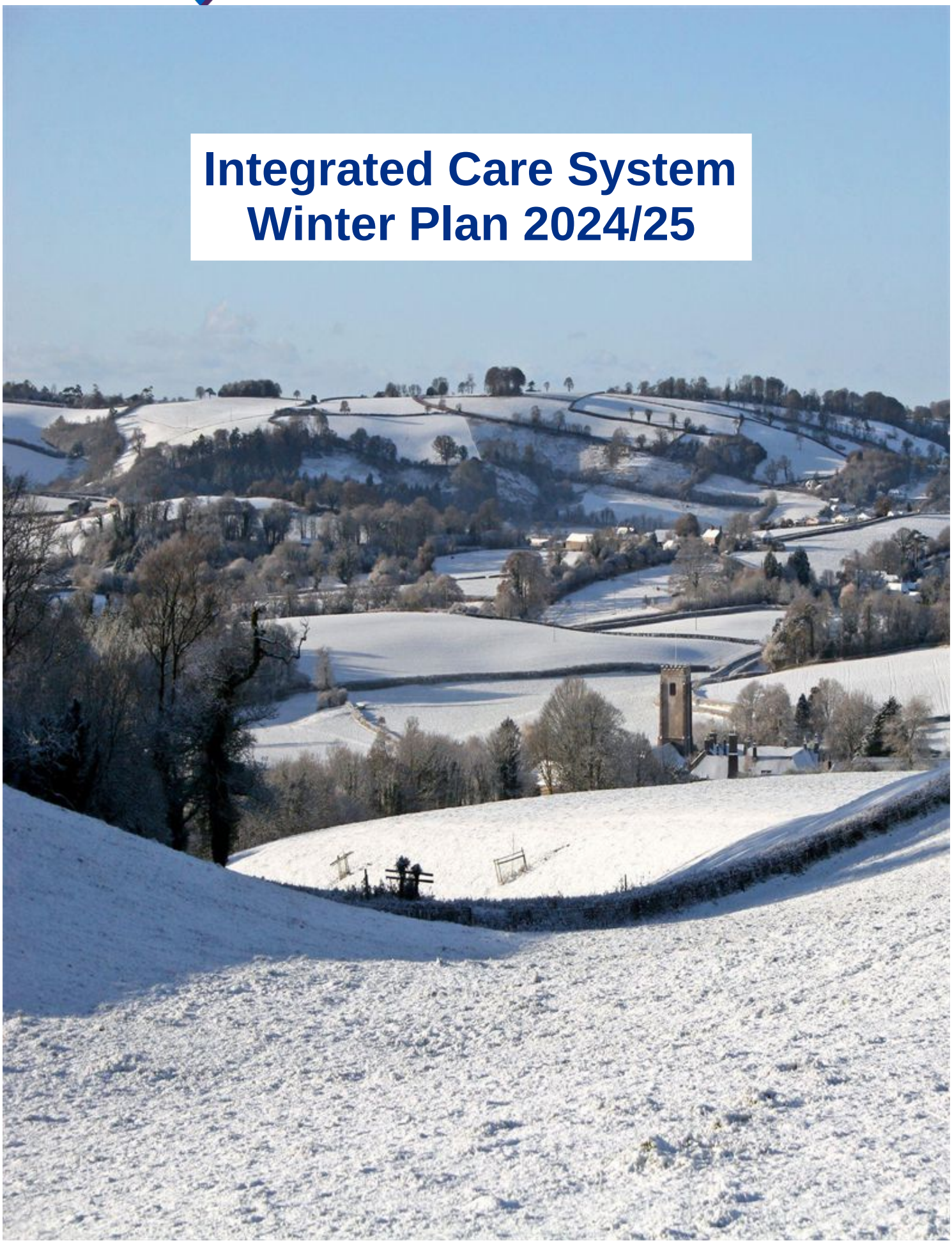
13. The Board is asked to:

- **TAKE ASSURANCE** that the 2024/25 Winter Plan is compliant with national requirements, that adequate escalation frameworks are in place and that the remaining risks are understood, with appropriate mitigations are in place.

- **AGREE** that the Finance and Performance Committee should undertake a detailed review of the system co-ordination arrangements in place for winter 2024/25.

One Devon

Integrated Care System Winter Plan 2024/25



Contents

Introduction

This document is a collective effort of the Devon Winter Planning Team[1] (WPT) to develop a system wider winter plan for Devon. Winter is a predictable event and therefore forms part of each partner's business as usual planning cycle. However, in order to maximise the robustness and effectiveness of individual plans, there is value in coming together to coordinate actions and ensure that we are collectively focussed on the key issues that drive the additional pressures that we know winter will bring. Consequently, this document seeks to give a settled, consensual view on behalf of the Devon health and care system on the following questions, and the sections of this document are named and numbered accordingly:

1. **What are the drivers of the particular challenges that the Devon health and care system will face over winter?**

2. **How well did the system's winter plan work last year?**

3. **How well do our plans for the coming winter address the drivers of pressures that we know we are likely to face?**

4. **What impact will the outputs of the 6 UEC focus areas have on performance over the course of the winter?**

5. **How will we coordinate our actions as a system over the winter period?**

6. **If additional winter monies were to be made available, what principles would we recommend are applied to realise maximum benefit, and what potential schemes do we have ready to go?**

7. **What are the success criteria by which we can judge if this plan has been effective?**

This Winter Plan is designed to be a live document, and it is anticipated that further updates/ iterations may be required. The audience that this document has been written for is primarily those within the Devon system who are responsible for leading the delivery of health and care services over the course of the winter.

[1] Supported and facilitated by Devon ICB, the Winter Planning Team includes senior membership from: Primary Care (Devon Collaborative Board), VCSE representation, Devon County Council, Torbay Council (via TSD), Plymouth Council, RDUH, TSD, UHP, SWAS, PPG, DPT, Livewell SW, and the MHLDN.

1) What are the drivers of the particular challenges that the Devon health and care system will face over winter?

1.1 Seasonality in demand

Demand for healthcare is known to be seasonal, with higher demand during the winter months. What is less understood is that there are in reality two different seasonal waves of demand, a summer surge, and a winter surge. The characteristics of each seasonal surge in demand are very different: -

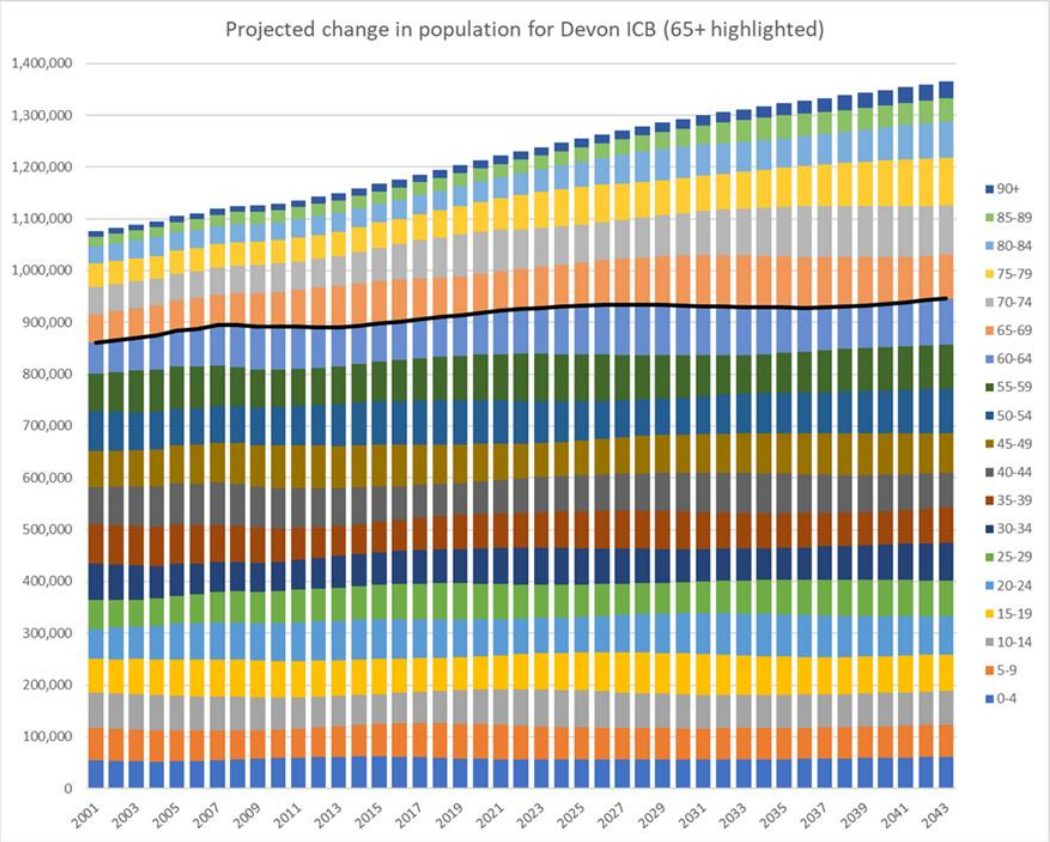
- Summer surge – This is linked to increased levels of tourism and people generally being more active in the warmer summer months. This increase in demand is generally linked to school age children through to people aged around 70. This surge in demand is also linked to increased presentations at emergency departments (ED) and higher levels of accidents and injuries. However, this demographic group is less likely to be admitted as an emergency hence it doesn't create a significant bed pressure on the system.

- Winter surge – This surge in demand is in the main restricted to older people aged 75+ and very young children under the age of 2. A significant proportion of the increase in demand is for respiratory conditions with an emphasis on increased infections (i.e. flu). More recently, the winter surge in demand is also seeing higher rates of covid across the population which is exacerbating the levels of surge. Demand in the winter can also be impacted by the weather with higher demand if the weather is very cold.

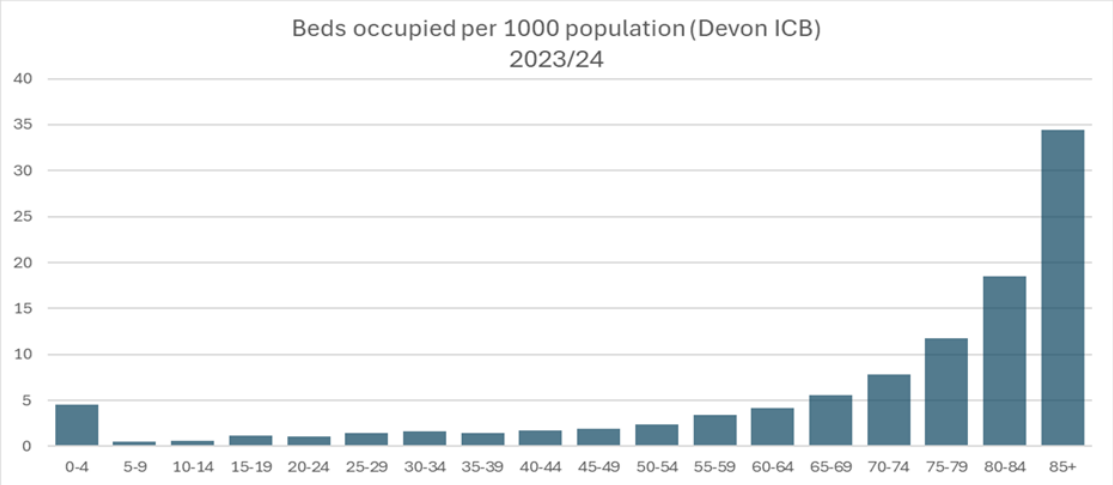
1.2 Our ageing population

Age is an important characteristic in understanding winter demand. The graph below illustrates that the projected demographic growth over the next 20 years in Devon is made up essentially by the 65+ age category, with the section of the population below 65 remaining broadly flat between now and 2043. This means every year in the Devon system the section of the population with the greatest health and care needs will

increase.

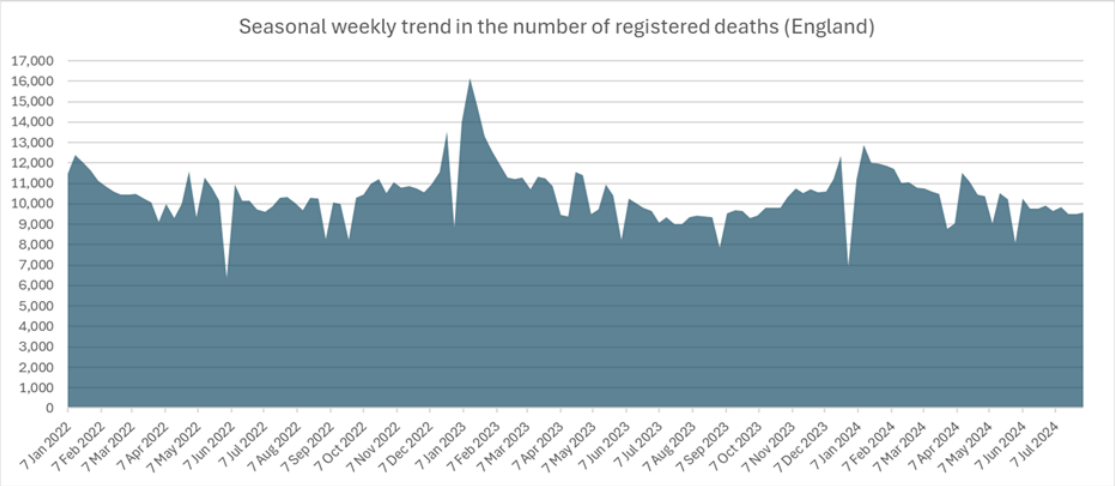


If we compare a person aged 85+ to a younger person aged 20 then the older person is about 2.5 times more likely to attend ED in any given year, they are 4 times more likely to be admitted from ED into a bed as an emergency and their average length of stay is around 3.7 times longer. Thus, the average person in Devon aged 85+ can exert a bed pressure that is around 32 times higher than a 20-year-old. It is for this reason that across Devon we see around 56% of our acute hospital beds occupied by patients aged 75+ even though they make up only around 13% of the total population.



This creates a more nuanced picture of the seasonality in demand. The healthcare system is under more pressure during the winter months even though the volume of activity presenting to ED is actually lower. However, there is a shift in the case mix with more older people (and young children) presenting to ED in the winter but fewer people in all other age bands. The increase in demand for older people in the winter increases the bed pressure which in turn impacts on ED / ambulance performance. It is for this reason that we model the impact of winter from the perspective of acute hospital beds.

The seasonality in demand is also linked to the increased mortality during the winter months. The chart below shows the registered number of deaths per week over the last couple of years for England. The winter on 2022/23 shows a particularly high number of registered deaths when compared to the winter of 2023/24. However, even in the latest winter deaths were about a third higher than seen during the summer months.



We know that a significant proportion of deaths occur within the hospital system (about half) and there is also a high level of resource usage for patients in their last few months of life. It is this higher mortality in the winter and increased bed usage at end of life that combines to create the significant bed pressure seen during the winter months.

1.3 Summary of analysis

We have shown that the increased demand in the winter months is primarily driven by increased demand for older people and to an extent very young children. This increased demand is strongly linked to respiratory infections and as such the size and nature of the seasonal wave can vary each year.

This increased demand in the winter has a significant impact on acute hospital beds as older people are more likely to be admitted and once admitted they tend to have a longer length of stay. This increase in demand will also place an additional pressure on complex discharge capacity.

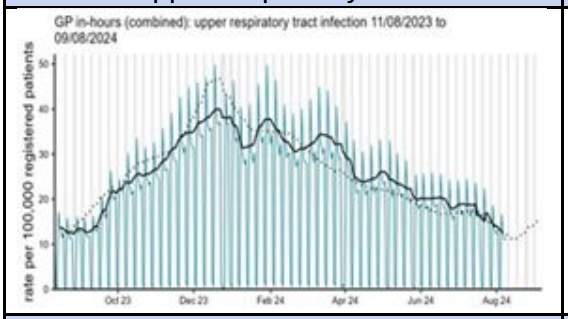
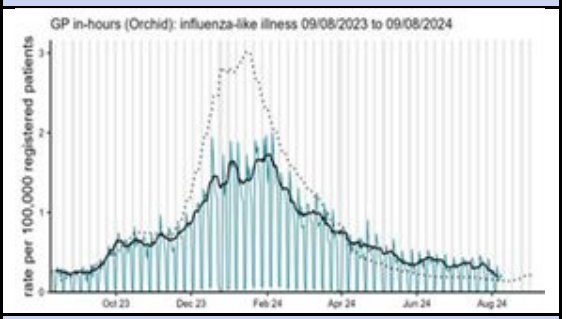
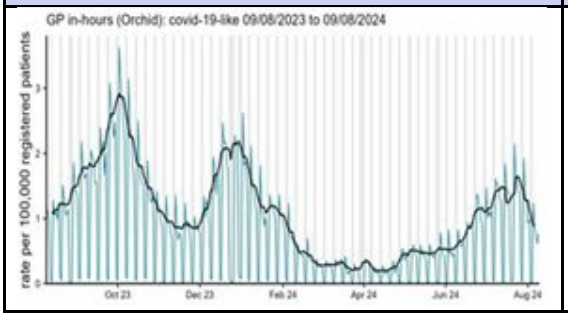
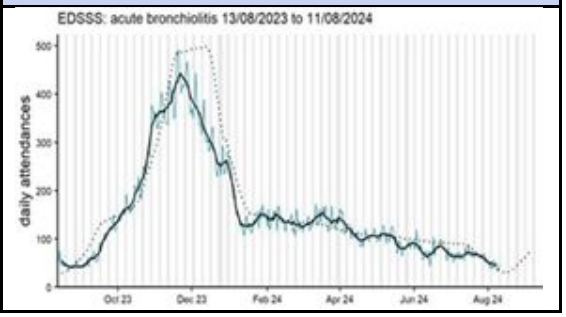
The winter of 2023/24 was relatively benign in terms of seasonal demand with most measures of respiratory infections showing lower levels than the 5-year average. The winter plans that were implemented did have an impact on the ability of the system to absorb some of the additional demand pressures. However, the system was still in a bed deficit situation throughout the winter period. This in turn impacted of the ED and ambulance performance. The improvement length of stay probably had the biggest single impact of all the schemes.

The coming winter of 2024/25 is expected to have higher seasonal demand that was seen in 2023/24 based upon the logic of regression to the mean. Whilst the length of stay improvements seen in 2023/24 were significant, they remain around 1 day above pre-pandemic levels, although currently Devon is in line with regional averages on this measure. The ability of the system to absorb the expected surge in demand is likely to only be possible if length of stay can be improved by this magnitude.

2) How well did the system's winter plan work last year?

2.1 Reflections on 23/24 winter plan

The charts below show the national surveillance system results covering the winter to 2023/24 (the solid black line is the 7-day rolling average) and the historical trends (dotted line). These charts cover both primary care and ED activity.

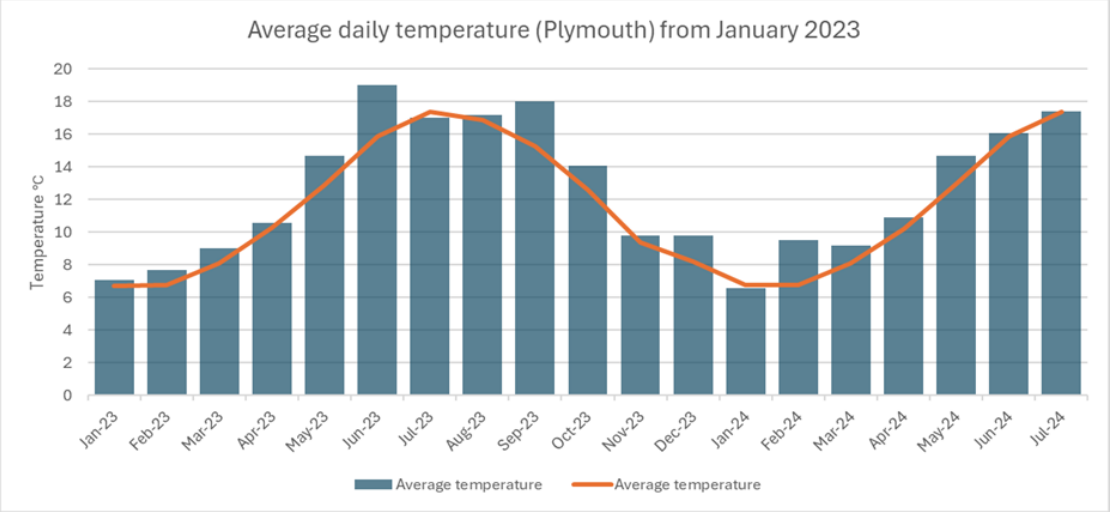
GP: Upper respiratory infections	GP: influenza like illness
	
GP: covid-19 like illness	**ED: acute bronchiolitis**
	

Generally, we can see that the winter of 2023/24 was relatively low in terms of the traditional sources of seasonal demand. The levels of upper respiratory infections, flu and bronchiolitis were all below the historic average peak demand. This is very different to the previous year when demand was significantly above average.

Whilst it is true that the recent peak demand was below historic average, we also saw that demand didn't reduce as fast as in previous years. This is not an unusual pattern and is fairly typical of infectious disease behaviour.

Covid demand is slightly different as in the last year we have seen three separate peaks in demand rather than the single annual peak for other respiratory infections. Covid still exhibits a seasonal pattern of demand with generally higher demand in the winter months.

The chart below shows the average daily temperature in Plymouth from January 2023 onwards compared to the expected average. The average temperature was above normal levels throughout last winter except for January 2024 when it was a marginal 0.2 °C below average.



Overall, we have shown that the normal sources of seasonal demand during the winter of 2023/24 were relatively low, but this should be viewed more as the exception than the rule.

2.2 Impact of schemes last winter

It is difficult to fully quantify the impacts of each individual scheme in relation to the winter of 2023/24. However, we do know that there has been some improvements, but these were not sufficient to remove the bed deficit in total. The known impacts are shown below: -

- Length of stay improvement of 0.8 days from Q4 2022/23 to Q4 2023/24 would have contributed to an improvement in bed usage of 255 beds across Devon. A number of schemes would have contributed to this improvement.
- ARI hubs reduced ED attendances by 900 patients over the peak winter demand period.

We have looked to quantify the difference between the expected and actual demand for those seasonal conditions i.e., respiratory infections and covid. We have estimated

that the normal winter surge in demand was particularly low in the winter of 2023/24 compared to the historic/ modelled levels: -

- We had expected a surge in respiratory beds occupied of 224 additional beds in January 2024 compared to the low point in the summer. We estimated that peak demand was approx. 20% lower than expected based upon the national surveillance data, equivalent to around 45 fewer beds occupied at peak winter
- We had originally modelled a covid peak in January 2024 of 101 hospital beds occupied but the actual peak was 59 beds. The earlier peak in Covid cases during October 2023 probably led to a lower peak at the height of the winter in January.

Overall, we have shown that there had been some significant improvements in the management of the system over the winter and when coupled with lower levels of seasonal demand this did contribute to lower overall system pressure. However, whilst these improvements did amount to around a 374 bed improvement in January 2024 (where it can be quantified) the overall health system was still in a bed deficit position.

The reduced length of stay is the largest single contributor to the level of improvement seen across the system. However, it should also be noted that the increase in LoS was also the main reason for the increased pressure that appeared in 2021/22. Whilst the system has made significant inroads in reducing LoS back to pre-pandemic levels we would still expect a further reduction of around 1-day LoS is possible for emergency admissions.

The results of the above improvements would have contributed to the improved performance for the 4hr wait in ED in Q4 2022/23 of around 6.0% compared to the previous year.

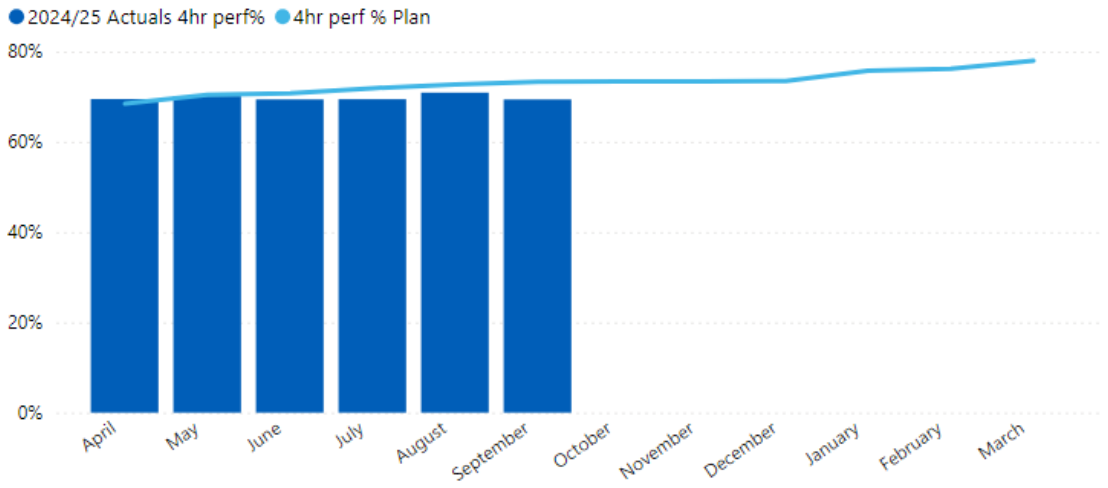
3) How well do our plans for the coming winter address the drivers of pressures that we know we are likely to face?

The A&E 4hr performance metric is regarded as a useful proxy indicator of overall system pressure and flow within unplanned care in the system, and not just at the ED front door[2]. Whilst imperfect, it has the advantage of being well defined, consistently captured and comparable across healthcare systems in England. We know from the Devon UEC story that there is very strong correlation between 4hr performance and beds occupied (r = -.90), and length of stay (r = -0.89) whereas there is no correlation between ED attendances (r = -0.24) or emergency admissions 1+ day LoS (r = -0.04)

In one sense, we already have a winter plan, as the annual operating plan that was signed off and submitted at the beginning of the financial year gives a trajectory across the whole of 24/25. It is proposed that the WPT track this data over the course of the winter to identify which metrics are adrift at times of dipping performance. The figure below shows planned against actual 4hr performance for the Devon system.

[2] https://nhsproviders.org/mission-impossible/5-impact-on-patients-and-staff

Devon system 4hr performance trajectory (2024/25)



Going into this winter, Devon has mixed experience in terms of performance against some of the key metrics that we know will matter over the course of the winter. At the time of writing, September 24 was the last full month of data available. Looking at trends, and comparing Devon the to the regional average, it is possible to see where we currently sit in comparison to peer systems.

Devon's All Type 4hr performance in September was 68.4% compared to a SW average of 70.2%. Having said that, Devon is currently tracking significantly higher than it was the same time last year. Using the same historical comparison, this is also the case for Type 1 performance, although Devon did 54.6% compared to the SW average of 58.58%. This is a concern in the sense that acuity comes to the fore during winter and the volume of attendances drop off.

Looking specifically at older adults, people over 75 spent an average of 464 minutes in ED in Devon during September, compared to the SW mean of 433.

Some more encouraging signs can be seen in current levels of bed occupancy. In September the proportion of >75yr old patients who had 0 day non elective length of stay was 18.3% in the SW and 20.6% in Devon. Looking at the wider picture, for all non-elective patients in the SW the average length of stay was 7.3 days in September, compared to 7.4 days in Devon. Finally, it should be noted that in September it was reported that the proportion of adult G&A with no criteria to reside patients was 16.8% in the SW and 10.5% in Devon. Looking at trend, Devon regularly tracks at this sort of level below the SW average, which is a mitigation to the very low inpatient bed base that it operates with.

3.1 Locality led approach

We will adopt an integrated approach for winter, with the acute trust winter plans (RDUH, TSD and UHP) will be combined with the locality plans as 'one plan' driven by local collaboration and participation in planning meetings and schemes.

The locality teams are linked in with primary care and VCSE to understand their winter planning and incorporate this into locality plans. The local authorities (Devon County Council, Torbay Council and Plymouth City Council) have been engaged in the Devon winter planning process and the operational elements of health and social care will be included within the community services element of the Locality plans as required.

The following sub sections give an overview of the plans at a locality, provider, and sector level, mindful of the specific challenges for our system that are outlined above.

3.2 North & East Locality

The N&E locality are going into winter with RDUH tracking below the 4hr trajectory agreed for 24/25. The self-assessment against the 10 UEC high impact interventions in the table below show a number of mature services, although there are differences between the Eastern and Northern site. It is the case that some of the core services are comparatively less well developed in Northern Devon (e.g. SDEC and Acute Frailty) although the site tends to deliver higher levels of 4-hour performance compared to Eastern Devon. The locality team will continue to support RDUH with any identified areas of development to improve the performance of high impact interventions.

The North and East Locality team are supporting RDUH in delivery of the winter plan and have identified several key areas of focus:

Hospital Discharge – RDUH's winter plan sets ambition to reduce NCTR this winter, with an internal metric as 9.5%. In support of this the locality team continue to lead the Hospital Discharge Transformation programme. For winter 24/25 this includes a new block contract for 10 P2 beds in Eastern Devon, and update of the contracts in Northern Devon to ensure a consistent specification if followed. This will enable the discharge teams to discharge patients with a higher acuity of need, but also with the expectation of a lower length of stay to improve flow from G&A beds. The RDUH winter plan also focuses upon a home first approach, the locality team are supporting with demand and capacity modelling to support the understanding of the increase required in Pathway 1 discharges, and any potential capacity gap within current delivery.

Virtual Wards – Following the recent CRG programme, a refreshed specification and KPIs have been agreed by the system. RDUH consistently perform well against LoS metrics but do not consistently achieve 80% occupancy. This is a target within the trust plan which the locality team will monitor and support.

UCR – The CRG is currently working with providers to define UCR capacity to enable the clarity of 'slots' which are available for winter to support admission avoidance activity, and referrals from key system partners. The locality team continue to support RDUH with this work.

Primary Care – The locality team are working in collaboration with Northern Primary Care Colleagues to consider an admission avoidance pilot for winter, this is in part to

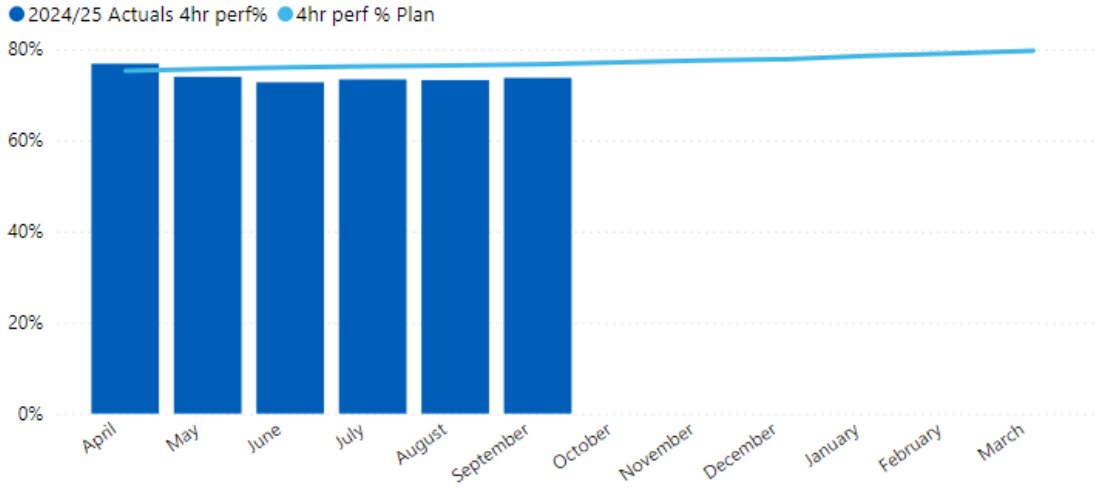
provide a solution to the significant gap in community urgent care delivery in North Devon.

VCSE – There are several VCSE providers in the North and East Locality who are supporting the winter plan. The below summarises the key deliverables:

- Enabling people to stay well and supported in their community and at home thus avoiding admissions.
- Enabling self-care and prevention at a community level
- Focusing tailored support to high intensity users
- Supporting discharge pathways
- Supporting vulnerable people and those impacted by health inequalities who are often disproportionate depend on UEC services.

Monitoring of delivery against trust, wider provider and locality winter plans will take place via the North and East Locality Planning & Delivery meetings.

RDUH 4hr performance trajectory (2024/25)



RDU workforce winter plan

Ensure adequate staffing levels are in place to meet anticipated demand across winter

- Modelling workforce requirements for permanent clinical and non-clinical staff to deliver a resilient winter: RDU have been robustly addressing cycles of recruitment and have fully recruited to the NQN's and where possible have increased our recruitment activity for unregistered workforce. At the time of developing the workforce winter plan, RDU have not received any additional funding to support additional workforce to manage the additional winter pressures so have limited opportunities to increase flexibility in workforce numbers. The Trust has however received funding for GP streaming and this will be in place for winter and should support flow.
- Required level of staffing in place to deliver the planned capacity outlined in the 2024/25 operating plan for the system: At the time of developing the winter plan,

RDU are currently c250WTE below the forecasted operating plan position however have plans in place through temporary staffing supply to address any gaps and a close eye on pay control measures. The Trust also have had over the summer and autumn months targeted recruitment campaigns to expedite critical roles. RDU have also proactively invested heavily in supporting hard to fill roles via the internal marketing and search and selection teams to attract and onboard. There is particular recent success in the northern area for medics.

- Plans to meet deficit in workforce: RDU are actively recruiting and working with teams to review workforce delivery models and onboard new starter pipeline expeditiously. In addition the Trust is working with NHSP to forward plan against rosters for bank staff plans, offering additional hours to existing staff and actively recruiting more workers to the bank.
- Temporary workforce requirements across winter: RDU have modelled plans based on current trends and previous winter demand which includes review of rosters, elective recovery plans and are working with NHSP as described above.
- Staff banks usage for deployment during periods of escalation: RDU have adopted NHSP which allows greater flexibility across North and East Devon and this has recently improved the fill rate. NHSP are working hard in partnership with the Trust and the wider system to onboard qualified staff as the system allows visibility of shifts to the wider NHSP workforce across Devon.
- Maximising the community workforce to ensure rehabilitation and reablement are delivered to all people requiring Intermediate Care services: RDU are in the process of seeking additional funding from the ICB to support care at home for patients that meet P1 criteria and are also looking for additional P2 capacity – at the time of writing this report, this has not yet been secured.

How the system will work together to support one another from a workforce perspective

- Systems and processes in place to support the deployment of staff from one provider to another where necessary : RDU have explored how we they support each other and in speciality areas have shared resource arrangements however the current pressures across the system would leave each individual organisation in a risky position from safe staffing perspective. However as detailed above now that all partners are signed up to NHSP bank this will be a step closer to achieving this. RDU have also introduced a MOU arrangement via staff passport which supports rapid deployment of staff between trusts.

Prioritisation of staff wellbeing across winter

- Initiatives are in place to support staff wellbeing across the winter: RDU have a range of the usual well-being initiatives for staff as a standard trust wide offer. Care Groups are also developing local well-being strategies to offer targeted, tailored and localised support. These include ensuring staff are taking regular breaks, that there is sufficient staffing plans in place to reduce the over reliance on overtime, fast track access to Occupational Health for any member of staff absent from work for work related reasons. RDU are also working proactively to support staff when they experience trauma in the workplace and deploy a wellbeing team to deliver this.

- Arrangements in place to ensure absenteeism (planned and unplanned) is aligned with demand and capacity: RDU are already experiencing increased sickness absence due to winter bugs and covid, in addition stress is playing a key factor in absence. The Trust anticipates that January will be the most challenged month looking at previous trend however very much depends on outbreak of flu and covid and norovirus which is unpredictable. They are planning where possible to ensure staffing templates are filled to meet predicted demand.
- Plans in place to support a successful vaccination programme for influenza and Covid-19 (if recommended) for staff and volunteers: RDU offer easy access flu and covid vaccines throughout the trust to all staff and this is available now and they will continue to encourage staff and volunteers to get vaccinated.

Maximising the roles of Primary Care, Social Care and VCSE partners

- Assumptions made about the role of those partners in supporting the workforce this winter and maximising the roles: Given the industrial action in primary care no assumptions have been made in terms of receiving support from them this winter. RDU continue to work with DCC to meet care in the community needs and have a jointly appointed team to ensure planning is as robust as possible. RDU work closely with the VCSE partners all year round and will plan with them to meet demands particularly for challenging periods. |There are several partnership forums where the team jointly plan how to support each other to meet the winter demands. With the current operational status this has been challenging to firm up more proactively.

- Relationship with these partners managed at system-level to ensure the greatest level of integration and joint working: RDU manage VCSE relationships very effectively at a locality level whereas with Social care it is at a system level with DCC. RDU have jointly appointed staff with DCC that work across the system to support integrated working.

North & East Locality UEC high impact intervention maturity assessment

Intervention	Score (0-8)	Comments
1) SDEC	3 (Progressing Maturity)	Location of SDEC sub-optimal in Northern. Space within Eastern insufficient for patient demand,
2) Acute Frailty	5 (Progressing Maturity)	Constraints for Northern have been identified as: 1. No funding for acute frailty team 2. Lack of Geriatricians for acute frailty 3. Local of acute frailty unit
3) Acute Hospital Flow	7 (Mature)	No bed space in Eastern discharge lounge limits utilisation.
4) Community Hospital Flow	7 (Mature)	Four community hospitals working across North and East to a defined SOP.
5) Care Transfer Hubs	5 (Progressing Maturity)	Open 7 days, fully operational.

Intervention	Score (0-8)	Comments
6) Intermediate Care	7 (Mature)	P2 pilots recently launched, further evaluation data required to understand impact.
7) Virtual Wards	7 (Mature)	Devon-wide SOP has been agreed as part of Devon UEC Recovery workstream, conditions for VW have been identified and agreed to ensure equity across the ICB
8) Urgent Community Response	7 (Mature)	Devon-wide specification has been agreed as part of Devon UEC Recovery workstream
9) SPOA	6 (Mature)	North - Physical space continues to be an issue. Planned move to relocate team. Development of team and model continues. East - Hospital Discharge team (SPOA) have now relocated with site management team. Continued work to improve staffing levels and skill mix.
10) Acute Respiratory Hubs	5 (Progressing Maturity)	Winter response funded centrally, no update on funding for winter 24/25.

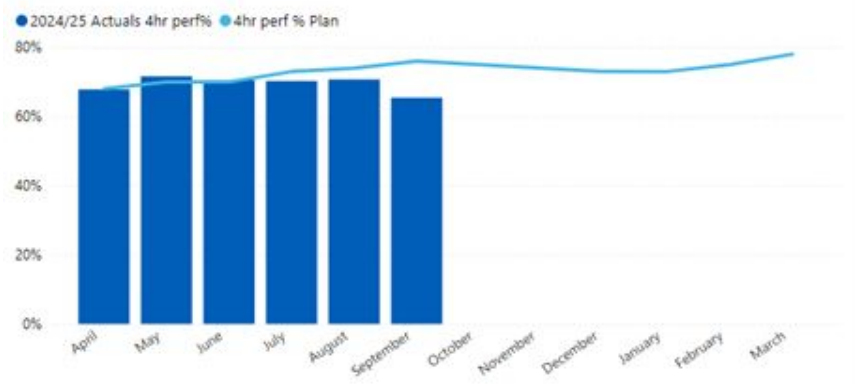
Summary from Devon Locality HII Maturity – Aug 24

3.3 South & West Locality

Similar to North & East, The South and West locality approaches winter with TSD as the south acute provider diverging from the set 4 hour trajectory. Unlike the other two acute providers, TSD have forecast a dip in performance over the course of the winter.

The high impact self-assessment, which is summarised below, highlights areas of progressing maturity within in SDEC, acute frailty, virtual wards and SPOA that were already well understood and have programmes of work both internal and in partnership with this ICB to inform and support through the 6 UEC high focus areas. Meanwhile, TSD as an Integrated Care Organisation are planning a dynamic organisational shift of resource into community-based frailty, pathways, and methodologies over the course of the winter. Whilst undoubtedly the right thing to do, this change will bring with it operational risks at a time when pressure and acuity is at its highest.

TSD 4hr performance trajectory (2024/25)



South Locality UEC high impact intervention maturity assessment

Intervention	Score (0-8)	Comments
1) SDEC	3 (Progressing Maturity)	Level 2 AMU is bedded every day. There are 10 trolleys and 2 x recliners which usually have overnight utilisation 80-90%.
2) Acute Frailty	4 (Progressing Maturity)	Limited by: • Workforce across the frailty MDT • Environment needs to be larger or co-located to be able to see either more patients or space for complexities. • Lack of consistent in and out of hospital SPOA and visibility on the DoS/NHS Service Finder.
3) Acute Hospital Flow	7 (Maturity)	Long Stay Inpatient Review Programme SOP pending final sign off.
4) Community Hospital Flow	5 (Progressing Maturity)	Out of Hospital pathways, including Community Hospitals/beds and the pathways/utilisation is under review at present
5) Care Transfer Hubs	7 (Maturity)	7 day working.
6) Intermediate Care	7 (Maturity)	Block provision of 29 beds continues to be fully open and staffed.
7) Virtual Wards	5 (Progressing Maturity)	Development of admission avoidance pathways in progress. 0800-2000 is currently not doable due to workforce shortages.
8) Urgent Community Response	7 (Maturity)	Referrals continue to increase and both by Care-co and self-referrals. No referrals declined.

Intervention	Score (0-8)	Comments
9) SPOA	5 (Progressing Maturity)	SPOA for Torbay and SD are now equitable but still separate covering community workload only. There are some VCSE pathways for the community team to utilise. Strong links and working pathways with Care Co.
10) Acute Respiratory Hubs	N/A	Service for winter pressures only. Expectation that next winter a higher maturity due to lessons learned during 2022/2023 and 2023/2024.

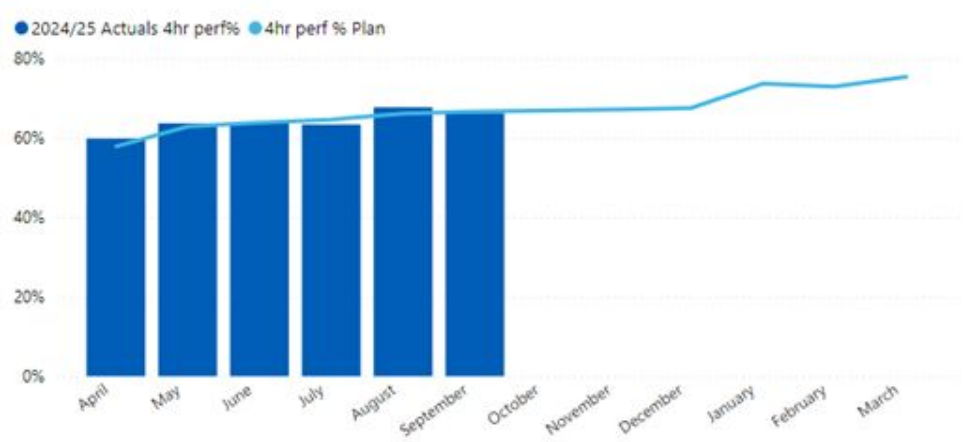
Summary from Devon Locality HII Maturity – Aug 24

3.4 Plymouth Locality

The Plymouth locality's approach to winter is underpinned by the 'One Plan' local approach to improving access, quality if care and patient experience in the Plymouth UEC service offer and pathway. This plan centres upon 15 goals for improvement, with a clear method to achieving the goals and improvements in quality and performance outcomes. It is clinically led and co-designed. The high level of confidence in these plans is reflected in the high impact intervention self-assessment that appears below.

The 'One Plan' approach is already seeing significant success in addressing many of the challenges around UEC performance that have been present with the system for some time. Currently, UHP is broadly tracking its 4hr performance trajectory, although there is a commitment to a step change in performance which is based around the opening of a new UTC in January.

UHP 4hr performance trajectory (2024/25)



West Locality UEC high impact intervention maturity assessment

Intervention	Score (0-8)	Comments
1) SDEC	4 (Progressing Maturity)	Medical Receiving Unit opened August 2024
2) Acute Frailty	4 (Progressing Maturity)	Constraint remains capacity, however series of moves underway to increase bed capacity, reduced medical outliers and improved medical LoS.
3) Acute Hospital Flow	6 (Mature)	Ward Process Improvement Programme in delivery - EDD's in place by 30/9/24 and 80% pts to leave on EDD (25% discharged by midday).
4) Community Hospital Flow	6 (Mature)	Improvements have continued to be made with a reduction in the previously identified off-pathway issues. Additional focus on Home first and drive towards 75% target on P1 will release community bed capacity.
5) Care Transfer Hubs	5 (Progressing Maturity)	Operates 7 days per week.
6) Intermediate Care	5 (Progressing Maturity)	IC plan in place and in delivery, additional capacity embedded in system and significant improvement in proportion of HomeFirst discharges up to 52% with plans in place to meet 75% target by October. DCC P1 procurement plans to ensure capacity. Demand modelling in Cornwall underway to set out run rate required to see improvements.
7) Virtual Wards	6 (Mature)	Integrate acute and community virtual ward model by Dec 2024.
8) Urgent Community Response	7 (Maturity)	Only gaps remain relating to capturing info on 2-hour work from DN service.
9) SPOA	5 (Progressing Maturity)	Collaborative approach with Acute GPS proving positive furthers coms work is underway to increase referrals and awareness.
10) Acute Respiratory Hubs	N/A	Service no longer active (winter 23/24)

Summary from Devon Locality HII Maturity – Aug 24

3.5 Mental Health

MHLDN Collaborative:

The MHLDN Collaborative key actions and recommendations below were agreed in the ICB UEC Board in September. These areas of focus correlate to the identified interdependencies of the UEC system acute flow specifically, rather than the broader overarching mental health system needs. It is noted that the UEC High Impact Initiative Assessments didn't have specific Mental Health areas, but the work outlined in the Collaborative actions will align to supporting our system partners. These are streams of work that will be led by the Collaborative across the system, with reporting into the existing infrastructure and the ICB UEC Board.

Key Actions and Recommendations:

- Work with SWAST on Ambulance Usage: Collaborate with the South Western Ambulance Service NHS Foundation Trust (SWAST) to understand and reduce the high number of mental health patients being taken to A&E. Explore alternative care options to reduce unnecessary A&E visits.
- Expand the High Intensity User (HIU) Pathway: Assess the effectiveness of the High Intensity User (HIU) pathway, including the role of the new Mental Health HIU Coordinator. If successful, consider expanding the programme to cover more areas or provide additional support to frequent users.
- Include Mental Health in system Winter Planning: Ensure that all providers have winter plans that address key mental health challenges like crisis response and patient flow. Regularly review and update these plans to respond to winter pressures.
- System utilisation of Mental Health Escalation Protocol: The system actively employs the Escalation Protocol to manage complex mental health cases that are at risk of delayed discharge. This approach prioritises clear communication, innovative problem-solving, and strong executive oversight to ensure timely discharges and better patient outcomes. See Escalation Protocol for Adults with Mental Illness from Acute General Hospital (Annex 3).
- Strengthen Liaison Services and Joint Care Pathways: Mental health providers to improve their liaison responses where they are below agreed local trajectory and actively lead improvement work with the local General Hospital. This will help to enhance joint care pathways, ensuring better integration between mental and physical health services and ensure improved working relationships (think MADE)
- Review Best Practices with NHSE Regional Team: Attend the planned NHSE regional team winter planning meetings, to review national and regional best practices. Use these insights to strengthen data monitoring, improve A&E mental health care, and implement effective strategies across the system Providers
- Review of attendees to A&E: only 29% of attendees to A&E in July were known to local mental health services – this requires review to understand a gap in community provision

In addition to the above, the Mental Health system will continue to promote via communication channels the alternatives to Emergency Departments for seeking mental health support including the Crisis cafes, 24/7 all age mental health crisis helplines, the VCSE led drop-in centres and will stand up a new crisis website resource.

The Collaborative is also aware of the GP collective action and is taking forward with ICB with focus on physical health monitoring especially for eating disorder and any associated risks this may pose.

Provider Winter Plans:

Livewell Southwest (LSW)

LSW have identified areas likely to be affected by winter pressures across the acute mental health pathway and have workforce planning in place to monitor and mitigate. This includes:

- Pre-winter staffing review and planning taking place
- Minimum staffing levels defined for services and understood for winter
- Strict A/L planning in line with agreed headroom for all services
- Ongoing focused work to fill vacancies in core teams
- Temporary staffing will be used to fill unplanned gaps
- Use of temporary redeployment to mitigate unplanned gaps in core teams across the organisation

As an integrated provider there will also be focus on joint working with the Local Authority and Adult Social Care to enable discharge flow from inpatient wards and close monitoring of capacity. The existing provisions in place such as the 24/7 all age crisis line, Joint Response Unit, Alternative to ED unit will all continue to be offered.

Winter schemes to manage surge/flow have been identified, subject to additional funding.

LSW Workforce winter plan

Ensure adequate staffing levels are in place to meet anticipated demand across winter

- Modelling workforce requirements for permanent clinical and non-clinical staff to deliver a resilient winter: Within current workforce affordability, LSW directorates can consider areas of highest risk or escalating risk. LSW have used previous years data to understand times of known surge through winter, particularly in urgent care teams and community services. They have modelled using the roster policy to ensure headroom and annual leave are planned within permitted levels.
- Required level of staffing in place to deliver the planned capacity outlined in the 2024/25 operating plan for the system: Most services are recruited or have staff coming into post for winter. There is no additional winter funding identified to manage the increase in demand and LSW have put in a proposal for additional therapy and adult social care workers in the discharge to assess (DTA) service should funding become available.

- Plans to meet deficit in workforce: LSW are actively recruiting to posts which are permitted within the Devon financial rules and using temporary staffing where there are gaps. They do not have any additional staffing to manage surge. Work will be prioritised to maintain system flow understanding some people will need to wait longer for planned interventions/treatment.
- Temporary workforce requirements across winter: An additional 3 WTE in the DTA would be required to manage the anticipated surge based on last winter's data.
- Staff banks usage for deployment during periods of escalation: LSW are working with NHSP to maximise opportunities for onboarding to create a broader pool of staff available to support services.
- Maximising the community workforce to ensure rehabilitation and reablement are delivered to all people requiring Intermediate Care services: The urgent care workforce is resourced separately to the wider community services. This enables LSW to prioritise the 2hr UCR and discharge work for people requiring intermediate care across the system.

How the system will work together to support one another from a workforce perspective

- Systems and processes in place to support the deployment of staff from one provider to another where necessary: There is good system working with LSW as an accepted key partner across the system in providing care. There is experience in managing redeployment already and any decisions regarding staff movement there is the ability to discuss in the correct internal forum initially.

Prioritisation of staff wellbeing across winter

- Initiatives are in place to support staff wellbeing across the winter: There is a OH/EAP offer and signposting through the weekly bulletin and internet. LSW have access to coaching, medication, professional advocacy alongside practice supervision and line management processes. LSW are able to consider risks in terms of employee wellbeing. Flu and Covid boosters are available to staff. Individual directorates have huddles, meetings which will provide some additional support in managing the day to day pressures. There is a Wellbeing group established.
- Plans in place to support a successful vaccination programme for influenza and Covid-19 (if recommended) for staff and volunteers: This has started currently, being publicised and promoted internally, staff have the ability to access vaccines externally depending on circumstances. Learning from previous programmes has been included and LSW are utilising a peer vaccinator approach.

Maximising the roles of Primary Care, Social Care and VCSE partners

- Assumptions made about the role of those partners in supporting the workforce this winter and maximising the roles: Partners are crucial in supporting an integrated offer this winter. LSW have good relationships with key stakeholders and already work collaboratively.

Devon Partnership Trust (DPT)

Taken from DPT Seasonal Operational Capacity and Resilience Plan 24-25.
The winter of 2024/25 is predicted to be another challenging one. DPT will likely experience a continuation of high operational pressure and staffing challenges and the ongoing impact of seasonal infections, in conjunction with the cost-of-living crisis, potential industrial action/GP collective action and civil unrest; requiring many aspects of the winter plan to be considered and adapted as we work through these predicted and unpredicted challenges. The health care system in Devon will also share the same challenges. The impact on partner organisations at different times this winter may also enhance the challenges DPT are expecting. Regular operational management meetings will continue within the organisation and healthcare system which will ensure appropriate command and control arrangements at all levels throughout this period. DPT will maintain a Winter Task Force [much like the ICC structure] that will be stood up from Mid-September 2024 until the end of March 2025 to manage these challenges.

Much of the work in previous plans has been implemented and continues to be in operation, including:

- First Response Service, including Crisis Cafes, 111 and 999 responses
- Crisis house in Exeter
- Liaison Psychiatry Core 24 delivery
- Home Treatment teams have been expanded and have been refocused on the function of home treatment
- Assertive Community Engagement, such as Voluntary Community and Social Enterprise (VCSE) provision
- Resource for MH Social Care Teams
- Discharge Facilitators. Repatriation Officers, In-Patient Care Coordinators
- Increased multiagency function within community services
- Silvercloud and Attend Anywhere – digital clinical platforms
- Preparing for Adulthood
- Section 12 App
- Additionally, we are planning on using Discharge funding to support several smaller schemes enabling flow, if funding is secure for 2024/5

DPT has a surge plan in place to deliver bed additionality and community options, dependent on winter funds being made available.

DPT Workforce winter plan

Ensure adequate staffing levels are in place to meet anticipated demand across winter

Unlike the acute Trusts peaks in demand for mental health services are usually between May and August each year. However, the Trust still suffers from the challenges of an increase in seasonal infections and the impact this has on staff and patients. Demand and capacity is mapped against previous years' actual demand and mitigations recorded in the main winter plan slide deck. DPT consider the staffing model is sufficient to deliver the planned care, urgent care staffing levels vary with

demand and acuity (business as usual) and are managed via substantive staff additional hours, bank or agency staffing (framework).

Based on last year's actuals for October 2024 to March 2025 the Trust used 19,000 bank shifts and 10,000 agency shifts, this was a mixture of backfill for vacancies, short-term absence, additional staffing for planned and unplanned patient acuity, and winter pressure). It should be noted that the use of agency staff has reduced (no Nursing off-framework agency used since 1st July 2024) and that as NHSP does not support long days the number of actual shifts may be greater as a long day will be recorded as 2 shifts as opposed to one as DPT would have recorded. The Trust works closely with NHSP/agencies (clinical staff excluding AHP's) to ensure all staff are appropriately trained before undertaking work for the Trust. Local induction is carried out as required. All other staff are via the Trust bank and staff are trained in line with all Trust policies and procedures.

How the system will work together to support one another from a workforce perspective

The safer staffing team has well-established processes with NHSP to deploy clinical bank (excluding AHP's which is via the Trust bank) staff as the need arises. They directly oversee the AHP and non-clinical bank staff. Use of agency staff is only from framework agency and subject to internal escalation for approval.

Prioritisation of staff wellbeing across winter

- DPT has a well-established staff well-being Hub Devon Wellbeing Hub.
- Planned absences will be highest over the festive period and DPT has well-established plans for these periods.
- The Trust is aligned with system partners to deliver a full vaccination programme to patients and staff, promoted via the intranet, screen savers, posters and peer vaccinators.
- Guidance around winter planning for travel is published on the Trust intranet (Daisy) alongside eLearning for driving in inclement weather (staff are encouraged to complete if they drive for work).
- The Trust has a number of initiatives to support ease of access to work salary deduction and salary sacrifice for cars and bikes. Arrangements with local bus companies for reduced-cost travel.
- DPT also has a memorandum of understanding with the Devon 4x4 volunteer drivers group to support staff travel should the inclement weather make travel to/from work challenging.

Maximising the roles of Primary Care, Social Care and VCSE partners

- The assumption is that system partners will maintain their current activity levels, with their own winter plans, unless additional winter funding from NHSE can be deployed to support the winter initiatives defined in the main winter plan.
- DPT is the lead provider in the Devon Mental Health Alliance.
- Management is overseen by the Devon Provider Collaborative

3.6 Primary Care

General Practice and Community Pharmacy are integral components of the urgent care system and are where most patients access advice and treatment for their urgent care needs. General Practice in Devon delivers over 35k patient contacts every day. The National General Practice Access Data tells us that General Practice in Devon is seeing 9.1% more patient contacts in 2024/25 than pre-pandemic levels.

As we approach winter all primary care providers will ensure they have taken the following steps as part of their core business operations:

For GP Practices this includes:

- Reviewing rota fill and staffing levels
- Reviewing and testing of Business Continuity Plans
- Ensuring “workflow” slot availability for 111 as per contractual requirement
- Looking at profiling of Enhanced Access capacity (to best fit with need/demand)
- Communications to patients regarding access to services, messaging regarding bank holiday provision and ensuing prescription requests are submitted in advance (backed up by ICB comms plan)

For Community Pharmacy this includes:

- Reviewing rota fill and staffing levels
- Reviewing and testing of Business Continuity Plans
- Ensuring resilient pharmacy rotas over weekends and bank holiday periods (led through the CCH)
- Promotion of Pharmacy first as appropriate

Without additional funding this winter, the actions available within primary care to respond to winter surge include:

- Practices continuing to triage to ensure best possible use of their planned capacity by meeting the needs of those with greatest identified clinical need, including by revising triage thresholds
- Potential stand-up the two planned revised PCN level models which include additional capacity (Sound and Torquay)
- ICB could request Practices stand down routine activity (e.g. LTC management) to refocus on urgent need

Additional Primary Care Schemes

Should additional winter funding be made available, Devon Collaborative Board would put forward the following primary care schemes (with the associated outcomes described below), that locality GP commissioning boards could opt to develop models to implement in their respective areas:

1) ARI Hubs

The additional resource will provide ARI surge capacity, supporting practices and PCNs to manage patients in primary care and avoid attendance at Emergency Departments or other urgent care settings.

Key outcomes/impacts

- Improved management of respiratory demand over winter though providing additional capacity to support primary and secondary care pressures.
- Reduced respiratory related accident and emergency attendances and acute, unplanned admissions.
- Reduced number of respiratory related calls to 999 and 111.
- Reduced delays in access to services and appropriate care through access to same day urgent assessment.
- Increased resilience across the Devon system through supporting general practice with increased capacity.
- Improved adult and children acute (respiratory) management in primary care.

Key measurables

- Number of referrals split by source.
- Total ARI appointments provided.
- ARI appointment outcomes.

2) Admissions Avoidance

The additional resource would support practices/PCNs over winter to pro-actively manage those patients most at risk of being admitted this winter. Most typically those with a high frailty score and / or End of Life patients.

Practices would work with secondary care colleagues to identify cohorts of patients where primary care intervention could reduce low value admissions and to identify and proactively manage high use patients. Interventions could include priority access by phone for those patients, priority access to vaccinations, completion or review of TEPs and ACPs and referrals to other services/community support including where appropriate third sector.

Key outcomes/impacts

- Reduction in unplanned admissions and A&E attendances across Devon.
- Prevention of exacerbations of known chronic health problems.
- Increase in the ability of vulnerable patients to remain healthy and safe at home this winter.
- Proactive identification where social care support is needed to allow earlier intervention.
- Reduction in the number of calls to 999 from high-risk patients.
- Reduction in the number of urgent contacts with Primary Care from high-risk patients.

Key measurables

- Patients at High Risk of Unplanned Admission to be identified with the clinical system.
- Number of admissions and A&E attendances for identified patients to be 'coded' during project duration.
- Recording of patient contacts by ARRS staff
- Recording of interventions for high-risk patients.
- Recording of the number of high-risk patient contacts with Primary Care.

3) Same Day Acute Need Primary Care Hubs

The additional resource would support same day primary care capacity through new models of delivery at PCN hub level. This would enhance the resilience of primary care as reduce the potential for overspill of activity to other providers

Expected outcomes/impacts

- Improved Sustainability of general practice
- Reduction in primary care patients being treated in the Emergency Department
- Improvement in patient satisfaction in access
- Improvement in staff wellbeing

Key measurables

- Net GP team capacity
- same day (%) performance
- PCN level ability to manage same day demand
- 'GP minors' walk in rates
- GPAS OPEL rating
- patient satisfaction pertaining to core access indicators
- practice resilience ratings

3.7 National guidance and planning

Since the Devon Winter Planning Team (WPT) was formed, NHS England have issued two communications regarding winter. The first instigated the process for submissions of High Impact Intervention returns and includes important guidance on maintaining patient safety and experience during times of winter surge, within temporary escalation spaces. The second communication required an SCC self-assessment.

Both documents have been considered by the WPT and the supporting provider level plans have been contributed to by the relevant Chief Nursing Officers and Chief Medical Officers

- PRN01454 – Winter and H2 Priorities Letter September 24
- PRN1560 – Temporary Escalation Spaces Principles September 24

3.8 NHSE 5 Ambulance Workstreams

NHS England (South West) is leading a programme of work to support the improvement of Ambulance Handover delays across the region. Over an initial period of 4 - 8 weeks there are nominated executive leads to support 5 key working groups that will meet and report back to a regionally led meeting weekly. The 5 groups include:

- Internal SWASFT actions
- System Care Coordination
- Alternative Community Pathways
- Hospital access and flow
- Timely handovers

The overarching aim of this work is to:

- ensure patients can access the right care in the right place at the right time
- identify and challenge the outputs by provider across the UEC system
- understand the clinical and operational factors influencing delays
- improve the patient's journey through the UEC system, both in hospital and in the community.

The output of this work will be shared with the national team who will oversee delivery against the proposed actions.

3.9 Winter Communications Plan

Devon ICS takes a system approach to winter communications planning. By working as a Devon system, we ensure we have one consistent approach to winter campaigns across both health and care services, and we ensure messages are targeted and timely. Communications are coordinated with a Devon-wide strategy, which includes themed weeks to ensure a consistent approach for maximum affect.

The national NHS winter campaign has been designed to reach the most vulnerable groups in our society providing them with clear, practical guidance on what they can do to stay as healthy as possible.

Messages are based on preventing infections (e.g., through effective hand and respiratory hygiene) and staying healthy, encouraging seasonal vaccine uptake, particularly amongst those at greatest risk and those experiencing health inequalities, and knowing which service you need, with a focus on helping to keep the elderly or those with long-term health conditions out of hospital.

At a local level, we also use the national branding and messages to target those areas where we need to raise awareness or increase our communications efforts. The Devon campaign aims to ease seasonal pressure on NHS services. It is designed to ensure that people who are most at-risk of preventable emergency admission to hospital are aware of and, where possible, are motivated to take, actions that may avoid admission this winter.

This plan supports our ambition to focus on addressing inequalities in uptake of vaccinations with a particular focus on areas of greatest need and defined cohorts who may be least likely to access vaccination and at-risk groups at higher risk of severe disease.

3.9.1 Approach

- Professionally developed, joined-up system approach to winter messaging.
- Informed by data and insight from previous campaigns, as well as learning from the COVID-19 vaccination programme and national messaging.
- Informed by behavioural science with behaviour change in mind.
- Ensure patients know where to go and reassure them services are there for them.
- Work closely with vaccination outreach teams to ensure that at-risk, vulnerable, and diverse communities are prioritised through innovative approaches.
- Explain to the public what we do to prepare for winter and reassure them on work underway to address the challenges.
- Recognise the difficulties people are facing in accessing GPs, waiting for ambulances, and accessing social care.
- Demonstrate good work that is going on to meet patient need across health and care and how additional winter funding is being used.
- Reassure patients about the commitment to providing good local services and help them make decisions about how and where to access care.
- Recognise the work of staff and impact positively on staff morale.

3.9.2 System priority areas for communications for 2024/25

- NHS 111 – choose well and behaviour change campaign to encourage contacting 111 before attending ED (online and phone).
- Seasonal vaccinations – Increase uptake in all eligible groups for flu, Covid-19 and RSV, with focus on outreach and health inequalities.
- GP access – Primary Care Access Recovery Plan: NHS App functionality, increasing self-directed care, implementing ‘Modern General Practice Access’, better digital telephony, care navigation, larger multidisciplinary teams
- Pharmacy and self-care – promoting Pharmacy First for minor illness, raising awareness of expanded pharmacy services, and local self-care campaign “Treatment starts at home”.
- Digital offer – online and video consultations, NHS app, NHS Quicker, ORCHA health and wellbeing app library, HANDi paediatric app.
- Mental health - support available for people, especially as we approach Christmas and New Year, 24/7 crisis lines, crisis cafes and talking therapies services.
- Inequalities – focus on diverse groups, working with local communities and community champions to undertake engagement and insight work, ensuring services are inclusive, translated, and easy read documentation. Support to access services and information outside of digital platforms, particularly for people with learning and/or physical disabilities.
- Early discharge – system-wide campaign to support early discharge from hospital and improve flow.

- Minor injuries and urgent treatment centres – localised campaigns by provider to promote MIU/UTC offer

3.9.3 Admissions avoidance

- A key element of the Devon system winter communications strategy is admissions avoidance.
- Part of this is development of a Stay Well campaign, developed with partner organisations, to help people remain healthy, with an umbrella title and branding that allow for local variation. This spans staying warm and preparing for cold weather, self-care, avoiding accidents, vaccination, fitness, and mental health
- More locally, this includes:
    - Promotion of The Moorings/crisis cafés (Devon Partnership NHS Trust)
    - One Plan for UEC (University Hospitals Plymouth NHS Trust) - the One Plan avoids admission by treating people in the community and as same day emergency care patients.
    - Healthy Lives Partnership in Plymouth with a focus on frailty (Livewell Southwest).
    - Promotion of NHS Quicker, with a new digital marketing campaign to increase awareness and usage of the app
    - Stay warm – working with local authorities, we will be incorporating messages targeting at older people with information on staying warm, advice on what to do if no longer in receipt of winter fuel allowance, signposting to warm spaces and other support

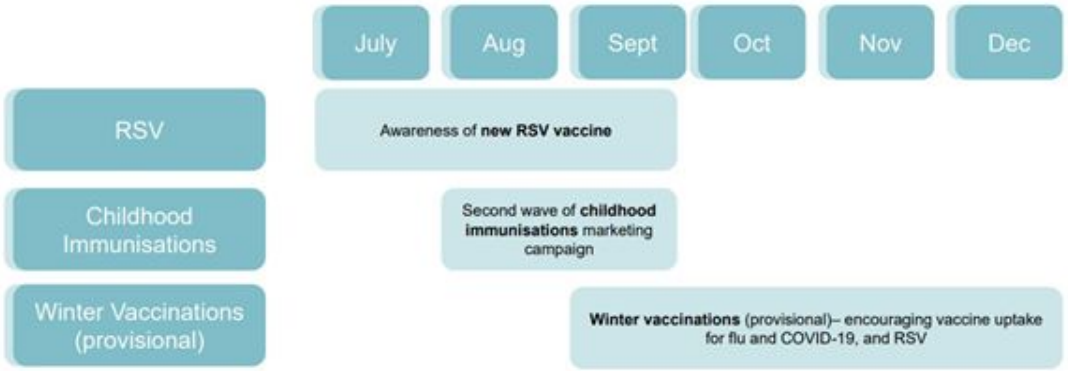
3.9.4 Media and resources

- Audiences are segmented and messages tailored to specific groups through local media and social media.
- Traditionally NHS Devon has gathered media and key stakeholders for a winter briefing, offering several interviews to cover a range of subjects including the plans for winter and the choose well messaging. This year, individual reporters will be targeted with media packages and specific projects, tailored to their area of interest e.g. NHS 111 and mental health (DPT and Livewell), Healthy Lives Partnership (UHP and Livewell), UEC pathways/MIU/UTC
- A wide range of paid and unpaid advertising channels are used across the system as part of winter marketing campaigns. They are all targeted, localised, and evaluated as being effective and value for money. These include:
    - Radio
    - Digital marketing
    - Social media
    - Print in newspapers and local magazines.
    - Outdoor advertising i.e. billboards and digital screens

3.9.5 Timeline

Phase 1 – Seasonal vaccinations

The flu, covid and RSV vaccination campaigns will run from September 2024, in line with the national marketing schedule.



Phase 2 - Winter

Wider winter messages and campaign will run from mid-October 2024 in line with the national marketing schedule.

September	October	November	December	January	February
Hypertension Know your numbers week	Boost your immunity – covid and flu	Keep warm & well	Keep warm & well		
Boost You Immunity - RSV				Mental Health	
Boost Your immunity – child flu		Boost your immunity – covid and flu	Pharmacy (winter messaging)		
	Pharmacy) half term		Pharmacy (prescriptions)		

3.9.6 Measuring impact and evaluation

Every year we fully evaluate our winter communications activities and provide an evaluation report for commissioners and learning from evaluations is factored into the development of this year's plan.

Measures include:

- Social media activity, reach, click through and engagement
- Digital marketing reports and insights
- Public recall survey
- Engagement with voluntary sector and Healthwatch
- Analysis of media coverage during periods of escalation and ED attendance data

4) What impact will the outputs of the 6 UEC focus areas have on performance over the course of the winter?

The UEC Implementation plan focuses on six initial core priorities identified through engagement and agreement with clinical leaders from across the system, with the starting point for each priority being to identify clinically agreed best practice (informed by National specifications where available) with the intention of rapidly embedding this across all sites in Devon. The agreed priorities being:

- Urgent Community Response
- Virtual Wards
- Community Falls, Frailty and End of Life
- Acute Frailty
- Same Day Emergency Care
- Urgent Treatment Centres

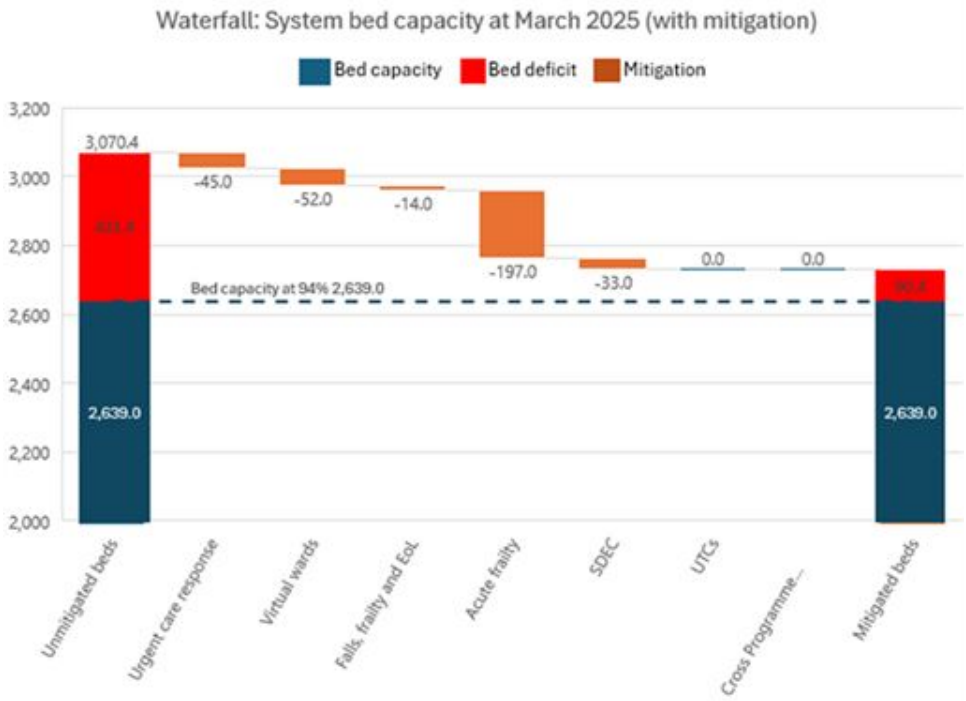
At a high level this plan will deliver:

- **136 fewer Ambulance Conveyances per month**
- **2765 fewer ED attendances per month** – By the end of March 2025 this will equate to an 11% reduction against currently planned activity.
- **962 fewer Emergency Admissions per month** – By the end of March 2025 this will equate to an 11% reduction against currently planned activity.
- **136 additional early discharges per month** against a daily number of undischarged patients with NCTR of between 189 and 282 (July-August 2024).

4.1 Mitigations

The waterfall diagram below shows the projected acute bed position in March 25 (assuming a 94% occupancy rate), along with the mitigations afforded by the UEC Recovery Programme outlined above. Assuming full realisation of all planned benefits would reduce 341 beds' worth of capacity in the system. This would result in a residual deficit of 90 beds. Given that the estimated bed deficit in the Devon system on an average day is 300, this would constitute a significant improvement on business-as-usual bed pressures.

Demand mitigation waterfall (March 2025)



However, the peak of demand during winter comes in January, where the unmitigated shortfall is 770 acute beds. The table below summarises the current modelled bed deficit over winter, offset by the mitigations within the 24/25 UEC Recovery Plan.

Waterfall summary table*

	Unmitigated bed equivalent deficit	Current UEC plan 24/25 mitigations	Bed equivalent remaining gap to be mitigated and managed
Oct	529.9	55.8	474.1
Nov	637.6	113.9	523.7
Dec	766.8	170.6	596.2
Jan	769.6	227.1	542.5
Feb	705.1	284.2	420.9
Mar	431.4	341.0	90.4

* Assuming 94% bed occupancy

There remains work to do with providers and partners to further reduce the bed equivalent remaining gap and this work is underway at time of writing. A combination of these additional mitigations plus the likely need for higher bed occupancy at times of peak pressure and robust system co-ordination and escalation actions will maximise NHS Devon's ability to keep ambulance delays to a minimum and reduce the risk of crowding in emergency departments

Clinical Directors will retain oversight of quality and safety throughout the period through our System Quality Group chaired by NHS Devon's Chief Nursing Officer

4.2 Additional Mitigations

Two additional sets of mitigations are being worked up and will be incorporated into the monthly waterfall projections. The first is the UEC reinvestment agreed by DIG in September and the second is the outputs of the 5 NHSE ambulance T&F groups that will report in the next couple of weeks. A third set of mitigations would also be available if any new winter monies are released.

In adding in any further mitigations to bolster the original trajectories agreed through the operating planning process, it will be important to avoid double counting of potential benefits.

5) How will we coordinate our actions as a system over the winter period?

5.1 System Coordination Centre

System coordination centres (SCC) were introduced by NHS England in 2022 to ensure the safest and highest quality of possible for the entire population by balancing clinical risk and escalation pressures within and across the entire system. This encompasses all acute, mental health, community, primary care and social care services. The SCC manages system pressures in line with the System Coordination Centre Standard Operating Procedure.

The NHS Devon SCC is situated at Aperture House in Exeter and ensures there is robust oversight of all system pressures. The SCC is operational 08:00-18:00, 7 days a week reporting to the Chief Operating Officer. Out of hours the ICB operates a manager and director on call rota with the director on call assuming responsibility for overseeing system pressures out of hours. A robust handover process occurs at 08:00 and 17:00 to ensure full visibility of pressures and risk going into any out of hours period. On call managers and directors chair any out of hours escalation call as required in line with the NHS Devon System Control Centre SOP and the NHS Devon Surge and Escalation SOP which can be viewed in the attached link.

Within Operating hours, the SCC utilises the SHREWD resilience dashboard and SWASFT ambulance monitoring to ensure constant monitoring of pressures within the system. The SCC will lead on the managing of pressure, demand and capacity within the system as follows:

- Collation of information from providers at to enable accurate system Opel level score at 10:00 daily. This is automated within SHREWD and reviewed in advance of each system call.
- Leading daily system calls at 11:00 and 16:30 each day. These calls enable early identification of potential isues and manage actions to rectify.
- Manage ambulance handover delays in line with the regional standard operating procedure
- Attendance at regional and national reporting and escalation calls as required.
- Initiating additional escalation calls, including GOLD escalation, in line with the surge and escalation SOP as required

Following the winter of 2023/24 the System Coordination Centre (SCC) took the opportunity to review and debrief our performance, processes and policies to identify opportunities for further improvement during 2024/25. From this process we were able to identify and implement the following key changes:

- Increase staffing levels to ensure greater seniority on each shift and enable more robust SCC leadership.
- Increased the operating hours of the SCC to provide greater cover for the system and reduce burden on on call teams.
- Reviewed the SCC against the NHSE SCC maturity indices and improved the maturity of the SCC by developing procedures and policies identified in the review. This has led the NHS Devon SCC to be recognised as the exemplar SCC in the region.
- Developed a robust induction and training programme for all staff with monthly refreshers.
- Developed a process of HOT debrief to enable any learning from incidents managed with an escalation route to directorate senior leadership team where required.
- Improved weekend and ‘holiday’ planning and briefing procedures to support out of hours management and on call teams.

System Escalation and Surge
NHS Devon Integrated Care Board (ICB) has a responsibility to manage and co-ordinate the response to surge pressures within the Devon Integrated Care System (ICS). This is achieved by through the NHS Devon Surge and Escalation Framework (Annex 2) which clearly identifies the escalations triggers and thresholds, the escalation meeting cadence, and the actions to be undertaken to enable de-escalation.

6) If additional winter monies were to be made available, what principles would we recommend are applied to realise maximum benefit, and what potential schemes do we have ready to go?

In previous years there has often been centrally issued extra funding to help relieve winter pressures. This is typically announced at short notice and with compressed turnaround timescales for the allocation and spend. In order to try and avoid a

recurrence of this situation, the Unscheduled Care Board has asked the Devon Winter Planning Team to develop principles that we suggest should be applied if similar allocations are announced for winter 24/25. This is done in the knowledge that no money may be forthcoming, and – if it is – it may well come with certain requirements or hypothecations that could make some of the following principles not applicable.

6.1 Proposed winter funding principles and priorities

a) Schemes must be compliant (or working toward compliance) with Devon core UEC clinical model and 24/25 recovery plan – which includes being in line with national guidance/ best practice.
b) Schemes should address the key drivers of UEC pressure, as set out in the Analysis section of this document and the wider Devon UEC Story.
c) In particular, schemes that aim to further reduce the number of frail elderly people attending ED, avoiding admission and reduced length of stay will be prioritised.
d) Similarly, schemes that aim to reduce the number of young children needing hospital attendance and admission will also be promoted.
e) Proposed schemes should provide an evidence base to provide assurance that proposed interventions would have the intended impact and will deliver value for money.
f) All sectors should be considered in the allocation of funding (community, primary care, mental health acute, social care and the VCSE) and set against the priorities set out above.
g) Consideration of fair shares, based on weighted population, need should be included in the allocation process.
h) Any resources allocated under such a process would be with the clear understanding that the funding would end at the agreed date, and clear exit plans should be agreed in advance so there are no risks of “cliff edge” issues or ad-hoc requests for funding extensions.

Whilst the WPT are keen to avoid duplication and will therefore issue any existing plans to avoid the requirement to translate the document into a different format. A standardised Devon Investment Group template has been developed and is available in.

A group of individuals to score proposals and thereby make recommendations on winter funding (should it become available) will be agreed by the WPT. If such a group would be needed, they would quickly convene and run through some example proposals to test the process before staring the scoring of the actual bids. Clearly, no individual would be able to sit on such a group if they have a personal or organisational interest in the outcome. This group may choose to consider the merits of a group of proposals collectively where there are overlaps or similarities that would make individual scoring unhelpful.

Ultimately, final decision-making on the allocation of funds rests with the organisation/ responsible officer(s) that have the statutory accountability for that spend. However, it

is suggested that the Devon UEC Clinical Reference Group and Unscheduled Care Board are asked to make recommendations on the allocation of any funds (should they appear and assuming agreement of the principles listed above). A long list of potential schemes received that the Winter Planning Team to date are included below.

1. CYP virtual ward (respiratory pathway)
2. Freeing up space on paediatric wards for seasonal demand
3. Primary Care:
    a. ARI Hubs
    b. Primary Care: Admissions Avoidance
    c. Primary Care: Same day acute
4. RDUH:
    a. Additional Medical Shifts (ED)
    b. SDEC expansion
    c. Supernumerary nurse in ED
    d. Extended GP streaming
    e. Extended GP streaming
5. LSW: Discharge to Assess Flow
6. North Devon Primary Care – Urgent and Emergency Care Service

7) What are the success criteria by which we can judge if this plan has been effective?

It is important that plan like this sets out in advance the criteria by which it should be judged, both during the period that the plan is live, as well as a retrospective assessment of impact to allow learning to be applied for the following winter.

The following success criteria are proposed:

a) Delivery against agreed operational plan performance trajectories (Section 3).
b) Implementation of the recommendations of the NHSE 5 ambulance Task and Finish Groups (Section 3.8)
c) Realisation of additional benefits from the 6 UEC Priority Group areas (Section 4).
d) Impact resulting from our communications plan (as summarised in Section 3.9.6)
e) Management of the key risks identified through the winter plan (Section 5.3).
f) Fewer System Critical Incidents declared in comparison to Winter 23/24 (Section 5.1.1)
g) If required, timely agreement of winter funding allocations (Section 6.1).
h) If forthcoming, delivery against the additional benefits supplied by winter funding .

Terms and Acronyms

Not every one of these terms appear in this plan, however, you may see or hear them referenced if you use our urgent and emergency care services.

A&E	Accident and Emergency
AMU	Acute Medical Unit
ARI	Acute Respiratory Infection
CRG	Clinical Reference Group
CQC	Care Quality Commission
CYP	Children and Young People
DN	District Nursing
DoS	Directory of Services
ED	Emergency Department
EPRR	Emergency Preparedness Resilience and Response
G&A	General and Acute
GP	General Practitioner
HIU	High Intensity User
ICS	Integrated Care System
IPC	Infection Prevention and Control
IUCS	Integrated Urgent Care Service
LA	Local Authority
LCP	Local Care Partnership
LoS	Length of Stay
MDT	Multi-disciplinary Team
MH	Mental Health
NCTR	No Criteria to Reside
NHSE	National Health Service England
OOH	Out of Hours
PCN	Primary Care Network
SDEC	Same Day Emergency Care
SPOA	Single Point of Access
UCB	Unscheduled Care Board
UCR	Urgent Community Response
UEC	Urgent & Emergency Care
UTC	Urgent Treatment Centre
VCSE	Voluntary, Community and Social Enterprise

List of Annexes to this document

Annex 1 – Draft Devon System Surge and Escalation Framework
Annex 2 – Draft System Control Centre SOP
Annex 3 – Escalation Protocol for Adults with Mental Illness

NHS Devon

NHS Devon Integrated Care Board

Intensive and Assertive Outreach Review (Mental Health)

Date of meeting	Date report produced
28 November 2024	28 October 2024

Author(s)		Report approved by	
Name and title:	Jacquie Mowbray-Gould Director, Mental Health, Learning Disability and Neurodiversity Collaborative	**Name and title:**	Peter Collins Chief Medical Officer
Phone:		**Date:**	4 November 2024
Email:	Jmowbray-gould@nhs.net		

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
N/A

Executive summary
In light of the recent high profile Valdo Calocane case, NHS England (NHSE) requires Integrated Care Boards to coordinate an urgent assessment of the current provision of intensive and assertive outreach services and that initial findings and anticipated actions are discussed at Board meeting in public. Following a review led by the Mental Health, Learning Disability, and Neurodiversity (MHLDN) Collaborative, looking at services provided by Devon Partnership NHS Trust (DPT) and Livewell Southwest (LSW) this report highlights

current gaps in service and support to those facing barriers to traditional mental health services.

Key findings reveal that, while about 30% of the approximately 600-person cohort meeting the NHSE specified needs currently receives intensive support, the remaining 70% often experience limited engagement due to capacity constraints. Community Mental Health Teams (CMHTs), typically managing high caseloads averaging 40 cases per practitioner, face challenges delivering intensive care at this scale. With the recommended caseload level for intensive care being 10–15 individuals per practitioner, current arrangements impact service efficacy and continuity.

Immediate mitigating actions suggested by the MHLDN Collaborative team, with minimal resource implications, include revising monitoring protocols, enhancing family engagement, and establishing a centralised register for high-risk individuals to strengthen tracking and follow-up.

In the longer term working alongside and with the MHLDN Collaborative, the recommendations anticipate the need to better understand the current commissioned service and to co design a sustainable service that can better meet the needs of the total population at risk. Changes to the service requiring new resource will require alignment with national planning and incorporation into planning rounds for 2025/26 and beyond.

NHS Devon is requested to:

- review these key points understand the current service provision and current risk; and
- to support a programme of work by NHS Devon with the MHLDN collaborative to progress immediate actions, and better understand the service transformation (any associate resource requirements) required to better serve a significantly vulnerable and at risk population.

Committees that have previously discussed/agreed the report, and outcomes of that discussion

This work has been led and completed by the MHLDN collaborative and the NHS Devon Head of Mental Health Commissioning on behalf of NHS Devon. The collaborative governance forums have reviewed and responded accordingly and DPT and LSW Boards have discussed the outcomes of this review to consider actions needed. The NHS Devon Executive considered this report at its meeting on 5 November 2024.

Key recommendations and actions requested

AGREE that NHS Devon should commission a programme of work in partnership with the MHLDN Collaborative to understand and improve the current provision and delivery of Intensive and Assertive Community Mental Health Treatment services, designing a sustainable deliverable and effective target operating model for the at-risk population in Devon.

ENDORSE immediate minimal-cost actions for providers, including Devon Partnership NHS Trust and Livewell South West, to implement immediate, low-cost interventions that address urgent needs within the current system.

NOTE the inherent risks and requirement for robust risk management recognising that, despite enhanced governance and programme improvements, the inherent risks associated with this high-risk group cannot be entirely mitigated. Strong governance and risk monitoring are essential to manage and respond to residual risks effectively.

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	Enhanced wellbeing and health outcomes for individuals with severe mental illness, particularly those needing intensive and assertive community care. Early intervention and targeted support will reduce health inequalities and prevent deterioration of conditions.
Improve services and reduced unwarranted variation	Standardised, high-quality mental health services across all providers. Reducing variation in service delivery ensures equitable care for all patients, addressing regional disparities and enhancing access to appropriate support.
Make more efficient use of our resources	Optimised allocation of resources through better workforce planning, integrated services, and targeted interventions. By improving operational efficiencies, we can reduce pressure on acute services and focus resources on prevention and early support.
Develop our culture and how we operate	A more collaborative, learning oriented culture that encourages cross-organisational cooperation. Improved staff engagement, training, and reflective practice will ensure a proactive, patient centred approach to delivering care, fostering innovation and continual service improvement.

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	The review and subsequent plans highlight gaps in pathway provision, such as the inability to provide intensive support to the full patient cohort via Community Mental Health Teams. Actions to improve workforce capacity to meet demand,

	training, and governance will be essential in raising the quality and consistency of mental health services across providers.
Health inequalities	The report identifies that certain vulnerable populations, particularly those with complex needs like homelessness and substance misuse, are not receiving the level of support required. Addressing these gaps will reduce health inequalities and ensure equitable access to intensive community care.
Workforce	Workforce shortages and training gaps will be a barrier to delivering comprehensive care pathways. The report also calls for improved staff wellbeing through supervision and reflective practice.
Resources and finance	There are financial implications related to any expansion of workforce capacity, enhancing training, and integrating services. Addressing the demand-capacity gap will require additional funding, and NHSE support is likely needed for resource allocation (MHIS/SDF).
Legal	Ensuring compliance with national guidance and legal frameworks is essential, particularly in areas such as safeguarding, the Mental Capacity Act, and the Mental Health Act. Policies need to be continually reviewed to remain legally compliant
Digital and Data	The report highlights a need for improved data collection and integration across health and social care services. Enhanced data dashboards and analytics will help monitor patient outcomes, track service effectiveness, and align resources with demand.
Engagement and consultation	Continued engagement with VCSE partners, patients, and experts by experience is vital. Incorporating their insights into service design and delivery will ensure services are more person-centred and responsive to patient needs. There may be further consultation required with stakeholders to address identified system wide gaps.

NHS Devon

NHS Devon Mental Health, Learning Disability and Neurodiversity Provider Collaborative

Intensive and Assertive Community Mental Health Treatment

Purpose

1. This report outlines the steps required to improve the provision of an intensive response for people with severe mental illnesses, such as psychotic illnesses and bipolar affective disorder, across Devon. The report responds to a directive from NHS England (NHSE) following the Valdo Calocane case, which highlighted gaps in care for high-risk individuals who struggle to engage with traditional mental health services. The focus is on both immediate actions with minimal resource implications and longer-term actions that will need to align to national guidance, as it is developed, and the operational planning guidance for 2025/26.

Scope: defined by NHSE September 2024

2. The group under consideration includes individuals who:

- Are presenting with psychosis (but not necessarily given a diagnosis of psychotic illness)
- May not respond to, want to or may struggle to access and use ‘routine’ monitoring, support and treatment.
- Lack insight into their condition and struggle to remain concordant with any treatment.
- Are vulnerable to relapse and/or deterioration with the potential for serious subsequent harm (e.g. suicide, neglect, violence and aggression)
- Have multiple social needs (housing, finance, self-neglect, isolation etc)
- Likely present with co-occurring problems (e.g. drug and alcohol use/dependence)
- May have had negative (e.g. harmful and/or traumatic) experiences of mental health services or other functions of the state (e.g. the criminal justice systems)
- Concerns may have been raised by family / carers.

Key Findings

- **Service Gaps**: 30% of the identified cohort of circa 600 currently receives intensive support, 70% do not. These individuals often face challenges such as homelessness and substance misuse, making engagement with services difficult. These findings are similar in other ICBs- regionally and nationally.

- **Workforce Constraints**: Current Community Mental Health Team (CMHT) caseloads are around 40 cases per practitioner, significantly higher than the recommended cap of 10–15 cases per practitioner for those requiring

intensive support. Without reducing these caseloads, practitioners in CMHTs are unable to provide the level of care and oversight needed for this high-risk cohort.

- **Need for Additional Specialist Support**: To manage these caseloads safely, there is a critical need for additional nurses, allied health professionals, peer support workers, psychologists, and psychiatry resources. In addition, the system needs to support improved access to bespoke housing alongside redesign of substance misuse services to ensure this group of people can access the care they need. These roles and commissioning changes are essential to ensure holistic care, including mental health interventions, substance misuse support, and housing assistance.

Enhanced Service Provision by Specialty Teams:

3. A substantial portion of the intensive support provided currently to high-risk individuals in Devon is currently delivered through Early Intervention in Psychosis (EIP), Community Forensic Teams, and Community Rehabilitation Teams. These specialty services deliver care to approximately 30% of the individuals in the cohort and offer a more comprehensive support model compared to standard CMHT provisions. Features of these teams include:

    - **Capped Caseloads**: Specialty teams operate with capped caseloads of 10–15 individuals per practitioner, a necessary cap to ensure that practitioners can deliver the intensity of care required. This approach allows these teams to engage more thoroughly with each individual, addressing complex needs more effectively.

    - **Enhanced Psychological Support**: These services include additional psychological input, critical for managing complex cases involving psychosis, substance misuse, and high levels of social vulnerability.

    - **National Training and Development**: Staff within these services often undergo nationally prescribed training programmes funded through national training budgets. These programmes include specialised training in managing severe mental illnesses, risk assessment, and trauma informed care.

    - **Higher Operational Costs**: Due to the capped caseloads, additional psychological input, and specialised training, these enhanced services are significantly more resource intensive. Managing cases at a ratio of 10–15 individuals per practitioner is approximately three times more expensive than CMHTs, which typically manage 35 to 40 cases per practitioner.

Next Steps:

Governance and Oversight:

- The ICB will consider the most appropriate approach to the delegation of oversight of the Intensive Outreach programme to the Mental Health, Learning Disability, and Neurodiversity (MHLDN) Collaborative. The MHLDN

Collaborative will be responsible for delivering the programme and reporting back to the ICB via the relevant Committee. This governance structure ensures cross organisational coordination and regular updates on progress, risks, and resource needs, ensuring that the programme remains aligned with NHS Devon's strategic objectives and required response to NHSE.

Immediate Actions - Providers (Minimal Cost):

- **Embed Did Not Attend (DNA) Policies**: Providers to ensure that Did Not Attend (DNA) is not used as a reason for discharge for high-risk individuals who meet the scope set out by NHSE.

- **Strengthen Family and Carer Involvement**: Develop family inclusive care plans and provide direct access to care coordinators for families to raise concerns.

- **Centralised Register**: providers to consider the establishment of a centralised register of high risk individuals, supported by regular daily huddle risk assessment meetings (or similar) across care teams to monitor engagement and follow up.

- **Distance Monitoring Protocol**: Implement protocols for low intensity, proactive monitoring of disengaged individuals using digital means (e.g. SMS check-ins, phone calls, home visits, routine family contact)

Longer Term Actions as part of the developing programme of work Commissioners and Providers (High Cost)

Workforce Strategy and Caseload Management:

- **Current Challenge**: CMHT practitioners are managing caseloads of approximately 40 individuals each. This is unsustainable for providing intensive support and risks poor outcomes for those with the most complex needs.

- **Recommended Caseload Cap**: To provide safe, effective care, caseloads for practitioners managing the high-risk cohort will need capped for **some** of the CMHT workforce to between **10–15 individuals** per practitioner. This will allow for more personalised and intensive support, improving outcomes and reducing the risk of disengagement.

Workforce Expansion: The delivery of this model will require:

- **Additional Care Coordinators**: Recruiting **19–30 Band 6 case managers/named practitioners into CMHTs** to reduce caseloads to the safe level of 10–15 individuals per practitioner.

- **Specialist Support**: Expanding **peer support**, **psychology**, and **psychiatry** services to provide a multi-disciplinary approach to care. These additional roles will ensure that individuals receive holistic, person-centred care,

including mental health interventions, substance misuse support, and assistance with housing and social needs.

Financial Planning and National Alignment:

- **Resource Intensive Actions**: Longer term actions, such as workforce expansion and implementing the full Intensive outreach model, will require financial resources. These actions will be considered as part of NHS Devon's **2025/26 operational planning**, hopefully aligning with NHSE national operational planning guidance once released.

- **Short Term Focus on Minimal Cost Actions**: In the interim, NHS Devon should prioritise actions with minimal cost, encouraging providers to revise policies, improving family engagement, consider a distance monitoring policy and implement some form of centralised register for this group

Acknowledgement of Risk:

- **Risk Management**: The nature of the population served means that full risk mitigation is unlikely. While the recommended actions aim to reduce risks and improve engagement, NHS Devon must recognise that some level of risk will remain, even with enhanced service delivery and workforce capacity. This understanding must be factored into the programme's governance and risk management framework.

Conclusion:

4. The Valdo Calocane case highlights the urgent need to address gaps in intensive mental health care for high-risk individuals in Devon. By capping caseloads for the workforce who care for this group at 10–15 individuals per practitioner and expanding the workforce to include peer support, psychology, and psychiatry, NHS Devon can ensure more comprehensive, person-centred care. Immediate actions can be taken with minimal cost, while longer-term resource needs will be addressed through national and local planning processes. NHS Devon is asked to acknowledge the inherent risks in working with this complex population and ensure that robust governance structures are in place to manage challenges noting not all risk will ever be fully mitigated.

5. The NHS Devon Board is asked to:

   - **AGREE** that NHS Devon should commissions a programme of work in partnership with the MHLDN Collaborative to understand and improve the current provision and delivery of Intensive and Assertive Community Mental Health Treatment services, designing a sustainable deliverable and effective target operating model for the at-risk population in Devon.

   - **ENDORSE** immediate minimal-cost actions for providers, including Devon Partnership NHS Trust and Livewell South West, to implement immediate, low-cost interventions that address urgent needs within the current system.

- **NOTE** the inherent risks and requirement for robust risk management recognising that, despite enhanced governance and programme improvements, the inherent risks associated with this high-risk group cannot be entirely mitigated. Strong governance and risk monitoring are essential to manage and respond to residual risks effectively.

NHS Devon

NHS Devon Integrated Care Board

Adoption of the Safe Learning Environment Charter

Date of meeting	Date report produced
28 November 2024	14 November 2024

Author(s)		Report approved by	
Name and title:	Stevie Morris Learning, Education and Clinical Workforce Lead	**Name and title:**	Piers Tetley, Chief People Officer
Phone:		**Date:**	14 November 2024
Email:	stevie.morris1@nhs.net		

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
N/A

Executive summary
Integrated Care Boards (ICBs) and NHS providers have been asked to sign up to fulfilling the standards of NHS England's Safe Learning Environment Charter. The Charter was developed in the context of widespread feedback of learner experience allegations across the NHS and a lack of robust organisational action to prevent, detect and respond.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
The NHS Devon Executive reviewed this at its meeting on 04 October 2024.

Key recommendations and actions requested
AGREE that NHS Devon should become a Safe Learning Environment organisation and sign up to the Safe Learning Environment Charter.

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	Safe Learning Environment Charter will demonstrate the impact on services and provide mitigations and recommendations as required
Improve services and reduced unwarranted variation	
Make more efficient use of our resources	
Develop our culture and how we operate	Safe Learning Environment Charter will enable our culture to be open and transparent of the impacts on learners, demonstrating clearly how the organisation operates

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	The Safe Learning Environment Charter assesses how changes in learning environments affect the quality of learning and impact on quality of services delivered. This includes evaluating whether services meet the expected standards, are safe, good quality, equality, and a positive experience for people.
Health inequalities	The Safe Learning Environment Charter reviews how learners are impacted through disparities in health outcomes among different population groups.
Workforce	The Safe Learning Environment Charter reviews the impact the workforce has on learners.
Resources and finance	None
Legal	None
Digital and Data	None

Involvement, Engagement and consultation	The Safe Learning Environment Charter considers how we will involve and engage learners

Adoption of the Safe Learning Environment Charter

Introduction

1. The Safe Learning Environment Charter is a new national charter that was published early 2024 to drive improvements and consistency of the safety and quality of learning within the clinical environment.

2. It is inclusive of all professional disciplines (clinical and non-clinical), representing and advocating for all levels and types of learners within any clinical / care environment.

3. Aligned to wider people agendas such as the People Promise, Equality Diversity and Inclusion and the NHS Long Term Workforce Plan, it aims to bring parity and equity to learners whose experiences aren't captured and included within existing people strategies. This charter is therefore seen as the “People Promise for learners”.

4. It is a vital mechanism to enable and drive forward wider workforce transformation aspirations and system recovery priorities as learners will want to transition to substantive employees.

Background

5. National and regional feedback mechanisms through the National Education Training Survey (NETS), General Medical Council (GMC) survey, National Students Survey, local academic institutes programme and placement evaluations affecting the retention of talent in pre-registration programmes highlighted deteriorating and challenging experience of learners in 2022.

6. The Ockenden report (2022) prompted the NHS Workforce, Transformation and Education Maternity Programme team to undertake a mapping exercise of all Immediate and Essential Actions (IEAs). Demonstrating the need to gain a better understanding of the student experience, quality of clinical placements and culture of the placement environment.

7. The NHS England (NHSE) undertook the first nationally co-ordinated Quality Review of Pre-registration Education focusing the multi-professional health students in the South West and midwifery across the rest of the country.

8. Between November 2022 and February 2023, the NHSE South West’s Workforce Transformation and Education team conducted feedback events capturing experiences, perspective and views of circa 2,500 learners and educators across pre-registration nursing, midwifery, allied health professionals, pharmacy, health care scientist learners, newly qualified registrants and clinical educators across the South West

9. The Health and Society Knowledge Exchange (HASKE) was commissioned to undertake thematic review of the data from across the national and regional Focus Groups resulting in the recommendation of the development of a Safe Learning Environment Charter to cover all professions across England.

10. The Charter has been developed in alignment to multiple national and local policy, strategies and functions regarding workforce, patient safety and quality (see Appendix B).

Context and System Position

11. The Safe Learning Environment Charter has in the first instance been launched in the South-West region only.

12. The One Devon Integrated Care System (ICS) is the first system to launch a system approach to implementing the Safe Learning Environment Charter.

13. NHS Devon has already established a programme of work to support system providers, this includes a system focus event that was held in June 2024, with communities of practice and strategic working groups with strong provider engagement and collaboration.

14. Within the One Devon ICS the following providers are already signed up to the Safe Learning Environment Charter

    - Royal Devon University Healthcare NHS Foundation Trust
    - Torbay and South Devon NHS Foundation Trust
    - Devon Partnership NHS Trust
    - Livewell Southwest
    - University Hospitals Plymouth NHS Trust

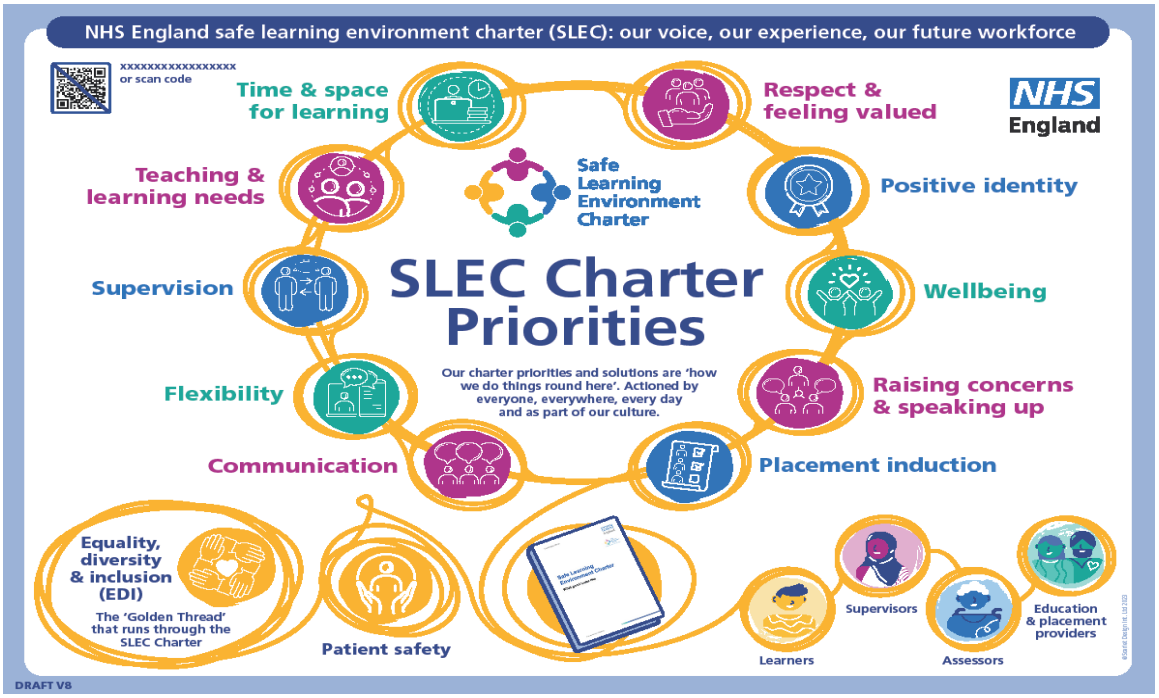
15. The programme of work is connected to and integrated into the delivery of several key NHS Devon ambitions and priorities within the workforce supply, retention and transformation agenda including.

    - Apprenticeship Strategy,
    - Advanced Practice Strategy,
    - Learner experience,
    - Placement Expansion,
    - Educator Workforce Strategy
    - Workforce Attraction, Supply
    - Workforce Retention,
    - Workforce Transformation

16. Devon’s approach is inclusive of people professions and non-registered workforce, across health and social care settings, recognising the breadth and scope of learners required to deliver high quality care to the population to Devon.

17. The Safe Learning Environment Charter has 10 pillars (see diagram 1) outlining good practice, responsibilities and expectations of learners, care providers and education providers prioritising the key enablers of change highlighted from the HASKE recommendations.

Diagram 1: 10 Pillars of the Safe Learning Environment Charter



Safe Learning Environment Charter

18. The 10 pillars will be assessed at provider level via a Maturity Matrix which will feed into the development of system Maturity Matrix dashboard to highlight areas of challenge as well as exemplars of best practice to identify opportunities for early intervention and transfer of best practice.

19. This approach will enable triangulation to other metrics such as the People Survey, Retention and Workforce Data, Patient Safety and Quality data to indicate areas of poor practice and culture and consider appropriate support, intervention and oversight from the provider and NHS Devon.

20. The Safe Learning Environment Charter reduces the gap between health, care and education providers to strengthen the shared responsibilities in the delivery of quality education and learning experiences (Figure 1)

21. Utilising existing feedback and assessment mechanisms such as the National Education Training Survey, alongside the self-assessment maturity matrix, will provide the assurance and oversight of the success and implementation of the Charter (Figure 2).

22. From a system perspective, we are working through with providers and the regional NHS England team how we get assurance on the impact of the safe learning environment charter being implemented and any issues arising.

23. Through adopting the Safe Learning Environment Charter, NHS Devon will be one of many organisations across the South West to published by NHS England as a safe learning organisation.

Figure 1 – shared responsibility and governance of learning experiences at provider, ICB and regional levels.

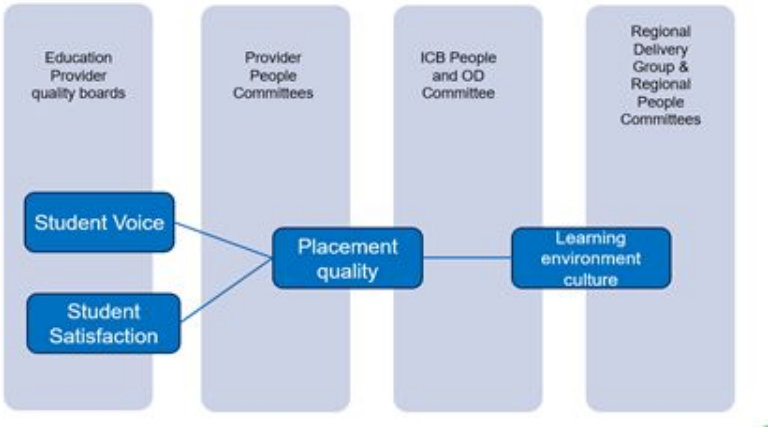
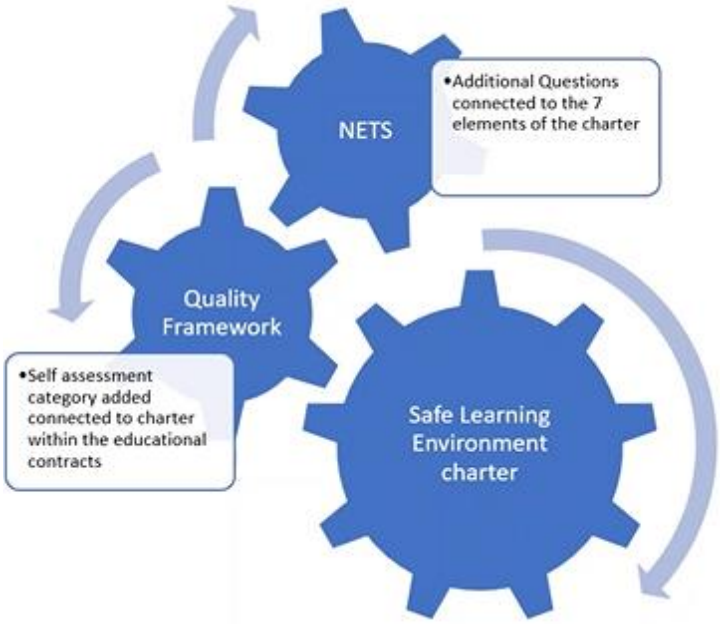


Figure 2: Interconnected feedback and assurance mechanisms



Compliancy Monitoring of Safe Learning Environment Charter

24. NHS Devon holds a safe learning environment community of practice with providers and academic institutions to work through each element of the charter, providing evidence of compliance against the 10 aspects of the charter.

25. The learner councils will be implemented within providers, with the outcomes being shared at NHS Devon's learner council and Learning and Education group, this enables NHS Devon to have direct understanding of the impact of implementation of the 10 aspects of the charter.

26. A quarterly report will be provided to the learning and education strategic oversight group and will be incorporated into an overall report to People and OD committee.

Recommendation

27. The Board is asked to **AGREE** that NHS Devon should become a Safe Learning Environment organisation and sign up to the Safe Learning Environment Charter.

Appendix A

Safe Learning Environment Charter

Respect and feeling valued
Learners are respected and feel valued in the learning environment, demonstrated by effective communication and engagement.

Positive identity
Learners are easily identified and viewed positively within the clinical environment.

Wellbeing
Learners understand the importance of physical, emotional, and psychological safety and are aware of services and resources that can support their health and wellbeing.

Raising concerns and speaking up
Learners know how to raise a concern and feel empowered to speak up, knowing that they will be appropriately supported.

Placement induction
Learners receive a placement induction that supports their learning and adequately prepares them for their roles. Placement induction processes are well-established and evidenced to support learners.

Communication
Learners have a clear pathway for support from both the education provider and the placement provider. They know by whom, when and how that support is delivered.

Flexibility
Learner wellbeing and professional development is supported by flexible working and learning practices, both in terms of accessibility to facilities and to forms of educational opportunities.

Supervision
Learners are supported by positive role models and appropriate levels of supervision. Continuity of supervision builds on individual learning needs, develops confidence and proficiency.

Teaching and learning needs

Learners are supported by supervisors who are adequately prepared for the role and understand the underpinning principles regarding how individuals learn in a practice setting. They are recognised as learners rather than workers and enabled to develop towards independent practice.

Time and space for learning

Learners are given time to reflect on and process learning experiences. They receive regular verbal and written feedback, providing opportunities for development and assessment to occur.

Appendix B

Policy Alignment

- The NHS Long Term Workforce Plan (2023) which emphasises the importance of nurturing the next generation of our workforce, workforce expansion, reducing attrition and improving retention. Enabling our NHS to be a safe environment for learners, staff, and patients.

- The NHS Educator Workforce Strategy (2023) which sets out actions to increase educator capacity and ensure that educators are adequately prepared for their role.

- The NHS England Equality, Diversity, and Inclusion (EDI) improvement plan (2023) which presents targeted actions to address the prejudice and discrimination – direct and indirect – that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce.

- The NHS People Promise (2021) which sets out the themes to describe how we should work together to improve the experience for everyone working in the NHS.

- The NHS England Education Quality Framework (2021) which details quality standards for the clinical learning environment and guides quality assurance processes.

- The NHS Health and Wellbeing Framework (2021) which sets out the strategic framework for NHS organisations and applies to placement providers.

- The NHS England Patient Safety Strategy (2019) which highlights the importance of continuous improvement work for developing effective patient safety systems and for embedding a patient safety culture across all settings of care.

- Devon Joint Forward Plan (2023) which highlights the priority to delivery solutions enabling the attraction, recruitment and retention of talent within our system provider

NHS Devon Integrated Care Board

Quality Report

Date of meeting	Date report produced
28 November 2024	11 November 2024

Author(s)		Report approved by	
Name and title:	John Trevains, Deputy Chief Nursing Officer Sara Wright, Head of Nursing & Quality	**Name and title:**	Penny Smith, Chief Nursing Officer
Phone:		**Date:**	11 November 2024
Email:	Sara.wright4@nhs.net		

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
N/A

Executive summary
The quality report provides a summary of key quality information, in the format of both quantitative and qualitative data. Sources range from NHS Devon data collection including patient experience; and direct from NHS Devon Nursing and Quality Directorate teams involvement in partner meetings, groups, quality committees and workstreams. The report is divided into sections but seeks to evidence the triangulation of quality information around key issues identified through quality governance process.

Section	Assurance	Trend from previous month
Overall assurance	**Satisfactory**– (areas of concern have additional focus and mitigating actions)	**No change**

Committees that have previously discussed/agreed the report, and outcomes of that discussion
Considered by the NHS Devon Executive at its meeting on 5 November 2024. Considered by the Quality and Patient Experience Committee at its meeting on 14 November 2024.

Key recommendations and actions requested
AGREE the overall assurance level relating to the quality position of the One Devon Integrated Care System as **satisfactory** and that adequate plans are in place to mitigate and improve quality risks.

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	All
Improve services and reduced unwarranted variation	
Make more efficient use of our resources	
Develop our culture and how we operate	

Outline the implications of matters covered in this report for the following areas	
Area	
Quality of services	Delivery of high-quality services.
Health inequalities	Addresses health inequalities.
Workforce	Addresses impact on workforce.
Resources and finance	Delivery of financial sustainability
Legal	None
Digital and Data	Identifies areas of risk and improvement required.
Engagement and consultation	Addresses experience and engagement.

Quality Report

Introduction and background

1. The quality report seeks to systematically report evidence and triangulate quality information around key issues identified through quality governance processes in line with NHS England (NHSE) guidance, as described within *Quality Functions: Responsibilities of Providers, Integrated Care Boards (ICB's) and NHS England* (2023). This guidance provides the framework for the quality operating model for delivering quality assurance as an ICB. Within this paper, in line with established healthcare quality principles, information is grouped across the areas of Safety, Patient Experience and Effectiveness/Outcomes.

Safety

Developments improving assurance:

2. **Patient Incident and Response Framework:** Incident management under the new Patient Incident and Response Framework (PSIRF) model is progressing across Devon, with all main providers having transitioned. Reporting is noting the increase in primary care sign up to the new system and national/regional work is under away to further support this to improve Primary Care level patient safety reporting.

3. **Never Events:** Regarding oversight of Never Events the safety systems team within NHS Devon regularly receives progress updates from the providers. The workstream to implement the Never Event focused improvement initiative, National Safety Standards for Invasive Procedures, (NATSIPS 2) has resumed. NHS Devon is closely monitoring reporting rates and overseeing improvement plans.

4. **Area of NHS Devon Quality focus: Urgent and Emergency Care (UEC) and Elective Care:** UEC continues to be of focus for NHS Devon, with long waits outside in ambulances and within Emergency Departments (ED). The UEC board has received key cascades regarding maintaining clinical quality in pressurised services and areas of unplanned escalation. These have been considered in each locality meeting and informed the system and provider winter plans. Further strategic work is planned with the clinical leadership in Devon regarding a data informed approach to harm identification. South West Ambulance Services NHS Foundation Trust has developed two Equality Quality Impact Assessments regarding ambulance handover and crew numbers. These are being reviewed and impact for Devon considered.

5. **Quality Improvement**: NHSE wrote to systems to update in relation to NHS IMPACT's Clinical and Operational Excellence Programme. Learning and improvement networks and improvement analytics and working guides. NHS IMPACT, Emergency Care Improvement Support (ECIST) and Getting It Right

First Time (GIRFT) have been working with colleagues from across the NHS to develop a series of improvement guides and supporting infrastructure. The purpose of this work is to bring together the best clinical and operational practice from across the country, to support further local improvement.

6. **Safeguarding focus:** Ofsted undertook a full inspection of Devon services to children and their families under the Inspecting Local Authority Children's Services (ILACS) framework. The inspection took place during the first two weeks of October 2024. The inspection team met with practitioners, managers and senior leaders and they also spoke to key partners; and sought feedback from children, young people and families. At time of writing a full report has not been received. Initial verbal feedback has been received including improvement work required to improve “front door” access to services. Further information will be included in the Quality Report to the Board’s meeting in January 2025.

7. **Infection, Prevention and Control (IPC): - Infection Management of Mpox Risk.** The National Health Security Agency (UKHSA) are leading the response, and the NHS Devon Infection Prevention and Control (IPC) team are monitoring the situation, with local preparatory actions currently continuing being implemented with an NHS Devon focus on supporting Primary Care Services to be prepared.

8. **Developments improving assurance: IPC-** NHS Devon has initiated a Health Protection Delivery Group with public health stakeholders to develop and deliver plans and services in the domain of infectious diseases such as avian flu and tuberculosis. Work on commissioning specifications is well progressed which will enable gaps in services to be addressed.

9. **Maternity:** All three providers are part of the national maternity and neonatal support programme. University Hospitals Plymouth NHS Trust (UHP) has completed its diagnostic and developed a single maternity improvement plan inclusive of actions arising from the Care Quality Commission (CQC). A report will be presented to the System Integrated Assurance Group (SIAG) meeting in December 2024. Throughout Quarter 3 2024/25 the Local Maternity and Neonatal System (LMNS) will be working with Devon trusts to ensure that evidence is collated and validated in preparation for Clinical Negligence Scheme for Trusts (CNST) submissions in March of 2025. Delay in implementation of funding for the Maternity Neonatal Voices Partnership poses a risk to Trust compliance. This is being addressed.

10. **Children & Young People - Developments improving assurance:** - NHSE has undertaken the second desktop review as part of the National Paediatric Audiology Quality Improvement Programme. Devon has seen an improved position with the three acute providers.

Patient Experience

11. Patient experience report themes arising from formal complaints to NHS Devon mainly report access issues to GP appointments and dental care. System

Patient Experience Network meetings are progress with key partners. Having focused on developing early resolution processes at the last meeting, partners are now committed to sharing learning and driving improvement and consistency for their populations.

12. Regarding increases in Dental access related complaints, the NHS Devon Quality team is keen to better understand plans for improving access so patients can be better informed when responding to complaints. Dental access for children in care is a key priority.

13. Development work is being progressed to report improved system partner data focused on patient experience at ICB level, inclusive of Friends and Family Test performance and other measures. A development workshop for system partners is being planned for later this year.

14. NHS Devon has now recruited to vacant posts within the team who will when fully inducted assist with capacity to deliver this work.

Effectiveness/Outcomes

15. **Mortality:** The pan Devon group continues to develop the quality and analysis of whole system data. The NHS Devon Chief Nursing Officer was directly involved in improvement and assurance work with University Hospitals Trust Plymouth. The NHS Devon Chief Medical Officer will lead going forward.

16. **S117 Aftercare Arrangements:** Assurance improvement work is underway to improve reporting and assurance of all S117 Aftercare arrangements in Devon. This is inclusive of delegated activity to providers Truist and specific commissioning responsibilities delivered by NHS Devon.

Assurance and Recommendations

17. Based on the assessment of the key issues and risks identified the overall level of assurance the Board can take from the information in the Quality Report is as follows:

Section	Assurance	Trend from previous month
Overall assurance	**Satisfactory** – (areas of concern have additional focus and mitigating actions)	**N/A**

Quality Report November 2024

Penny Smith, Chief Nursing Officer, NHS Devon ICB
Developed by:
The Nursing & Quality Directorate including
The Women & Children's Commissioning Team

Editors:
John Trevains, Director of Nursing
Sara Wright, Head of Nursing & Quality

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Contents

Executive Summary of Key Points 1:

National Cascades/ Reports: The Care Quality Commission (CQC) - The State of Health Care and Adult Social Care in England 2023/24 report was published October 2024. The report highlighted some 'areas of specific concern', involving issues around safety, quality, workforce, and inequalities.

In September 2024, Sarah-Jane Marsh National Director of Urgent and Emergency Care and Deputy Chief Operating Officer and Vin Diwakar National Director of Transformation, NHS England wrote to systems to update in relation to NHS IMPACT's Clinical and Operational Excellence Programme. Learning and improvement networks and improvement analytics and working guides. NHS IMPACT , Emergency Care Improvement Support (ECIST) and Getting It Right First Time (GIRFT) have been working with colleagues from across the NHS to develop a series of improvement guides and supporting infrastructure. The purpose of this work is to bring together and codify the best clinical and operational practice from across the country, to support further local improvement.

In September 2024, Dr Claire Fuller, NHS National Primary Care Medical Director and Dr Aidan Fowler, NHS National Director of Patient Safety, NHSE wrote to systems to share the published Primary Care Patient Safety Strategy.

Primary Care: NHS Devon plays an important role in implementing the Primary Care Patient Safety Strategy to improve patient safety across primary care services. The priority for the Safety Systems Team is to ensure that general practices are registered with the new national patient safety system known as LfPSE to enable shared learning. Progress is being made on extending practice registration in this area but is subject to further regional and national attention as part roll out plans.

Elective Care: The System Clinical Risk and Long Waits Group continues to provide a forum for assurance in relation to the risk profile associated with long waits.

Urgent Emergency Care (UEC): Work is ongoing regarding improving urgent care performance and monitoring quality outcomes, Noting improvements made but handover times are still requiring improvement. Work is also being progress to respond to potential resourcing changes proposed by Ambulance services.

Patient Safety: The number of never events reported since April 2024 to September 2024 is higher than previous years. Torbay and South Devon NHS Foundation Trust (TSDFT) reporting the highest number currently amongst our NHS provider trusts, noting these are low or no harm incidents. Work is being progressed to support and monitor.

Executive Summary of Key Points 2:

Patient Experience: The GP patient survey 2024 shows Devon benchmarks well against other areas, with 78% of patients reporting a good overall experience. Work is under way to explore improvements to increase this rating for those that did not report a positive experience. GP and Dental access are main themes of concern reported to NHS Devon. With new recruits now in place, the NHS Devon team internal performance on response times will improve in coming months.

Continuing Health Care: NHS Devon is benchmarked within the middle grouping compared to other organisations nationally for spend, conversion rates for eligibility are 13 % and not considered an outlier. Referral rates are also currently comparable. NHS Devon is mindful of capacity challenges in terms of demand and team capacity and is working to address this to improve key performance indicators to national target levels.

Infection Management: The Health Care Acquired Infection (HCAI) Sharing and Resource Group have created a regional infection control learning group for collaboration and sharing of local successes and issues across the region. Regional C-Diff work indicates that Devon rates are some of the lowest in the region, with links to good performance in urology pathways noted. Work is ongoing in preparation and awareness of the new Mpox variant. Work has been progressed on commissioning specifications for community swabbing and Tuberculosis related services.

Maternity: Throughout Q3 2024/25 the Local Maternity and Neonatal System (LMNS) will be working with Devon trusts to ensure that evidence is collated and validated in preparation for Clinical Negligence Scheme for Trusts (CNST) submissions in March of 2025.

Mental Health: The national review of intensive and assertive community treatment asks all systems to review their services by Q2 2024/25 to ensure there are clear polices and practice in place for patients with Serious Mental Illness who require intensive community treatment. NHS Devon has initiated the review for Devon, the information returned has been reviewed to support the submission. Safeguarding and serious incident learning has been incorporated to support the review.

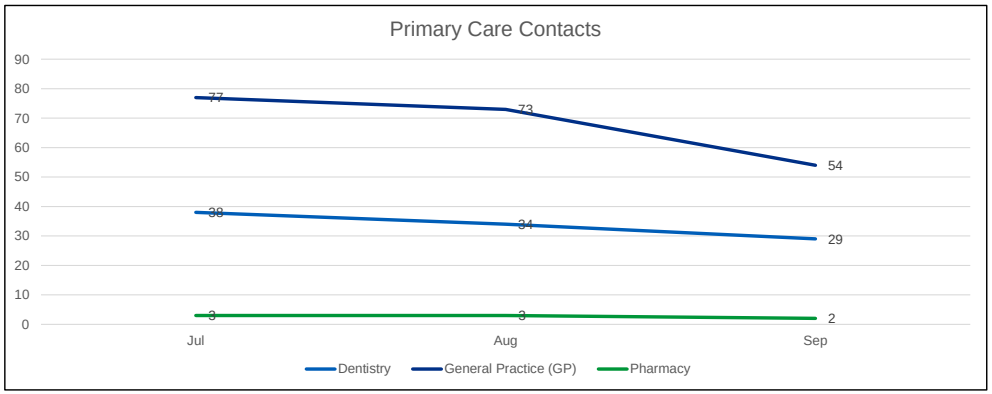
Section 117 (S117): The S117 Internal Audit report has been received. Management responses and actions to recommendations arising from Limited Assurance reports have been reviewed by the NHS Devon Executive. Previously reported quality assurance work within NHS Devon has been added to a joint audit improvement action plan. Work is underway to collaborate with other ICBs on this matter to improve delivery and assurance.

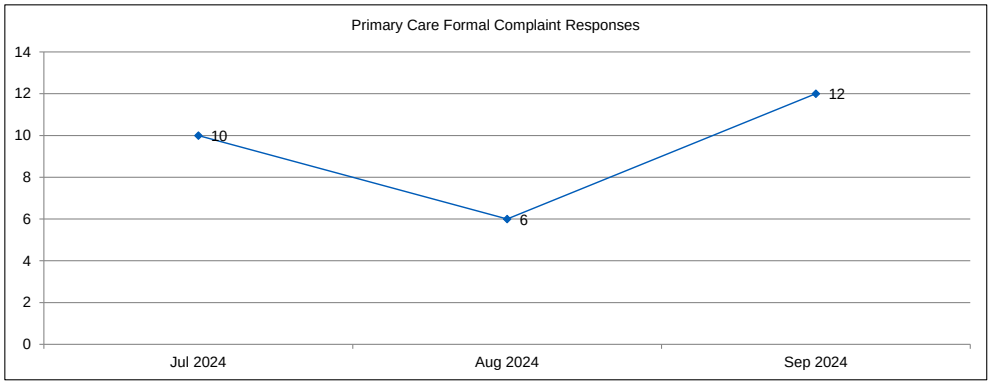
Children & Young People: NHSE has undertaken the second desktop review as part of the National Paediatric Audiology Quality improvement Programme. Devon has seen an improved position with the three acute providers.

Mortality: University Hospitals Plymouth NHS Trust (UHP) has a SHMI score above the expected level based on national data. Data quality is being scrutinised via the Devon Morbidity and Mortality Group with extensive work on-going with UHP to improve understanding, improvement in coding and practice.

Primary Care 1: Data Slide

Patient Experience





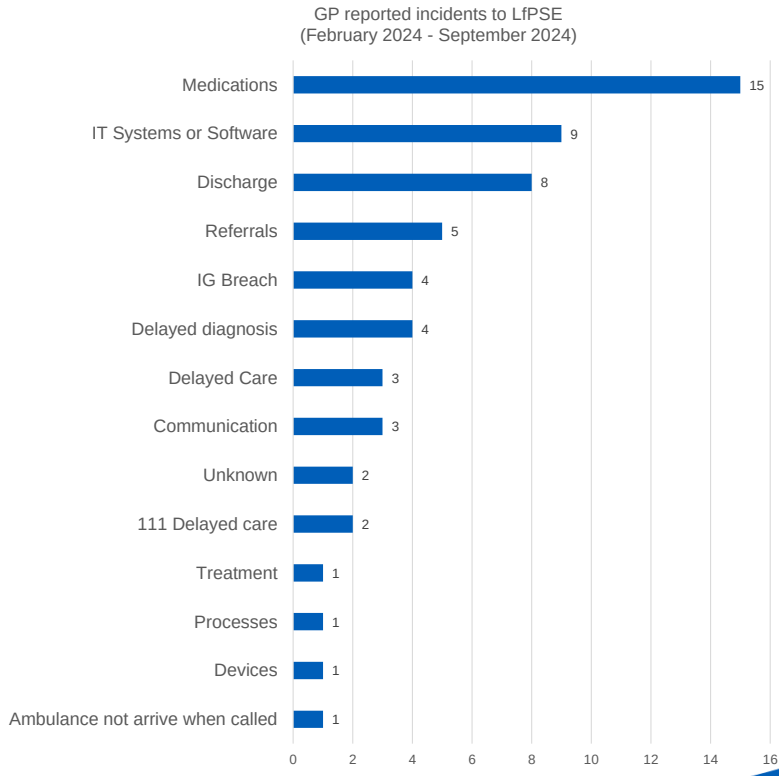
Incidents

41% of GP's registered on LfPSE

31% of GP's reported at least one event

2% of GP's are in the process of registering

Chart 1: Type of incident reported by GPs



Primary Care 2: Narrative/ Assurance Information

Please see previous data slide and Appendix 1: Primary Care Deep Dive

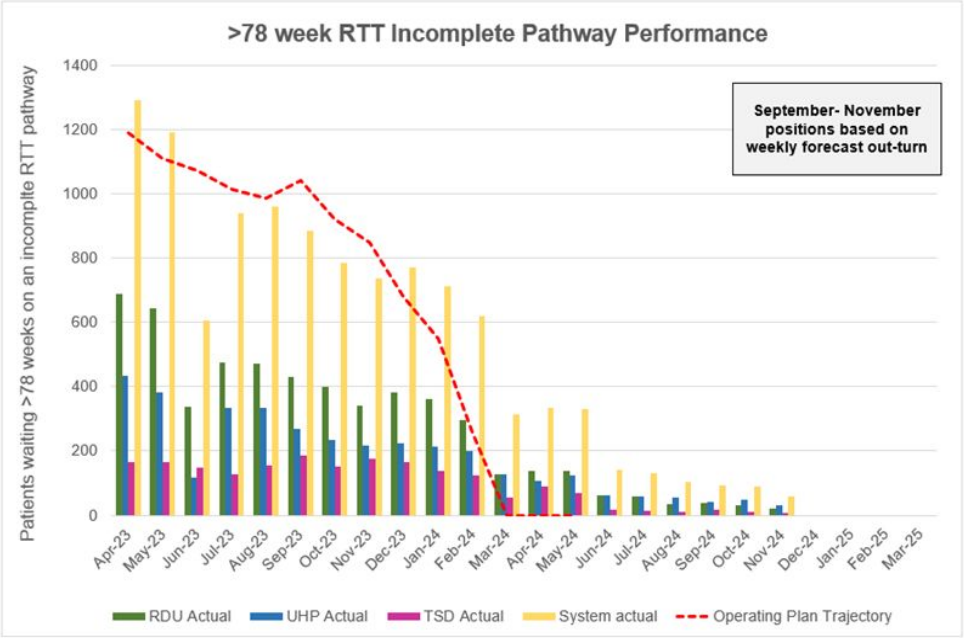
Quality Domain (Safety Experience Effectiveness)	Quality Overview: summary to include actions (including what is hoped to be achieved) and where actions are being monitored	Are quality related risks discussed/ considered to be suitably managed within providers/at system level? Do any risks identified require escalation (and if so, where should they be escalated?)
Patient Experience:	Dental contacts are the main Primary Care contacts for NHS Devon, main themes relate to dental access; - Dental access concerns and complaints are responded to providing details of the national work to improve England's oral healthcare. It does not resolve the current position that Devon patients are experiencing difficulty accessing an NHS Dentist in the area. - Paignton dental practice immediate closure, without notice. Those who were receiving treatment have been allocated a temporary dentist to satisfy these needs, including reimbursement of any payment made to the practice directly. General practice contact remains at a stable volume into Patient Experience. The main contact relates to appointments and prescribing which are directed back to the practice in most cases. Significant events this quarter: - GP practice group in Plymouth following change in management has increasingly been impacted by patient being unable to speak or make contact with the practice for appointments or medication. - Recent communication relating to another Plymouth GP practice where they contacted over 600 patients advising they were no longer able to remain with the practice as they are outside their boundary. Pharmacy contact is minimal, however an event in Holsworthy caused concerns to residents when the only main pharmacy temporarily closed. NHS Devon has not received any contacts regarding Optometry.	- Primary Care Commissioners are working through plans to improve dental access, including dental education for young people. - Commissioning and quality managers working with provider to increase GP cover but also stabilise the practices affected. - Support provided by Primary Care Commissioning and the practice had made NHS Devon aware of the plans. A data error occurred, and it is now understood that the practice should have contacted 2k+ patients,. All 600+ patients have now been advised they can remain with the practice. - Delays added to concerns being raised to NHS Devon. Resolution now in place and alternative premises to reopen the pharmacy now in place.
Safety	General practice The ICB plays a crucial role in implementing the Primary Care Patient Safety Strategy to improve patient safety across primary care services. The priority for the safety Systems Team is to ensure that general practices are registered with the new LfPSE, to enable shared learning. Identified themes from events reported by GPs are regarding: • Medications – specifically regarding the wrong type of medication being prescribed, followed by the wrong dosage of medications. • IT and software • Discharge summaries from acute Trusts Chart 1 illustrated the type of incidents being reported.	Supporting GPs to register onto LfPSE provides resource, which is limited within the team. In addition, some GP are pushing back as this is not a contractual requirement. Communication is shared with Primary Care Commissioning colleagues and engagement colleagues are supporting the communication.

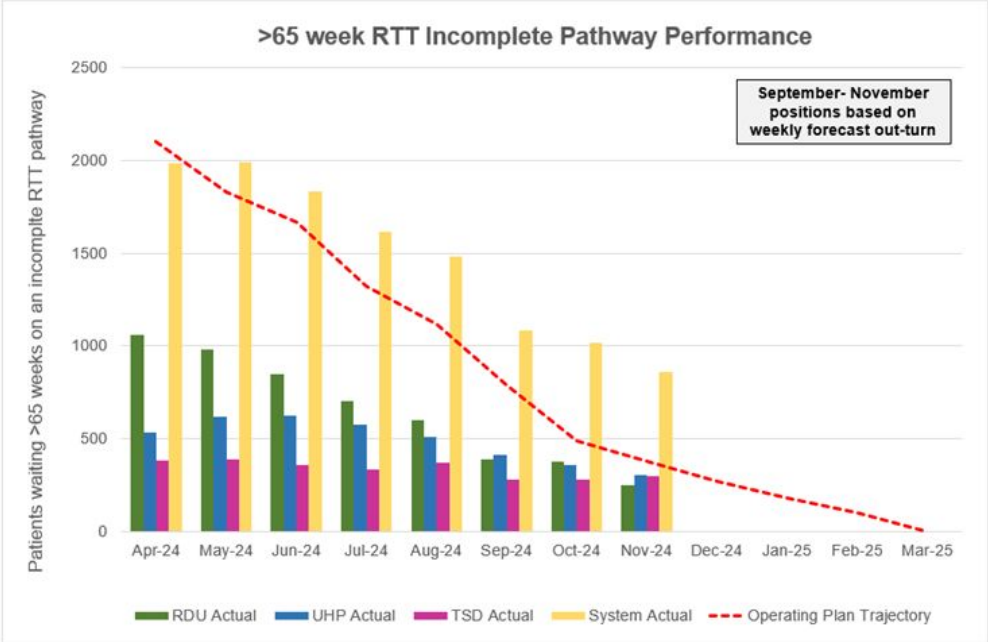
Primary Care 3: Narrative/ Assurance Information

Quality Domain (Safety Experience Effectiveness)	Quality Overview: summary to include actions (including what is hoped to be achieved) and where actions are being monitored	Are quality related risks discussed/ considered to be suitably managed within providers/at system level? Do any risks identified require escalation (and if so, where should they be escalated?)
Safety	In September 24, Dr Claire Fuller, NHS National Primary Care Medical Director and Dr Aidan Fowler, NHS National Director of Patient Safety, NHSE wrote to systems to share the published Primary Care Patient Safety Strategy. Co-designed with NHS front-line staff and lay patient safety partners, the strategy builds on the wider NHS Patient Safety Strategy and aims to develop a supportive environment within primary care where learning can be shared more widely to benefit patient and staff safety and wellbeing. The intention is to ensure that we manage safety with an approach based on safety science and systems thinking. The strategy seeks to build on existing provision and support staff to better involve patients in work to improve safety. It highlights patient safety training for staff, and modernised incident recording and response systems. It sets the ambition and vision for patient safety in primary care to encourage discussion and exploration. It is not about implementing everything on day one in all sectors of primary care. The strategy draws together best practice, providing a range of ideas and opportunities that can be shared. It is not a contractual requirement on primary care providers, or ICBs.	The ICB held meetings during September and October 24 to agree how the strategy can be incorporated into primary care assurance and improvement.

Elective Care 1: Data Slide

For provider specific information, please see Locality Slides





Elective Care 2: Narrative/ Assurance Information

Please see data slide(s) above:

Quality Domain (Safety Experience Effectiveness)	Quality Overview: summary to include actions (including what is hoped to be achieved) and where actions are being monitored	Are quality related risks discussed/ considered to be suitably managed within providers/at system level? Do any risks identified require escalation (and if so, where should they be escalated?)
Safety	**Long Waits Overview** (See tables 1&2 on previous slide): 78ww Position The system remains behind trajectory in September for 78ww clearance with a total of 72 against a plan of zero, with patients remaining to be seen in October with a predicted position of 62 (data as of 13/09/24). It should be noted however that discussions with NHSE SW and national colleagues around the exit from tier 1 for elective performance remains favourable as long as overall improvement trajectory continues. 65ww Position Patients within the 65ww cohort are also behind trajectory for September and October with a position of 897 for September and 667 for October against planned positions of 378 and 104 respectively.	Highlights & Escalations on Elective Workstreams Devon Elective Care Improvement Board 19th September 24-19/09/2 The System Clinical Risk and Long Waits Group continues to provide a forum for assurance in relation to the risk profile associated with long waits. The group are now considering further assurance around long waiting patients on Valproate. The group report to the Elective Care Improvement Board.
Experience	**TSDFT Gynaecology Services:** 2023/24 has seen an increase in the number of gynaecology complaints, predominantly due to waiting times for appointments and procedures. Friends and family feedback for the gynaecology outpatient service is overwhelmingly positive. The service is categorised by the Trust as 'fragile' due to the length of delays and workforce issues. The Trust is currently on track to deliver the standard of no patient waiting over 65 weeks for	Cases are managed in collaboration with the administration team to respond quickly to patient needs when they have been escalated.

Urgent & Emergency Care (UEC) 1: Data Slide

Data taken from NHS Dorset ICB Performance and Demand Dashboard Oct 2024

Handovers

DiiS Dorset Intelligence & Insight Service

Outlines the Total Handover Delay Hours Lost and Average Handover Time across the South West ICB areas

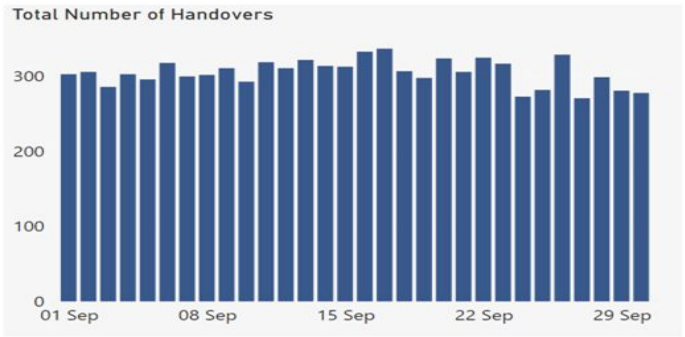
Last Refreshed: 22/10/2024 12:31:08

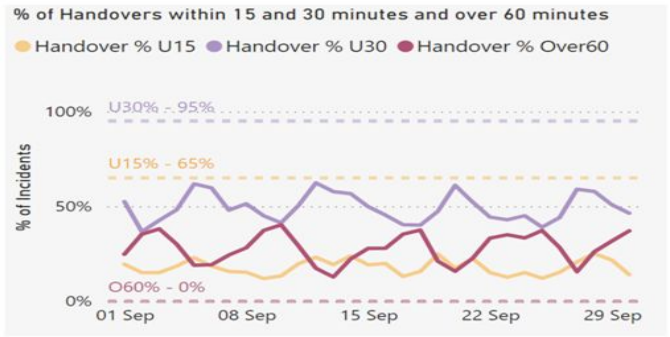
ICB: Devon

Date: Sep 2024

VIEW BY HOSPITAL

% of Handovers Under 30 Minutes - Latest Position	Handover Hours Lost (Over 15 Minutes) - Latest Position	Average Handover Time (Mins) - Latest Position	Handover Hours Lost (Over 15 Minutes) - Current Month	Average Handover Time (Mins) - Current Month	Handover Hours Lost (Over 15 Minutes) - Previous Month	Average Handover Time (Minutes) - Previous Month
48.5%	315.6	77.53	8,104.2	93.32	8,191.6	68.12
21/10/2024	21/10/2024	21/10/2024	Oct 2024	Oct 2024	Sep 2024	Sep 2024





UEC 2: Narrative/ Assurance Information

Please see data slide(s) above and the QPEC UEC Deep Dive.

Quality Domain (Safety Experience Effectiveness)	Quality Overview: summary to include actions (including what is hoped to be achieved) and where actions are being monitored	Are quality related risks discussed/ considered to be suitably managed within providers/at system level? Do any risks identified require escalation (and if so, where should they be escalated?)
Safety Experience	SWASFT QEIA- Hospital Withdrawal & Discharge Direct to Emergency Departments. A QEIA has been received from SWASFT in relation to a reduction in resourcing. The changes SWASFT propose have the potential to be significant across Devon. Work is underway to look at impacts and make appropriate mitigations to proposed plans	Following the meeting 22/10/2024 NHS Dorset ICB will be recirculating the QEIA with request for agreement to approve.
Safety Experience	Though noting some improvements handovers continue to fall short of target with 48.5% taking over 30 mins- (target 0%). Across Devon the largest average number of hours lost at one trust was 1 hour 44 mins at TSDFT. The lowest was 26.44 minutes at NDDH. However, early indicators within University Hospitals Plymouth (UHP), the most challenged UEC provider, continue to evidence positive impact of the Medical Receiving Unit on ED pressure alongside the concerted improvement work being progressed by the ICB UEC team.	Harm continues to be monitored by SWASFT under lead commissioning arrangements with NHS Dorset ICB. PSIIs specific to Devon will be reported to the ICB under the PSIRF framework.

Patient Safety Events 1: Data Slide

Chart 1: Top 25 reported incident onto LfPSE by clinical incident areas

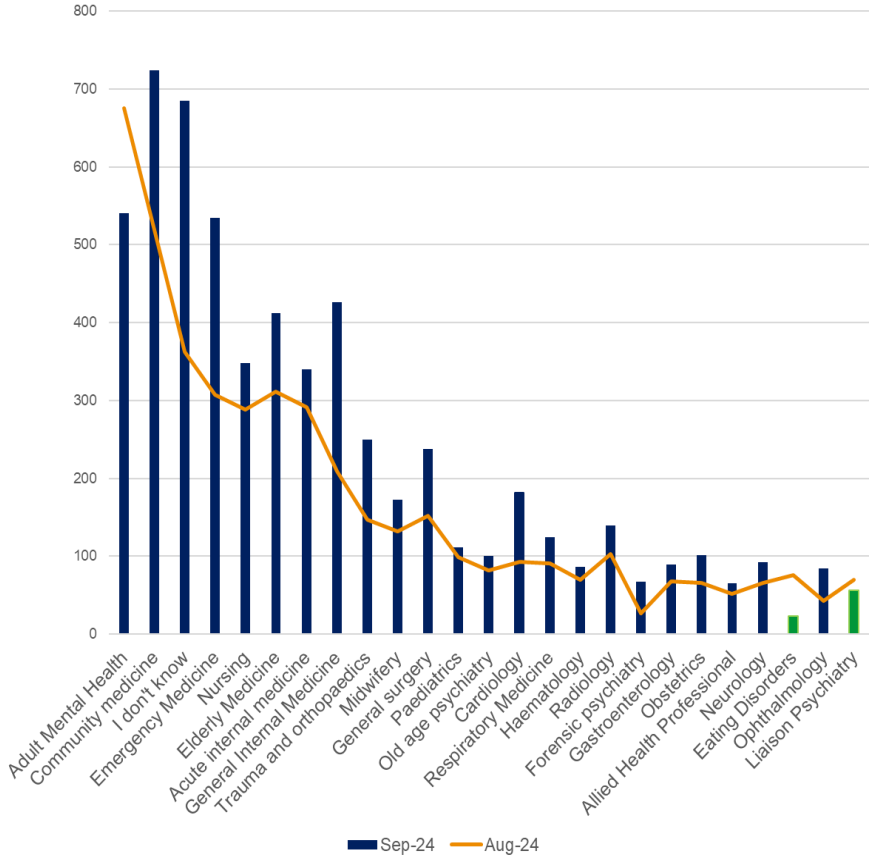
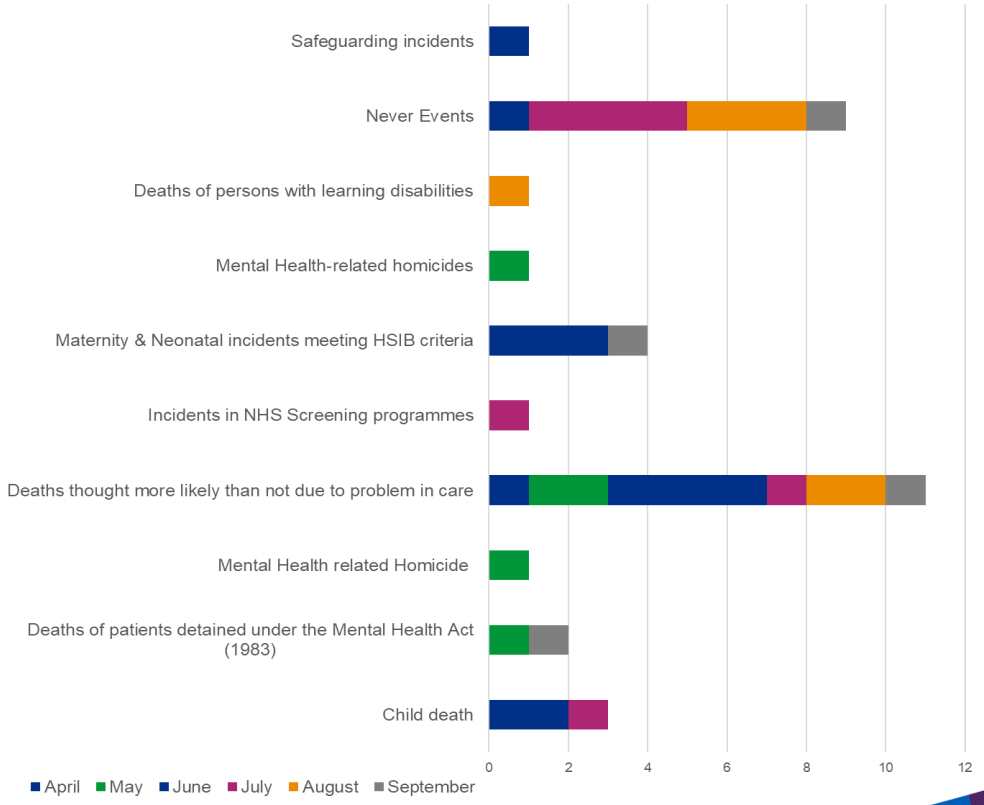


Chart 2: National priorities reported by Provider



Patient Safety Events 2: Data Slide

Chart 3: Open serious incident per month

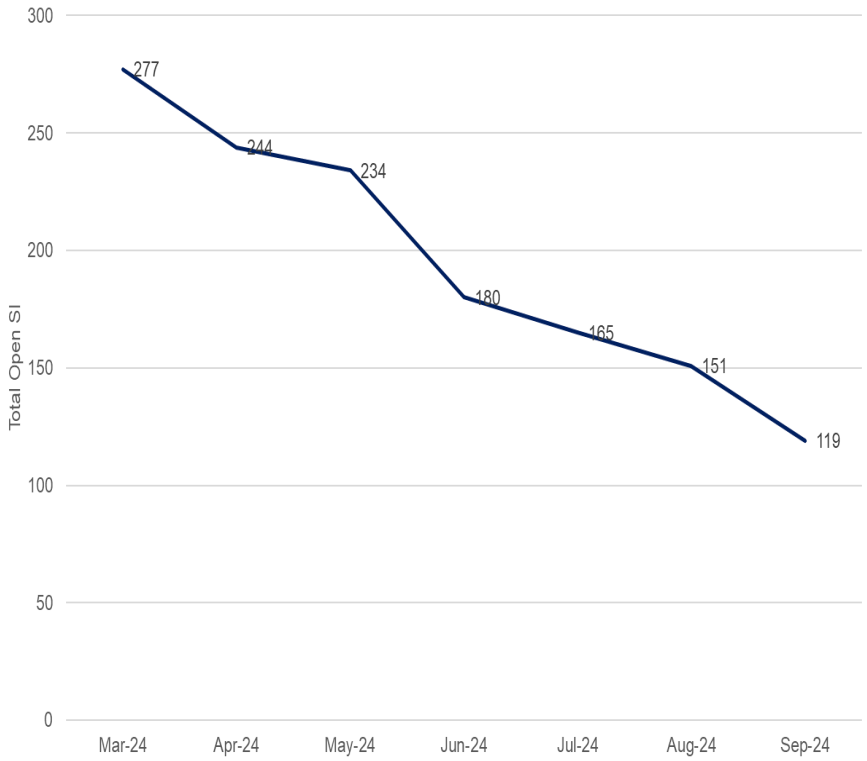


Chart 4: Reported never events April 2024 – September 2024

An increase in the number of days between reported never events indicates improvement.

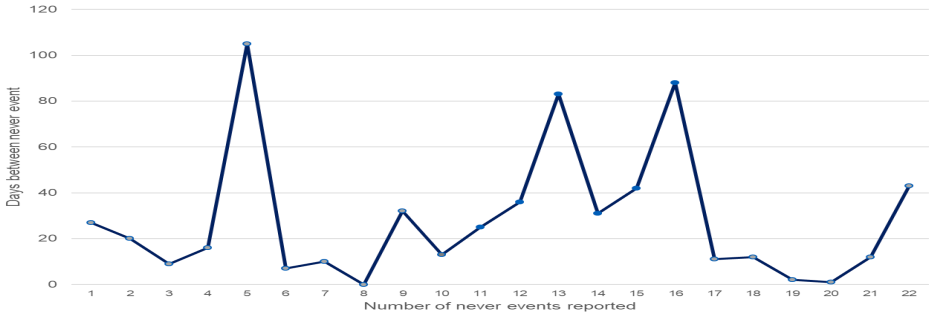
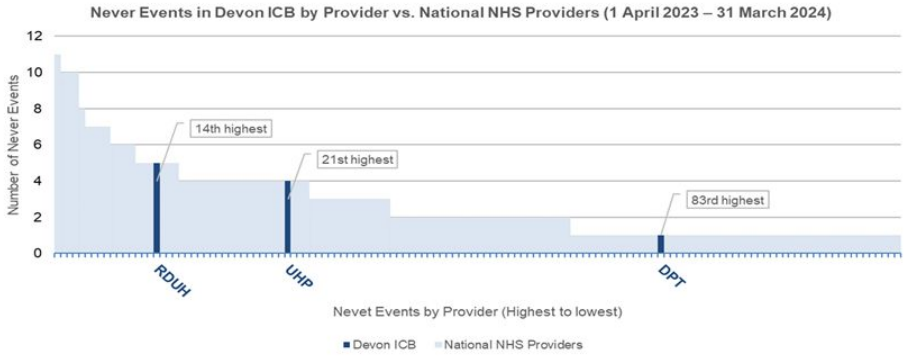


Chart 5: Never Events reported by Devon NHS Trusts compared to other providers nationally during the year of 2023/24



Patient Safety 3: Narrative/ Assurance Information

Please see data slide(s) above:

Quality Domain (Safety Experience Effectiveness)	Quality Overview: summary to include actions (including what is hoped to be achieved) and where actions are being monitored	Are quality related risks discussed/ considered to be suitably managed within providers/at system level? Do any risks identified require escalation (and if so, where should they be escalated?)
Safety	**Serious Incidents (SI)** Currently, there are 119 open serious incidents, with 18 investigation reports completed and submitted to NHS Integrated Care Board (NHS Devon) for review and approval for closure. This will reduce the number of open SIs further by the end of next month. Good progress is being made in closing incidents under the old system. During quarter two NHS Devon received a total of 80 completed SI investigation reports, which were subsequently reviewed and closed. NHS Devon has requested providers to submit a timeline detailing when all open SIs and never events will have completed investigation reports. The Safety Systems Team are in regular contact with all Providers that have open serious incident on the Strategic Executive Information System (StEIS), to ensure they are on track to complete their investigations prior to StEIS is closed in late Autumn. Chart 3 illustrates the number of closed SI per month.	The number of SI being closed each month is being reduced. NHSE have confirmed StEIS will remain active until next year, proving additional time for providers to close SI on StEIS.
Safety	**National and local Patient Safety Incident Investigations (PSII)** PSIRF enables Providers to establish their own local patient safety priorities by analysing historical themes and trends. These priorities are outlined in their PSIRF plan and policy, which must be approved by NHS Devon ICB. Alongside these local priorities, PSIRF also sets certain national priorities that all Providers must address through mandatory Patient Safety Incident Investigations (PSII). Some of these investigations will be conducted locally by the provider, while others will involve an independent PSII. During quarter two, **17** national PSII were reported and **8** local PSII. Chart 2 illustrates the number of national priorities PSII reported since April 2024 to end of quarter 2 2024/25.	TSDFT have not yet reported any local PSII. Ongoing discussion continue between CNO's to resolve. TSDFT have reported a significant number of never events since April 2024. Ongoing discussion continue between CNO.
Safety	**National Priority: Never events** The number of never events reported since April 2024 to October 2024 is 10. There were 7 never events for the same period last year. TSDFT currently reporting the highest number amongst our NHS provider trusts, noting these are no or low harm events. Work is being progressed to support and monitor. Immediate learning has been identified from TSDFT reported never events and actions are in place to help prevent re-occurrence of similar incidents. The safety Systems Team has drafted a never event summary report, which included the implementation of NatSSIPs 2 work. Chart 4 and 5 illustrates reported never events and national comparison.	TSDFT have reported an increase in never events since April 2024. This is being monitored and support given regarding improvement work. Never event learning summary is being finalised and will then be shared with Providers and wider.

Patient Safety 4: Narrative/ Assurance Information

Quality Domain (Safety Experience Effectiveness)	Quality Overview: summary to include actions (including what is hoped to be achieved) and where actions are being monitored	Are quality related risks discussed/ considered to be suitably managed within providers/at system level? Do any risks identified require escalation (and if so, where should they be escalated?)
Safety	**Learning from Patient Safety Events (LfPSE)** A NHSE letter was sent to all General Practices in September, to encourage them to register an account on LfPSE, to enable them to report events themselves but also allow them to be visible of incidents that are being reported about their services from other health and social care providers. From the letter and work that the Safety Systems Team are continuing to complete we now have a total of 43% of practices registered, of which 31% of practices have recorded at least one event. Meeting have taken place with PPG, WMS and Mayflower Group to enable them set up with reporting to LfPSE. Chart 1 illustrates the top clinical areas reported.	Reporting within main providers remains consistent. Reporting from independent Providers and general Practices requires follow up. Communication is shared with Primary Care Commissioning colleagues to support with communication to general practices.
Safety	**Patient Safety Incident Response Framework (PSIRF)** NHS Devon ICB PSIRF policy is being reviewed by NHSE and will then be presented at Executive Committee. A follow up letter is being sent to all those Independent Providers who have not yet submitted a revised incident reporting policy that reflects the new PSIRF rather than the existing serious incident framework (2015). Regular communication with contracting colleagues, including a monthly update on providers progress is shared. Independent Providers that have had their PSIRF policy approved by the ICB include Practice Plus Group Urgent Care Limited, SpaMedica, Express Diagnostics, and Stroke Association.	Contracting colleagues are updated monthly with received, reviewed and approved PSIRF policies from independent providers.
Safety	**Central Alerting System (CAS):** A review of the ICB's process for managing patient safety alerts is underway, with the goal of offering clear recommendations to improve efficiency, consistency, assurance of provider responses, and the sharing of learning and best practices. Current outstanding safety alerts across the system: • NatPSA/2023/010/MHR - Medical beds, trolleys, bed rails (A new safety alert is likely to be issued to replace this one) • NatPSA/2024/004/MHRA - educing risks for transfusion-associated circulatory overload (Acute Trusts)	The review and recommendations will be shared within QAM. Outstanding safety alerts are monitored by the safety systems team.
Safety	**Medical examiners:** From the 9th September 2024 all deaths across all health settings that are not investigated by a coroner will be reviewed by NHS medical examiners.	Monitoring of the number of reviews completed by Medical Examiners will be monitored and escalated within QAM if needed.
Safety	**Patient Safety Syllabus training:** One year after launching the patient safety syllabus training levels 1 and 2 on ESR, the Safety Systems Team has received the completion statistics for each Directorate.	Updates will be shared with all Directors. Communication is going to going within the next staff webinar.

Patient Experience 1: Data Slide

Table one: contact received in quarter 2

Formal complaints	**4**
Informal concerns	531
Ombudsman investigations	3
Primary care hub sign off	28

Table two: open and unallocated cases*

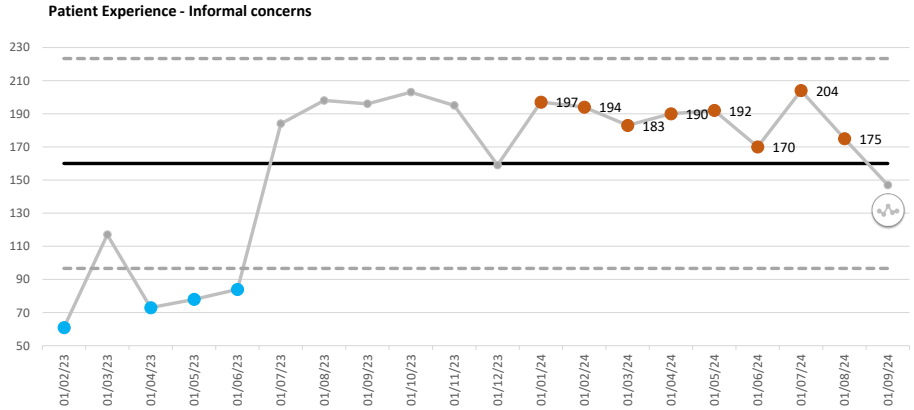
as at 10 October 2024

Formal complaints	13
Informal concerns	75
Ombudsman investigations	9
Primary care hub sign off	2
Unallocated cases	33

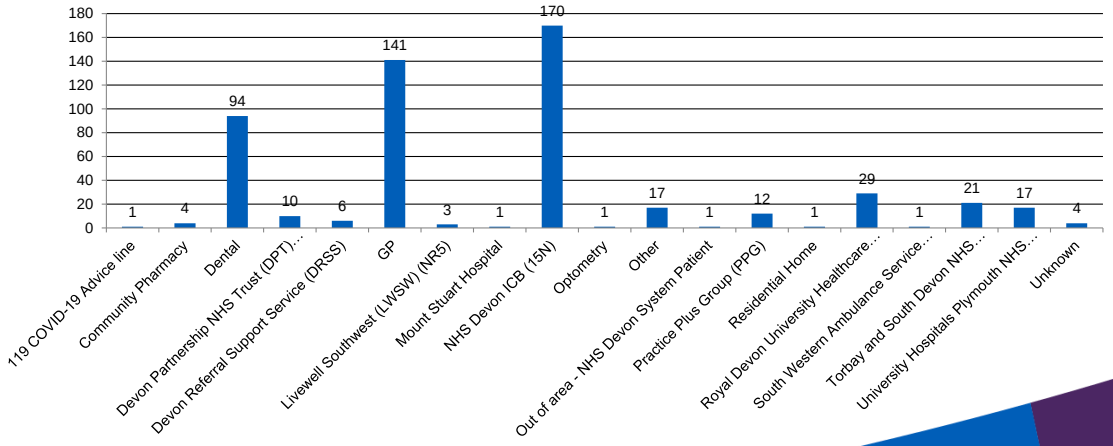
Table three: top themes of quarter 2

Theme	Number received	Main topic
Access to service	318	Mainly relating to dental access
Quality of care	105	Mainly relating to GP services
Communication	103	Mainly relating to GP services

Graph one: new contacts by month



Graph two: quarter two contacts by provider



Patient Experience 2: Narrative/ Assurance Information

Please see data slide(s) above:

Quality Domain (Safety Experience Effectiveness)	Quality Overview: summary to include actions (including what is hoped to be achieved) and where actions are being monitored	Are quality related risks discussed/ considered to be suitably managed within providers/at system level? Do any risks identified require escalation (and if so, where should they be escalated?)
Experience	**General position** The number of unallocated cases has increased, at peak during quarter 2 there were 40 cases outstanding, including cases from June 2024. That situation is now improving as newly recruited staff are commencing work in November 2024 The oldest complaint is 2 years old but is being well managed with the family. The final report is expected from the external investigator at the end of October. The number of informal concerns continues to reduce, down 18% compared to the end of quarter 1. *Activity throughout quarter 2 is illustrated in table 1 and 2 and graph 1 and 2.*	It is anticipated the unallocated cases may not reduce quickly throughout quarter 3 as new staff are trained. As new staff receive training and build confidence the backlog is expected to reduce substantially, with the intention of only having cases awaiting allocation during times of staff absence.
Experience	**Main topics** **Dental** Dental access continues to be the main reason for contact. The team is continuing to respond to contacts with the same template response as previously agreed, as there is no update to the situation. **Primary Care Services (Plymouth GP)** The volume of contact has reduced , however we continue to receive concerns regarding access to services. **Postural Tachycardia Syndrome (PoTs)** Contact relating to PoTs has reduced in quarter 2. UHPT are responding to patients' complaints regarding the service, and hope to finalise these in quarter 3. **Continuing Healthcare (CHC)** The number of formal complaints has reduced. However the team continues to receive contact from clients seeking updates on CHC processes. *The top themes of quarter 3 are illustrated in table 3.*	National improvement plans in place for dental situation, however no update available to give clients at time of report. Work underway to address this and provide improved communications. Formal complaints shared with primary care and contracting teams who have provided information about contract assurance processes. UHPT are working towards a long-term resolution for effected patients. Plans to work with CHC team, however due to capacity across both teams unlikely to be able to progress until restructure concludes.

Patient Experience 3: Narrative/ Assurance Information

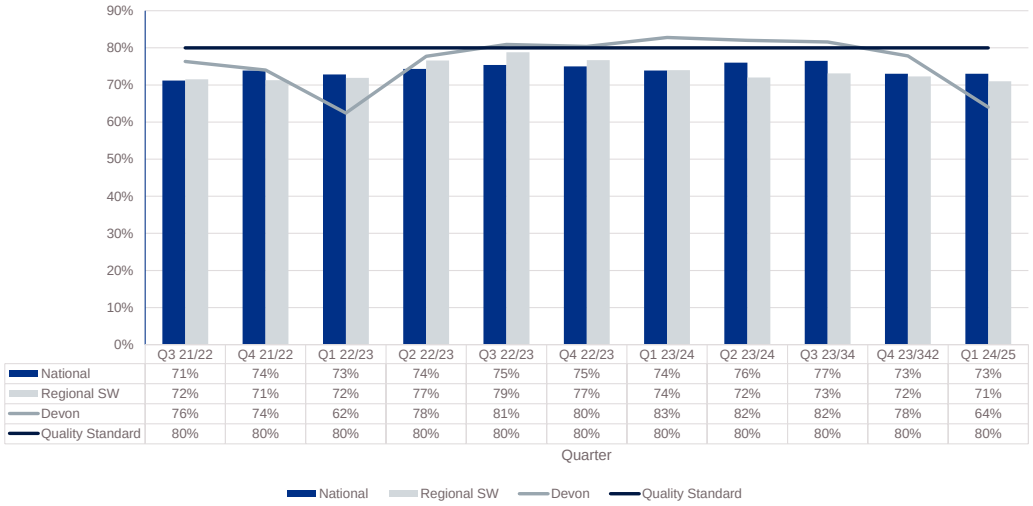
Quality Domain (Safety Experience Effectiveness)	Quality Overview: summary to include actions (including what is hoped to be achieved) and where actions are being monitored	Are quality related risks discussed/ considered to be suitably managed within providers/at system level? Do any risks identified require escalation (and if so, where should they be escalated?)
Experience	**Activity and learning** **General practice** Following a practice border review, the patient experience team have identified the need for practices to consider how certain patients, can be supported with a transition between practices. **Actions from complaints** - Improved process for informing clients when their complaint reaches six months. Over the next 12 months the team aim to reduce the number of complaints reaching six months. - The team has developed a process for logging actions and learning from complaints. **Supporting out of area patients** Following a PHSO recommendation the team is working with the mental health collaborative to consider how families with patients placed out of area can be better supported to visit.	ICB to work with primary care to consider how complex patients. such as those with critical illnesses or conditions such as autism, can be supported. Cases reaching six months is expected to reduce as team capacity increases and cases can be picked up quicker. Consideration being given to how travel costs and associated expenses can be supported.
Experience	**System activity** **Devon Patient Experience Network** - Healthwatch and PPG have been invited to attend future meetings. - The network discussed early resolution and how this can be implemented across the system. **Devon scores highly in GP patient survey** The GP patient survey 2024 shows Devon benchmarks well against other areas, with 78% of patients reporting a good overall experience. Work is under way to improve ratings from those not reporting a good experience. **Other activity** - RDUH have offered to support TSDFT's patient experience team, who are having capacity challenges. - LSW have introduced a new system developed by Imperial College Healthcare Trust to output themes and trends from the friends and family test. LSW are reporting higher levels of positive feedback than concerns/complaints.	Team capacity has made network attendance challenging, however improved staff levels will enable more consistent attendance. - Reported at October ICB Quality Assurance Meeting (QAM).

Safeguarding: Narrative/ Assurance Information

Quality Domain (Safety Experience Effectiveness)	Quality Overview: summary to include actions (including what is hoped to be achieved) and where actions are being monitored	Are quality related risks discussed/ considered to be suitably managed within providers/at system level? Do any risks identified require escalation (and if so, where should they be escalated?)
Safety Effectiveness	**Safeguarding Children** Ofsted undertook a full inspection of Devon services to children and their families under the Inspecting Local Authority Children's Services (ILACS) framework. The inspection took place during the first two weeks of October 2024. The inspection team met with practitioners, managers and senior leaders and they also spoke to key partners; and sought feedback from children, young people and families. At time of writing a full report has not been received. Initial verbal feedback has been received inclusive of improvement work required to improve “front door” access to services. Additional information on progress will be supplied at the next QPEC update A meeting has taken place with LWSW to explore how training compliance data can be shared with the ICB for the Data dashboard. Livewell have agreed to send in the required data on a monthly basis. The Safeguarding team are now in attendance at the LWSW Patient Safety Forum, where the safeguarding quarterly report is presented.. An action plan has been created in readiness for a visit to UHP working on tissues around identification of and response to children presenting with injuries. The audit questions have now been created and visit has been proposed for late November/early December.	Awaiting the outcome of the report. Held at a system level Held at a provider level
Safety Effectiveness	**Safeguarding Adults:** Safeguarding Adults TDSAP Board Face to Face development meeting took place 8/10/24 with all key providers and agencies in attendance .Positive enthusiasm and commitment to priorities from Safeguarding Adult Reviews shared	Held at a system and adult safeguarding partnership

Continuing Health Care (CHC) 1: Quality Metrics Data Slide

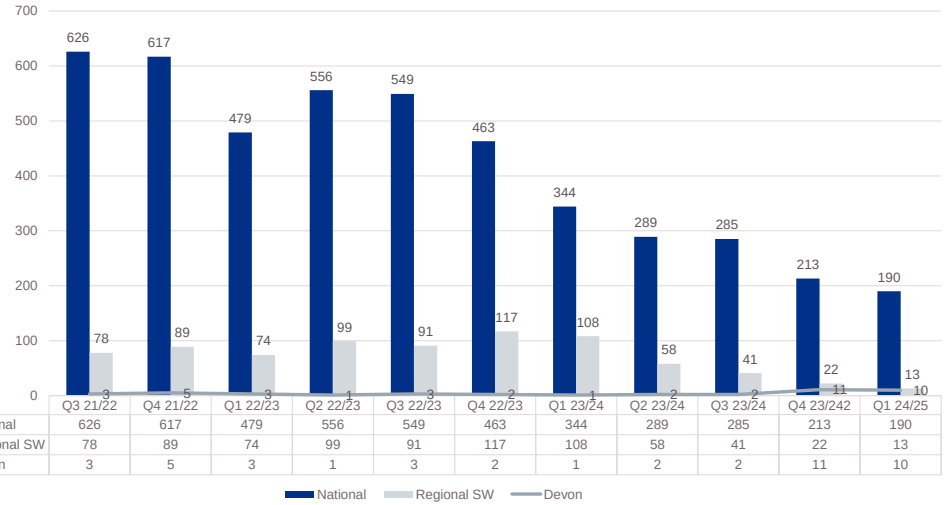
% Referrals completed in 28 days



	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/34	Q4 23/342	Q1 24/25
National	71%	74%	73%	74%	75%	75%	74%	76%	77%	73%	73%
Regional SW	72%	71%	72%	77%	79%	77%	74%	72%	73%	72%	71%
Devon	76%	74%	62%	78%	81%	80%	83%	82%	82%	78%	64%
Quality Standard	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

60% of Assessments completed within 28 days for Q2 2024/25

Incomplete Referrals 28 days at end of quarter by >12 weeks

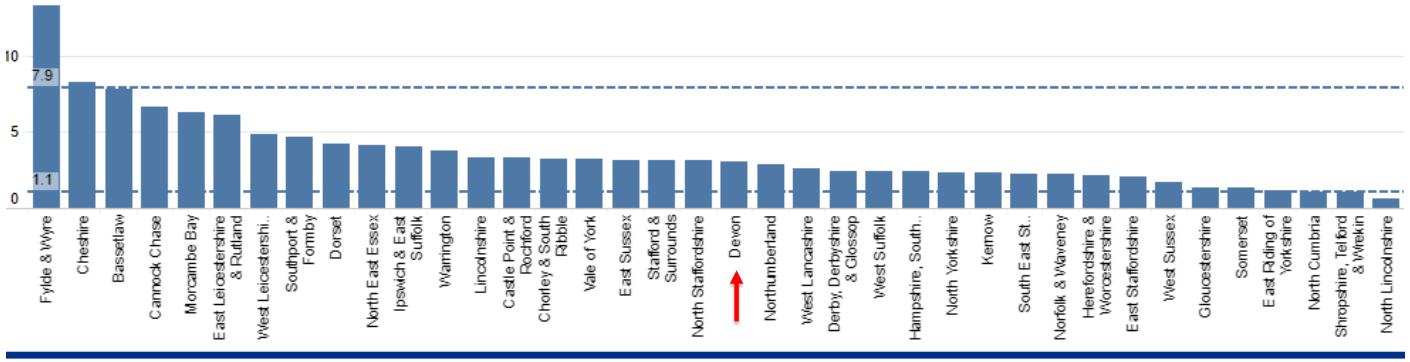


	Q3 21/22	Q4 21/22	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/242	Q1 24/25
National	626	617	479	556	549	463	344	289	285	213	190
Regional SW	78	89	74	99	91	117	108	58	41	22	13
Devon	3	5	3	1	3	2	1	2	2	11	10

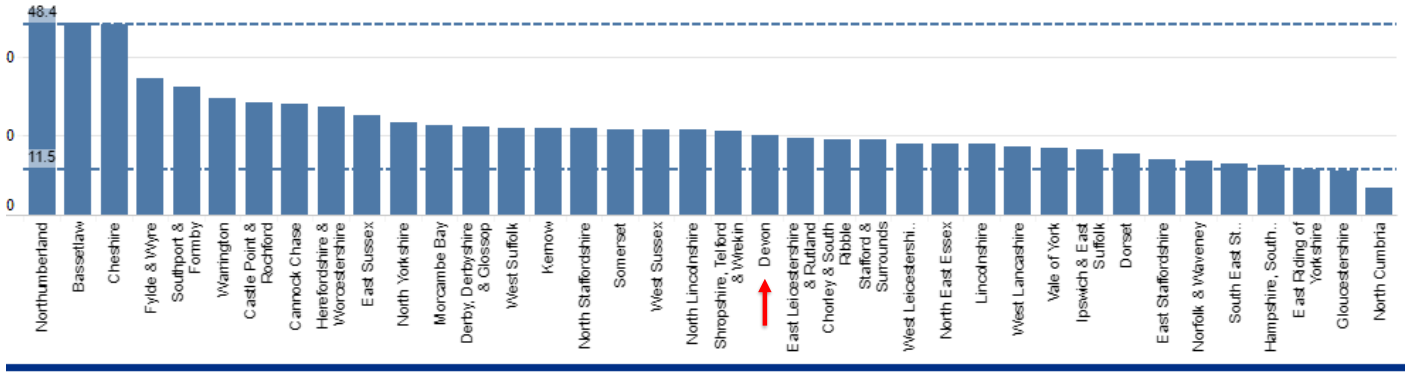
7 Assessments incomplete over 12 weeks for Q2 2024/25
30 Assessments incomplete over 28 days for Q2 2024/25

Projections	Q1	Q2	Q3	Q4
Percentage of assessments completed within 28 days	>60% - 64.9%	>65% - 69.9%	>70% - 74.9%	>80%
Number of incomplete assessments over 12 weeks	10 to 14	10 to 14	5 to 9	1 to 4

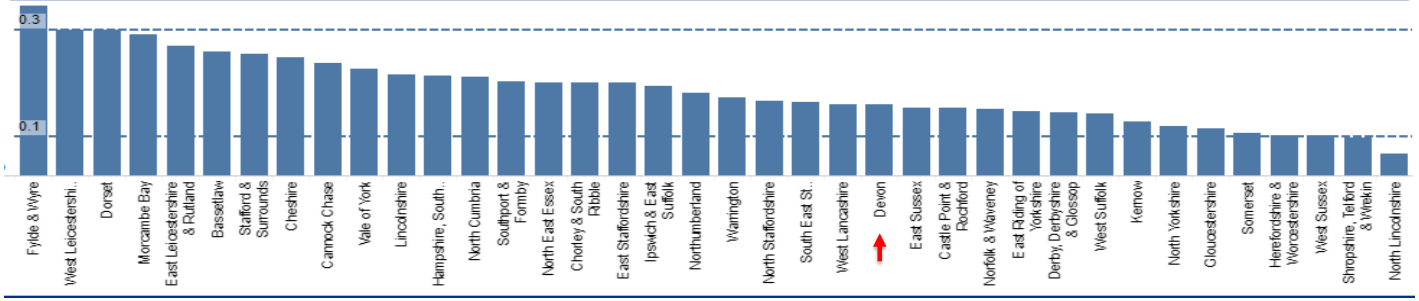
CHC 2: Assessment Activity Data Slide



Number assessed as eligible for Standard CHC (per 50k)



Number of new referrals for Standard CHC (per 50k)



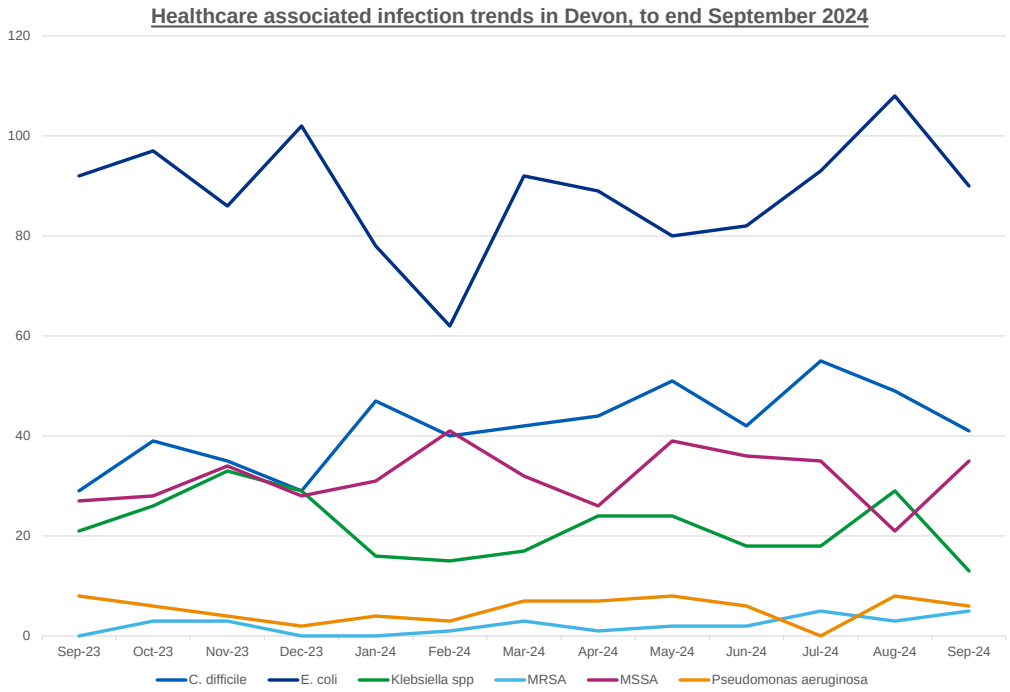
Standard CHC assessment conversion rate

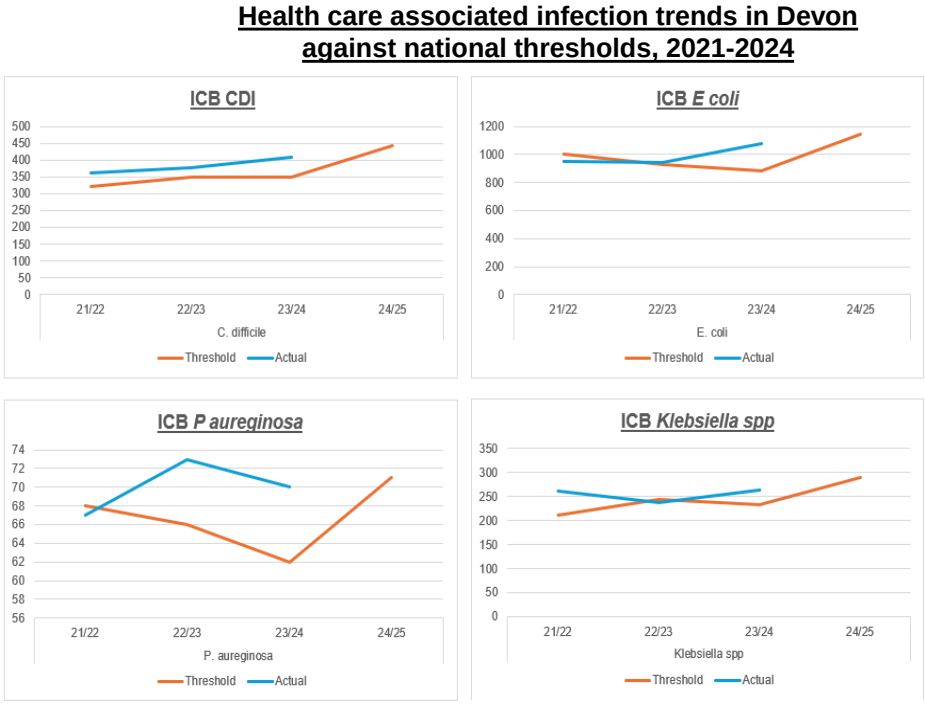
CHC 3: Q2 Update Narrative/ Assurance Information

Please see data slide (s) above:

Quality Domain (Safety Experience Effectiveness)	Quality Overview: summary to include actions (including what is hoped to be achieved) and where actions are being monitored	Are quality related risks discussed/ considered to be suitably managed within providers/at system level? Do any risks identified require escalation (and if so, where should they be escalated?)
Safety And Effectiveness	KPI – 80 % Assessments completed within 28 day: The CHC national Framework, determines that a 80% assessments are to be completed within 28 days. For 2024/25 the ICB is subject to a performance improvement plan – as the service just missed meeting its KPIs at the end of Q4 2023/24. The KPI for Q1 was met. Due to workforce capacity issues the KPI and projection was not met. Target was between 65% and 69.9%- achieved 60% Mitigations are that recruitment is underway for clinical assessors, and that the outsourcing contract has been temporarily increased to cope with demand. It will continue to be monitored during Q3.	This will be discussed with NHS England Q2 quality assurance meeting (29 October 2024). This has been reported through the ICBs corporate risk register. Despite not meeting this KPI target, the corporate risks relating to CHC, have been adjusted from 20 down to 16 for October 24. This is due to improved clinical capacity.
Safety And Effectiveness	KPI – in complete assessments over 12 weeks: Q2 target met. Target to have less than 14 incomplete assessments over 12 weeks. Achieved out of 30 assessments over 28 days – 7 were incomplete over 12 weeks.	This KPI will continue to be monitored throughout Q3 as the target reduces again in Q3. Challenges remain with workforce capacity and outcomes agreed with the ICBs partner organisations.
Safety And Effectiveness	Assessment activity: The assessment activity is comparative with other ICBs. . Conversion rates to CHC eligibility are 13 %, this is not an outlier. Referral rates are currently “middle of group” when benchmarked.	NHSE present these slides to the ICB and are currently assured on the activity for NHS Devon

Infection Management 1: Data Slide





Infection Management 2 : Narrative/ Assurance Information

Please see data slide (s) above:

Quality Domain (Safety Experience Effectiveness)	Quality Overview: summary to include actions (including what is hoped to be achieved) and where actions are being monitored	Are quality related risks discussed/ considered to be suitably managed within providers/at system level? Do any risks identified require escalation (and if so, where should they be escalated?)
Effectiveness	**HCAI Sharing and Resource Group** Devon ICB, RDUH East and Torbay have collaboratively created a new regional infection control learning group, with the aim of fostering collaboration and sharing of local successes and issues across the region. The group meets quarterly. **Health Protection Delivery Group** Devon ICB is leading this county wide group with public health colleagues to address commissioning gaps in services regarding pan Devon TB and high consequence infectious disease response services.	Suitably managed: yes Risk escalation: no Suitably managed: yes Risk escalation: no
Safety	**Tuberculosis (TB)** The Devon system has seen an increased number of tuberculosis cases (14 in South Devon in 2024 to date). The tuberculosis services at the affected Trust are requiring additional resource to reflect the need, and ICB staff have also been offered to support. A needs assessment is being undertaken by UKHSA. UKHSA and Devon ICB are working together to progress a pan-devon TB business case. Latent tuberculosis (LTBI) screening options in appropriate populations are progressing, with funding identified and Trusts approached to undertake this work. ***C. difficile* regional work** In October, Devon ICB contributed to a regional meeting regarding a regional increase in males *with C. difficile*. Highlights from the Devon data included: • Slightly more GP presentations by women than men. • Only one case defined as complex lives/homeless- unlikely to be a causative factor. • 7% of men and 10% of women admitted from nursing homes. • Low numbers of cases on a surgical waiting list- unlikely to be a causative factor. • Majority of cases female, including at each Trust- however Torbay has a higher proportion of female cases than other areas, potentially reflecting an older demographic. The Devon system has one of the lowest increases in males with C. difficile across the region, and this analysis was well received by the regional team. Regional C-Diff work indicates that Devon rates are some of the lowest in the region, linked to good performance in urology pathways. **Mpox guidance in primary care settings** The mpox guidance released in September 2024 sets expectations for primary care PPE, guidance to practices has been issued and the ICB is exploring options on how to provide additional support to practices . **High Consequence Infectious Disease (HCID) response** The Devon system is looking to commission a community HCID swabbing service, as this is a current system gap. This would be a service for specific HCIDs, as not all are appropriate for community swabbing.	Suitably managed: yes Risk escalation: yes- risk is on the ICB risk register, with similar risk on public health risk registers. Suitably managed: yes Risk escalation: no Suitably managed: yes Risk escalation: In hand via additional support actions being explored Suitably managed: in progress, mitigations in place if needed Risk escalation: no

Maternity: Perinatal Transformation:

Schedule of Topics:
- Three Year Delivery Plan
- Peninsula Acute Sustainability Programme
- **Equity & Equality**
- Peninsula LMNS

Complex Social Factors

Purpose: Data on women & birthing people with complex social factors is currently recorded on maternity information systems. This information is used to inform care needs and for transfers of care to health visiting. Historically there has been non consistent definition for 'complex social factors' leading to inconsistencies in care & gaps in service knowledge & provision.

Deliverable: A system wide definition and criteria for recording of complex social factors has been devised and agreed between maternity & health visiting.

Next steps: RDUH will include these criteria in developments on EPIC, embedding their use in practise.

Definition: Significant life experiences with potential to adversely impact maternity and parenting journey and/or impact the unborn/newborn baby

Complex Social Factors (on their own)

- Substance misuse – drugs and alcohol
- Recent migrant, refugee or asylum status, including trafficking
- Difficulty speaking or understanding English
- Aged under 20
- Domestic abuse / sexual assault
- Poverty / Rural Poverty (IMD 1+2, financial or rural challenges)
- Homelessness / no fixed abode / travelling community

Additional factors – Identification of two or more factors from the list below or one factor with additional concerns to be considered as complex and at a minimum should trigger a supervision conversation about cumulation of risk (this list is not definitive):

- ACES (which will impact pregnancy or parenting)
- Care leavers
- Housing concerns
- Unemployment / job insecurity
- Unstable income / food insecurity
- Parental complex health need, including physical disability or learning difficulty & certain prescribed medications
- Parental neurodiversity
- Parental mental health concerns – previous admissions or history of psychosis
- Criminal justice involvement
- Previous safeguarding involvement – including previous children removed

There is also an understanding that information on social complexity needs to be recorded for partners / other adults in the household and that this should be included at booking and in transfer to health visiting documentation

Infant Feeding Strategy

Purpose: Development of a multi-disciplinary system wide infant feeding strategy to ensure that women, birthing people & families have the information and support that they need when they need it, both in perinatal hospital settings and within the community.

Deliverable: Infant feeding strategy & accompanying implementation plan.

Next steps: Sign off of the strategy & implementation plan and handover of ownership to the system community of practise, chaired by a system infant feeding lead.

The Devon Infant Feeding Strategy covers care delivered by maternity services, neonatal units & health visitors. It also includes actions around working with our communities to make them more supportive and inclusive of infant feeding choices and needs.

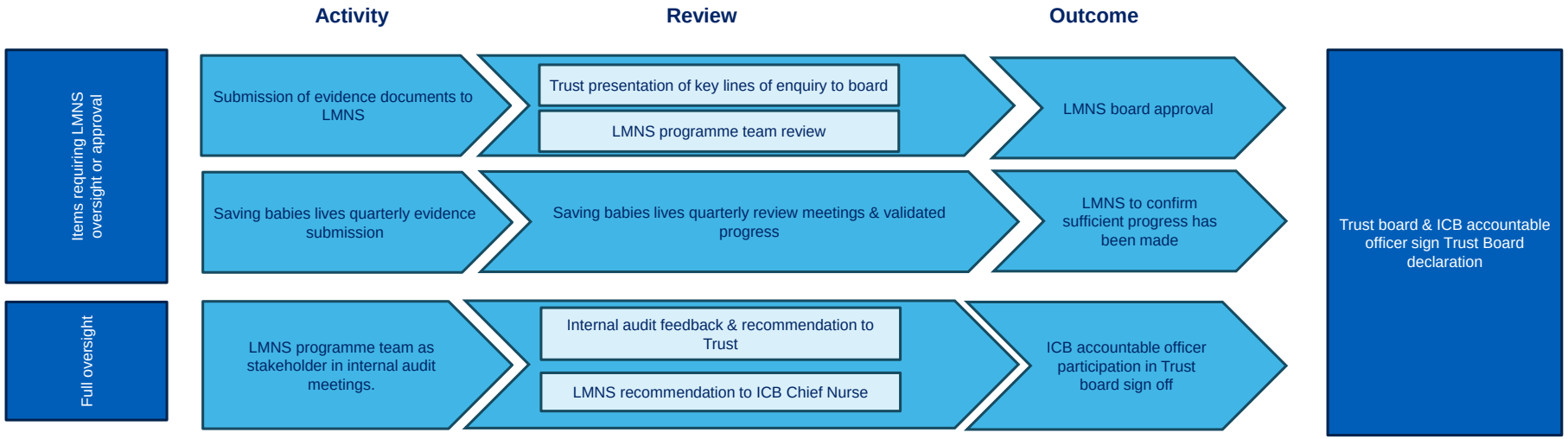
Objective / Priority Description	Strategic aim/goal that objective seeks to improve
Provide all women, birthing people and families with the information and skills to feed their baby safely	Put the correct support in place to improve the duration of breastfeeding and to prevent women from stopping breastfeeding before they wish to.
Maternity, neonatal and health visiting services will achieve Level 3 Unicef BFI accreditation and those already at Level 3 will work towards the Gold award	Increase breastfeeding rates at first feed and 6-8 weeks through enhanced support.
Infant feeding data collection and quality will be improved	Improve experience/ satisfaction with infant feeding support.
Deliver accessible, consistent, evidence-based information and support across all healthcare and community support services	Put the correct support in place to improve the duration of breastfeeding and to prevent women from stopping breastfeeding before they wish to. All professionals and peer supporters to work more closely together and provide consistent advice.
Reduce the health inequalities related to infant feeding	Increase breastfeeding rates at first feed and 6-8 weeks through enhanced support. Put the correct support in place to improve the duration of breastfeeding and to prevent women from stopping breastfeeding before they wish to.

Maternity: Perinatal Quality & Safety:

Schedule of Topics:
- **Saving Babies Lives & CNST**
- Perinatal Quality Surveillance Model
- National Publications

Clinical Negligence Scheme for Trusts Year 6 (2024) & Saving Babies Lives Version 3

- Throughout quarter 3 2024/25 the LMNS will be working with Devon trusts to ensure that evidence is collated and validated in preparation for Clinical Negligence Scheme for Trusts (CNST) submissions in March of 2025.
- The below diagram outlines how the LMNS & ICB will work with Trusts to ensure that this is completed appropriately.



Maternity: Perinatal services development

Quality Domain (Safety Experience Effectiveness)	Quality Overview: summary to include actions (including what is hoped to be achieved) and where actions are being monitored	Are quality related risks discussed/ considered to be suitably managed within providers/at system level? Do any risks identified require escalation (and if so, where should they be escalated?)
Safety	**Recruitment of a lead midwife for the LMNS:** Recruitment to this role will support the LMNS to fulfil its role as a critical friend through appropriate clinical knowledge & experience and to fulfil the needs of our national mandate to key national perinatal strategy. Recruitment is likely to be completed by February 2025. **Validation of Saving Babies Lives (version 3)** The LMNS is required to undertake quarterly review of trust evidence demonstrating compliance with all 70 interventions in Saving Babies Lives. Quarter 3 reviews are currently underway and have not yet been finalised. At the end of quarter 3 the LMNS must articulate whether Trusts have made sufficient progress in becoming compliant with all interventions to contribute to CNST compliance. Currently 2 out of 3 Trusts have already demonstrated sufficient progress in 2024/25. All quarter 3 reviews will be the final round within the CNST compliance period and will be completed by the end of November 2024. **Validation of Clinical Negligence Scheme for Trusts (CNST)** The ICB accountable officer (AO) for CNST (Chief Nurse) must countersign Trust declarations of compliance. The LMNS will be a key stakeholder in the internal audit reviews of CNST evidence and will provide an overview to the AO to support assurance ahead of counter signing in January/February 2025.	On risk register Not at present Not at present
Experience	**Preparation for procurement of enhanced Maternity & Neonatal Voices Partnership (MNVP)** An enhanced MNVP is needed to ensure that NHS Devon & the LMNS are compliant with national requirements and that Trusts are supported to be compliant with the Clinical Negligence Scheme for Trusts (CNST). Completion of the tender is anticipated in December 2024/January 2025.	Risks are present in all providers around the current MNVP provision as it has an impact on their ability to meet CNST. An NHS Devon accompanying paper for consideration by the Quality & Patient Experience Committee in November.

Mental Health: Narrative/ Assurance Information

Domain	Summary to include actions (including what is hoped to be achieved) and where actions are being monitored
Safety and Effectiveness	**National review of intensive and assertive community treatment:** • All systems have been asked to review their community services by q2 24/25 to ensure there are clear polices and practice in place for patients with Serious Mental Illness who require intensive community treatment and follow up but where engagement is challenged. • NHS Devon has initiated the review for Devon with the two mental health providers, the information returned has been reviewed to support the submission. Safeguarding and serious incident learning has been incorporated to support the review. In addition, the ICB has reviewed its processes for system oversight and assurance as the commissioner of Mental Health services. • The review highlights that there are some areas of good practice and policies overall identify what good practice looks like. • The deep dive review has offered the system the opportunity to understand some of the challenges in meeting best practice. • Key findings from the review are contact and engagement issues, workforce and training, policy and pathway gaps and strengthened governance and assurance. • The submission was presented at the Collaborative Senate 25th September 2024.
Safety	**LWSW** The ICB is embedded in the three LWSW patient safety forums for reviewing incident response and sharing learning - Patient Safety Learning Improvement group (PSLIG), People Safety Forum and Safety Quality and Performance committee (SQP). **Culture of Care** – LWSW are working with the Mental Health Learning Disability and Neurodiversity (MHLND) collaborative and DPT colleagues to progress the inpatient quality transformation programme. Work includes embedding a patient centered framework, addressing challenge with the physical environment, considering estates and the therapeutic environment and activities. Link to other LWSW strategies such as Triangle of Care. Executive lead identified for the 6 areas of focus. PMO and QI team supporting, governance is being determined.

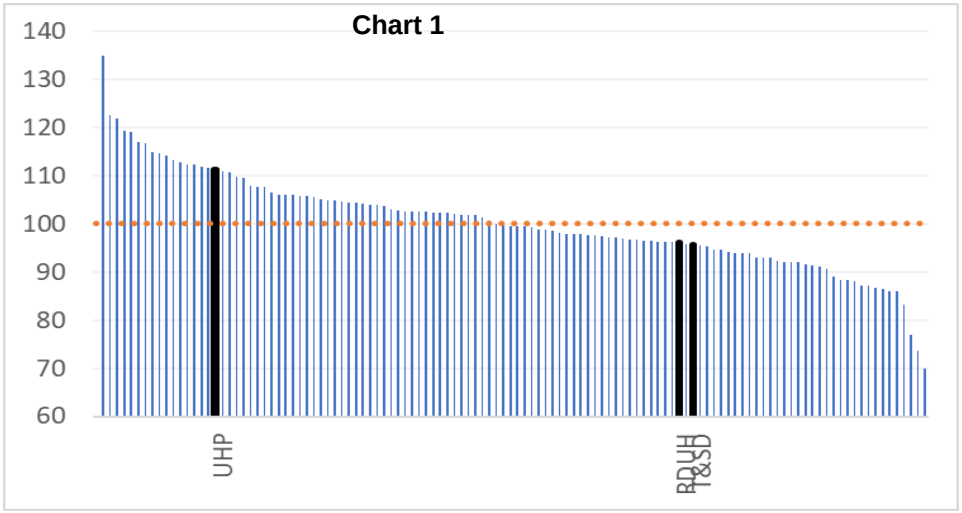
S117 Assurance :

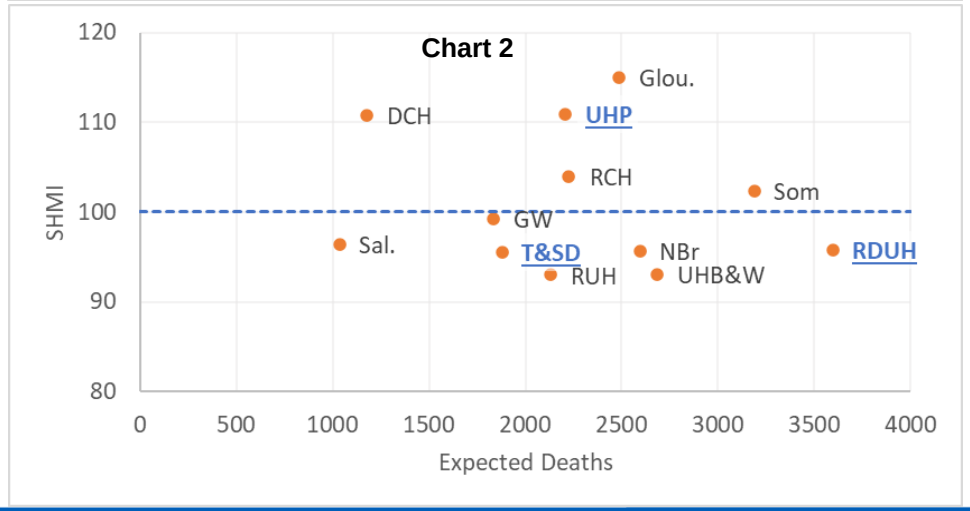
Quality Domain (Safety Experience Effectiveness)	Quality Overview: summary to include actions (including what is hoped to be achieved) and where actions are being monitored	Are quality related risks discussed/ considered to be suitably managed within providers/at system level? Do any risks identified require escalation (and if so, where should they be escalated?)
Effectiveness	Audit report received- Management responses to recommendations arising from Limited Assurance reports require approval by the NHS Devon Executive. Previous reported quality assurance work has been added to a joint audit improvement action plan. Inclusive of following points: • S117 increasing (due to an increase in those detained under MHA and made eligible) • Out of date s117 reviews to be addressed in recovery plan • Responsible Clinicians – To fully observe Section 117 responsibilities and to make decisions about discharging people from Section 117. • Social Care - To engage fully with Section 117 responsibilities in line with local and national guidance as set out in the Mental Health Code of Practice. • Named Mental Health Practitioner/Care/ Recovery Co-ordinators - To engage fully with Section 117 responsibilities in line with local and national guidance as set out in the Mental Health Code of Practice. • MHA Manager for The Trust - To support clinical staff and Locality MHA Managers with advice and raise concerns as necessary with senior managers within the Trust, Clinical Commissioning Group or Local Authority • To maintain the Section 117 register, prompt reviews across both health and social care. • To ensure the Section 117 register is available to partners as required.	A detailed recovery action plan is being written following discussion with Executive Committee in November.

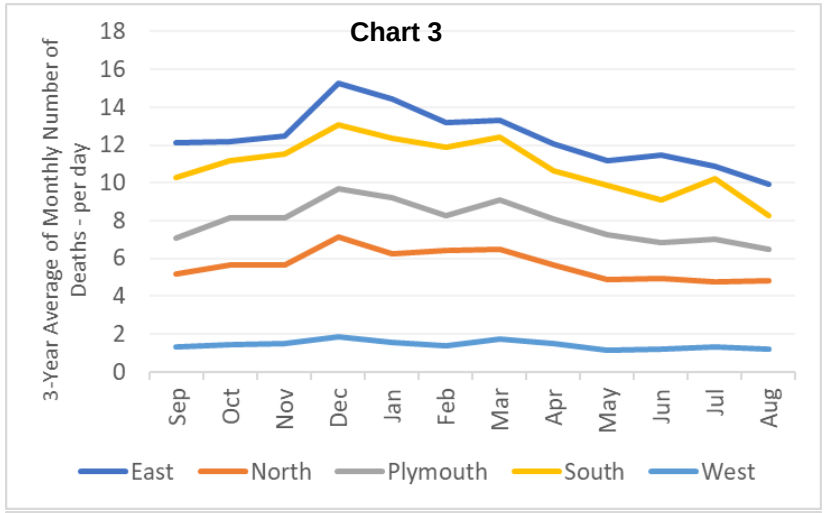
ICB Learning Disabilities and Autism Delivery:

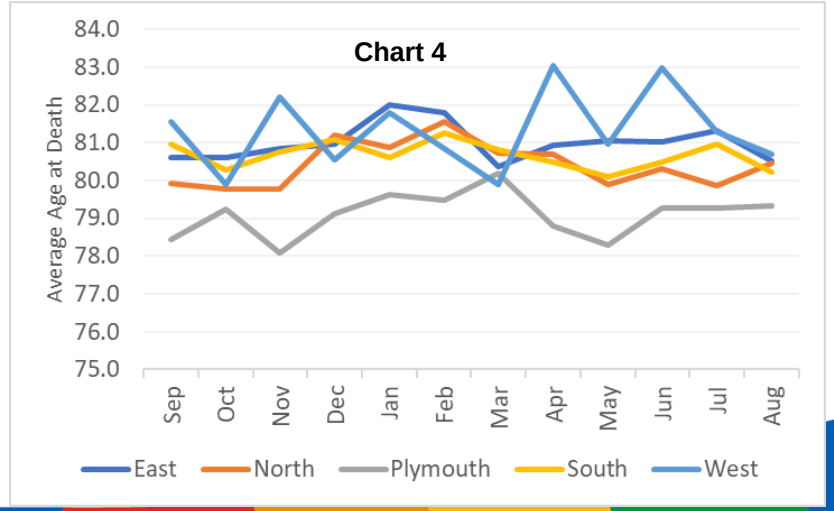
Quality Domain (Safety Experience Effectiveness)	Quality Overview: summary to include actions (including what is hoped to be achieved) and where actions are being monitored	Are quality related risks discussed/ considered to be suitably managed within providers/at system level? Do any risks identified require escalation (and if so, where should they be escalated?)
Safety	LeDeR • A Bank Senior Reviewer is now in post • Five Bank LeDeR Reviewers have been recruited , scheduled to start in the first week of November. • Interviews for the LeDeR and Tackling Health Inequalities Lead (8a) role are set to commence November.. • The current review backlog is expected to reduce with new recruits now in place,	• Improvement now anticipated with new recruits in place to address review backlog
Effectiveness Safety	Learning Disability and Autism Partnership meeting (including Health Inequalities, Preventions, and Improvement Group) Last meeting 17th October 2024 included the following topic areas : • LeDeR • Assuring Transforming / Inpatient numbers • Annual Health Checks • Oliver McGowan Mandatory Training • STOMP / STAMP deep dive • Digital flags	• Learning Disability and Autism Partnership meeting (including Health Inequalities, Preventions, and Improvement Group)
Safety	Safe & Wellbeing Reviews • Safe and wellbeing reviews evaluate the safety and general welfare of individuals receiving care or living away from their local area, with the goal of ensuring they receive adequate support. • Their welfare is monitored, and any arising concerns or risks due to being away from their usual support networks or environments are addressed.	• In the month of September 24 there were 15 safe and wellbeing checks complete.
Safety	Care & Treatment Reviews (CTR) • Care (Education) and Treatment Reviews (C(E)TRs) are part of NHS England's commitment to transforming services for people of all ages with a learning disability and autistic people. C(E)TRs are for people who have been admitted to a mental health hospital or for people who are at risk of admission. • They are undertaken by commissioners to ensure that people are only admitted to hospital when necessary and for the minimum amount of time possible. Care and Treatment Reviews (CTRs) are for adults and C(E)TRs are for children and young people.	• Completed C(E)TR's in the month of September 24 was 6.
Safety	Inpatient Admissions • Devon ICB have had 4 people removed from the cohort due to discharge, • Currently Devon ICB and CYP are within the target numbers and SWPC exceed the target. There are currently 2 pending discharges for the Devon ICB patients and 1 for the SWPC. • CYP inpatient numbers have increased from 2 to 3 with admissions and discharges being more frequent than adults (less length of stays). • The inpatient cohort for Devon ICB patients has remained between 17 to 24 over the past 5 years with an average of 20. • Devon ICB have identified the cohort has change significantly since 2015 with most admissions now having dual diagnosis of Autism and MH conditions.	• Delayed discharges for the adult cohort are linked to lack of suitable community placements, housing and the legal frameworks required for safe discharges. • Please see slide with current inpatient numbers and locations

Mortality 1: Data Slide









Mortality 2: Narrative/ Assurance Information

Please see data slide (s) above:

Quality Domain (Safety Experience Effectiveness)	Quality Overview: summary to include actions (including what is hoped to be achieved) and where actions are being monitored	Are quality related risks discussed/ considered to be suitably managed within providers/at system level? Do any risks identified require escalation (and if so, where should they be escalated?)
Safety	Chart 1 of previous slide shows a SHMI score of 100 represents expected deaths balancing with observed deaths. Providers T&SD and RDU are both below this marker. University Hospitals Plymouth (UHP) has a SHMI score above 100, meaning more deaths observed in comparison to what was expected in the twelve-month period. Chart 2 of previous slide shows expected deaths, based on activity, give an indication of the relative scale of providers in relation to each other – Royal Devon University Hospitals Trust (RDUH) being one of the larger providers in the Southwest, so having more expected deaths.	Partners share data and actions at the Devon Morbidity and Mortality Group and extensive work is on-going with UHP to drive understanding, improvement in coding and practice. Actions shared include deep dives and cross referencing with Medical Examiner data when coding is considered the main reason for SHMI ratings. When partners identify specific potential coding anomalies, they also review specific pathways of care and cases. Examples of this include sepsis in TSD and women's in UHP. TSD have made improvements in their coding, despite the absence of an Electronic Patient Record (EPR), as well as evidence repeat audits where deep dives have taken place. The ICB Head of Nursing attends the main provider Morbidity & Mortality Groups.
Safety	Charts 3 and 4 of previous slide show average volumes of deaths occurring within each month for each Primary Care Network (PCN) [adjusted to a per-day figure to account for varying month length], followed by average age at death, over the previous three years.	This data is examined by partners at the Devon Morbidity and Mortality Group, allowing them to consider the health inequalities aspect of the workstream.

NHS Devon Integrated Care Board

NHS Devon (ICB) Finance Report M6

Date of meeting	Date report produced
28 November 2024	29 October 2024

Author(s)		Report approved by	
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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
N/A

Executive summary

The presentation of the NHS Devon Integrated Care Board (ICB) Finance Report seeks to provide the necessary assurance on the current and projected financial position of the ICB for the year ended 31 March 2025.

This report details the NHS Devon financial position as at 30 September 2024, setting out the year to date and forecast financial position. Overall, NHS Devon is reporting a year to date (YTD) and forecast outturn (FOT) surplus of £14.2m and £28.4m respectively in accordance with the plan.

The assurance ratings in this report are based on an assessment of the key issues and risks identified and are as follows:

Section	Assurance	Trend from previous month
Overall assurance	**Satisfactory**	**No change**
Financial performance	Satisfactory	No change
Savings and efficiencies	Satisfactory	Improvement
Financial risks	Satisfactory	No change

Committees that have previously discussed/agreed the report, and outcomes of that discussion

NHS Devon Executive reviewed this report on 05 November 2024. It was also reviewed by the Finance and Performance Committee at its meeting on 14 November 2024.

Key recommendations and actions requested

AGREE the overall assurance level relating to the financial position of NHS Devon of **satisfactory assurance** and that adequate plans are in place to mitigate the risks relating to the delivery of planned savings and efficiencies and to the management of the financial risks identified at plan stage.

Impact on NHS Devon objectives

Objective	Impact
Improve population health	All
Improve services and reduced unwarranted variation	
Make more efficient use of our resources	
Develop our culture and how we operate	

Outline the implications of matters covered in this report for the following areas

Area	
Quality of services	None
Health inequalities	None
Workforce	None
Resources and finance	Delivery of financial sustainability
Legal	None
Digital and Data	None
Engagement and consultation	None

NHS Devon (ICB) Finance Report M6

Executive Summary

1. The presentation of the NHS Devon Integrated Care Board (ICB) Finance Report seeks to provide the necessary assurance to the Board on the financial position of the year to date (YTD) 30 September 2024 and the year ended 31 March 2025.

2. NHS Devon's funding envelope includes allocations for Primary Medical Care Services, Elective Recovery, Ambulance capacity funding and Discharge funding as well as funding for Service Development.

3. The One Devon Integrated Care System (ICS) submitted an original deficit plan of £85.4m and an expectation that £207.9m of efficiency savings are needed to meet that plan. Within the plan NHS Devon's financial position was an underspend of £23.0m with a requirement to deliver £74.7m of efficiency savings (£31.8m net of system provided embedded efficiency).

4. After the initial plan was submitted, NHS England (NHSE) required the One Devon ICS to revise its plan to a deficit of £80.0m. Consequently, the ICS efficiency savings target increased from £207.9m to £213.3m. NHS Devon's required underspend rose from £23.0m to £28.4m, resulting in a total efficiency savings requirement of £80.1m (£37.3m net of system-provided embedded efficiency).

5. At month 6, NHS England (NHSE) has provided the One Devon ICS with £80.0m in non-recurrent deficit support, with the expectation that the One Devon ICS will achieve financial balance by the end of the year. The deficit support will be repayable in subsequent years.

Financial Position

6. The following detailed report reflects the budget set compared with the actual commitments against that budget for the period to 30 September 2024 and the year ending 31 March 2025.

As at 30 September 2024	Year to date			Forecast		
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000	Plan £000	Actual £000	Variance Favourable / (Adverse) £000
Total Net Expenditure	1,501,185	1,501,185	0	2,948,718	2,948,718	0
Resource Allocation	1,515,395	1,515,395	0	2,977,137	2,977,137	0
Total Commissioned Services	**14,210**	**14,210**	**0**	**28,419**	**28,419**	**0**

7. Overall, NHS Devon is reporting a YTD and FOT planned surplus of £14.2m and £28.4m respectively.

8. Due to the £80.0m in non-recurrent deficit support from NHSE the NHS Devon position sits within an overall FOT balanced system position.

9. As of month 6, projected overspends include £1.9m in Mental Health and £0.5m in Continuing Healthcare (CHC), partially offset by underspends of £0.8m in Acute services and £0.2m in Community Health services. The net overspend has been mitigated by contingencies held in reserves, which were allocated in the initial plan to manage such variances.

10. Service line variances are detailed in the Detailed Financial Performance section and appendix 3.

Savings Plan

11. NHS Devon's updated 2024/25 plan includes a saving requirement of £80.1m.

12. NHS Devon is currently showing YTD savings of £26.1m in line with the plan and is expecting to meet the planned efficiency savings by the year end.

13. Details are disclosed in the Savings and Efficiencies section.

Risks

14. The revised NHS Devon plan identified risks of £22.0m, with mitigations to present a net zero risk, although £14.3m of the mitigations had yet to be identified.

15. At month 6, the risks are estimated at £17.4m, including risks relating to increases in prescription drug prices, growth in Continuing Healthcare costs and efficiency risks. These risks have been offset by assumptions for prescribing pricing, review of non-recurrent opportunities, post plan non-recurrent flexibility and an agreement to share system risk with providers. There are no unidentified mitigations at Month 6.

16. In addition to the financial risks within Continuing Healthcare there is concern around the data quality given current staffing levels. Short term recruitment is being sought to provide additional capacity until the new staffing structures have been finalised.

17. A reminder of these risks is set out in the Risks section of the report.

Detailed Financial Performance

18. The YTD and FOT by main service heading as at 30 September 2024 is as follows:

Service	Year to date			Forecast		
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000	Plan £000	Actual £000	Variance Favourable / (Adverse) £000
Acute	737,509	736,972	537	1,410,431	1,409,619	812
Mental Health	161,920	162,874	(954)	324,429	326,344	(1,914)
Community Health	173,889	173,743	146	351,627	351,434	192
Continuing Care	83,580	83,849	(269)	169,180	169,689	(509)
Primary Care	142,351	142,277	73	282,582	282,559	23
Delegated Primary Care	121,706	121,706	0	232,944	232,944	(0)
Delegated Dental	37,512	37,512	0	75,025	75,025	0
Delegated Pharmacy	18,173	18,173	0	35,719	35,719	0
Delegated Optomotry	6,260	6,259	0	12,520	12,520	0
Other Programme Services	17,975	17,114	861	35,950	35,899	51
Total Commissioned Services	**1,500,875**	**1,500,478**	**396**	**2,930,408**	**2,931,752**	**(1,345)**
Running Costs	9,490	8,490	1,000	18,980	18,980	0
Net Expenditure	**1,510,365**	**1,508,968**	**1,396**	**2,949,388**	**2,950,732**	**(1,345)**
Reserves/Contingencies	(9,180)	(7,783)	(1,396)	(670)	(2,015)	1,345
Total Net Expenditure	**1,501,185**	**1,501,185**	**0**	**2,948,718**	**2,948,718**	**0**
Resource Allocation	1,515,395	1,515,395	0	2,977,137	2,977,137	0
Total Commissioned Services	**14,210**	**14,210**	**0**	**28,419**	**28,419**	**0**

19. Further detail of the budgets, actual spend and variances making up the main service areas above is provided in appendix 3.

Acute Services

20. Acute services include contracts with our main system acute providers as well as contracts with acute providers in Cornwall, Somerset, Bristol and London. It also includes our contract with South Western Ambulance, contracts for patient transport and contracts for acute procedures undertaken in the independent sector and by other non-NHS providers.

21. NHS Devon and system providers have agreed a set of block contract payments that also include top-up payments and growth funding allocations. NHS Devon's budget under these financial arrangements has been set to match the payments.

22. At month 6 there is a FOT underspend of £0.8m. However, £0.5m spend relating to this area is currently sitting in reserves, which will be adjusted for in month 7, resulting in an underspend of £0.3m. This is comprised of a £0.06m overspend in referral management, offset by a similar underspend in Any Qualified Provider (AQP) expenditure, a £0.1m underspend in patient transport, and a further £0.1m underspend resulting from the 2023/24 final agreed position on out of area contracts.

Mental Health Services

23. The Mental Health budget commissions Mental Health, Learning Disability, Autism and Neurodiversity services for adult, children and young people. The main contracts for the services are with Devon Partnership NHS Trust (DPT) and

Livewell Southwest with the CAMHS service for Northern, Eastern and Southern localities being provided by Children and Families Health Devon through a contract with Torbay and Southern Devon NHS Foundation Trust (TSD). This section also includes spend relating to individual adult placements for mental health and learning disability services.

24. In 2024/25 NHS Devon is planning to invest an additional £13.1m (4.46%) in Mental Health services based on the Mental Health Investment Standard target. In addition to this NHS Devon has received £24.0m of Service Development Fund (SDF) Transformation funding for Mental Health and Learning Disability & Autism Services.

25. At month 6 there is a FOT overspend of £1.9m, due to growth in Right to Choose ADHD/ASD assessments (£1.1m) and s117 Learning Disability and Mental Health costs (£0.9m), partially offset by an underspend in Individual Patient Placements (£0.1m).

26. There are a growing number of providers in the Right to Choose ADHD/ASD assessment pathway, with many of them now providing services under the NHS Devon Right to Choose ADHD/ASD assessment contract, which is providing more control and understanding of costs. However, these arrangements are not managing the level of referrals which is impacting on the overall increase in spend.

27. Plans are being developed to seek to address the backlog of children's assessments through a procured service with a single provider which will help reduce the growing right to choose activity. In addition to this we have recently appointed a Woman's and Children's Transformation Director to focus amongst other things on improvements in children's services.

28. Mitigating actions in relation to the placements position are covered in the continuing healthcare section of the report.

Community Health Services

29. Community Healthcare services include contracts with ICS partners for the provision of community healthcare (including community hospitals and children's services) as well as Minor Injury Units.

30. It also includes provision for community based acute procedures delivered through GP practice specialisms and other non-NHS providers as well as joint arrangements with Local Authorities under the provisions of the Better Care Fund.

31. At month 6 there are various over and underspends across Community Health Services both YTD and FOT, resulting in an overall FOT underspend of £0.2m. The main year end predicted overspend is in Physical Disability Placement costs of approximately £0.1m, which is offset by underspends in Discharge to Access costs (£0.3m).

Continuing Healthcare

32. Placements includes Continuing Care budgets comprising of Continuing Care Administration, Continuing Healthcare (CHC), Interim Funding, Joint Funding, Children's Continuing Care and Funded Nursing Care (FNC).

33. The placements budget represents a particular risk to the ICB financial position that requires robust financial management. The key risks relate to local authority disputes to the external provider review programme & breaches from the continuation of 4-week Hospital Discharge Programme.

34. Some examples of other risks include:

- Fluctuations in the number of clients eligible for financial support
- Assessments exceeding 28 days
- Unexpected exceptional levels of support required for some clients
- Responsible commissioner cases

35. The Month 6 forecast is £0.5m over budget. The current overspend is a result of greater than budgeted End of Life and Funded Nursing Care clients but offset, in part, by an underspend in Interim funding. However, it must be noted that there is significant risk in delivery and concerns around data quality given current staffing levels.

36. The following actions are being progressed to address the overspending position within continuing healthcare and placements.

- Resetting the membership and purpose of the control centre to include provider colleagues and focus on discharge.
- Increasing the case mix of assessments completed through the existing external contractor.
- Recruitment to vacancies and Phase 2 structure led by the deputy director of nursing with dedicated HR support.
- Temporary external resource to strengthen the team starting in October.
- Engagement of Channel 3 (digital partner) to scope the work needed to address costs of care and eligibility as well as reductions in support costs from external partners.

Other Programme

37. All Other Programme area picks up the remaining community-based provision of healthcare services including hospice care and other voluntary sector grant based commissioned services. This area also includes the element of our integrated urgent care contract that relates to NHS 111.
38. Although we are reporting a YTD £0.9m underspend across various services at month 6, it is expected that spend will catch up to result in an overall £51k underspend of which £23k relates to the NHS 111 services.

Primary Care Services

39. Primary Care includes expenditure on Primary Care Prescribing, GP Medical Services, Enhanced Services, Out of Hours and Other Primary Care related expenditure including GP IT.

Prescribing

40. Expenditure data for the first four months of 2024/25 was available at the time of reporting and a national forecast has now been made available which gives a forecast that is consistent with a breakeven position.

41. However, there are multiple factors influencing our prescribing expenditure which makes forecasting and comparison to prior periods more difficult than usual. This includes national price changes to Direct Oral Anticoagulant (DOAC) drugs, national changes to Category M and uncertainty surrounding the usage of drugs that are coming off patent.

42. We continue to face price fluctuations with pressures being seen in Apixaban and price reductions expected to be seen in Riveroxaban. At this stage our best estimate is that these moving parts largely net off one another which has led to our continued use of a breakeven forecast.

Delegated GP Commissioning

43. As at month 6 we are reporting a YTD and FOT breakeven position across delegated primary medical care.

Other Primary Care

44. Other Primary Care services include contracts for Enhanced GP Services, Out of Hours GP services, Home Oxygen services and provision for GP IT costs.

45. At month 6, YTD there are minor underspends reported within Out of Hours GP services and Other Primary Care but is expected to breakeven by the year end.

Delegated Pharmacy, Ophthalmic & Dental

46. At month 6 we are reporting a YTD and FOT breakeven position against the delegated POD services. We do however anticipate a potential underspend against the dental allocation even after providing for the dental recovery programme but have not declared this at this stage.

Running Costs

47. The pay and associated costs for NHS Devon are categorised into programme and administrative costs according to whether they relate to healthcare services and are solely concerned with management of the organisation. Variances relating to programme pay costs are reported within other earlier sections including acute services, placements and other programme costs.

48. Each year NHS Devon receives a specific allocation for its running costs and has an obligation to report against it separately and must not overspend against the limit set.

49. NHS Devon's allocation for the year is £19.0m and at month 6 the ICB is reporting a FOT balanced position, with the running costs budgets been set in line with the consultation currently taking place. Further information will be shared in future months.

50. The recent pay award announcement of 5% is above the planning assumption of 2%. NHS Devon has received national funding that covers the cost of the increase.

Resource Allocation

51. Revenue resources contained within our financial plans and financial systems are set out below.

Allocation Description	Year to date ICB
2024/25 Recurrent core allocation	2,337,140
2024/25 Additional discharge allocation	10,641
2024/25 Additional physical and virtual bed capacity fundin	41,869
2024/25 Allocation baseline reset (limited public health exe	859
2024/25 Ambulance capacity funding	7,545
Pay Award - Cost increases on initial allocations	6,743
Learning disability and autism FTA	(917)
Running Costs Allowance	19,461
Delegated Primary Medical Care Services	236,680
Delegated Dental/Optomotry/Pharmacy	122,144
M3 Recurrent Allocations	112
M6 Recurrent Allocations	8,679
Recurrent Allocation	**2,790,956**
SDF Cancer	12,813
SDF Maternity	2,129
SDF LD and Autism	2,916
SDF CYP	710
SDF Mental Health	20,762
SDF Prevention and Long Term Conditions	1,808
SDF Primary Care	3,005
SDF Community Services	1,745
Other SDF	1,924
Elective Recovery Funding	45,437
Adult Long COVID	1,362
Charge exempt overseas visitor and UK cross border adju	(672)
COVID-19 Testing	1,801
Pay Award	800
Repayment of prior year deficit	(11,686)
Delegated ERF	1,808
Delegated Primary Care Allocation	(142)
Delegated Primary Care Allocation - RDUHFT contract	(1,103)
Pay Award - Cost increase on Secondary Dental plans	67
Pay Award - Cost increase on Secondary Dental ERF	8
M3 Non Recurrent Allocations	14,035
M4 Non Recurrent Allocations	22,798
M5 Non Recurrent Allocations	(5,032)
M6 Non Recurrent Allocations	68,888
Non-Recurrent Allocation	**186,181**
Total Allocation	**2,977,137**

52. The key non-recurrent allocations in month 6 include £80m in non-recurrent deficit support and the anticipated removal of £15m of system support funding.

Budget Reserves

53. To support NHS Devon in achieving its financial plan, budget reserves are maintained for both anticipated and unforeseen costs. These reserves currently

include contingency funds, undistributed allocations, as well as, expected non-recurrent allocations.

54. The reserve position at month 6 is as follows:

Reserve Description	Forecast		
	Budget £000	Committed £000	Variance Favourable/ (Adverse) £000
System Reserves	15,211	14,211	1,000
Service Development Funding	14,252	14,252	0
Investment Reserves	(11,551)	(11,731)	180
Allocation Reserves	(18,581)	(18,746)	165
Total	**(670)**	**(2,015)**	**1,345**

55. System reserves relate mainly to undistributed funds from the system plan and will be distributed in year.

56. Service development funds are those allocations yet to be delegated to budgets but that have expected commitments.

57. Investment reserves include recurrent budgets at plan that relate to ICB commitments and efficiency savings (negative reserve) that have yet to be delegated to budgets as well as a contingency.

58. The allocation reserve includes in year allocations received that have yet to be delegated to budgets as well as a provision (negative reserve) for allocations confirmed and distributed at the planning that have yet to be received.

Conclusion

59. Based on the above reported position and detailed analysis the assurance on the reported financial performance is considered **satisfactory**.

Savings and Efficiencies

60. Delivery of the planned surplus of £28.4m requires savings of £80.1m. The table below provides a summary of the month 6 YTD and FOT position against the £80.1m target. The target represents a 2.8% saving against NHS Devon overall resource. If the embedded system provider efficiencies are excluded the remaining savings £37.3m target is 4% of NHS Devon influenceable budget.

Scheme	Plan Status	Risk RAG Status	Recurrent / Non Recurrent	Year to date			Forecast			Plan
				Plan Savings Delivery £000	Actual Savings Delivery £000	Variance Favourable / (Adverse) £000	Plan Savings Delivery £000	Actual Savings Delivery £000	Variance Favourable/ (Adverse) £000	Total
Acute - System provider embedded efficiency	Fully Developed		R	15,786	15,786	0	31,571	31,571	0	31,571
Community - System provider embedded efficiency	Fully Developed		R	3,486	3,486	0	6,970	6,970	0	6,970
Mental Health - System provider embedded efficiency	Fully Developed		R	2,154	2,154	0	4,308	4,308	0	4,308
				21,426	21,426	0	42,849	42,849	0	42,849
Non-System provider embedded efficiency	Fully Developed		R	498	498	0	1,000	1,000	0	1,000
Prescribing - medicines management	Fully Developed		R	735	735	0	2,732	2,732	0	2,732
- secondary care interface	Plans In Progress		R	151	151	0	560	560	0	560
- specific schemes	Fully Developed		R	207	207	0	768	768	0	768
Continuing healthcare	Plans In Progress		R	810	887	77	3,000	3,000	0	3,000
Learning disabilities and autism placements	Fully Developed		R	0	0	0	4,750	4,750	0	4,750
Commissioning	Plans In Progress		R	0	0	0	2,500	2,500	0	2,500
Digital	Fully Developed		R	0	0	0	1,000	1,000	0	1,000
Hold back growth	Fully Developed		R	1,914	1,914	0	3,829	3,829	0	3,829
Running cost reductions	Fully Developed		R	0	0	0	4,177	4,177	0	4,177
In year allocations review	Plans In Progress		N/R	330	330	0	2,000	2,000	0	2,000
Primary care underspend	Fully Developed		N/R	0	0	0	500	500	0	500
Primary Care	Fully Developed		N/R	0	0	0	5,000	5,000	0	0
System risk share	Fully Developed		N/R	0	0	0	5,412	5,412	0	0
Unidentified	Unidentified		N/R	0	0	0	0	0	0	10,412
Total				**26,071**	**26,148**	**77**	**80,077**	**80,077**	**0**	**80,077**

61. The green RAG status denotes plans that are fully developed, or in progress where there is a low risk to delivery. The amber RAG status reflects plans, whether fully developed, in progress or opportunities that have been identified where there is a medium risk to delivery. The red RAG status has been given to those schemes where an opportunity has yet to be identified to the level that plans can be worked up and therefore represents a high risk.

62. The majority of the achievement so far is due to savings already delivered in contracts at tariff.

63. Prescribing savings plans concentrate on the following schemes:

- Addressing Low Priority Prescribing: This includes medications with significant safety concerns, lack of robust evidence of clinical effectiveness,

or those that are clinically effective but deemed a low priority for NHS funding.
- Improving Uptake of Clinically and Cost-Effective Medicines: Promoting the use of the most clinically effective and cost-efficient medications.
- Using Best Value Biologic Medicines: Adhering to NHS England commissioning recommendations to use biologic medicines that offer the best value.
- Appropriate Prescribing and Supply of Blood Glucose and Ketone Meters, and Testing Strips: Ensuring the correct prescribing and supply of these essential items.
- Identifying Patients with Atrial Fibrillation: Using best value direct-acting oral anticoagulants for patients with atrial fibrillation.

64. Continuing healthcare savings plans include the schemes below:

- Continued grip and control of front end assessment threshold and reviews which will reduce client numbers.
- Ensure clients receiving 1:1/2:1 packages are regularly reviewed to determine if care is still appropriate.
- Assess short-term stay hospital discharge clients in a timely manner to determine their long-term funding stream (KPI for CHC Assessment 28 days).
- Review of s117 clients in a timely manner reducing unnecessary costs.

65. The main risks to delivery of NHS Devon savings programme were:

- The learning disabilities and autism placements scheme was linked to a system programme reviewing high costs placements. This programme has since amended its focus on more longer-term strategic opportunities.
- The opportunity to deliver £5m savings in primary care mentioned above was originally targeted at Dental slippage after funding the dental transformation programme.

66. Since Month 5 further work has been completed on reviewing budgets and spend to mitigate the above risks to the extent that we are now confident they can be managed in year.

67. Based on the above analysis and the movement in the risk and maturity of the planas since month 5 assurance of full delivery of the NHS Devon efficiency plan is considered to have moved from limited to **satisfactory.**

Risks

68. The assessment of financial risk (and mitigations) at month 6 and for the year ended 31 March 2025, is as follows.

Headline	Description	M5 £000	M6 £000	Movement £000	Risk at Revised Plan £000
Prescribing	Risk of additional cost where no cheaper stock is obtainable (NCSO) - Price concessions	2,000	2,000	0	2,333
Placements	Inflation/Growth risk on Continuing Healthcare costs	1,500	1,200	(300)	1,314
Contract Risk	Risk in relation to variability on inter-system API contracts	0	0	0	1,035
Better Care Fund	Risk in relation to DCC BCF overspend	2,300	2,000	(300)	0
Learning Disabilities and Autism	Risk to delivery of the £4.8m savings target	4,750	4,750	0	3,563
SWAST	Impact of ongoing negotiations with other ICB partners relating to handover delay cost share	0	0	0	1,000
Inflation Risk	Contract inflationary pressures as a result of the 0.2% tariff reduction	0	0	0	1,532
System Risk Share	Net system risk at plan	1,624	1,624	0	0
Primary Care	Delivery of stretch efficiency target	5,000	5,000	0	0
Drugs and Devices	Risk of additional volume/price changes in acute drugs and devices above contract baseline	780	780	0	780
Efficiency Risk	Unidentified savings	0	0	0	10,412
Total Risk		**17,954**	**17,354**	**(600)**	**21,969**
Prescribing	Prescribing pricing and Cat. M assumptions	2,000	2,000	0	2,000
Inter-system capacity	Potential for repatriation	0	0	0	1,000
Allocation Review	Hold back further non recurrent allocations above savings target	0	0	0	1,200
System Risk Share	Agreement to share system risk with providers	310	310	0	3,445
Primary Care	Identification of non-recurrent opportunities	5,000	5,000	0	0
Reserves	Post plan non-recurrent flexibility	7,591	6,991	(600)	0
CIP Stretch Opportunities	Identification of non-recurrent opportunities	3,053	3,053	0	0
Unidentified Mitigations	Plans to be identified	0	0	0	14,324
Total Mitigation		**17,954**	**17,354**	**(600)**	**21,969**
Net Risk		**0**	**0**	**0**	**0**

69. The revised NHS Devon plan identified risks of £22.0m, with mitigations to present a net zero risk, although £14.3m of the mitigations had yet to be identified.

70. At month 6, the risks are estimated at £17.4m, including risks relating to increases in prescription drug prices, growth in Continuing Healthcare costs and efficiency risks. These risks have been offset by assumptions for prescribing pricing, review of non-recurrent opportunities, post plan non-recurrent flexibility and an agreement to share system risk with providers.

71. The following controls, actions and assurances are in place to manage this risk:

- In conjunction with Devon County Council an options paper is being prepared that seeks to mitigate the current projected BCF overspend. This work to produce the options paper has resulted in a reduction of the risk.
- A business case is being prepared by the Nursing directorate address the recommendations of the Channel 3 review into continuing care as well as the current lack of internal resource. Whilst this is ongoing other work on the delivery of the efficiencies has allowed us to reduce the overall risk in placements.
- Identification of PDC benefit as a result of NHSE bridging the system deficit.
- System Recovery Plan (which is encapsulated in the 2024/25 operational and financial plans) in place. This is a dynamic plan that continually assesses progress against system-wide savings, identification of new schemes and performance against key finance and performance trajectories.
- Implementation of tighter restrictions in relation to new investment that requires Devon Investment Approval with investment over £10k needing to be agreed through the investment process.
- Implementation of a budget holder manual which has been rolled out to Executive Budget Holders and Budget Managers to be followed up through formal budget delegation and holding budget holders/managers to account through monthly meetings.

72. Based on the reduced levels of overall risk and unmitigated risk it is proposed the assurance that the ICB risks can be managed is considered **satisfactory.**

Other Financial Information

Statement of Financial Position

73. The statement of financial position (SoFP) provides a snapshot of NHS Devon's financial position at that date. The SoFP is made of two parts which must always equal each other: the top part (total assets employed) which shows NHS Devon's assets and liabilities (what the ICB owns and is owed), and the bottom part (total taxpayers' equity) which shows how NHS Devon has been financed.

74. NHS Devon's position at 30 September 2024 is shown in appendix 1.

Capital

75. NHSE have approved NHS Devon capital schemes totalling £2.15m. Schemes include £0.30m for primary care capital grants, £1.74m GP IT and just over £0.1m for NHS Devon IT needs.

Better Payment Practice Code

76. The Better Payment Practice Code requires NHS Devon to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

77. NHS Devon's current performance against the target of 95% is detailed below:

Better Payment Practice Code	M06	
	Number	£000
Non NHS Creditors - % of bills paid within target	99.86	99.74
NHS Creditors - % of bills paid within target	99.84	100.00

Cash

78. There are several key cash performance targets that ICBs are measured against; these are set out in appendix 2.

Assurance and Recommendations

79. Based on the assessment of the key issues and risks identified the overall level of assurance NHS Devon will achieve its planned forecast outturn is as follows:

Section	Assurance	Trend from previous month
Overall assurance	**Satisfactory**	**No change**
Financial performance	Satisfactory	No change
Savings and efficiencies	Satisfactory	Improvement
Financial risks	Satisfactory	No change

80. The NHS Devon Board is asked to **take assurance** from the information provided with regard to the NHS Devon financial position as at the period ended 30 September 2024.

81. The Board is also asked to agree the overall assurance level relating to the financial position of NHS Devon of **satisfactory assurance** and agree that adequate plans are in place to mitigate the risks relating to the delivery of planned savings and efficiencies and to the management of the financial risks identified at plan stage.

Appendix 1: Statement of Financial Position

Statement of Financial Position	M6
Property Plant & Equipment	5,508
Intangible Assets	0
Non Current Assest	**5,508**
Inventories	1,903
Trade & Other Receivables - NHS	404
Trade & Other Receivables - Non NHS	32,233
Cash & Cash Equivalents	1,670
Current Assets	**36,210**
Total Assests	**41,718**
Trade & Other Payables - NHS	(55,804)
Trade & Other Payables - Non NHS	(109,760)
Other Liabilities	(5,478)
Borrowings / Cash in Transit	(6,875)
Provisions	(2,203)
Current Liabilities	**(180,120)**
Total Assets Employed	**(138,401)**
General Fund	(138,401)
Total Taxpayers Equity	**(138,401)**

Appendix 2: Cash

There are several key cash performance targets that the ICB is measured against:

Measure	Month 6
ICBs must operate within their Cash Drawdown Requirement *The cash drawdown requirement is based on the revenue and capital resource limits, amended for various non-cash items like depreciation. At present NHS England has calculated this to equate to £2,948m for Devon ICB for the period ended 31st March 2025.*	52.4% of the Cash Drawdown Requirement has been utilised as at month 6 where 50.0% would be expected based on a straight-line trajectory. The additional drawdown used is partly due to payments made in 2024/25 that relate to 2023/24 where allocations were received too late for drawdown in 2023/24.
ICBs daily and monthly forecasting accuracy and notional charges NHS England is working on implementing a regime of bank charges against ICBs based on the accuracy of daily and monthly cash forecasting*. The start date for any charges to flow through the scheme to the ICB has not yet been confirmed.	The calculations used for the notional charges for September are currently being reviewed by NHSE and Shared Business Services.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown.	The ICB has met the requirement to manage their cash balance at the bank on the last day of the month to be no greater than 1.25% of the drawdown for that month.

**Although forecasting is carried out as accurately as possible it sometimes difficult to predict 2 months in advance (the requirement by NHS England) the exact timings and amounts of all income received and all payments made.*

Appendix 3: Operating Expenditure

The detailed financial position as at 30th September 2024 and 31st March 2025.

Service	Year to date			Forecast		
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000	Plan £000	Actual £000	Variance Favourable / (Adverse) £000
NHS Royal Devon & Exeter Foundation Trust	309,673	309,673	(0)	572,168	572,168	(0)
NHS University Hospitals Plymouth NHS Trust	186,634	186,634	0	365,480	365,479	0
NHS Torbay and South Devon NHS FT	149,701	149,679	23	298,479	298,479	0
NHS South Western Ambulance Trust	41,271	41,271	0	82,542	82,542	0
NHS Taunton and Somerset	5,580	5,501	78	11,159	11,081	78
Independent Sector	17,993	17,979	13	36,606	36,606	0
Low Volume Activity	8,997	8,997	0	8,997	8,997	0
Non Contract Activity	2,080	2,080	(0)	4,540	4,540	0
AQP	1,055	1,022	33	2,110	2,043	67
Referrals Management	1,151	1,179	(29)	2,301	2,361	(60)
Patient Transport	6,300	6,194	107	12,601	12,480	121
Other Acute Services	7,074	6,763	312	13,449	12,844	605
Acute	**737,509**	**736,972**	**537**	**1,410,431**	**1,409,619**	**812**
Devon Partnership NHS Trust	94,898	94,898	0	189,796	189,795	1
Livewell MH Services	4,092	4,093	(0)	8,185	8,185	0
University Hospitals Plymouth MH	22,903	22,903	0	45,807	45,807	0
Children and Families Health Devon	10,527	10,527	0	21,054	21,054	0
Individual Patient Placements	7,684	7,646	38	15,457	15,382	75
Section 117	14,613	15,070	(456)	29,727	30,639	(913)
ADHD	771	1,309	(538)	1,541	2,617	(1,076)
MH Low Volume Activity and NCA	422	422	(0)	844	844	(0)
Other Mental Health	6,009	6,007	3	12,019	12,021	(2)
Mental Health	**161,920**	**162,874**	**(954)**	**324,429**	**326,344**	**(1,914)**
Livewell Southwest	251	251	0	502	502	0
Royal Devon and Exeter Community	51,523	51,523	0	103,047	103,047	0
Torbay and South Devon FT	36,781	36,781	0	73,562	73,562	0
University Hospitals Plymouth Community	31,044	31,044	0	62,088	62,088	0
Children and Families Health Devon	6,972	6,972	(0)	13,945	13,945	(0)
Individual Patient Placements	1,040	1,072	(32)	2,170	2,234	(64)
SWAST Tiverton MIU	815	815	1	1,630	1,629	1
MIU Contracts	240	187	53	480	477	2
Hospices	4,703	4,705	(1)	9,406	9,406	0
Better Care Fund_Plymouth CC	4,292	4,292	0	8,584	8,584	0
Better Care Fund_Devon CC	19,259	19,259	0	42,251	42,251	0
Better Care Fund Torbay	2,046	2,046	(0)	4,092	4,092	0
Demand and capacity	1,620	1,583	37	3,239	3,174	65
Prevention	1,630	1,629	0	3,260	3,260	0
Other Community Services	11,673	11,583	90	23,371	23,183	188
Community Health	**173,889**	**173,743**	**146**	**351,627**	**351,434**	**192**
Continuing Healthcare	74,212	74,280	(68)	150,245	150,352	(107)
Funded Nursing Care	9,368	9,569	(201)	18,935	19,338	(403)
Continuing Care	**83,580**	**83,849**	**(269)**	**169,180**	**169,689**	**(509)**

Service	Year to date			Forecast		
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000	Plan £000	Actual £000	Variance Favourable / (Adverse) £000
Prescribing	120,169	120,169	0	240,338	240,338	(0)
Enhanced Services	7,008	7,008	0	14,015	14,015	0
Delegated Commissioning - Co Comm	121,706	121,706	0	232,944	232,944	(0)
Delegated Commissioning - Optometry	6,260	6,259	0	12,520	12,520	0
Delegated Commissioning - Pharmacy	18,173	18,173	0	35,719	35,719	0
Delegated Commissioning - Dental	37,512	37,512	0	75,025	75,025	0
GP Out Of Hours	4,948	4,882	66	9,896	9,896	0
GP IT	2,155	2,155	0	4,310	4,310	0
Other Primary Care	8,071	8,064	7	14,024	14,000	23
Primary Care	**326,002**	**325,927**	**74**	**638,790**	**638,767**	**23**
NHS 111	6,087	6,074	13	12,174	12,151	23
Chime Audiology	2,216	2,176	40	4,432	4,432	0
All Other Commisionned Services	9,672	8,864	808	19,344	19,316	28
Other Programme	**17,975**	**17,114**	**861**	**35,950**	**35,899**	**51**
Total Commissioned Services	**1,500,875**	**1,500,478**	**396**	**2,930,408**	**2,931,752**	**(1,345)**
Pay	7,097	5,580	1,517	14,194	14,194	0
Non Pay	2,412	2,910	(498)	4,824	4,824	0
Income	(19)	(0)	(19)	(39)	(39)	0
Running Costs	**9,490**	**8,490**	**1,000**	**18,980**	**18,980**	**0**
Net Expenditure	**1,510,365**	**1,508,968**	**1,396**	**2,949,388**	**2,950,732**	**(1,345)**
System Reserves	7,691	0	7,691	15,211	14,211	1,000
SDF Reserves	7,070	0	7,070	14,252	14,251	0
Investment Reserves	1,375	6,897	(5,522)	(6,838)	(10,565)	3,727
Non Recurrent ICB Reserves	(25,316)	(14,680)	(10,635)	(23,294)	(19,912)	(3,383)
Total Net Expenditure	**1,501,185**	**1,501,185**	**0**	**2,948,718**	**2,948,718**	**0**
Resource Allocation	1,228,167	1,228,167	0	2,899,570	2,899,570	0
Total Surplus	**(273,018)**	**(273,018)**	**0**	**(49,148)**	**(49,148)**	**0**

NHS Devon Integrated Care Board

One Devon (ICS) Finance Report M6

Date of meeting	Date report produced
28 November 2024	22 October 2024

Author(s)		Report approved by	
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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
N/A

Executive summary
The presentation of the One Devon Integrated Care System (ICS) Finance Report seeks to provide the necessary assurance on the financial position and risk relating to the ICS financial plan for the year ending 31 March 2025. The report details the One Devon ICS financial position for the period ended 31 August 2024 against the finance plan submitted for the financial year 24/25 on the 12 June 2024. This report is accompanied by an 'Integrated Care System Financial Performance and Assurance Review' slide pack that has been developed for NHS Devon to use as part of its monthly financial assurance reviews that it carries out with the Trusts.

NHS Devon carried out financial assurance reviews with all Trusts in September 2024.

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance	Trend from previous month
Overall assurance	**Satisfactory**	**No change**
Financial performance	Satisfactory	No change
Savings and efficiencies	Limited	No change
Financial risks	Limited	No change
Workforce	Satisfactory	No change

Committees that have previously discussed/agreed the report, and outcomes of that discussion

NHS Devon Executive reviewed this report on 05 November 2024. It was also reviewed by the Finance and Performance Committee at its meeting on 14 November 2024.

Key recommendations and actions requested

AGREE the overall assurance level relating to the financial position of the One Devon Integrated Care System of **satisfactory** and that adequate plans are in place to mitigate the risks relating to the delivery of planned savings and efficiencies and to the management of the financial risks identified at plan stage.

Impact on NHS Devon objectives

Objective	Impact
Improve population health	**All**
Improve services and reduced unwarranted variation	
Make more efficient use of our resources	
Develop our culture and how we operate	

Outline the implications of matters covered in this report for the following areas

Area	
Quality of services	None
Health inequalities	None

Workforce	None
Resources and finance	Delivery of financial sustainability
Legal	None
Digital and Data	None
Engagement and consultation	None

One Devon (ICS) Finance Report M6

Financial Performance to date

1. The presentation of the One Devon Integrated Care System's (ICS) Finance Report seeks to provide the necessary assurance on the financial position of the ICS for the year ending 31 March 2025.

2. This report details the One Devon ICS financial position as at 30 September 2024.

3. As part of the 2024/25 planning round, One Devon ICS initially submitted a deficit plan of £85.4m. This position was revised to a deficit plan of £80.0m, against which finances have been monitored since month 2, with the £5.4m improvement being managed through a system risk share. In month 6 the receipt of £80m non-recurrent deficit funding, phased in the second half of the year, has enabled the One Devon ICS to forecast delivery of a balanced outturn for 2024/25.

4. The year to date position at month 6 is adverse by £0.7m, reflecting the residual unfunded element of industrial action.

5. The One Devon ICS is reporting £66.6m efficiency achievement in the first 6 months of the year. This is £5.7m above plan. The forecast is to achieve the plan of £213.3m.

6. At the planning stage risks of £88m were identified of which £17m were mitigated, resulting in a net risk of £71m. Gross risks by month 6 have reduced to £94m, driven in majority by risks relating to the efficiencies programme, resulting in a net risk of £35m which is an improvement of £6.1m on month 5.

7. The committee can take **satisfactory assurance** that the plan to date is delivering subject to the unforeseen impact of industrial action.

8. The headline messages in the following sections are considered in further detail in the attached 'Integrated Care System Financial Performance and Assurance Review' slide pack (Appendix 1). This slide pack has been developed to support obtaining an increased in-depth financial assurance from the organisations within the system.

Financial Position (see detail in Section 1 of the ICS Financial Review Pack)

9. In month 6 the receipt of £80m non-recurrent deficit funding phased in the second half of the year has enabled the One Devon ICS to forecast delivery of a balanced outturn for 2024/25.

10. As at month 6 the One Devon ICS is reporting a year to date £15.9m deficit against an plan deficit of £15.2m. The cumulative position at month 6 is adverse by £0.7m, reflecting the financial impact of the proportion of industrial action that was unfunded. The forecast for the year is currently at breakeven. The year to date and forecast position as at 30 September 2024 is as follows:

Organisation	Year to date			Forecast		
	Plan surplus / (deficit) £000	Actual surplus / (deficit) £000	Variance favourable / (adverse) £000	Plan for the year surplus / (deficit) £000	Forecast surplus / (deficit) £000	Variance favourable / (adverse) £000
Devon ICB	14,210	14,210	(0)	28,419	28,419	0
Devon Partnership NHS Trust	1,974	1,974	0	3,591	3,591	0
Royal Devon University NHS FT	(11,059)	(11,051)	8	(2,790)	(2,790)	0
Torbay and South Devon NHS FT	(9,622)	(9,622)	0	(13,624)	(13,624)	0
University Hospitals Plymouth NHST	(10,701)	(11,404)	(703)	(15,596)	(15,596)	(0)
Total	**(15,198)**	**(15,894)**	**(696)**	**(0)**	**0**	**0**

11. A straight-line extrapolation of the year to date spend predicts a £85.4m deficit. This run-rate forecast can be bought back to a balanced position once non-recurrent allocations and efficiencies to be delivered in H2 are taken into account.

Efficiencies (see detail in section 2 of the ICS Financial Review Pack)

12. The One Devon ICS is reporting £66.6m efficiency achievement in the first 6 months of the year. This is £5.7m above plan. The forecast is to achieve the plan of £213.3m.

13. The Devon Partnership NHS Trust (DPT) position YTD is impacted by the phasing of schemes as they have matured. Whereas, the University Hospitals Plymouth NHS Trust (UHP) over performance YTD is related to early achievement of non recurrent savings, which is forecast to return to plan.

14. The One Devon ICS has delivered against the significant step-up in planned delivery since quarter 1.

Organisation	Year to date			Forecast		
	Plan CIP delivery £000	Actual CIP delivery £000	Variance fav / (adv) £000	Plan for the year £000	Forecast £000	Variance fav / (adv) £000
Devon ICB	4,645	4,722	77	37,228	37,228	(0)
Devon Partnership NHS Trust	7,408	7,030	(378)	15,739	15,730	(9)
Royal Devon University NHS FT	21,187	22,484	1,297	63,610	63,610	0
Torbay and South Devon NHS FT	10,648	10,663	15	39,900	39,900	0
University Hospitals Plymouth NHS Trust	16,994	21,677	4,683	56,801	56,802	1
Total	**60,882**	**66,576**	**5,694**	**213,278**	**213,270**	**(8)**

15. The 2024/25 plan is that 70% of savings as recurrent and is on forecast to deliver. At month 6, 56% of year to date efficiency was recurrent (59% M5), against a plan of 75%.

16. At month 6, there is a shortfall in recurrent savings of £6.3m, which has been offset by delivery of non-recurrent savings £12m ahead of the plan at this point in the year. Providers expect all but £1.8m of efficiencies to return to the planned proportions of recurrent and non-recurrent savings by the year-end as schemes mature.

	Year to date			Forecast		
	Plan CIP delivery £000	Actual CIP delivery £000	Variance benefit / (adverse) £000	Plan for the year £000	Forecast £000	Variance benefit / (adverse) £000
Recurrent efficiencies	45,985	39,727	(6,258)	150,076	148,234	(1,842)
Non-recurrent efficiencies	14,897	26,849	11,952	63,202	65,034	1,832
Total	**60,882**	**66,576**	**5,694**	**213,278**	**213,268**	**(10)**
Recurrent %	75.5%	59.7%		70.4%	69.5%	
Non-recurrent %	24.5%	40.3%		29.6%	30.5%	

17. None of the efficiencies target remains unidentified at month 6 with scheme maturity progressing. 71% of schemes are rated as fully developed (57% M5) and high-risk schemes have reduced from 18% to 10%.

18. Risks to the delivery of the system CIP plan are:

- The profile of savings is strongly skewed to the second half of the year, with 71% of the savings plan profiled for delivery in H2.
- Recurrent efficiencies has not been delivered fully to plan as at Month 6. The shortfall of £6.3m is offset by the non-recurrent savings achievement, which has been recognised earlier in the year than planned.
- High risk schemes are at 10% (18% M5).

19. Based on the above there is **limited assurance** around delivering the the full efficiency requirement.

20. Proposed mitigations:.

- The ICB Chief Finance Officer holds monthly Financial Assurance Reviews with all providers where the recurrent vs non-recurrent delivery risk is discussed.
- Trusts have achieved a reduction in unidentified efficiences to zero by the end of Month 4 and this will is followed by reviewing the progress of scheme maturity monthly.
- Trusts have worked on de-risking efficiency plans so that less than 20% of the efficiency plan is high risk by end of month 5 and have reduced this further to 10% at the end of month 6.

Financial Risks (see detail in section 3 of Financial Review Pack)

21. At the planning stage risks of £88m were identified of which £17m were mitigated, resulting in a net risk of £71m. Gross risks by month 6 have reduced to £94m, driven in majority by risks relating to the efficiencies programme resulting in a net risk of £35m which is an improvement of £6.1m on month 5.

22. There is currently therefore only **limited assurance** regarding management of the financial risks identified by the system as they remain significant.

	DPT £000	RDUH £000	TSD £000	UHP £000	ICB £000	System £000	*System Prior month £000*
Total risks	**-3,498**	**-28,667**	**-20,245**	**-24,039**	**-17,354**	**-93,803**	***-103,539***
Total mitigations	**0**	**22,384**	**11,067**	**8,000**	**17,354**	**58,805**	***62,331***
Unmitigated risk per PFR	**-3,498**	**-6,283**	**-9,178**	**-16,039**	**0**	**-34,998**	***-41,208***

23. NHS Devon has a risk on the corporate risk register relating to 'Delivery of the System Control Total for 2024/25' with a residual risk score of 16 (4 Likelihood x 4 Impact).

24. The following controls and assurances are in place to manage this risk:

- Establishment of Programme Management Office (PMO) and review and escalation processes for variance from agreed trajectory.
- Integrated Care System (ICS) monthly finance report for escalation to Finance and Planning Board (FPB), and Senior Leadership Group.
- System Recovery Plan (which is encapsulated in the 2024/25 operational and financial plans) in place. This is a dynamic plan that continually assesses progress against system-wide savings, identification of new schemes and performance against key finance and performance trajectories.
- System Vacancy Control Panel in place to prevent an increase in workforce growth and to support a reduction in running costs.
- Triple Lock Sign-Off Process in place for all revenue investments above £100k, with sign-off required by the organisation, system and NHS England (NHSE) regional team.
- Cost Improvement Programmes (CIPs) in place that contain cost reduction strategies that aim to identify and implement measures to achieve cost savings and efficiency improvements while maintaining or enhancing the quality of healthcare services provided to patients.
- Monthly Finance and Performance Assurance packs developed with monthly meetings with all providers.
- System wide implementation of finance playbook.
- Run Rate analysis developed locally to inform risk profile.

Workforce, including agency (see detail in section 4 of the ICS Financial Review Pack)

25. The One Devon ICS is reporting a less than 0.1% (£8.7m) adverse expenditure against plan at month 6. Of this total, additional income to offset pay costs above the plan of £7.3m has been received, resulting in an unfunded variance of £1.4m. The forecast indicates a £17m adverse expenditure, which is offset in part by additional funding receipts such as externally funded posts and packages of care which were not in place at planning stage.

	Year to date (excl capitalised)			Full Year (excl capitalised)			WTE current month		
Class	Plan £000	Actual £000	Variance fav/(adv) £000	Full Year Plan £000	Forecast £000	Variance fav/(adv) £000	Plan wte	Actual wte (per PWR)	Variance fav/(adv)
Substantive	838,059	841,972	-3,913	1,669,041	1,675,146	-6,105	32,157	31,830	327
Bank	42,129	46,169	-4,040	76,062	86,010	-9,948	1,195	1,372	-177
Agency	20,212	21,004	-792	37,566	38,558	-992	448	572	-123
	900,400	909,145	-8,745	1,782,669	1,799,714	-17,045	33,800	33,774	26

26. Trusts reported an overspent position YTD of £0.8m against plan on agency costs at month 6 (M5 £0.6m adv). The forecast indicates the adverse position at year end is £1m.

27. TSD is £2.7m adverse to plan year to date (M5 £2.4m), however the rate of deterioration is reducing.

28. Off framework agency staff are low numbers and specific actions are being taken to address each individual case. Some instances are due to continuation of contracts to their end to avoid penalties. Situation is monitored in detail by the Workforce Delivery Group.

Organisation	Agency expenditure: year to date			Forecast		
	Plan £000	Actual £000	favourable / (adverse) £000	Plan for the year £000	Forecast £000	favourable / (adverse) £000
Devon Partnership NHS Trust	4,908	5,647	(739)	8,506	9,978	(1,472)
Royal Devon University NHS FT	9,390	7,082	2,308	18,530	14,164	4,366
Torbay and South Devon NHS FT	3,359	6,065	(2,706)	5,657	9,711	(4,054)
University Hospitals Plymouth NHST	2,555	2,210	345	4,873	4,705	168
Total	20,212	21,004	(792)	37,566	38,558	(992)

29. NHSE set a system level agency cap of £51.1m (2.9% of total pay) in 2024/25. The system has planned to restrict agency costs to £37.6m (2.1% of pay costs). The forecast position indicates that this lower target will be overspent by £1m.

30. Further mitigations are in place through the Workforce Delivery Group which is focused on 5 priority areas that will drive down both workforce numbers and costs. The priority areas are:

- Temporary staffing (medical and non-medical) - To improve service and workforce resource planning, such that the requirement for temporary staffing is understood, in advance, and managed. Overall shift from agency to bank to substantive.
- Workforce Transformation - To develop a co-ordinated approach to addressing workforce needs for the present and future. To design a

standardised approach to planning the workforce resource, to get the best out of a limited resource.

- Rostering - To gain the maximum benefit from planning staff resources through rostering tools.
- Medical Productivity - Aim to create a system wide approach to improving the administration and management of the job-planning process. Focus on "non-standard" job plan expectations, but with the understanding that this will be a long-term shift.
- Workforce Controls - Continuation of standard good practice that has evolved in recent years, pushing down on non-standard approaches to recruiting and challenging the need for all new staff. The RSP team have concluded a workforce control audit which will be reviewed by providers to agree further actions required.

31. The committee can take **satisfactory assurance** that the workforce controls and priority areas will deliver the workforce cost and WTE reductions.

Organisational Positions

32. Sections 6-9 of the attached Financial Assurance and Performance packs provide the detail for each organisation within the system. The detail of the NHS Devon position is contained within a separate report.

Capital

System Capital (Including impact of IFRS 16)

Organisation	Plan	Actual	Variance	Plan	Allocation	Forecast	Variance to Plan
	YTD	YTD	YTD	Year Ending	Year Ending	Year Ending	Year Ending
	£'000	£'000	£'000	£'000	£'001	£'000	£'000
Devon Partnership Trust	2,206	1,128	1,078	10,333	8,480	9,764	569
Royal Devon University NHS FT	8,111	8,470	(359)	50,528	35,827	54,703	(4,175)
Torbay and South Devon NHS FT	7,253	5,001	2,252	22,071	17,472	19,073	2,998
University Hospitals Plymouth Trust	24,131	9,755	14,376	54,396	43,597	49,070	5,326
	41,701	**24,354**	**17,347**	**137,328**	**105,376**	**132,610**	**4,718**

33. Year to date provider spending is £14.3m below plan in relation to capital expenditure, this is in part due to delays whilst plans were reprioritised due to capital allocation of less than plan.

34. Devon providers have a total allocation of £105.4m which includes the £20m system IFRS16 allocation. Forecast expenditure currently £4.7m below plan, but above allocation by £27.2m. Clarification is being sought from NHSE on whether the system should be managing to plan or allocation and whether national contingency will be available.

35. Providers are reporting that capital limitations are impacting operational delivery. A review of operational and clinical risks across the system around the limitations in capital over the MTFP period has been commissioned and the first draft has been reviewed. Additional analysis has been requested and a final report is due in November.

36. Appendix 2 is the capital slide pack for Month 6 that was reviewed with the region during October which provides further detail. (to follow)

Productivity

37. The Devon system has seen significant productivity improvements year to date compared to the first four months of 2023/24, with an improvement of 7%.

38. This is primarily driven by higher activity growth despite industrial action earlier in the year. This improvement is the best in the southwest and more than double the national improvement.

Organisation	M1-4 compared to prior year		
	Inflated Adjusted	Cost Weighted	Implied Productivity
Royal Devon University NHS FT	5.5%	14.4%	8.4%
Torbay and South Devon NHS FT	0.9%	4.6%	3.7%
University Hospitals Plymouth NHS	5.5%	13.3%	7.3%
Devon	4.3%	11.7%	7.0%
National	4.0%	6.9%	2.8%

Assurance and Recommendations

39. Based on the discussions held with ICS organisations and review of the financial and workforce reports from each organisation it is recommended that the overall level of assurance that the ICS will achieve the planned forecast outturn for 2024/25 as at Month 6 is as follows:

Section	Assurance	Trend from previous month
Overall assurance	**Satisfactory**	**No change**
Financial performance	Satisfactory	No change
Savings and efficiencies	Limited	No change
Financial risks	Limited	No change
Workforce	Satisfactory	No change

40. The NHS Devon Board is requested to **AGREE** the overall assurance level relating to the financial position of the One Devon Integrated Care System of **satisfactory assurance** and that adequate plans are in place to mitigate the risks relating to the delivery of planned savings and efficiencies and to the management of the financial risks identified at plan stage.

NHS Devon Integrated Care Board (ICB)

Integrated Care System (ICS) financial review pack, month 06
September 2024

Updated: 21 October 2024

#OneDevon

Scope, objectives and decisions

Scope and objectives

Present the headline indications of the financial performance across the System: emerging pressures, efficiency progress and expectations.

Part 1 sections

1. Financial reporting and forecast versus plan and run rate indicators
2. Bridge from run-rates to Organisations' full year plans 2024/25
3. Efficiency programme delivery and planning status across system
4. Summary of risks identified at organisation level and impact on the ICS
5. High level workforce indications from Provider Workforce Returns (PWR)

Part 2 sections

6. Devon Partnership NHS Trust
7. Royal Devon Hospitals NHS Foundation Trust
8. Torbay and South Devon NHS Foundation Trust
9. University Hospitals Plymouth NHS Trust
10. Devon ICB

Decisions / agreement required regarding

- Determine the adequacy of the reporting of each element
- Consider further development of monthly monitoring reporting

NHS Devon ICS summary at month 06

1.0 - Financial reporting and forecast

- With the receipt of £80m NR deficit funding in M06, the ICS is forecasting to deliver a balanced outturn for the year.
- Trusts have received funding to address the costs of industrial action in Q1. The ytd position has improved from £2.7m adverse to £0.7m adverse as a result.
- Forecast pressure on pay, purchase of healthcare and clinical supplies and services, offset by additional income and underspends on premises and 'other' non-pay costs. The favourable position on drugs expenditure is forecast to deteriorate in H2.

3.0 - Efficiency programme

- ICS performance at M06 is £5.7m above plan (*M05 £0.3m*). This is the result of NR mainly non-pay savings achieved early. Recurrent schemes are £1.6m below plan (*M05 £2.0m adv*).
- CIP forecast is to deliver the plan. NR proportion of forecast at 30%, in line with plan:
  - RDUH is forecasting a £7.5m switch from NR to recurrent schemes as a result of developing maturity of CIP planning during the year.
  - UHP is forecasting a £8.0m switch from recurrent to NR schemes. UHP plans to reverse this by the year-end.
- The System is reporting significant improvements in scheme maturity and risk assessment in M06. 71% of scheme value is reported as fully developed (*M05 57%*). 60% of scheme value is reported as low risk (*M05 48%*).
- TSD and UHP are reporting high risk schemes over 15% of the Trusts' programme value.

4.0 - Risks and mitigations

- The ICS is reporting £35.0m of net unmitigated risk (*M05 £41.2m*). The majority of the unmitigated risk value identified relates to the CIP programme.

5.0 - Workforce indicators

- YTD expenditure is above plan by £8.7m (*M05 £7.4m*). Pay costs are above plan mainly in substantive (£3.9m) and bank staffing (£4.0m). The summary analysis of the YTD cost to plan indicates that circa £1.4m of the adverse position is unfunded.
- Forecast expenditure is £17.0m adverse to plan (*M05 £3.8m*). TSD has revised its forecast and is now reporting a £8.6m forecast overspend in pay. RDUH is also reporting a further £4m pressure on the pay forecast. Substantive pay expenditure forecast is £6.1m adverse (*M05 £3.8m adv*), and bank expenditure forecast has risen to £9.9m
- WTE numbers are 26 below plan in M06 (*M05 96 wte below plan*). It is recognised that there are inconsistencies between the wte total count in contractual obligations against the "productive" wte count in the PWRs. This continues to be investigated.
- Bank and agency expenditure and wte numbers are above plan.

1.0 - Financial Position, month 06.

The ICS has received £80m NR deficit funding and trusts have received funding to cover the costs of industrial action in M06

Data from organisational PFR and IFR returns

Organisation	Year to date			Forecast		
	Plan surplus / (deficit) £000	Actual surplus / (deficit) £000	Variance favourable / (adverse) £000	Plan for the year surplus / (deficit) £000	Forecast surplus / (deficit) £000	Variance favourable / (adverse) £000
Devon ICB	14,210	14,210	(0)	28,419	28,419	0
Devon Partnership NHS Trust	1,974	1,974	0	3,591	3,591	0
Royal Devon University NHS FT	(11,059)	(11,051)	8	(2,790)	(2,790)	0
Torbay and South Devon NHS FT	(9,622)	(9,622)	0	(13,624)	(13,624)	0
University Hospitals Plymouth NHST	(10,701)	(11,404)	(703)	(15,596)	(15,596)	(0)
Total	**(15,198)**	**(15,894)**	**(696)**	**(0)**	**0**	**0**

Comments on position

- The ICS has received £80m NR deficit funding in M06. The forecast position is adjusted from £80m deficit in M05 to a balanced position in M06.
- Trusts have received funding to cover the costs incurred from industrial action in Q1. The ytd adverse variance has improved to £0.7m (*M05 £2.7m adv*) as a result.
- Forecasts are set to achieve plan at each organisation.

1.1 - Summary financial performance, month 06.

Data from organisational PFR and IFR returns

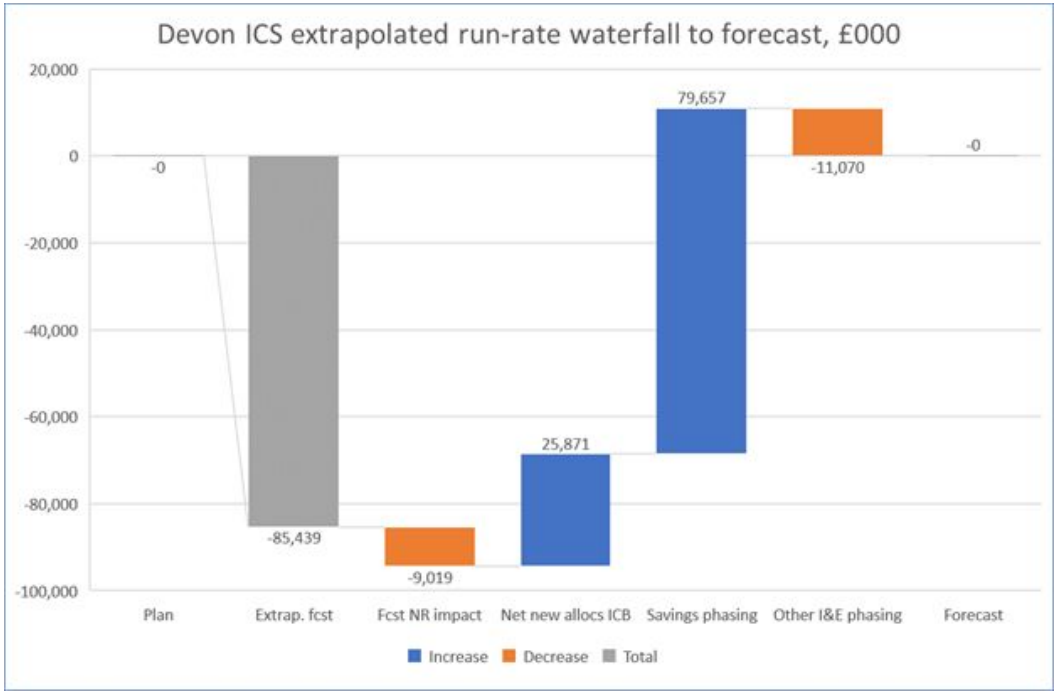
Commentary

- YTD variance £0.7m adverse, after trusts' receipt of funding to cover costs incurred through industrial action in Q1.
- Pay ytd variance £8.6m adv (*M05 £7.3m adv*). In-month expenditure against plan has improved significantly at TSD. The forecast overspend has increased to £16.7m (*M05 £3.5m*). This is due mainly to TSD revising its forecasts in M06, such that pay is now forecast at £8.6m adverse.
- Non-pay pressures in purchased healthcare, £3.4m in M06 forecast to increase significantly to £23.8m adverse, mainly at UHP. Additional funding from NHSE is forecast to mitigate much of this increase.
- Drugs expenditure improvement to £1.3m favourable in M06 (*M05 £0.2m fav*), is not forecast to be maintained with £4.8m adverse forecast.
- Extrapolated run-rate is based on straight-line extrapolation of actual year to date figures. However, the ICB income allocation, has been profiled as per forecast rather than straight lined, in order to ensure that large allocation amendments, such as the £80m deficit support, do not distort the run-rate prediction.

Class	Group	Plan ytd £000	Actual ytd £000	Variance fav/(adv) £000	Variance fav/(adv) (%)	FY Plan £000	Forecast £000	Fcst vs Plan fav/(adv) £000	Fcst vs Plan fav/(adv) (%)	Extrapolated run rate £000	Run-rate vs plan fav/(adv) £000	Run-rate vs plan fav/(adv) (%)
Op Inc	Income NHSE PC	-361,496	-365,279	3,783	1%	-723,509	-726,826	3,317	0%	-730,559	7,050	-1%
	Income other op	-118,436	-128,601	10,165	9%	-246,640	-261,187	14,547	-6%	-257,201	10,561	-4%
	Income pat care	-1,109,556	-1,104,815	-4,741	0%	-2,196,573	-2,218,650	22,077	-1%	-2,209,631	13,058	-1%
	Commissioning RRL	-1,515,395	-1,515,395	-0	0%	-2,977,137	-2,977,137	0	0%	*-2,977,137*	0	0%
Op Inc Total		-3,104,883	-3,114,090	9,207	**0%**	-6,143,859	-6,183,800	39,941	**-1%**	-6,174,528	30,669	**0%**
Op Exp Total	Healthcare	191,037	194,453	-3,416	2%	365,901	389,740	-23,839	-7%	388,906	-23,005	-6%
	Social care	52,040	54,322	-2,282	4%	103,446	107,044	-3,598	-3%	108,644	-5,198	-5%
	Pay	900,325	908,912	-8,587	1%	1,782,510	1,799,248	-16,738	-1%	1,817,824	-35,314	-2%
	S&S Clin	107,518	112,651	-5,133	5%	205,200	213,603	-8,403	-4%	225,302	-20,102	-10%
	S&S other	16,282	16,470	-188	1%	29,164	30,445	-1,281	-4%	32,940	-3,776	-13%
	Drugs	143,762	142,443	1,319	-1%	284,897	289,690	-4,793	-2%	284,886	11	0%
	Estab	15,709	15,122	587	-4%	32,400	32,012	388	1%	30,244	2,156	7%
	Premises	44,633	42,838	1,795	-4%	90,407	83,370	7,037	8%	85,676	4,731	5%
	Transport	6,967	6,867	100	-1%	13,946	14,233	-287	-2%	13,734	212	2%
	Deprecn	60,346	58,722	1,624	-3%	122,113	119,475	2,638	2%	117,445	4,668	4%
	ClinNeg	28,663	27,929	734	-3%	57,328	56,239	1,089	2%	55,858	1,470	3%
	Other	34,909	33,355	1,554	-4%	70,050	64,757	5,293	8%	66,710	3,340	5%
	Commissioning	1,501,185	1,501,185	0	0%	2,948,718	2,948,717	1	0%	3,002,370	-53,652	-2%
Op Exp Total		3,103,376	3,115,269	**-11,893**	0%	6,106,080	6,148,573	-42,493	-1%	6,230,539	-124,459	-2%
SoCI	Finance and Other	16,705	14,714	1,991		37,779	35,227	2,552		29,428	8,351	
Net Total		**15,198**	**15,894**	**-696**		**0**	**0**	**0**		**85,439**	**-85,439**	

2.0 – Financial run rate waterfall to plan, month 06.

Data from organisational PFR and IFR returns



Commentary

- The plan and forecast for the ICS for the year is revised from £80.0m deficit to a balanced position, due to the receipt of £80m NR deficit funding in M06. The straight-line extrapolated run-rate indicates a £85.4m deficit[1].
- Extrapolated run-rate is based on straight-line extrapolation of actual year to date figures. However, the ICB income allocation, has been profiled as per forecast rather than straight lined, in order to ensure that large allocation amendments, such as the £80m deficit support, do not distort the run-rate prediction
- Key elements of the reconciliation to the £0m net forecast position comprise the following:
  - £25.9m – Net ICB allocations adjustment to the M01-06 extrapolated total to reflect the impact of non-recurrent benefits and expenditure, comprising mainly the expenditure incurred by the ICB and phasing of (mainly) ERF allocation currently forecast at £125.1m.
  - -£9.0m – exclusion of NR impacts on ytd position, including NR savings recorded.
  - £80m Expected increase in CIP savings delivery in H2.

[1] ICB allocation is not extrapolated, but matches the applied revenue resource limit

3.0 - Efficiency planning and delivery, month 06.

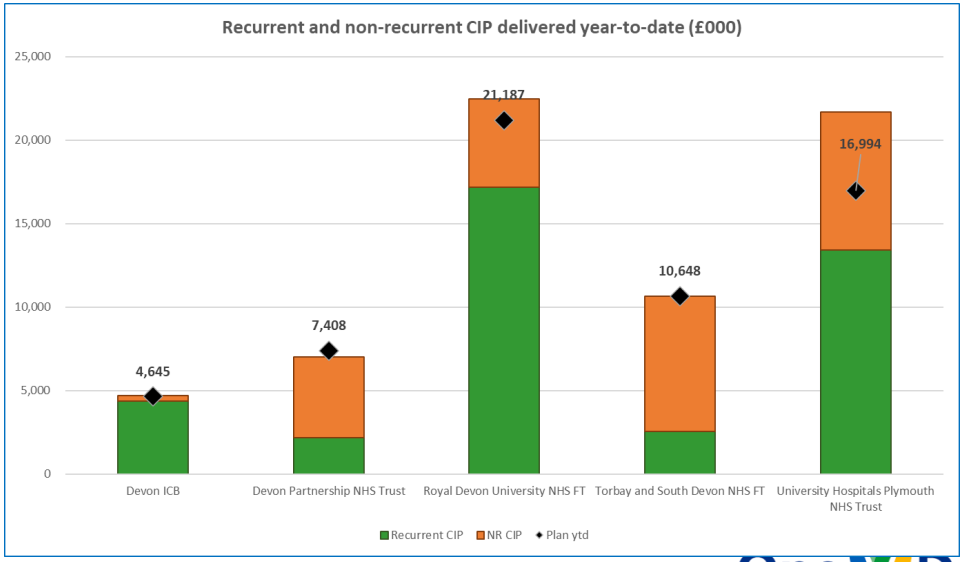
The system wide forecast is to deliver the CIP programme for the year.

Data from organisational Provider Financial Return (PFR) and Integrated Finance Return (IFR) returns

Organisation	Year to date			Forecast		
	Plan CIP delivery £000	Actual CIP delivery £000	Variance fav / (adv) £000	Plan for the year £000	Forecast £000	Variance fav / (adv) £000
Devon ICB	4,645	4,722	77	37,228	37,228	(0)
Devon Partnership NHS Trust	7,408	7,030	(378)	15,739	15,730	(9)
Royal Devon University NHS FT	21,187	22,484	1,297	63,610	63,610	0
Torbay and South Devon NHS FT	10,648	10,663	15	39,900	39,900	0
University Hospitals Plymouth NHS Trust	16,994	21,677	4,683	56,801	56,802	1
Total	**60,882**	**66,576**	**5,694**	**213,278**	**213,270**	**(8)**

Year to date and forecast CIP

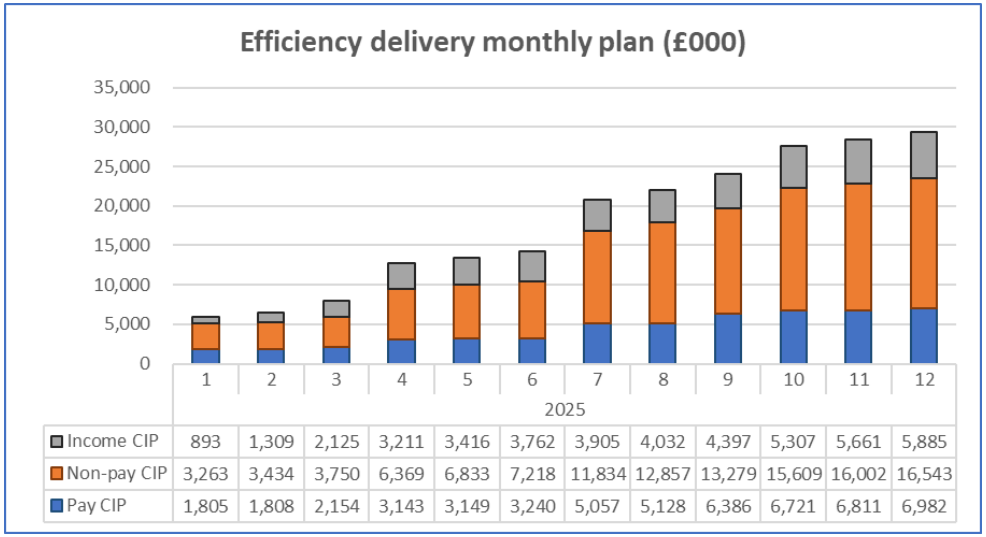
- YTD overall £5.7m above plan (*M05 £0.3m fav*). UHP and RDUH are delivering savings above plan values. DPT is reporting a £0.4m adverse position.
- Across the system, 56% of delivered CIP is recurrent (*59% in M05*)
- UHP position is the result of profiling and early achievement of NR savings, which is forecast to balance out.



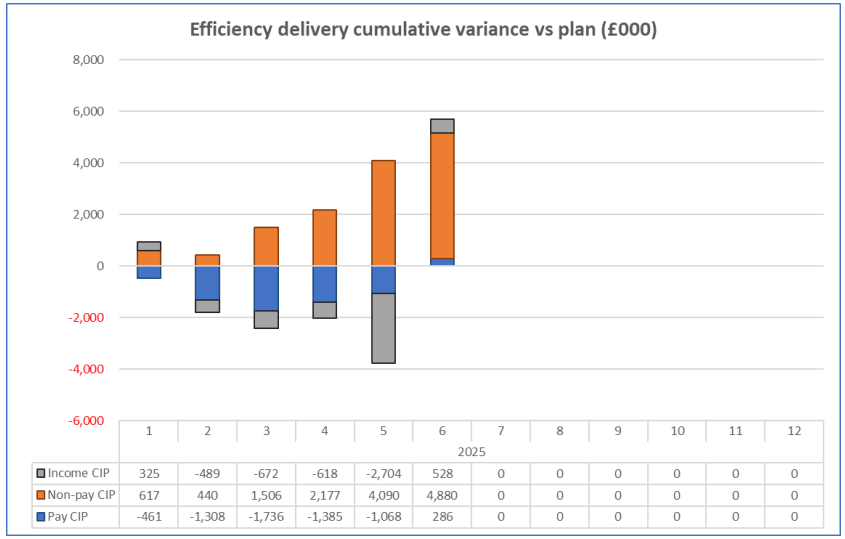
3.1 - Efficiency planning and delivery, month 06.

System wide plan profile shows a step-up in savings delivery planned from M07. Non-pay CIP continues to be delivered significantly above plan.

Data from organisational PFR and IFR returns



	1	2	3	4	5	6	7	8	9	10	11	12
Income CIP	893	1,309	2,125	3,211	3,416	3,762	3,905	4,032	4,397	5,307	5,661	5,885
Non-pay CIP	3,263	3,434	3,750	6,369	6,833	7,218	11,834	12,857	13,279	15,609	16,002	16,543
Pay CIP	1,805	1,808	2,154	3,143	3,149	3,240	5,057	5,128	6,386	6,721	6,811	6,982



	1	2	3	4	5	6	7	8	9	10	11	12
Income CIP	325	-489	-672	-618	-2,704	528	0	0	0	0	0	0
Non-pay CIP	617	440	1,506	2,177	4,090	4,880	0	0	0	0	0	0
Pay CIP	-461	-1,308	-1,736	-1,385	-1,068	286	0	0	0	0	0	0

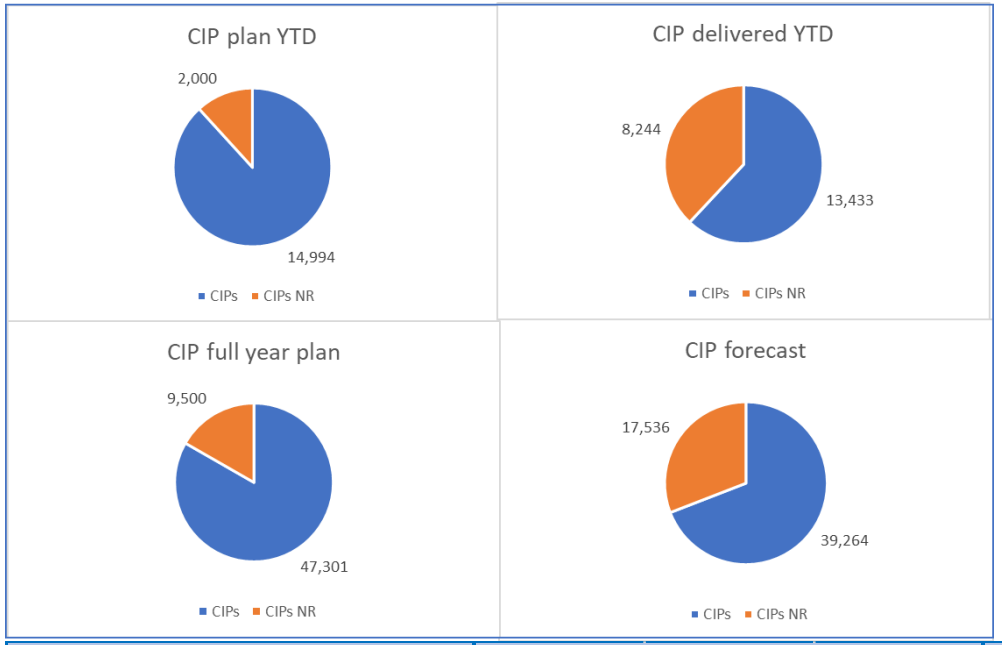
CIP plan profile and variance against plan ytd

- The savings plan is unchanged from the previous month and profiled across the year as follows:
  - Q1 – 10%
  - Q2 – 19%
  - Q3 – 31%
  - Q4 – 40%
- Across the system, non-pay related CIP is significantly above plan. Income and pay related CIP are slightly above plan.
- Pay CIP has achieved 102% of £15.3m plan (*M05 91% of £12.1m plan*) ytd.

3.1.1 - Efficiency planning and delivery, month 06.

System wide forecast is to deliver the £213.3m CIP programme. Recurrent savings schemes are delivering below plan and are now forecast to underachieve by £1.8m (*M05 £0.9m adv*).

Data from organisational Provider Financial Return (PFR) and Integrated Finance Return (IFR) returns



Year to date and forecast CIP

- YTD position shows NR savings delivered above plan and recurrent savings below plan:
  - TSD is £5.8m above plan for NR savings (*M05 £3.8m*), but is expecting to return to plan for the year.
  - UHP has realised £6.2m NR savings above plan (*M05 £3.3m*) for specific schemes, including growth funding controls; receipt of advice and guidance income; and utilities rebate.
- There remains a shift between recurrent and NR in two trusts:
  - RDUH forecast £7.5m shift to recurrent schemes. All unidentified allocation at the time of the plan submission was classed as NR. This has been adjusted as scheme details developed.
  - UHP forecast £8.0m shift to NR schemes. UHP is planning to return to the planned proportions of recurrent and NR savings by the year-end as schemes mature.

	Year to date			Forecast		
	Plan CIP delivery £000	**Actual CIP delivery** £000	**Variance** benefit / (adverse) £000	**Plan for the year** £000	**Forecast** £000	**Variance** benefit / (adverse) £000
Recurrent efficiencies	45,985	39,727	(6,258)	150,076	148,234	(1,842)
Non-recurrent efficiencies	14,897	26,849	11,952	63,202	65,034	1,832
Total	**60,882**	**66,576**	**5,694**	**213,278**	**213,268**	**(10)**
Recurrent %	75.5%	59.7%		70.4%	69.5%	
Non-recurrent %	24.5%	40.3%		29.6%	30.5%	

3.2 - Efficiency plan maturity, month 06.

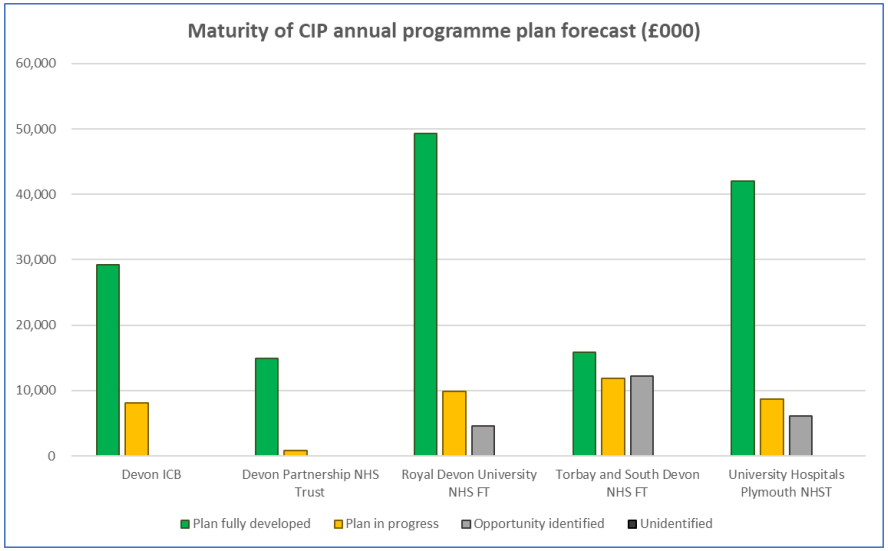
Good progress in improving forecast programme maturity across the ICS in month 6.

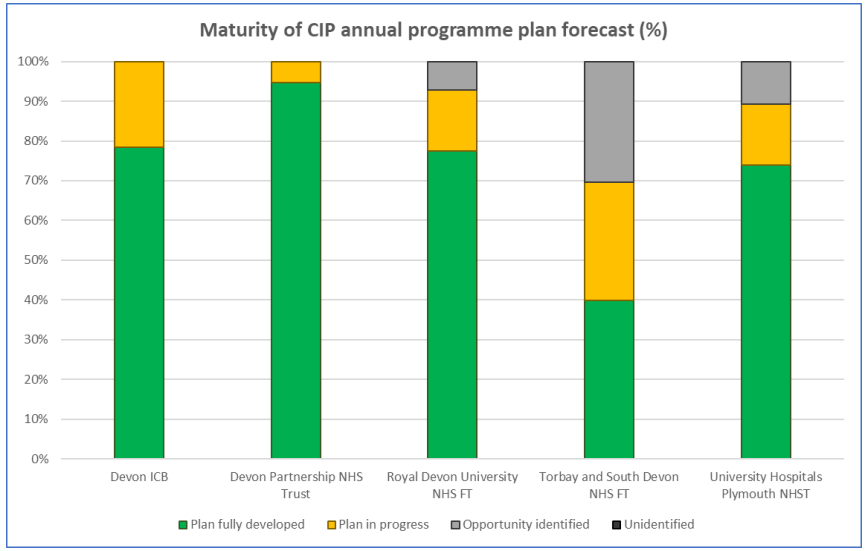
Data from organisational PFR and IFR returns

Organisation	Plan fully developed Fcst £000	Plan in progress Fcst £000	Opportunity identified Fcst £000	Unidentified Fcst £000	Total value Fcst £000
Devon ICB	29,168	8,060	0	0	37,228
Devon Partnership NHS Trust	14,897	833	0	0	15,730
Royal Devon University NHS FT	49,241	9,824	4,545	0	63,610
Torbay and South Devon NHS FT	15,897	11,852	12,151	0	39,900
University Hospitals Plymouth NHST	41,996	8,676	6,129	0	56,801
Total	**151,199**	**39,245**	**22,825**	**0**	**213,269**
Percent of total	71%	18%	11%	0%	100%

Plan maturity rating

- After a lull in M05, the System has reported improved maturity of CIP schemes in M06.
- 71% of CIP forecast relates to schemes rated as fully developed (*M05 57%*).
- Opportunities identified have reduced from 22% to 11% as plans are developed.





3.3 - Efficiency plan risk status, month 06.

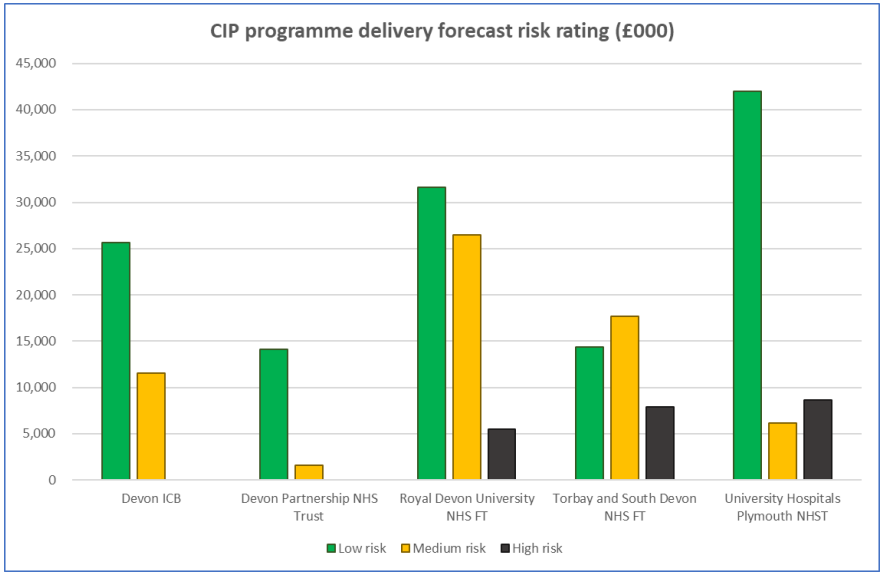
CIP programme risk assessment has improved in M06

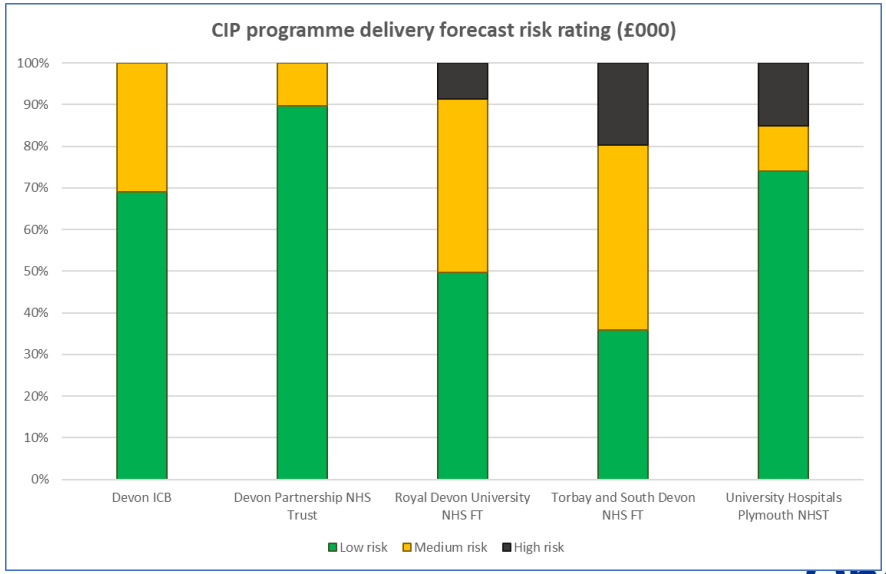
Data from organisational PFR and IFR returns

Organisation	Low risk Fcst £000	Medium risk Fcst £000	High risk Fcst £000	Total value Fcst £000
Devon ICB	25,668	11,560	0	37,228
Devon Partnership NHS Trust	14,109	1,621	0	15,730
Royal Devon University NHS FT	31,651	26,437	5,522	63,610
Torbay and South Devon NHS FT	14,328	17,672	7,900	39,900
University Hospitals Plymouth NHST	41,996	6,180	8,625	56,801
Total	**127,752**	**63,470**	**22,047**	**213,269**
Percent of total	60%	30%	10%	100%

Plan forecast risk rating

- 60% of CIP forecast relates to schemes rated as low risk, according to the PFR returns *(M05 - 48%)*.
- 10% of schemes by value is classified as high risk (*M05 18%*). However, TSD (20%) and UHP (15%) have significant value of high risk schemes as at M06.





3.4 - Efficiency plan forecast across NHSE categories, month 06.

Values from consolidated list of priorities identified by NHSE in the PFR

Data from organisational PFR and IFR returns

CIP savings forecast by NHSE category	Devon ICB £000	DPT £000	RDUH £000	TSD £000	UHP £000	Total £000
Agency	0	157	5,694	0	282	**6,133**
Bank	0	0	0	0	0	**0**
E-rostering and E-job planning	0	0	0	0	2,033	**2,033**
Establishment review	0	589	0	16,718	2,188	**19,495**
Pathways	11,079	12,621	9,563	8,105	28,480	**69,848**
Clinical Support Services	0	0	431	0	2,291	**2,722**
Medicines	4,060	0	1,139	1,480	1,623	**8,302**
Estates & Facilities	0	282	713	347	4,928	**6,270**
Digital	0	0	1,062	40	264	**1,366**
Enabling Functions (inc corporate)	4,177	0	13,314	487	1,732	**19,710**
Procurement	2,000	0	1,257	2,160	758	**6,175**
Other	11,412	833	197	6,869	0	**19,311**
Income	0	0	30,240	3,694	10,183	**44,117**
Commissioning	4,000	1,248	0	0	2,040	**7,288**
Community based primary care	500	0	0	0	0	**500**
Unidentified	0	0	0	0	0	**0**
Total	**37,228**	**15,730**	**63,610**	**39,900**	**56,802**	**213,270**

Plan forecast categories

- The forecast is to achieve the plan total for 2024/25 of £213.3m
- The NHSE categories of savings do not map immediately to the priorities identified for longer term efficiency programme development in the ICS PMO Workstreams.

4.0 - Devon ICS financial risk and mitigations summary, month 06.

The value of net unmitigated risk reported by the ICS is reduced in month 06 to £35.0m reflecting a fall in the value of identified risks and mitigations.

Data from organisations' month 06 PFR and IFR returns

	DPT £000	RDUH £000	TSD £000	UHP £000	ICB £000	System £000	*System Prior month £000*
Risks							
Commissioning	0	0	0	0	0	**0**	***-5,000***
Cost pressures & inflation	-1,517	-1,670	-2,850	-9,350	-2,780	**-18,167**	***-13,644***
Demand volume	0	0	-2,943	0	0	**-2,943**	***-4,943***
Efficiencies, CIP	-1,651	-13,615	-7,900	-8,000	-9,750	**-40,916**	***-41,149***
ERF risks	0	-5,066	0	-3,200	0	**-8,266**	***-10,940***
IA cost & lost activity	0	0	-476	-800	0	**-1,276**	***-3,515***
ICB risk share	0	-3,987	-974	-800	-1,624	**-7,385**	***-7,559***
Income issues	-255	-4,329	-2,564	0	0	**-7,148**	***-8,226***
Other	0	0	0	351	0	**351**	***-350***
Pay award pressures	-75	0	0	-2,240	0	**-2,315**	***-1,875***
Social Care & CHC	0	0	-2,538	0	-3,200	**-5,738**	***-6,338***
Total risks	**-3,498**	**-28,667**	**-20,245**	**-24,039**	**-17,354**	**-93,803**	***-103,539***
Mitigations							
Additional efficiencies	0	7,638	2,900	2,300	8,053	**20,891**	***16,303***
Balance sheet flexibilities	0	550	1,981	0	0	**2,531**	***1,531***
Cost controls	0	4,804	5,000	2,000	2,000	**13,804**	***12,367***
ERF mitigations	0	1,576	0	2,000	0	**3,576**	***9,210***
IA additional funding	0	0	0	0	0	**0**	***439***
ICB risk share mitigated	0	3,987	186	800	310	**5,283**	***4,669***
Income recognition	0	3,770	1,000	900	0	**5,670**	***5,221***
Other	0	59	0	0	6,991	**7,050**	***12,591***
Total mitigations	**0**	**22,384**	**11,067**	**8,000**	**17,354**	**58,805**	***62,331***
Unmitigated risk per PFR	**-3,498**	**-6,283**	**-9,178**	**-16,039**	**0**	**-34,998**	***-41,208***

Commentary

- The system-wide net unmitigated risk position has reduced in month 06 to £35.0m, (*M05 £41.2m*)
  - The position has improved in each organisation, apart from DPT, which is reporting a small increase in the net unmitigated position.
  - The CIP programme across the system is the main risk factor identified. After identified mitigations, the unmitigated value is £20.0m (*M05 £24.8m*)

5.0 - Pay cost, excluding capitalised staff, month 06.

Comments

- The YTD position is £8.7m adverse to plan (*M05 £7.4m adverse*). Trusts have identified the range of key cost pressures impacting on this, (see slide 5.0.1).
- The net position on wte is 26 wte below plan in M06 (*M05 96 wte below plan*), but the position varies across trusts:
  - TSD is reporting 141 wte above plan in both substantive and temporary staffing
  - UHP is reporting 112 wte above plan, with substantive staffing shortfall offset by bank staffing
  - RDUH and DPT are reporting wte below plan levels in substantive and bank
- The forecast indicates that the overspend rates will continue for the year, with a total forecast of £17.0m adverse.
- Trusts are aware that the wte numbers reported in the PWR do not reflect Trusts' contractual payroll and agency obligations. Trusts are working to develop a functional monthly process to reconcile the wte numbers between the PWR and contractual obligation. The key impact on the wte numbers mis-match is expected to relate to overtime.

Data from Trust PFR and PWR returns

		Year to date (excl capitalised)			Full Year (excl capitalised)			WTE current month		
Organisation	**Class**	**Plan** £000	**Actual** £000	**Variance** fav/(adv) £000	**Full Year Plan** £000	**Forecast** £000	**Variance** fav/(adv) £000	**Plan wte**	**Actual wte** (per PWR)	**Variance** fav/(adv)
Devon Partnership NHS Trust	Substantive	87,683	87,612	71	179,143	180,937	-1,794	3,598	3,516	82
	Bank	4,491	5,230	-739	8,859	8,438	421	229	184	45
	Agency	4,908	5,647	-739	8,506	9,978	-1,472	77	104	-27
		97,082	98,489	-1,407	196,508	199,353	-2,845	3,904	3,805	99
Royal Devon University NHS FT	Substantive	322,831	327,195	-4,364	644,497	654,433	-9,936	12,140	11,983	157
	Bank	15,093	14,284	809	29,974	28,568	1,406	443	369	75
	Agency	9,390	7,082	2,308	18,530	14,164	4,366	263	315	-52
		347,314	348,561	-1,247	693,001	697,165	-4,164	12,847	12,667	180
Torbay and South Devon NHS FT	Substantive	159,114	158,440	674	315,724	312,446	3,278	6,214	6,225	-11
	Bank	7,781	10,695	-2,914	10,599	18,414	-7,815	224	294	-70
	Agency	3,359	6,065	-2,706	5,657	9,711	-4,054	69	129	-60
		170,254	175,200	-4,946	331,980	340,571	-8,591	6,508	6,649	-141
University Hospitals Plymouth NHST	Substantive	268,431	268,725	-294	529,677	527,330	2,347	10,204	10,105	99
	Bank	14,764	15,960	-1,196	26,630	30,590	-3,960	298	525	-227
	Agency	2,555	2,210	345	4,873	4,705	168	39	24	16
		285,750	286,895	-1,145	561,180	562,625	-1,445	10,542	10,654	-112
Total by class	**Substantive**	**838,059**	**841,972**	**-3,913**	**1,669,041**	**1,675,146**	**-6,105**	**32,157**	**31,830**	**327**
	Bank	**42,129**	**46,169**	**-4,040**	**76,062**	**86,010**	**-9,948**	**1,195**	**1,372**	**-177**
	Agency	**20,212**	**21,004**	**-792**	**37,566**	**38,558**	**-992**	**448**	**572**	**-123**
Total		**900,400**	**909,145**	**-8,745**	**1,782,669**	**1,799,714**	**-17,045**	**33,800**	**33,774**	**26**

5.0.1 - Pay cost, analysis of funded and unfunded pressures on pay plan, month 06.

The unfunded pressures on the pay budget have increased slightly in month 06.

Data from Trust PFR and narrative returns

Paycost YTD versus budget	DPT £m	RDUH £m	TSD £m	UHP £m	Total £m	Prior month Total £m
prior month YTD (over)/underspend	*-1.55*	*-0.81*	*-4.89*	*-0.14*	***-7.39***	***-5.78***
reported YTD (over)/underspend	-1.41	-1.25	-4.95	-1.14	**-8.74**	**-7.39**
Offset by additional funding:						
EPCs	1.20				**1.20**	**1.04**
Industrial Action (funded)	0.04			0.58	**0.62**	**0.00**
Other funded activity		3.00	2.20	0.33	**5.53**	**4.82**
					0.00	**0.00**
Non-funded YTD position (-ve adverse)	**-0.17**	**1.75**	**-2.75**	**-0.24**	**-1.40**	**-1.53**
Recognised unfunded pressures:						
Industrial Action (unfunded)		0.30			**0.30**	**1.14**
Medical agency activity and high cost locums	0.46		0.12		**0.58**	**0.50**
enhancements 23/24		0.30			**0.30**	**0.30**
CIP slippage/(advance)	0.53	-1.30	-0.20	0.62	**-0.35**	**1.08**
activity pressure on bank and agency			3.28		**3.28**	**2.29**
Recruitment slippage	-0.84				**-0.84**	**-0.49**
Other agency					**0.00**	**0.05**
B2-3 Lump settlement excess of accrual				0.50	**0.50**	**0.00**
					0.00	**0.00**
YTD against budget net of pressures	**-0.01**	**1.05**	**0.45**	**0.88**	**2.38**	**3.34**

Capitalised staff costs YTD versus budget	DPT £m	RDUH £m	TSD £m	UHP £m	Total £m	Total £m
prior month YTD (over)/underspend	*0.05*	*0.10*	*-1.00*	*-0.19*	***-1.04***	***-0.83***
reported YTD (over)/underspend	0.05	0.17	-1.70	-0.25	**-1.73**	**-1.04**

- The overall unfunded cost pressure is £1.4m, a slight improvement on the M05 position.
- The net unfunded pressure has improved in M06 for TSD from £3.1m adverse to £2.8m adverse.

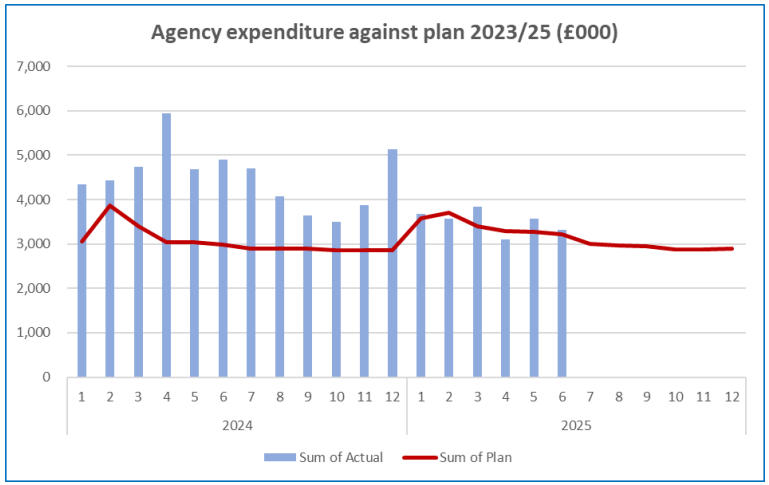
- Capitalised staff costs are £1.7m above plan.

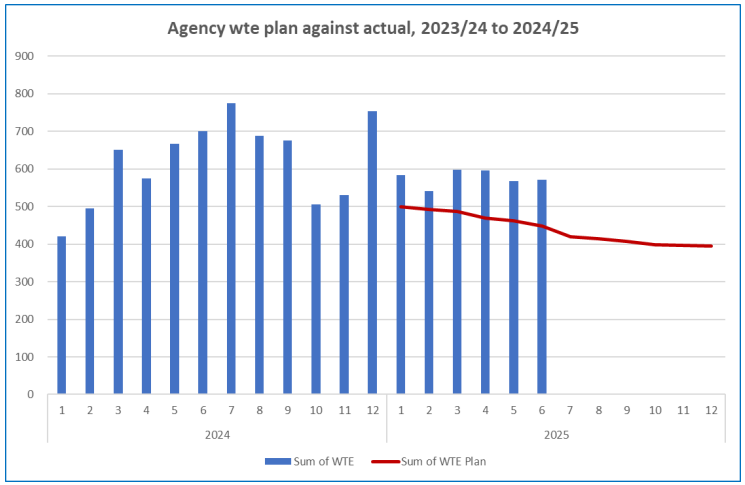
5.1 - Agency expenditure and forecast, month 06.

Expenditure is £0.8m above plan ytd, and the forecast is for £1.0m adverse against the full year plan.

Data from Trust PFR returns

Organisation	Agency expenditure: year to date			Forecast		
	Plan £000	Actual £000	favourable / (adverse) £000	Plan for the year £000	Forecast £000	favourable / (adverse) £000
Devon Partnership NHS Trust	4,908	5,647	(739)	8,506	9,978	(1,472)
Royal Devon University NHS FT	9,390	7,082	2,308	18,530	14,164	4,366
Torbay and South Devon NHS FT	3,359	6,065	(2,706)	5,657	9,711	(4,054)
University Hospitals Plymouth NHST	2,555	2,210	345	4,873	4,705	168
Total	**20,212**	**21,004**	**(792)**	**37,566**	**38,558**	**(992)**





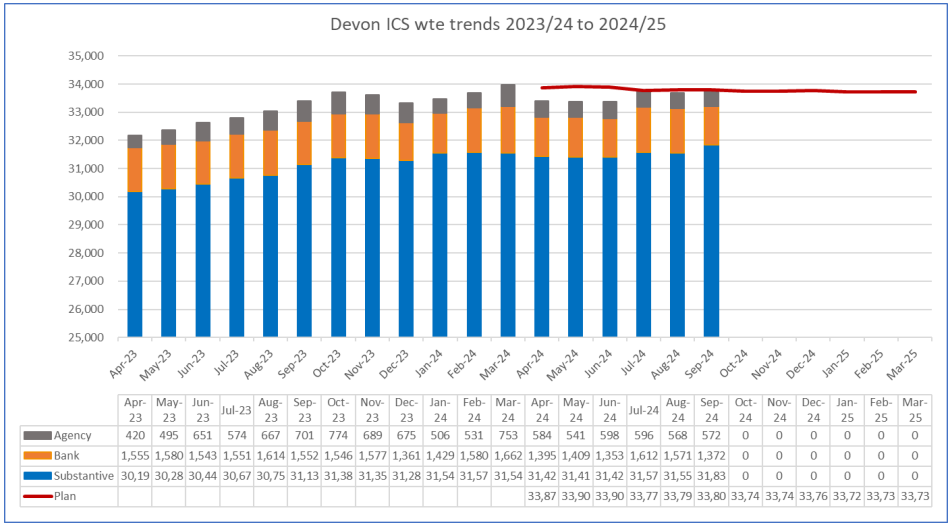
Comments

- System wide position has deteriorated to £0.8m adverse in M05 (*M05 £0.6m adv*).
- The forecast has moved to £1.0m adverse (M05 £3.4m favourable), due mainly to the revised forecast for TSD.
- DPT ytd is £0.7m adverse to plan. The plan appears to have been set low, resulting in forecast variance. Forecast is to overspend by £1.5m.
- Agency wte numbers are 28% above plan (*M05 23%*)
- Off framework agency staff in low numbers and specific actions are being taken to address each. Some instances are due to continuation to end of contract to avoid penalties. The situation monitored in detail by the ICS Workforce Development Group.

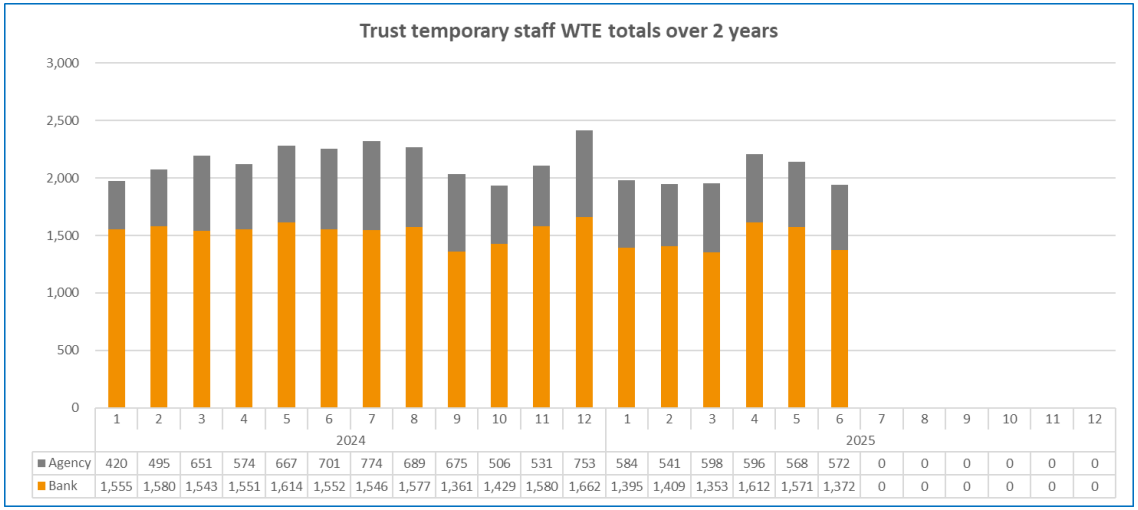
5.2 - WTE trends, month 06.

Staff numbers are marginally lower than the year's highest total recorded in M04 and are higher than M05, 2023/24.

Data from Trust PWR returns



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Agency	420	495	651	574	667	701	774	689	675	506	531	753	584	541	598	596	568	572	0	0	0	0	0	0
Bank	1,555	1,580	1,543	1,551	1,614	1,552	1,546	1,577	1,361	1,429	1,580	1,662	1,395	1,409	1,353	1,612	1,571	1,372	0	0	0	0	0	0
Substantive	30,19	30,28	30,44	30,67	30,75	31,13	31,38	31,35	31,28	31,54	31,57	31,54	31,42	31,41	31,42	31,57	31,55	31,83	0	0	0	0	0	0
Plan													33,87	33,90	33,90	33,77	33,79	33,80	33,74	33,74	33,76	33,72	33,73	33,73



	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12
Agency	420	495	651	574	667	701	774	689	675	506	531	753	584	541	598	596	568	572	0	0	0	0	0	0
Bank	1,555	1,580	1,543	1,551	1,614	1,552	1,546	1,577	1,361	1,429	1,580	1,662	1,395	1,409	1,353	1,612	1,571	1,372	0	0	0	0	0	0

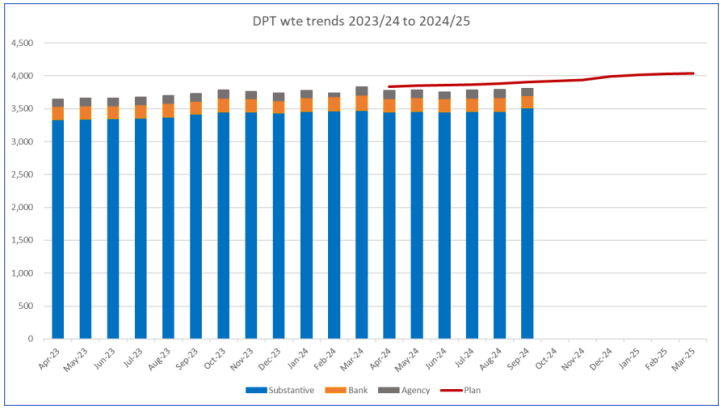
Comments on trends

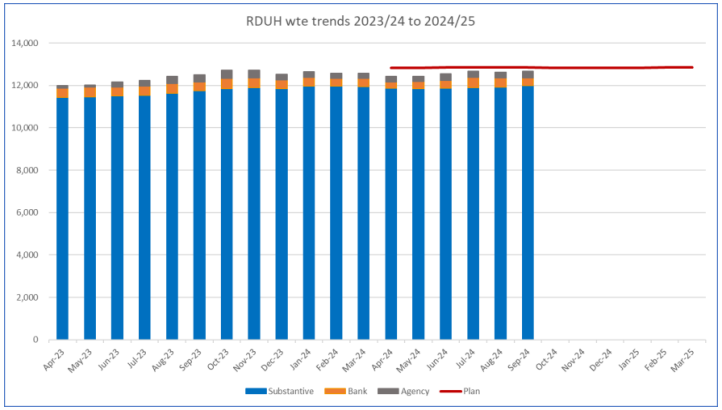
- DPT wte numbers have risen overall through 2024/25 and are higher than H1 of 2023/24. Overall wte remains below plan.
- RDUH total wte rising overall in 2024/25 and are above equivalent months in 2023/24. However, wte totals are below plan.
- TSD total wte have been relatively variable in 2024/25 and have moved above plan since M04
- UHP wte numbers are relatively stable in 2024/25, and have fallen slightly in M05, but are slightly above plan.

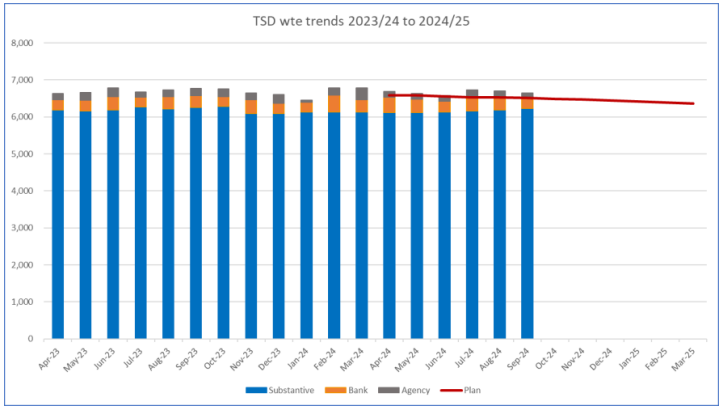
5.3 - WTE plan trends, month 06.

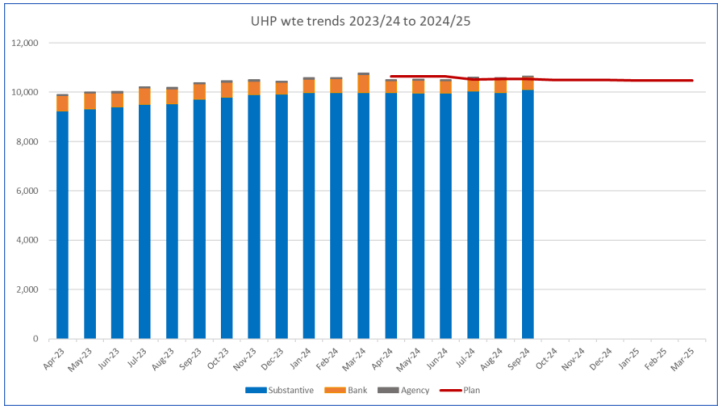
Two trusts report wte numbers above plan; two are consistently below plan in 2024/25.

Data from ICB consolidated workforce plan submission, 02 May 2024 and Trust PWR returns









Comments on trends in 2024/25

- DPT wte plan numbers rising by 202. Actual wte rising slightly but remain below plan
- RDUH total plan wte rising by 43 wte. Actual wte rising, but slightly below plan
- TSD wte plan reducing by 223 wte. Reduction accelerating in H2. Actual wte is above plan, but has reduced in M06
- UHP wte plan reducing by 166 wte. Actual wte have risen slightly above plan.

6.0 - Devon Partnership NHS Trust summary at month 06

6.1 - Financial reporting and forecast

- The Trust is forecasting to deliver against plan. Adverse YTD position in pay and income is offset by underspends in expenditure on healthcare services and expenditure related to estates and facilities. The forecast position indicates that these variances will not extend significantly in the second half of the year.

6.2 - Efficiency programme

- YTD savings delivery is reported as £0.4m adverse to plan. Performance has continued to improve from the position in M03 *(£1.2m adv*). The remaining gap is the result of phasing changes, with a number of schemes expected to deliver later than initially planned.
- DPT is forecasting that the programme will deliver (*M05 £0.7m adverse to forecast*) the annual savings target.
- The CIP programme appears to be carrying low risk:
  - 95% of scheme value is in fully developed schemes
  - 90% of scheme value is rated as low risk. No schemes are rated as high risk of non-delivery.
- However, the efficiency programme is predominantly composed of non-recurrent schemes: 57% of the plan for the year and 65% of the forecast is termed as non-recurrent savings.

6.3 - Risks and mitigations

- DPT is reporting £3.5m (*M05 £2.3m*) of net unmitigated risk. This is down from the Q2 peak of £4.4m in M04. The key risks identified are in the CIP programme and in emerging cost pressures.

6.4 - Workforce indicators

- Workforce expenditure and reported wte numbers have been stable through Q2, with a slight downward trend in the overall overspent position. YTD expenditure is above plan by £1.4m (*M05 £1.5m*). Pay costs are above plan in temporary staffing. The summary analysis of the YTD cost to plan indicates that circa £0.2m (*M05 £0.5m*) of the adverse position is unfunded.
- WTE numbers in M06, of 99 wte below plan are little changed from M05 (9*2 wte below plan*). Agency numbers are above plan. This is to be expected, given the additional workload arising from extra packages of care (EPCs) trending above planned numbers.

6.1 - DPT Summary financial performance, month 06.

Data from month 06 Trust PFR return

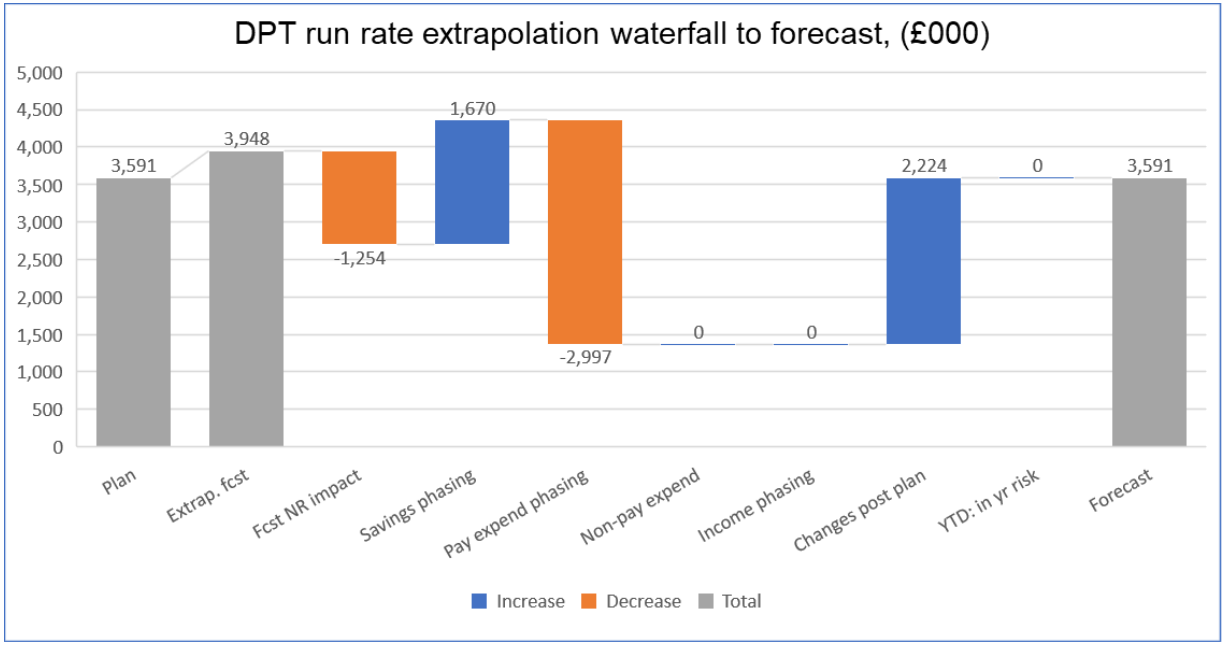
Key indicators

- YTD net position in line with forecast. Income and expenditure totals are both within 2% of plan (*M05 within 1% of plan*).
- No significant movements within main expenditure classifications: Pay YTD expenditure is £1.4m above plan (*M05 £1.5m*). Purchase of healthcare expenditure is £2.9m below plan (*M05 £1.3m*) and estates and facilities related expenditure £1.6m under plan (*M05 £1.6m*)
- The forecast is to deliver against plan, with no significant change in total income or expenditure. Variances within expenditure are forecast to be in similar elements to the YTD figures, but of proportionally lower value.
- The run-rate projection based on the average of the values ytd, projected to the full year, is consistent with the forecast position

Class	Group	Plan ytd £000	Actual ytd £000	Variance fav/(adv) £000	Variance fav/(adv) (%)	FY Plan £000	Forecast £000	Fcst vs Plan fav/(adv) £000	Fcst vs Plan fav/(adv) (%)	Extrapolated run rate £000	Run-rate vs plan fav/(adv) £000	Run-rate vs plan fav/(adv) (%)
Op Inc	Income NHSE PC	-80,619	-81,443	824	1%	-161,737	-163,153	1,416	1%	-162,886	1,149	1%
	Income other op	-6,498	-5,092	-1,406	-22%	-13,134	-12,230	-904	-7%	-10,184	-2,950	-22%
	Income pat care	-112,885	-109,630	-3,255	-3%	-227,021	-225,211	-1,810	-1%	-219,260	-7,761	-3%
Op Inc Total		-200,002	-196,165	-3,837	**-2%**	-401,892	-400,594	-1,298	**0%**	-392,330	-9,562	**-2%**
Op Exp	Healthcare	78,831	75,927	2,904	-4%	157,559	155,077	2,482	-2%	151,854	5,705	-4%
	Social care	0	0	0	0%	0	0	0	0%	0	0	0%
	Pay	97,082	98,489	-1,407	1%	196,508	199,353	-2,845	1%	196,978	-470	0%
	S&S Clin	1,248	1,298	-50	4%	2,500	2,674	-174	7%	2,596	-96	4%
	S&S other	1,014	1,146	-132	13%	2,023	2,393	-370	18%	2,292	-269	13%
	Drugs	1,074	1,070	4	0%	2,149	2,326	-177	8%	2,140	9	0%
	Estab	1,812	793	1,019	-56%	3,624	2,173	1,451	-40%	1,586	2,038	-56%
	Premises	4,224	3,896	328	-8%	8,447	9,209	-762	9%	7,792	655	-8%
	Transport	1,584	1,347	237	-15%	3,167	3,088	79	-2%	2,694	473	-15%
	Deprecn	5,153	5,163	-10	0%	10,325	10,325	0	0%	10,326	-1	0%
	ClinNeg	360	439	-79	22%	719	746	-27	4%	878	-159	22%
	Other	4,974	4,364	610	-12%	9,940	8,987	953	-10%	8,728	1,212	-12%
Op Exp Total		197,356	193,932	**3,424**	-2%	396,960	396,351	609	0%	387,864	9,096	-2%
SoCI	Finance and Other	672	259	413	-61%	1,341	652	689	-51%	518	823	-61%
Net Total		**-1,974**	**-1,974**	**0**		**-3,591**	**-3,591**	**0**		**-3,948**	**357**	

6.1.1 – Financial run rate waterfall to plan, month 06.

Data from trust PFR return



Commentary

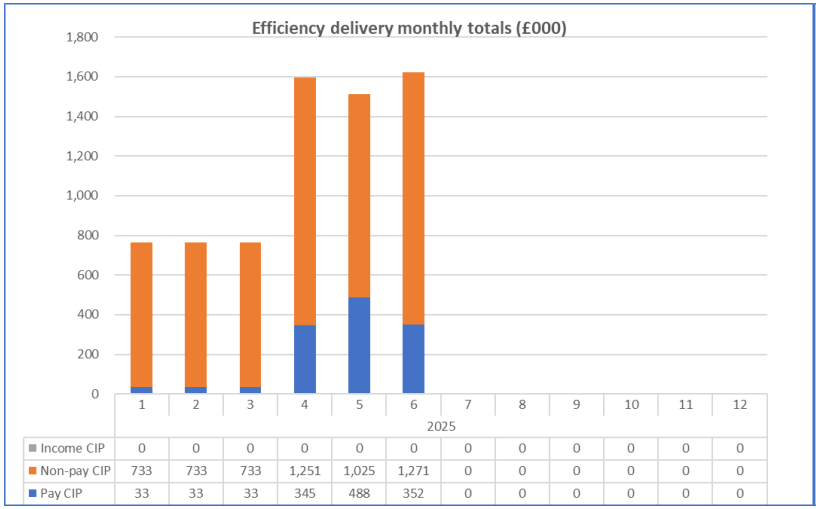
- The plan and forecast for DPT is unchanged at £3.6m surplus. The straight-line extrapolated run-rate indicates a £3.9m surplus.
- Key elements of the reconciliation waterfall include the following:
  - (£1.7m fav) – Phasing of efficiency programme impact. The relatively low value reflects the even distribution of efficiencies across the year.
  - (£3.0m adv) - Planned increase in expenditure on pay in H2. This reflects the planned introduction of the new Learning Disability Unit and Gender Service expansion
  - (£2.2m fav) - Developments post planning, which comprise mainly phased receipt of income on CAMHS and deferred receipt of HEE income to H2. This is offset by the profile of expenditure on patient placements which increases in H2

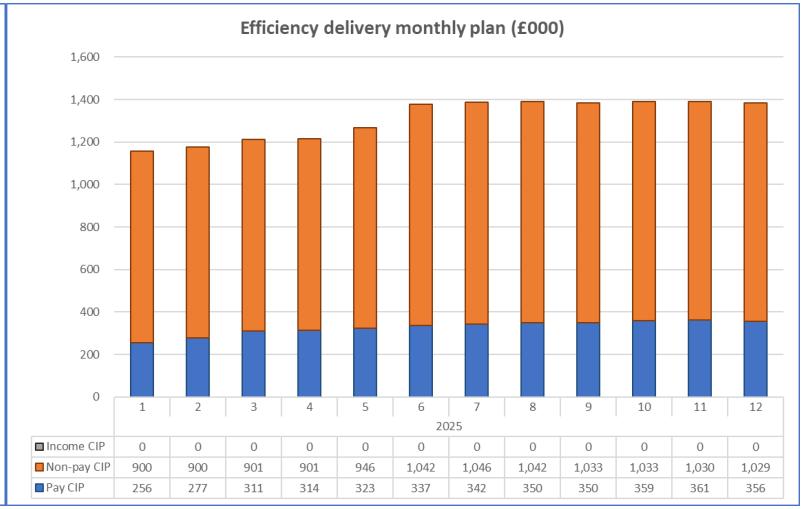
6.2 - DPT Efficiency programme.

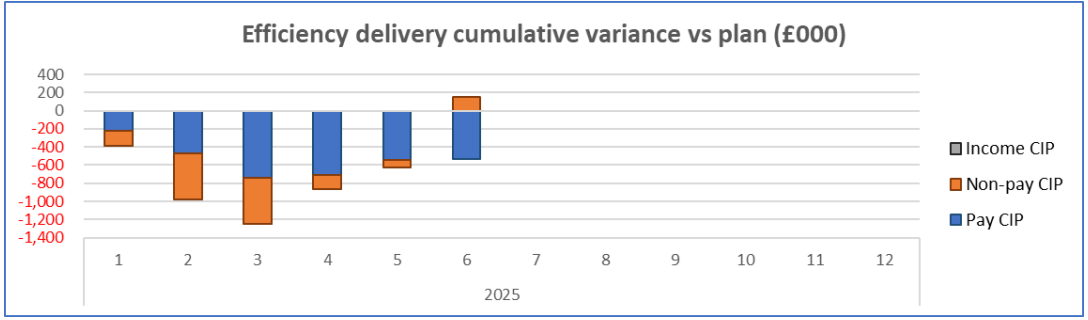
YTD delivery is £0.4m below plan. The DPT forecast has improved and is expected to deliver against plan.

Data from month 06 Trust PFR return

Organisation	Year to date			Forecast		
	Plan CIP delivery £000	Actual CIP delivery £000	Variance fav / (adv) £000	Plan for the year £000	Forecast £000	Variance fav / (adv) £000
Devon Partnership NHS Trust	7,408	7,030	(378)	15,739	15,730	(9)







Year to date and forecast CIP

- YTD delivery is £0.4m below plan (*M05 £0.6m below*).
- The forecast indicates that the efficiency plan will be achieved (*M05 £0.7m adv)*.
- Pay CIP delivery has improved through Q2. The plan assumes that the annual leave accrual (NR) will significantly reduce during the year. It is expected that benefits will be seen in H2.
- Non-pay CIP has improved to the point that the H1 total CIP delivery is £0.1m above plan.

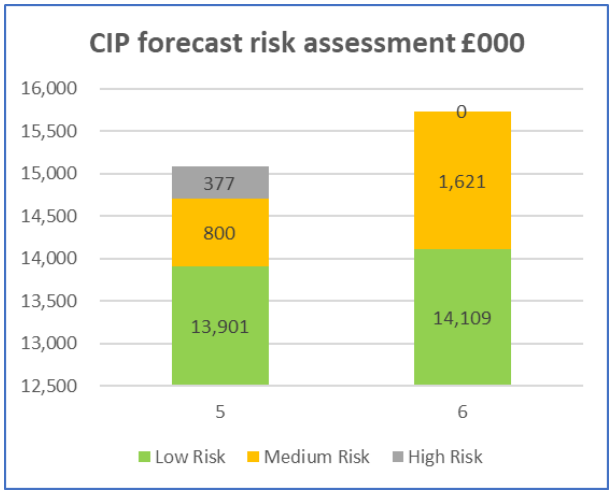
Spread of plan across quarters

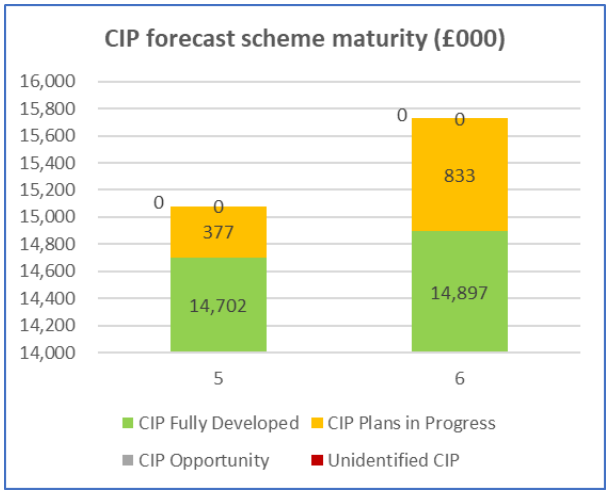
Q1 – 23%
Q2 – 25%
Q3 – 26%
Q4 – 26%

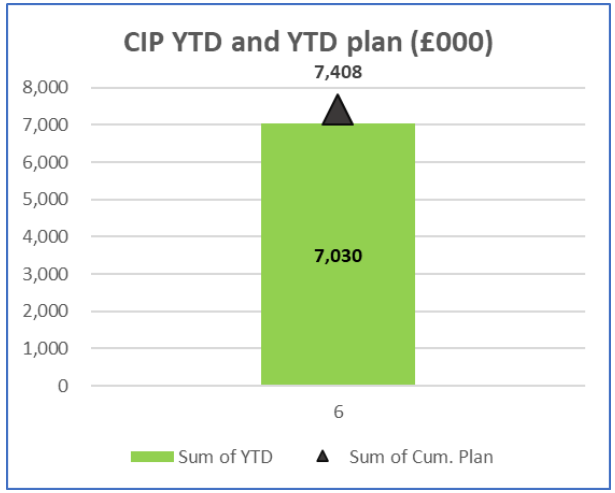
6.2.1 - DPT Efficiency plan delivery, maturity and risk.

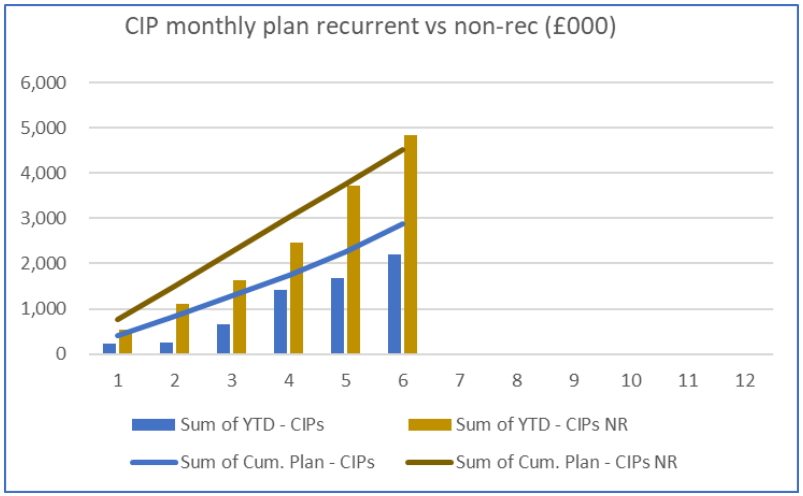
CIP programme low risk schemes for 90% of the plan; and 95% in fully developed plans.

Data from month 06 Trust PFR return









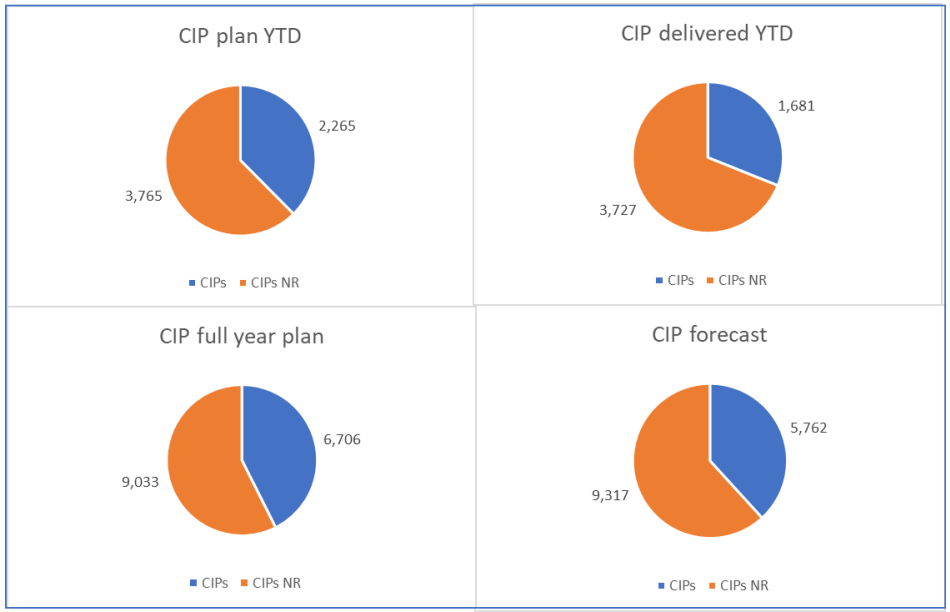
Commentary

- The forecast in M06 is to achieve the plan of £15.7m. DPT has identified no high risk schemes, by value (*M05 £0.4m*). Low risk schemes of £14.1m (*M05 £13.9m*), which is 90% of the plan value.
- £14.9m of the plan is classified as fully developed schemes, 95% of the plan value (*M05 £14.7m*).
- Delivery of recurrent CIP has improved in M06 to 76% of plan (*M05 74%*). NR CIP delivery has improved from 99% to 107%

6.2.2 - DPT Efficiency plan delivery, maturity and risk.

A high proportion of the CIP plan is from non-recurrent schemes. The forecast indicates recurrent schemes will not be delivered in full

Data from month 06 Trust PFR return



Commentary

- Non-recurrent schemes comprise 57% of the total CIP plan. The forecast indicates that the NR schemes will increase by £1.2m to 65% (*M05 £0.3m, to 62%*) of the forecast CIP delivery.
- There are limited expectations for the balance between recurrent and NR savings plans to be improved in 2024/25 due to the nature of the schemes, but DPT is continuously seeking to make any NR CIPs achieved recurrently. Further work required within Placed People and Productivity programmes which were planned as recurrent.
- DPT reports that it is continuing to work closely with directorates to develop a program of recurrent savings for 2025/26.

	Year to date			Forecast		
	Plan CIP delivery £000	**Actual CIP delivery** £000	**Variance** benefit / (adverse) £000	**Plan for the year** £000	**Forecast** £000	**Variance** benefit / (adverse) £000
Recurrent efficiencies	2,890	2,193	(697)	6,706	5,545	(1,161)
Non-recurrent efficiencies	4,518	4,837	319	9,033	10,185	1,152
Total	**7,408**	**7,030**	**(378)**	**15,739**	**15,730**	**(9)**
Recurrent %	39.0%	31.2%		42.6%	35.3%	
Non-recurrent %	61.0%	68.8%		57.4%	64.7%	

6.3 - DPT financial risks and mitigations position.

The adjusted unmitigated net risk assessment has increased from £2.3m (M05) to £3.5m.

Data from month 06 Trust PFR

	DPT £000	DPT Prior month £000
Risks		
Commissioning	0	0
Cost pressures & inflation	-1,517	-543
Demand volume	0	0
Efficiencies, CIP	-1,651	-1,474
ERF risks	0	0
IA cost & lost activity	0	0
ICB risk share	0	0
Income issues	-255	-502
Other	0	0
Pay award pressures	-75	-75
Social Care & CHC	0	0
Total risks	**-3,498**	**-2,594**
Mitigations		
Additional efficiencies	0	0
Balance sheet flexibilities	0	0
Cost controls	0	67
ERF mitigations	0	0
IA additional funding	0	0
ICB risk share mitigated	0	0
Income recognition	0	209
Other	0	0
Total mitigations	**0**	**276**
Unmitigated risk per PFR	**-3,498**	**-2,318**

Commentary

- The ICS total net risk reported in the month 6 Integrated Finance Return (IFR) is £35.0m (*M05 £41.2m*).
- The DPT reported net unmitigated risk has increased to £3.5m (*M05 £2.3m; M04 £4.4m*). The value of risks has increased, reflecting higher value of risks in cost pressures, and no specific mitigations are recognised.
- CIP related risk remains low, at £1.7m.
- DPT notes that the increasing 'emerging cost pressures' are related to pressures that are anticipated to be mitigated by SDF funds. From a system perspective this is arguably in the baseline.

6.4 - DPT workforce summary, month 06.

YTD pay-cost against plan position has improved slightly from M05, The forecast position of £2.8m adverse is a small deterioration on the M05 forecast.

Data from month 06 Trust PFR, PWR and narrative returns

Key indicators

- YTD pay-cost against budget reduced slightly to £1.4m adv (*M04 £1.5m adv*), continuing a three-month trend of slight improvement.
- The forecast in M06 has increased to £2.8m adverse (*M05 £2.5m adv*).
- WTE position is little changed in total at 99 wte below plan (*M04 82 wte below*) continuing stability in reported numbers for the past three months.
- Agency numbers are above plan in M06 at 27 wte over (*M05 34 wte over*)

		Year to date (excl capitalised)			Full Year (excl capitalised)			WTE current month		
Organisation	**Class**	**Plan** £000	**Actual** £000	**Variance** fav/(adv) £000	**Full Year Plan** £000	**Forecast** £000	**Variance** fav/(adv) £000	**Plan wte**	**Actual wte** (per PWR)	**Variance** fav/(adv)
Devon Partnership NHS Trust	Substantive	87,683	87,612	71	179,143	180,937	-1,794	3,598	3,516	82
	Bank	4,491	5,230	-739	8,859	8,438	421	229	184	45
	Agency	4,908	5,647	-739	8,506	9,978	-1,472	77	104	-27
		97,082	98,489	-1,407	196,508	199,353	-2,845	3,904	3,805	99

Paycost YTD versus budget	**DPT £m**	**DPT prior month £m**
prior month YTD (over)/underspend	*-1.55*	*-1.67*
reported YTD (over)/underspend	-1.41	-1.55
Offset by additional funding:		
EPCs	1.20	1.04
Industrial Action (funded)	0.04	
Non-funded YTD position (-ve adverse)	**-0.17**	**-0.51**
Recognised unfunded pressures:		
Industrial Action (unfunded)		0.04
Medical agency activity and high cost locums	0.46	0.38
CIP slippage/(advance)	0.53	0.55
Recruitment slippage	-0.84	-0.49
Other agency		0.05
YTD against budget net of pressures	**-0.01**	**0.02**

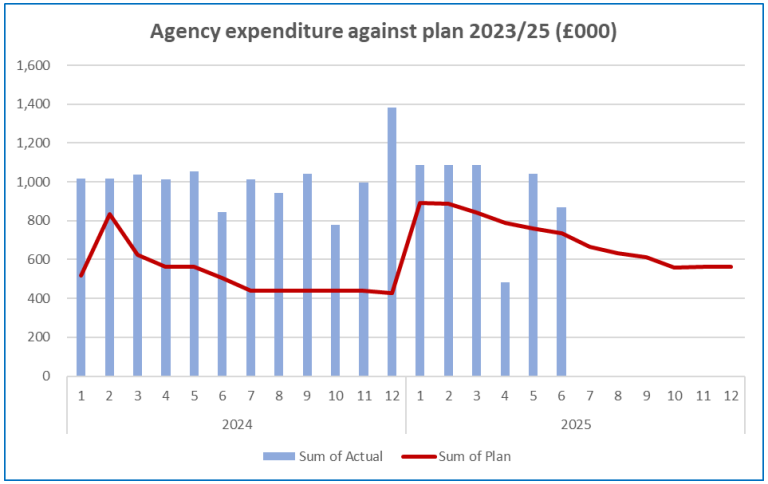
Analysis of funded and unfunded pressures on the pay plan

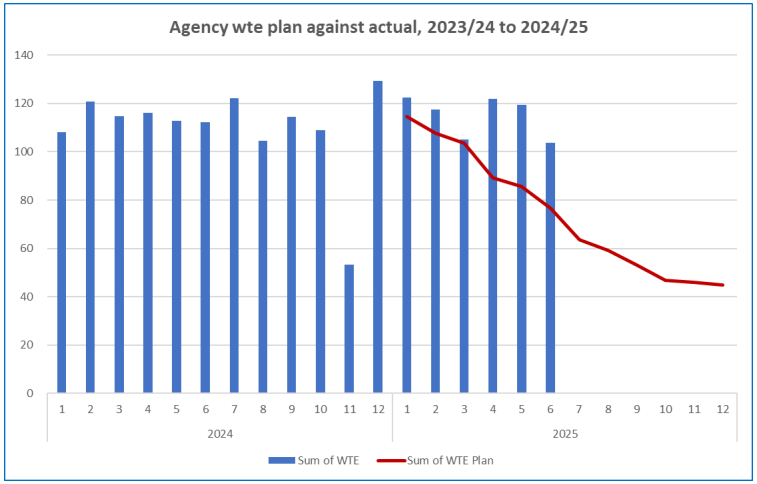
- DPT has £0.2m unfunded overspend against its pay budget, ytd in M06. This continues the improvement from M05.
- Recruitment slippage is increasing.
- DPT is reporting a £0.1m underspend against plan for capitalised staff costs, reflecting scheme delivery timing

6.4.1 - DPT workforce agency summary, month 06.

Agency cost and wte trends are above the original plan submission.

Data from month 06 Trust PFR and PWR returns





Note: NHSE is aware of the DPT changes to agency wte plans but these cannot be reflected in the formal submitted PWR plan for wte, on which the numbers in these charts are based.

Commentary

- M06 agency expenditure ytd £0.7m above plan. In month costs have reduced, but plan is also to reduce expenditure.
- Agency wte (104 wte) is above the submitted plan (77 wte). but is below DPT's amended plan following agency cost and WTE recalculations (M06 118 wte). This will continue to be a pressure, due to the planned reduction in reliance in agency set against challenges in recruitment and the need for temporary staffing to cover extra packages of care (EPCs) in excess of plan.
- DPT maintained reductions in agency cost rates in month 05.

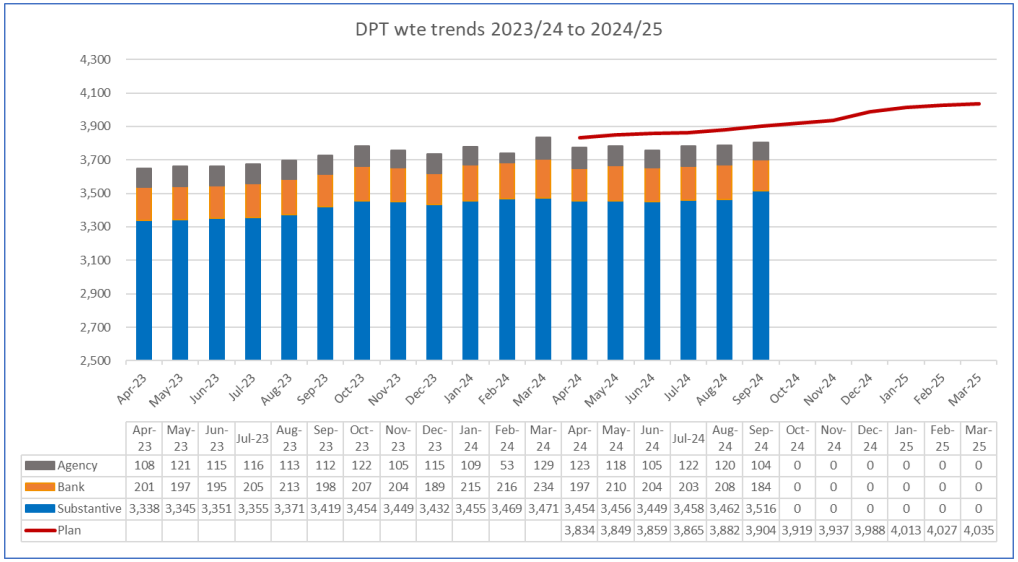
Off-framework agency

- One locum doctor (Liaison Psychiatry) on off-framework. This will move to framework, once compliance process completed. No completion date confirmed as yet.

6.4.2 - DPT workforce summary, month 06.

DPT workforce total numbers are expected to rise due to impact of new services provided by the Trust and changes to rules on safe staffing in other services

Data from month 06 Trust PWR return



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Agency	108	121	115	116	113	112	122	105	115	109	53	129	123	118	105	122	120	104	0	0	0	0	0	0
Bank	201	197	195	205	213	198	207	204	189	215	216	234	197	210	204	203	208	184	0	0	0	0	0	0
Substantive	3,338	3,345	3,351	3,355	3,371	3,419	3,454	3,449	3,432	3,455	3,469	3,471	3,454	3,456	3,449	3,458	3,462	3,516	0	0	0	0	0	0
Plan													3,834	3,849	3,859	3,865	3,882	3,904	3,919	3,937	3,988	4,013	4,027	4,035

Actual trend

- Actual wte numbers continue the slight rising trend since month 03, but remain below the plan position.

Plan trend

- The DPT workforce plan identifies growth, April 2024 to March 2025, of 202 wte (revised to 217 wte in v2 of the plan). DPT identifies the three key areas as:
  - Opening of a new ward in 2025/26 and the associated gearing up for this.
  - Additional investment in mental health in schools teams as a result of national funding and direction of travel.
  - Addressing the underlying significant vacancies within children's services.

7.0 - Royal Devon University Healthcare NHS Foundation Trust summary at month 06

7.1 - Financial reporting and forecast

- RDUH has recorded £7.0m NR deficit funding in M06. The plan deficit for the year is revised to £2.8m (M05 £9.8m adv).
- Funding has been received to cover the additional cost of industrial action in Q1. RDUH is reporting a ytd position that matches plan in M06 (*M05 £0.4m deficit due to IA costs*).
- Forecast is to achieve the plan for the year.
- Financial pressures evident in YTD and forecast for clinical supplies and services, due to cardiology devices and insulin pumps.
- Pay expenditure is £1.1m adverse ytd. The forecast has increased to £3.9m adverse (*M05 £0.5m fav*). This reflects the expected increased expenditure on ERF schemes in H2.

7.2 - Efficiency programme, Delivering Best Value (DBV)

- RDUH is reporting ytd delivery above plan by £1.3m in M06 (*M05 £0.4m adverse*). The forecast for the year is to achieve the DBV plan in full
- The assessment of the risk profile and maturity assessment of the DBV programme has improved from M05 to M06, particularly with regard to advancing the maturity of scheme development and consequent reduction of risk assessed.
- RDUH is continuing to forecast a £7.5m improvement in recurrent savings, changing from NR.

7.3 - Risks and mitigations

- RDUH is reporting £6.3m of unmitigated risk in M06 (*M05 £7.6m*). The net unmitigated risk attached to the CIP programme has improved to £6.0m (*M05 £8.8m*) but remains the main element of the unmitigated risks.

7.4 - Workforce indicators

- YTD expenditure is £1.2m above plan (*M05 £0.8m*). Substantive staff expenditure is £4.4m adverse, offset by £3.1m underspends in temporary staffing. This position is offset by £3.0m additional pay-related income.
- The forecast at M06 has moved to £4.2m above plan (*M05 £0.2m favourable*). Further funding is recognised to address this position.
- WTE numbers are below plan, including in substantive staff. Agency wte have risen in M06 and may be expected to rise further in October, due to the prevalence of respiratory illness across the workforce.

7.1 - RDUH Summary financial performance, month 06.

YTD position reflects the revised plan in M06. Funding has been received for RDUH's share of the ICS plan deficit and to cover costs incurred due to industrial action in Q1. The forecast is to achieve the plan.

Data from month 06 Trust PFR return

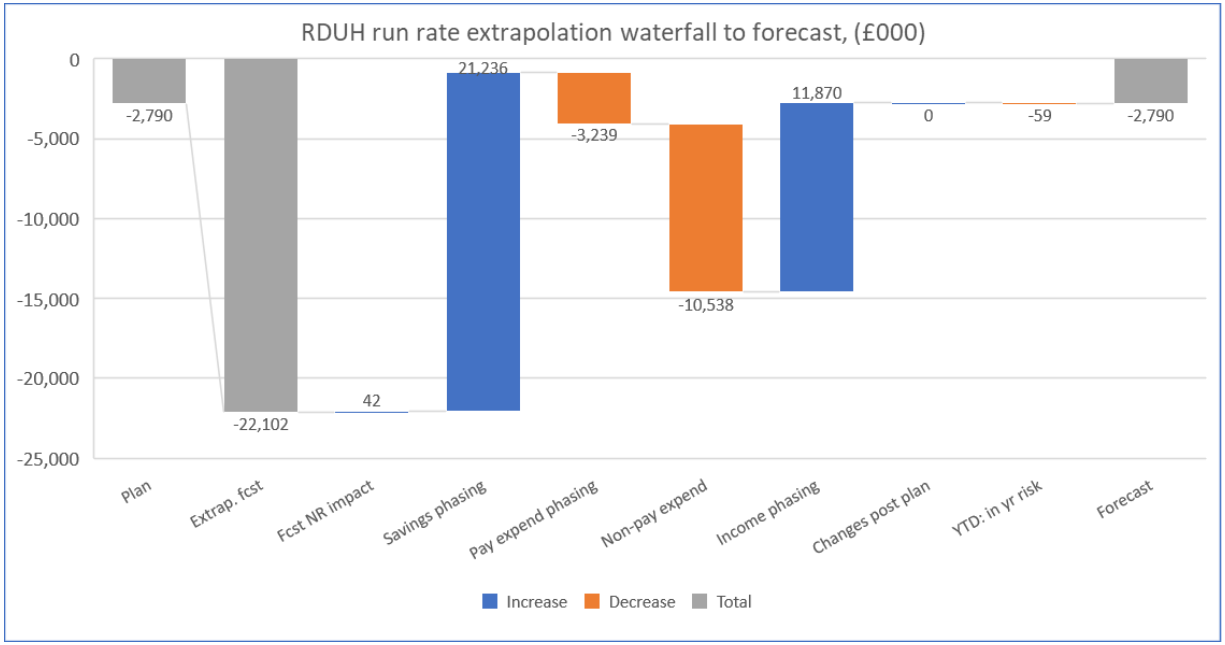
Comments

- RDUH has recorded £7.0m NR deficit funding in M06. The plan deficit for the year is revised to £2.8m.
- The ytd position reflects plan. The M05 £0.4m adverse position, due to IA costs in Q1, has been funded. The forecast is to achieve the revised plan.
- Income is above plan with (mainly) non-pay expenditure similarly increased.
  - Clinical supplies and services high expenditure is £3.9m adv (*M05 £2.1m adv*) and forecast to be £9.1m adv (*M05 £6.3m adv*). In M05 this was mainly due to increased expenditure on cardiology devices and insulin pumps
  - Drugs expenditure remains below plan at £0.4m (*M05 £0.6m fav*), improved from the M04 position of £1.6m adverse. The forecast is on plan (*M05 £2.5m fav*).
  - Premises costs £1.6m YTD adverse position (*M05 £1.4m adv*) is due to gas prices
- Pay-costs YTD position is £1.1m adv (*M05 £0.7m adv*). The forecast has moved to £3.9m adverse (*M05 £0.5m fav*), but the Trust has identified £3.0m of funded activity above plan.
- The Trust's plan profile includes material future flows of income from ERF and a material increase in delivering efficiencies.

Class	Group	Plan ytd £000	Actual ytd £000	Variance fav/(adv) £000	Variance fav/(adv) (%)	FY Plan £000	Forecast £000	Fcst vs Plan fav/(adv) £000	Fcst vs Plan fav/(adv) (%)	Extrapolated run rate £000	Run-rate vs plan fav/(adv) £000	Run-rate vs plan fav/(adv) (%)
Op Inc	Income NHSE PC	-96,377	-100,372	3,995	4%	-192,777	-196,278	3,501	2%	-200,744	7,967	4%
	Income other op	-57,429	-63,640	6,211	11%	-119,375	-131,695	12,320	10%	-127,280	7,905	7%
	Income pat care	-394,354	-393,364	-990	0%	-805,088	-810,587	5,499	1%	-786,728	-18,360	-2%
Op Inc Total		-548,160	-557,376	9,216	**2%**	-1,117,240	-1,138,560	21,320	**2%**	-1,114,752	-2,488	**0%**
Op Exp	Healthcare	14,461	16,301	-1,840	13%	27,599	32,102	-4,503	16%	32,602	-5,003	18%
	Social care	261	156	105	-40%	525	312	213	-41%	312	213	-41%
	Pay	347,236	348,328	-1,092	0%	692,842	696,699	-3,857	1%	696,656	-3,814	1%
	S&S Clin	44,447	48,322	-3,875	9%	85,537	94,592	-9,055	11%	96,644	-11,107	13%
	S&S other	7,223	8,692	-1,469	20%	12,375	16,156	-3,781	31%	17,384	-5,009	40%
	Drugs	65,476	65,080	396	-1%	131,866	131,937	-71	0%	130,160	1,706	-1%
	Estab	9,811	9,761	50	-1%	20,802	19,522	1,280	-6%	19,522	1,280	-6%
	Premises	11,399	13,021	-1,622	14%	24,254	27,270	-3,016	12%	26,042	-1,788	7%
	Transport	3,108	2,998	110	-4%	6,228	5,996	232	-4%	5,996	232	-4%
	Deprecn	21,813	21,973	-160	1%	45,166	45,166	0	0%	43,946	1,220	-3%
	ClinNeg	13,260	13,260	0	0%	26,521	26,520	1	0%	26,520	1	0%
	Other	14,166	14,456	-290	2%	28,809	28,357	452	-2%	28,912	-103	0%
Op Exp Total		552,661	562,348	**-9,687**	2%	1,102,524	1,124,629	-22,105	2%	1,124,696	-22,172	2%
SoCI	Finance and Other	6,558	6,079	479	-7%	17,506	16,721	785	-4%	12,158	5,348	-31%
Net Total		**11,059**	**11,051**	**8**		**2,790**	**2,790**	**0**		**22,102**	**-19,312**	

7.1.1 – Financial run rate waterfall to plan, month 06.

Data from trust PFR return



Commentary

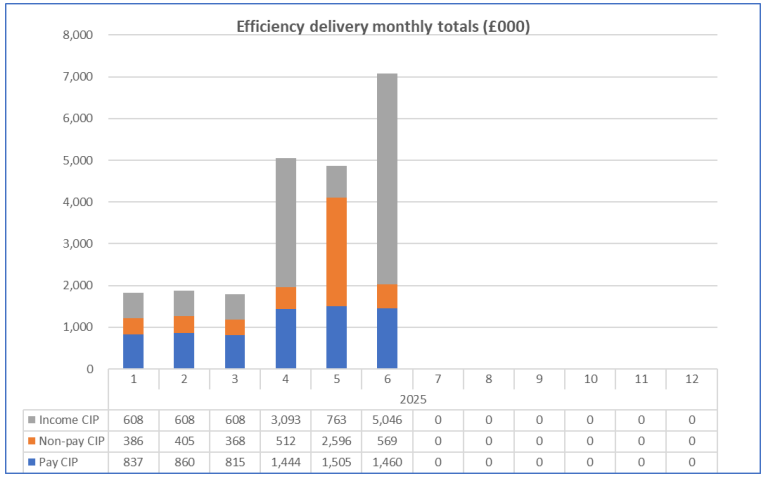
- The plan and forecast for RDUH has been adjusted to reflect the receipt of system funding to address the plan deficit. The RDUH plan and forecast is revised to £2.8m deficit.
- The straight-line extrapolated run-rate indicates a £22.1m deficit.
- Key elements of the reconciliation to the £2.8m deficit forecast position comprise the following:
  - (£21.2m) impact of the phasing of the efficiency programme, with 67% of the total value planned for delivery in H2.
  - (-£1.9m) net impact of planned increase in activity costs and income in H2.
- RDUH has not identified any further significant financial changes post the plan submission.

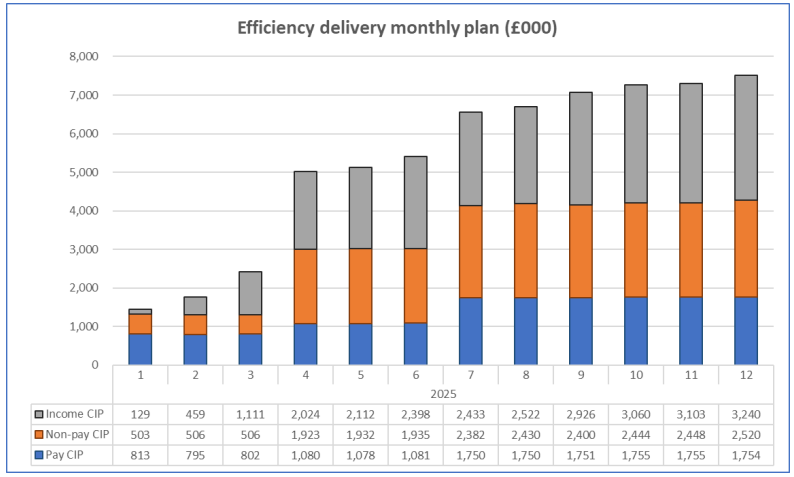
7.2 - RDUH efficiency programme, month 06.

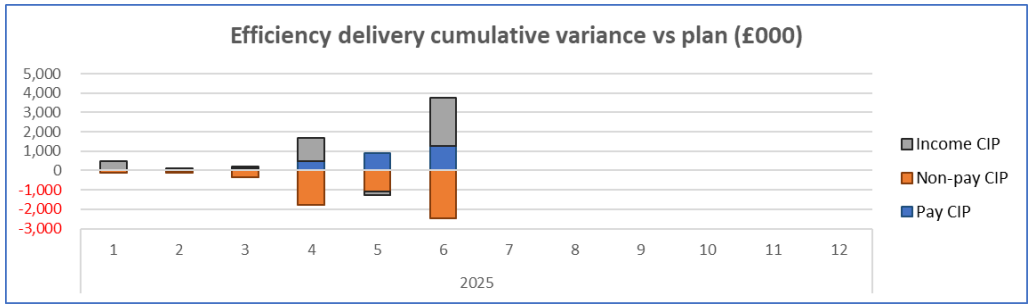
RDUH is £1.3m above plan at M06, and is forecasting to achieve the plan in full

Data from month 06 Trust PFR return

Organisation	Year to date			Forecast		
	Plan CIP delivery £000	Actual CIP delivery £000	Variance fav / (adv) £000	Plan for the year £000	Forecast £000	Variance fav / (adv) £000
Royal Devon University NHS FT	21,187	22,484	1,297	63,610	63,610	0







Spread of plan across quarters

Q1 – 9%
Q2 – 24%
Q3 – 32%
Q4 – 35%

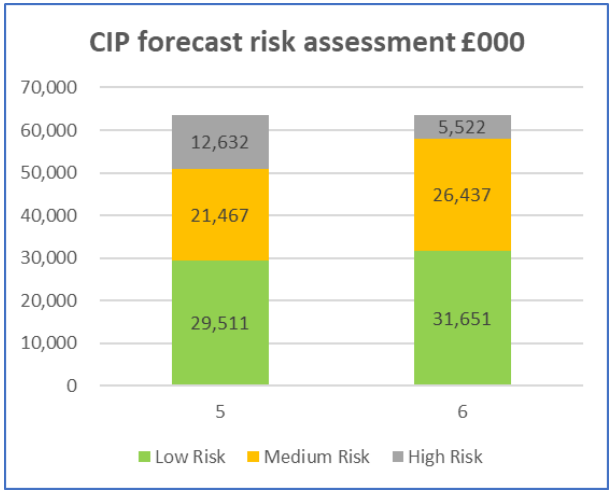
Year to date and forecast CIP

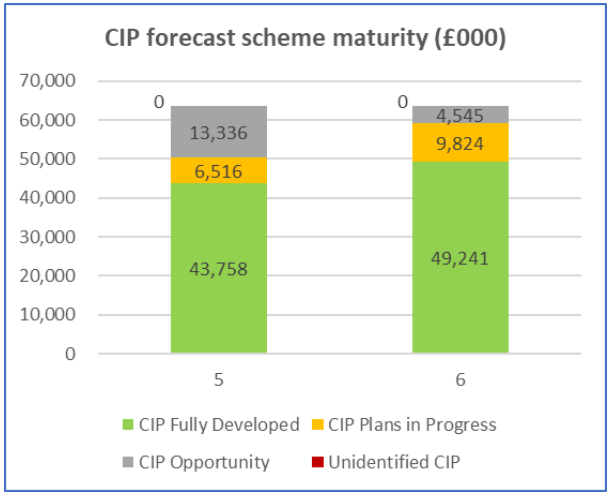
- YTD is £1.3m above plan (*M05 £0.4m adv*).
- The forecast is unchanged to deliver against plan.
- Actual savings in Q2 have delivered against the plan step-up.
- Income CIP delivery has increased significantly, through recognition of income under the 'Being Paid Fairly' workstream, in M06 and will be received via ERF. Income exceeds plan by £1.3m ytd.
- Pay CIP is £1.3m favourable to plan (*M05 £0.9m fav*)
- Non-pay CIP is £2.5m adverse to plan ytd (*M05 £1.1m adv*). RDUH expects to recover this position through budget underspends in H2.
- RDUH is confident that the progress seen in M07 indicates that the step-up in planned savings will be delivered.

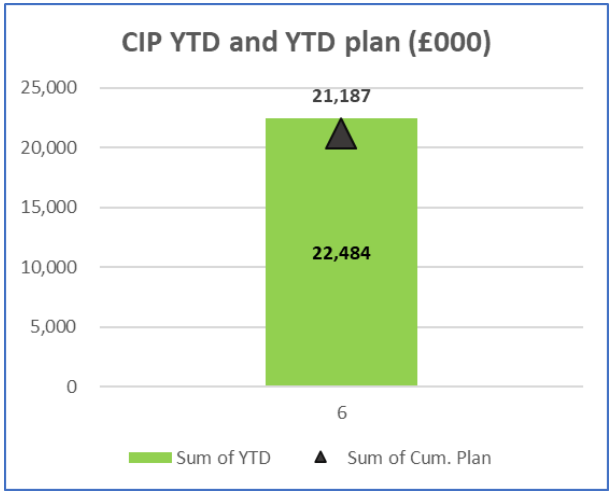
7.2.1 - RDUH Efficiency plan delivery, maturity and risk.

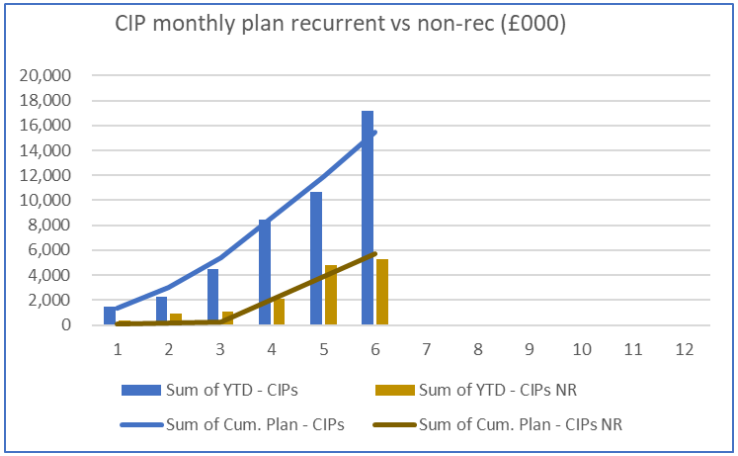
The CIP programme status of schemes has improved particularly in the progress of development and reduction of schemes identified as high risk.

Data from month 06 Trust PFR return









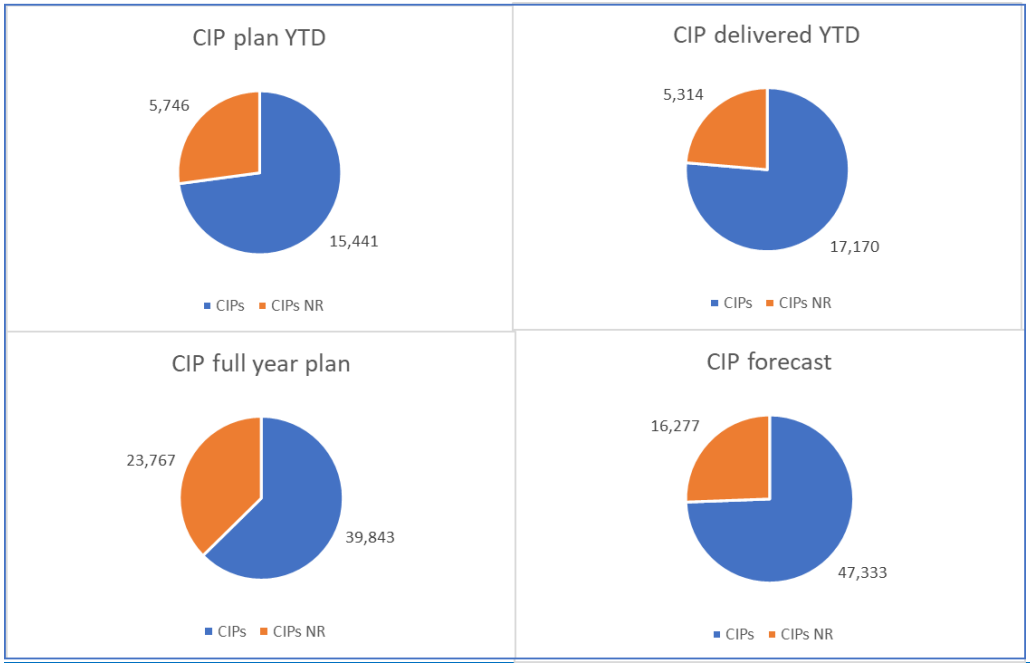
CIP programme risk and maturity

- The proportion of CIP schemes assessed as high risk is 8.8% (*M05 19.9%*). Low risk schemes account for 49.8% of the programme value (*M05 46.4%*)
- Steps that are being taken to reduce the level of high risk schemes are set out on slide 7.2.3
- 77.4% of the value of the programme is in fully developed schemes (*M05 68.8%*). The value of schemes that have not developed past identification of the opportunity has reduced from 21.0% to 7.1%.
- YTD delivery of recurrent schemes is above plan by £1.7m (*M05 £1.3m adv*)

7.2.2 - RDUH Efficiency plan delivery, maturity and risk.

RDUH is £1.3m above plan in delivery of savings YTD. The forecast position includes a shift of £7.5m from NR to recurrent savings

Data from month 06 Trust PFR return



Comments

- The proportion of recurrent savings in the CIP programme has increased from 63% in the plan to 74% in the forecast.
- YTD recurrent CIP delivery is £1.7m above plan (*M05 £1.3m adv*)
- Of the CIP delivered YTD, 76% is recurrent (*M05 69%*).

	Year to date			Forecast		
	Plan CIP delivery £000	**Actual CIP delivery** £000	**Variance** benefit / (adverse) £000	**Plan for the year** £000	**Forecast** £000	**Variance** benefit / (adverse) £000
Recurrent efficiencies	15,441	17,170	1,729	39,843	47,333	7,490
Non-recurrent efficiencies	5,746	5,314	(432)	23,767	16,277	(7,490)
Total	**21,187**	**22,484**	**1,297**	**63,610**	**63,610**	**0**
Recurrent %	72.9%	76.4%		62.6%	74.4%	
Non-recurrent %	27.1%	23.6%		37.4%	25.6%	

7.2.3 - RDUH Efficiency plan delivery, maturity and risk.

Actions planned to address the risk profile of the DBV programme

Data from month 04 Trust narrative

Steps to reduce high risk schemes:

Being Paid Fairly (BPF) - £2.1m

This largely relates to an income gain from moving to Clinical Coding Data Set (CDS) 6.3 with expected implementation from October. The Trust monitors the BPF programme monthly through a workstream meeting chaired by the deputy CEO, risks are monitored and mitigating actions set and followed up in this forum. Income was recognised in M06.

Procurement - £0.9m

Devon wide procurement transformation programme is high risk because of the delay to the programme in appointing the consultancy support, completed in M05. Latest financial trajectory being reviewed by Head of Procurement before being shared with DBV team which will enable a reassessment of risk. This will be discussed and followed up at the non-pay financial recovery workstream meetings chaired by the Chief Medical Officer.

Non-recurrent - £9.5m

Regular review of opportunities available and discussed fortnightly through the Trust's Finance Recovery Board. Care Groups and Corporate functions have been challenged to identify additional NR opportunities. NR schemes are transacted on a monthly basis, given that they are high risk by nature

7.3 - RDUH financial risks and mitigations position.

The net unmitigated risk position has improved from £7.6m (M05) to £6.3m in M06.

Data from month 06 Trust PFR

	RDUH £000	RDUH Prior month £000
Risks		
Commissioning	0	0
Cost pressures & inflation	-1,670	-2,971
Demand volume	0	0
Efficiencies, CIP	-13,615	-14,200
ERF risks	-5,066	-3,620
IA cost & lost activity	0	-439
ICB risk share	-3,987	-3,987
Income issues	-4,329	-3,110
Other	0	0
Pay award pressures	0	-1,000
Social Care & CHC	0	0
Total risks	**-28,667**	**-29,327**
Mitigations		
Additional efficiencies	7,638	5,350
Balance sheet flexibilities	550	550
Cost controls	4,804	2,800
ERF mitigations	1,576	5,210
IA additional funding	0	439
ICB risk share mitigated	3,987	3,987
Income recognition	3,770	3,412
Other	59	0
Total mitigations	**22,384**	**21,748**
Unmitigated risk per PFR	**-6,283**	**-7,579**

Commentary

- The ICS total net risk reported in the month 6 Integrated Finance Return (IFR) is £35.0m (M05 £41.2m). The RDUH net unmitigated risk has reduced to £6.3m.
- The main area of risk remains the delivery of the CIP programme. Key elements of this include the implementation of the system wide procurement arrangement, provided by Capita and hosted by UHP. The programme has been delayed, but is now expected to deliver a reduced level of savings for 2024/25 from Q3.
- RDUH has identified risks from expected income recognition and funding of ERF activity. The risk assessment is largely driven by new schemes being delayed in starting or under-delivery of activity and income, partially offset by cost. Elements of this are mitigated against.

7.4 - RDUH workforce summary, month 06.

Data from month 06 Trust PFR, PWR and narrative returns

Comments

- YTD overspend in pay is increased from £0.8m in M05 to £1.2m in M06.
- YTD substantive expenditure is above plan by £4.4m (*M05 £3.5m*). This rise comes after 3 months of reducing ytd overspend. Temporary staffing costs have reduced in M06.
- The forecast at month 06 is £4.2m over plan (*M05 £0.2m favourable*). This reflects the expected growth in ERF activity in H2. The substantive pay expenditure is forecast at £9.9m over pan (*M05 £6.6m adv*). Agency expenditure is forecast to be £4.4m below plan (*M05 £4.7m fav*).
- WTE numbers are improved at 180 below plan (*M05 219 below*). Substantive staff numbers improved to 157 wte below plan (*M05 208 wte below*). Agency staff wte are above plan by 52 wte (*M05 2 wte over plan*)

		Year to date (excl capitalised)			Full Year (excl capitalised)			WTE current month		
Organisation	**Class**	**Plan** £000	**Actual** £000	**Variance** fav/(adv) £000	**Full Year Plan** £000	**Forecast** £000	**Variance** fav/(adv) £000	**Plan wte**	**Actual wte** (per PWR)	**Variance** fav/(adv)
Royal Devon University NHS FT	Substantive	322,831	327,195	-4,364	644,497	654,433	-9,936	12,140	11,983	157
	Bank	15,093	14,284	809	29,974	28,568	1,406	443	369	75
	Agency	9,390	7,082	2,308	18,530	14,164	4,366	263	315	-52
		347,314	348,561	-1,247	693,001	697,165	-4,164	12,847	12,667	180

Paycost YTD versus budget	**RDUH £m**	**RDUH prior month £m**
prior month YTD (over)/underspend	*-0.81*	*-1.09*
reported YTD (over)/underspend	-1.25	-0.81
Offset by additional funding:		
Other funded activity	3.00	3.00
Non-funded YTD position (-ve adverse)	**1.75**	**2.19**
Recognised unfunded pressures:		
Industrial Action (unfunded)	0.30	0.30
enhancements 23/24	0.30	0.30
CIP slippage/(advance)	-1.30	-0.89
YTD against budget net of pressures	**1.05**	**1.90**

Analysis of pay expenditure against plan YTD

- The pay YTD overspend has increased from £0.8m in M05 to £1.3m in M06.
- After identified funded elements of pay expenditure, the net ytd position is £1.8m below plan (M05 £2.2m below)
- Income associated with the substantive pay overspend of £3.0m is identified from a range of sources, including genomics, cancer alliance, HEE funding and activity linked to ERF.
- The RDUH plan was adjusted in M05 to reflect the planned income and expenditure adjustments relating to the consultants' pay award.
- The YTD expenditure against capitalised staff costs plan is £0.2m favourable (*M05 £0.1m fav*).

7.4.1 - RDUH agency workforce summary, month 06.

Agency expenditure has been maintained below plan for 11 months. WTE numbers are above plan in M06.

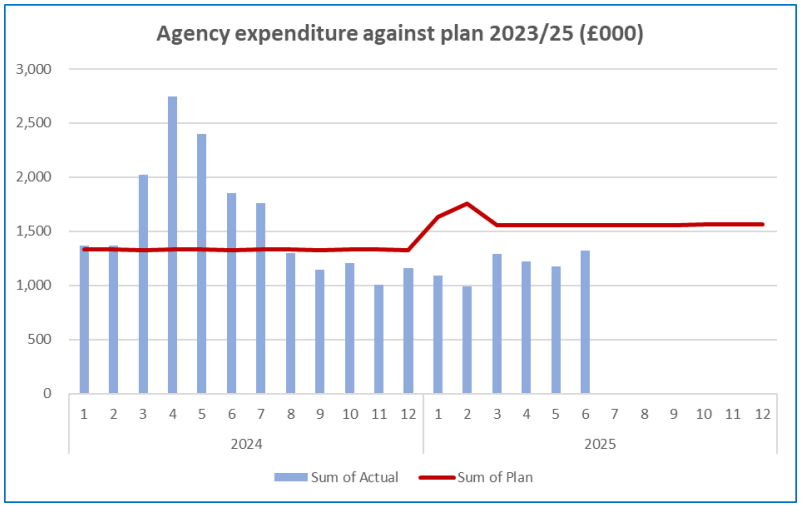
Data from month 06 Trust PFR, PWR and narrative returns

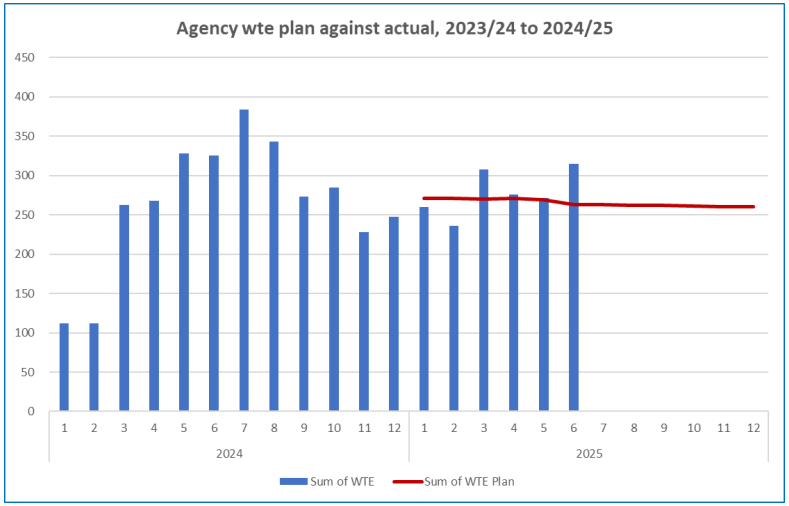
Comments

- Agency expenditure continues to be below plan, whilst wte is 52 wte above plan (*M05 2 wte above plan*). This reflects increase in reliance on agency staffing through the August holiday period.

Off-framework agency

- The ICS Workforce Delivery Group monitors in detail the progress in removing off-framework agency staffing at its fortnightly meetings. High level data is presented here for information.
- RDUH has identified 9 off-framework workers as at 10 Oct 2024. One of these is new. Three other instances have recently ceased or transferred to alternative appointment routes.
- Five of the posts are for workers at the employees' children's nursery, which is acknowledged by NHSE to be a specific role. Despite RDUH entering a contract with the Workforce Alliance Framework, the Alliance has not managed to supply the higher demand for nursery nurses on-framework. Pressure is being applied to get the off-framework agency sub-contracted to on-framework
- Covid and other respiratory illnesses are creating pressures on the workforce in October, so demand for agency work should be expected to increase.

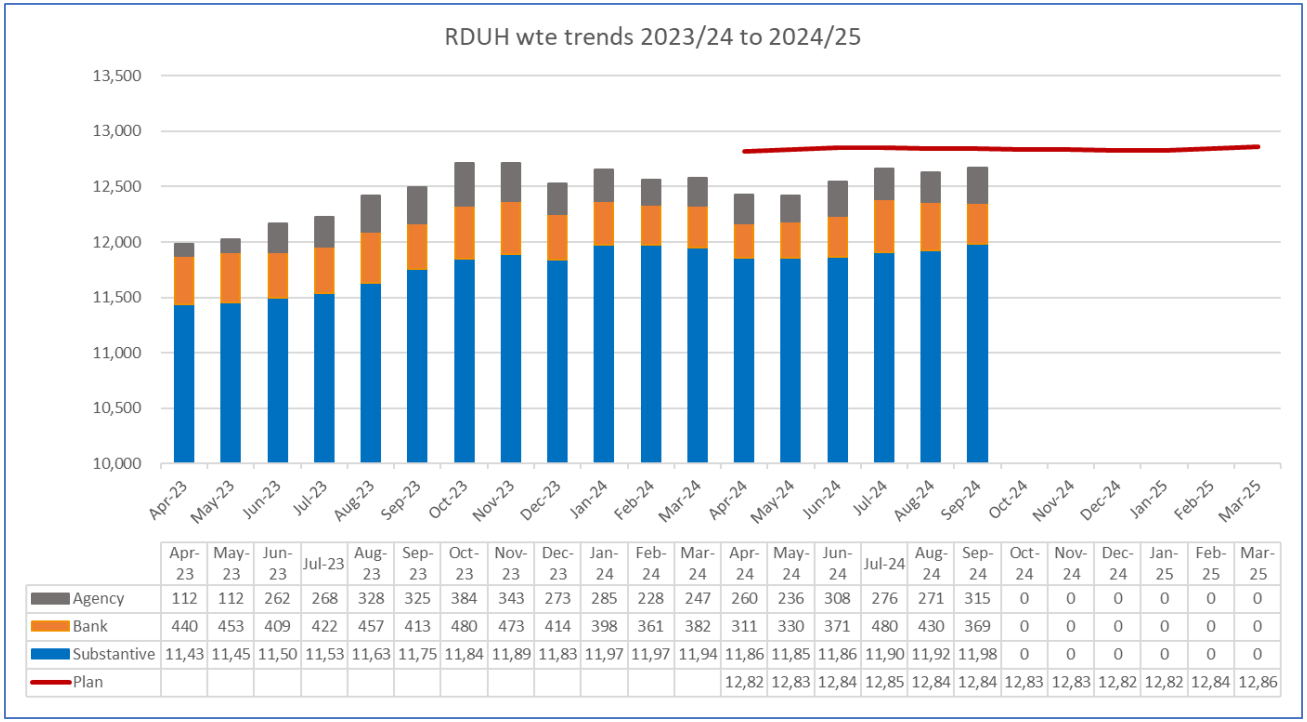




7.4.2 - RDUH workforce summary, month 06.

RDUH workforce total numbers are planned to rise marginally during 2024/25.

Data from month 06 Trust PWR return



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Agency	112	112	262	268	328	325	384	343	273	285	228	247	260	236	308	276	271	315	0	0	0	0	0	0
Bank	440	453	409	422	457	413	480	473	414	398	361	382	311	330	371	480	430	369	0	0	0	0	0	0
Substantive	11,43	11,45	11,50	11,53	11,63	11,75	11,84	11,89	11,83	11,97	11,97	11,94	11,86	11,85	11,86	11,90	11,92	11,98	0	0	0	0	0	0
Plan													12,82	12,83	12,84	12,85	12,84	12,84	12,83	12,83	12,82	12,82	12,84	12,86

Actual trend

- Actual wte numbers are rising slightly from the start of the year. But are still below the plan profile for the year.

Plan trend

- The RDUH workforce plan identifies increase by 43 wte (<0.5%) over the year (April 2024 to March 2025)

8.0 - Torbay and South Devon NHS Foundation Trust summary at month 06

8.1 - Financial reporting and forecast

- TSD has recorded £34.0m NR deficit funding in M06. The plan deficit for the year is revised to £13.6m (*M05 £47.7m adverse*).
- TSD is reporting a YTD position to plan (*M05 £0.5m adv*). The Trust has received funding in M06 to cover expenditure incurred due to industrial action in Q1, which has resulted in the improved position in M06.
- Pay expenditure is £4.9m adverse to plan (*M05 £4.9m adv*). In month expenditure is £0.1m above plan, which is a significant reduction from the previous months' circa £1m overspend against plan.
- The pay overspend is offset by income above plan by £3.9m (*M05 £2.7m*) and underspends overall in non-pay expenditure.
- TSD has reviewed its forecast in M06. The forecast is to achieve the plan position for the year, but now reflects a £8.6m forecast overspend in pay; £4.1m over in drugs; and £3.8m in social care services. These pressures are offset by a £9.1 forecast underspend in 'other' non-pay areas, primarily delivered through deferred investments.

8.2 - Efficiency programme

- Delivery is against plan YTD in M06. The forecast for the year is to achieve the CIP plan in full
- TSD has restated its savings delivery in months 04 and 05. Net recurrent savings in the two months have been increased by £0.3m and NR savings reduced by the same value. TSD has also reclassified elements of the savings, such that in M06 pay related savings are above plan.
- The CIP programme risk and maturity profile has not improved significantly from M04 to M06. The value of the lowest risk and fully developed schemes has increased, but the value of the high risk and little-developed schemes has not improved from M05.
- There is a significant future risk in the shift from recurrent to non-recurrent delivery of savings. The YTD value of NR CIP achieved matches the forecast value of NR CIP for the full year.

8.3 - Risks and mitigations

- TSD is reporting unmitigated risk of £9.2m (*M05 £11.2m*). The main factor in the unmitigated risk position is the net risk assessed in the CIP programme, at £5.0m

8.4 - Workforce indicators

- YTD expenditure is £4.9m adverse to plan (*M04 £4.9m adv*). Of this, £2.7m is unfunded (*M05 £3.1m*) with main cause being through the staffing requirement to deliver against activity demand pressures.
- WTE numbers are 141 above plan in month 06, due to temporary staffing demand (*M05 163 wte above plan*)
- TSD has identified a suite of actions that are implemented to improve controls over staffing and pay costs. The in-month pay overspend has reduced significantly in M06 from a little under £1m per month to <£0.1m in M06.

8.1 - TSD Summary financial performance, month 06.

The YTD position to plan at M06. The forecast is to achieve the plan.

Data from month 06 Trust PFR return

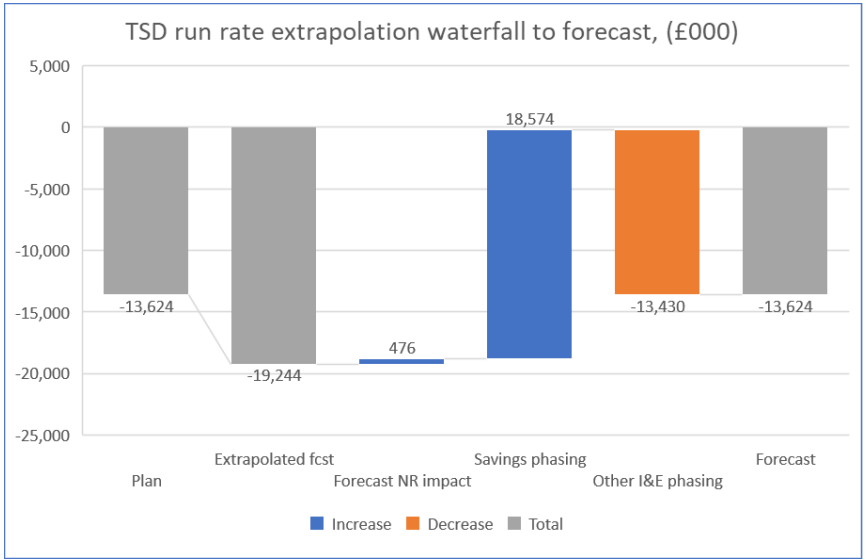
Key indicators

- TSD has recorded £34.0m NR deficit funding in M06. The plan deficit for the year is revised to £13.6m (*M05 £47.7m adverse*).
- Funding has been received to cover the additional cost of industrial action in Q1. TSD is reporting a ytd position that matches plan in M06 (*M05 £0.5m deficit due to IA costs*).
- Income is £3.9m favourable to plan (*M05 £2.7m fav*).
- Pay is £4.9m adverse to plan (*M05 £4.9m adv*). The in-month pay expenditure reduced by £1.1m in M06 and was less than £0.1m above plan for the month.
- Non-pay items are £1.1m favourable to plan (*M05 £1.4m fav*). "Other" items of expenditure are £3.7m favourable (*M05 £3.1m fav*) relating to slippage on planned investments.
- TSD has completed a detailed forecast review in M06. As a result, the 3% ytd overspent pay position is now reflected in the forecast £8.6m adverse position. Drugs expenditure is forecast at 9% over plan (£4.1m adv). Social care expenditure pressures of £3.8m (4%) are also forecast. These pressures are offset by increased income forecast of £5.8m (1%) and £9.1m underspend on 'other' expenditure.
- The forecast is to deliver to plan.

Class	Group	Plan ytd £000	Actual ytd £000	Variance fav/(adv) £000	Variance fav/(adv) (%)	FY Plan £000	Forecast £000	Fcst vs Plan fav/(adv) £000	Fcst vs Plan fav/(adv) (%)	Extrapolated run rate £000	Run-rate vs plan fav/(adv) £000	Run-rate vs plan fav/(adv) (%)
Op Inc	Income NHSE PC	-26,444	-28,195	1,751	7%	-52,884	-52,884	0	0%	-56,390	3,506	7%
	Income other op	-16,803	-19,114	2,311	14%	-33,954	-37,834	3,880	11%	-38,228	4,274	13%
	Income pat care	-298,800	-298,625	-175	0%	-586,138	-588,069	1,931	0%	-597,250	11,112	2%
Op Inc Total		-342,047	-345,934	3,887	**1%**	-672,976	-678,787	5,811	**1%**	-691,868	18,892	**3%**
Op Exp	Healthcare	44,823	43,201	1,622	-4%	85,032	85,390	-358	0%	86,402	-1,370	2%
	Social care	51,779	54,166	-2,387	5%	102,921	106,732	-3,811	4%	108,332	-5,411	5%
	Pay	170,254	175,200	-4,946	3%	331,980	340,571	-8,591	3%	350,400	-18,420	6%
	S&S Clin	15,960	15,769	191	-1%	29,887	28,892	995	-3%	31,538	-1,651	6%
	S&S other	3,113	3,388	-275	9%	5,563	6,636	-1,073	19%	6,776	-1,213	22%
	Drugs	22,336	24,174	-1,838	8%	44,400	48,497	-4,097	9%	48,348	-3,948	9%
	Estab	1,374	1,343	31	-2%	2,750	2,775	-25	1%	2,686	64	-2%
	Premises	12,014	12,892	-878	7%	24,220	22,206	2,014	-8%	25,784	-1,564	6%
	Transport	1,665	1,636	29	-2%	3,331	3,254	77	-2%	3,272	59	-2%
	Deprecn	10,988	10,186	802	-7%	21,990	21,309	681	-3%	20,372	1,618	-7%
	ClinNeg	4,706	4,629	77	-2%	9,413	9,315	98	-1%	9,258	155	-2%
	Other	9,377	5,660	3,717	-40%	18,571	9,440	9,131	-49%	11,320	7,251	-39%
Op Exp Total		348,389	352,244	**-3,855**	1%	680,058	685,017	-4,959	1%	704,488	-24,430	4%
SoCI	Finance and Other	3,280	3,312	-32	1%	6,542	7,394	-852	13%	6,624	-82	1%
Net Total		**9,622**	**9,622**	**0**		**13,624**	**13,624**	**0**		**19,244**	**-5,620**	

8.1.1 – Financial run rate waterfall to plan, month 06.

Data from organisational PFR and IFR returns



Commentary

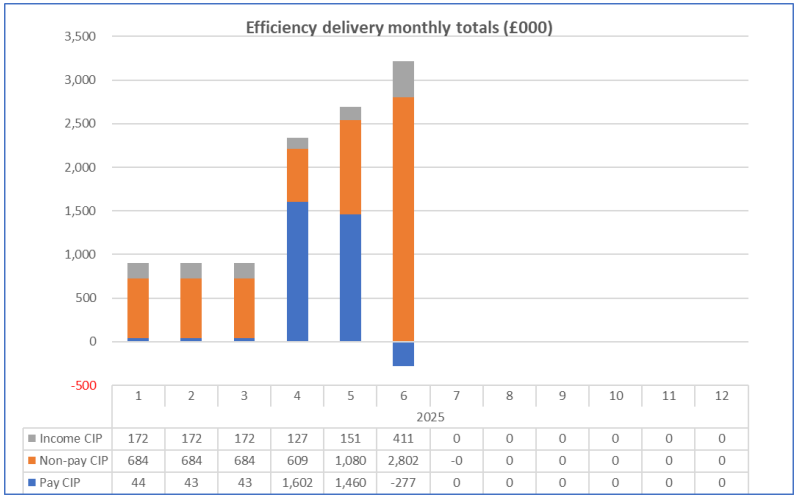
- The plan and forecast for TSD has been adjusted to reflect the receipt of system funding to address the plan deficit. The TSD plan and forecast is revised to £13.6m deficit.
- The straight-line extrapolated run-rate indicates a £19.2m deficit.
- Key elements of the reconciliation to the £13.6m deficit forecast position comprise the following:
  - (£18.6m) impact of the phasing of the efficiency programme, with 73% of the total value planned for delivery in H2.
  - (-£13.4m) primarily reflects the impact of phasing of the receipt of the NR deficit funding recorded by TSD.

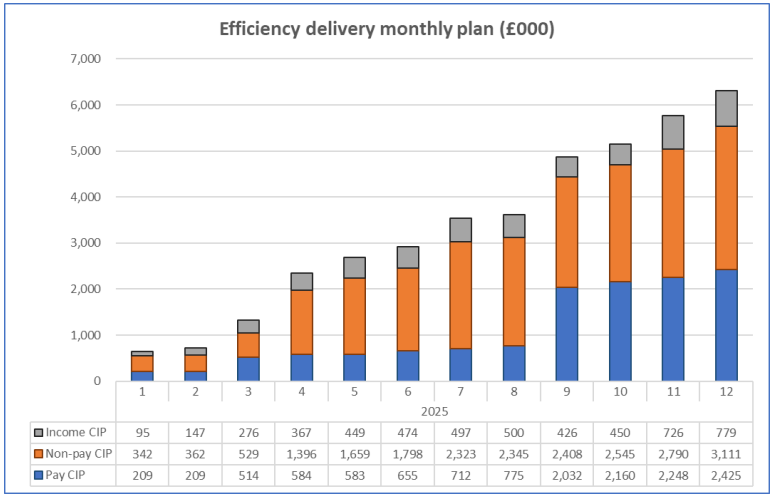
8.2 - TSD efficiency programme.

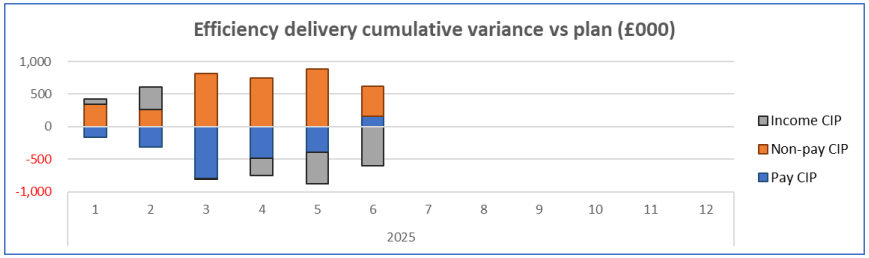
TSD is continuing to achieve the CIP plan YTD at month 06. The plan is forecast to be achieved in full.

Data from month 06 Trust PFR return

Organisation	Year to date			Forecast		
	Plan CIP delivery £000	Actual CIP delivery £000	Variance fav / (adv) £000	Plan for the year £000	Forecast £000	Variance fav / (adv) £000
Torbay and South Devon NHS FT	10,648	10,663	15	39,900	39,900	0







Spread of plan across quarters

Q1 – 7%
Q2 – 20%
Q3 – 30%
Q4 – 43%

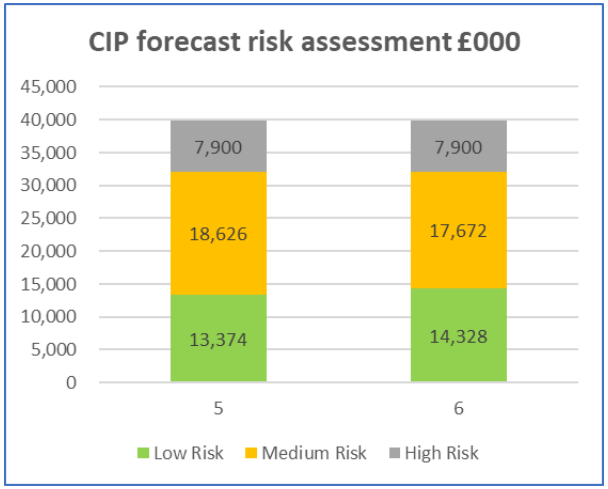
Year to date and forecast CIP

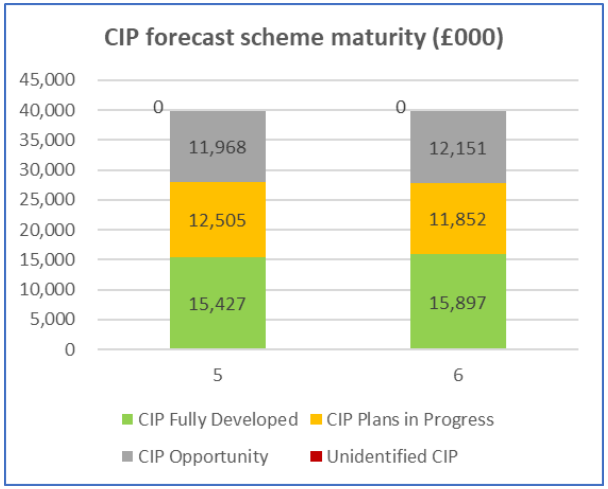
- TSD continues to deliver to plan in YTD to M06.
- The forecast is to deliver the plan in full. TSD reports that the PMO has full governance in place to demonstrate CIP delivery and a clear risk and issues log which will be visible at its Recovery Group. The majority of programme is set to deliver in the final months of the year.
- Pay efficiencies are above plan cumulative total in M06. Income ytd efficiencies are below plan
- Note: TSD has restated its savings delivery in months 04 and 05. Net recurrent savings in the two months have been increased by £0.3m and NR savings reduced. There has also been a reclassification of savings from non-pay to pay. Due to the design of the monitoring model, the in-month adjustments are visible in the charts (chart 1), but the prior month ytd figures are unchanged (chart 3).

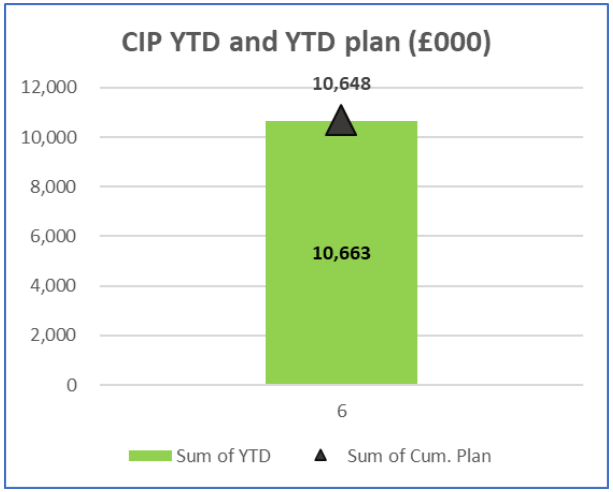
8.2.1 - TSD Efficiency plan delivery, maturity and risk.

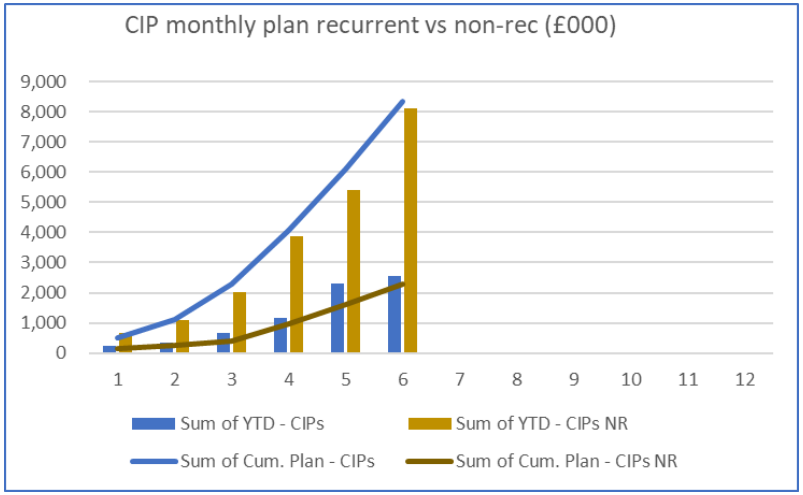
Assessment of CIP programme risk and maturity has not improved significantly from M05 to M06.

Data from month 06 Trust PFR return









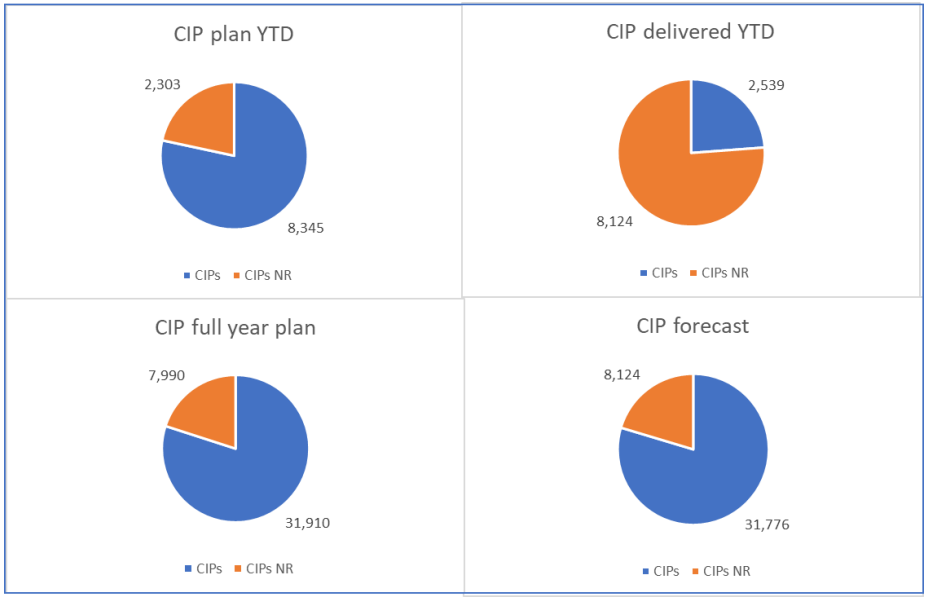
Efficiency plan risk and maturity

- TSD is reporting £7.9m of high risk schemes in M06 (*M05 £7.9m*), which is 19.8% of the programme. The value of schemes assessed as low risk has increased to £14.3m which is 35.9% of the programme, (*M05 £13.4m; 33.5%*).
- CIP programme maturity has improved slightly in M06. Fully developed schemes are shown as £15.9m which is 39.8% of the programme, (*M05 £15.4m*).
- Recurrent scheme delivery is significantly behind plan YTD. The percentage of scheme delivery ytd has deteriorated to 30% from 38% in M05.
- NR schemes are significantly above plan: 353% in M06

8.2.2 - TSD Efficiency plan delivery, recurrent and non-recurrent savings.

The underperformance of the planned recurrent CIP schemes represents a risk to future years' financial planning.

Data from month 06 Trust PFR return



Efficiency plan delivery

- TSD is delivering the value of the CIP plan YTD at M06, but there is a significant future risk in the shift from recurrent to non-recurrent delivery of savings. The YTD value of NR CIP achieved matches the forecast value of NR CIP for the full year.
- TSD does not plan to amend its forecast, but states that it will instead focus on delivery of recurrent savings in H2.
- The shift from recurrent to NR savings has continued in M06, with a £5.8m trend to NR (M05 £3.8m). The forecast is not significantly changed.

	Year to date			Forecast		
	Plan CIP delivery £000	**Actual CIP delivery** £000	**Variance** benefit / (adverse) £000	**Plan for the year** £000	**Forecast** £000	**Variance** benefit / (adverse) £000
Recurrent efficiencies	8,345	2,539	(5,806)	31,910	31,776	(134)
Non-recurrent efficiencies	2,303	8,124	5,821	7,990	8,124	134
Total	**10,648**	**10,663**	**15**	**39,900**	**39,900**	**0**
Recurrent %	78.4%	23.8%		80.0%	79.6%	
Non-recurrent %	21.6%	76.2%		20.0%	20.4%	

8.3 - TSD financial risks and mitigations position.

The net unmitigated risk has reduced in month 06 to £9.2m.

Data from month 06 Trust PFR

	TSD £000	TSD Prior month £000
Risks		
Commissioning	0	0
Cost pressures & inflation	-2,850	-2,850
Demand volume	-2,943	-2,943
Efficiencies, CIP	-7,900	-7,900
ERF risks	0	0
IA cost & lost activity	-476	-476
ICB risk share	-974	-974
Income issues	-2,564	-2,564
Other	0	0
Pay award pressures	0	0
Social Care & CHC	-2,538	-2,538
Total risks	**-20,245**	**-20,245**
Mitigations		
Additional efficiencies	2,900	2,900
Balance sheet flexibilities	1,981	981
Cost controls	5,000	5,000
ERF mitigations	0	0
IA additional funding	0	0
ICB risk share mitigated	186	186
Income recognition	1,000	0
Other	0	0
Total mitigations	**11,067**	**9,067**
Unmitigated risk per PFR	**-9,178**	**-11,178**

Commentary

- The ICS total net risk reported in the month 6 Integrated Finance Return (IFR) is £35.0m (M05 £41.2m).
- The net unmitigated risk position for TSD has reduced from £11.2m in M05 to £9.2m in M06.
- Net unmitigated risks of £5.0m are identified against the CIP programme (*M05 net £5m*).

8.4 - TSD workforce summary, month 06.

Pay expenditure in M06 is less than £0.1m above plan. This is a significant improvement on previous months' performance of circa £1.0m overspend per month.

Data from month 06 Trust PFR, PWR and narrative returns

Commentary

- Pay costs YTD are adverse to plan by £4.9m (*M05 £4.9m*). The overspend in M06 is <£0.1m. The average monthly overspend from previous months was £1.0m.
- Substantive pay expenditure is £0.7m below plan (*M05 £0.3m adverse*). Temporary pay expenditure is £5.6m above plan (*M05 £4.6m adv*)
- WTE totals are 141 above plan, predominantly in temporary staffing (*M05 163 wte above*).
- The forecast for the year was reviewed in month 06. The forecast now shows a £8.6m overspend for the year, with a £3.3m underspend in substantive staff offset by temporary staffing overspend of £11.9m. Agency costs are forecast to overspend by £4.1m.

		Year to date (excl capitalised)			Full Year (excl capitalised)			WTE current month		
Organisation	**Class**	**Plan** £000	**Actual** £000	**Variance** fav/(adv) £000	**Full Year Plan** £000	**Forecast** £000	**Variance** fav/(adv) £000	**Plan wte**	**Actual wte** (per PWR)	**Variance** fav/(adv)
Torbay and South Devon NHS FT	Substantive	159,114	158,440	674	315,724	312,446	3,278	6,214	6,225	-11
	Bank	7,781	10,695	-2,914	10,599	18,414	-7,815	224	294	-70
	Agency	3,359	6,065	-2,706	5,657	9,711	-4,054	69	129	-60
		170,254	175,200	-4,946	331,980	340,571	-8,591	6,508	6,649	-141

Paycost YTD versus budget	**TSD £m**	**TSD prior month £m**
prior month YTD (over)/underspend	*-4.89*	*-3.84*
reported YTD (over)/underspend	-4.95	-4.89
Offset by additional funding:		
Other funded activity	2.20	1.82
Non-funded YTD position (-ve adverse)	**-2.75**	**-3.07**
Recognised unfunded pressures:		
Industrial Action (unfunded)		0.30
Medical agency activity and high cost locums	0.12	0.12
CIP slippage/(advance)	-0.20	0.40
activity pressure on bank and agency	3.28	2.29
YTD against budget net of pressures	**0.45**	**0.05**

Funded and unfunded elements of the pay position YTD

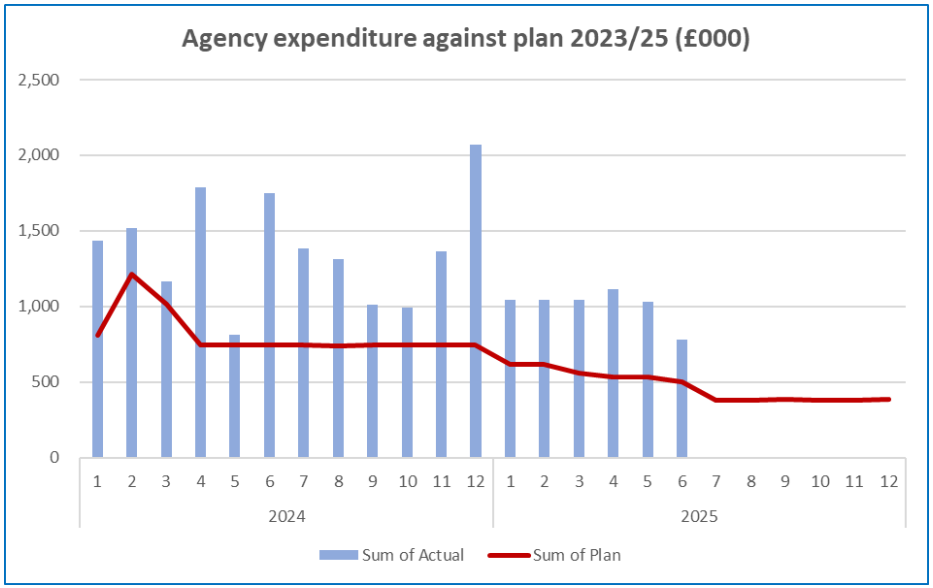
- The reported overspend has steadied at £4.9m in M06. After accounting for additional funding, the unfunded overspend is £2.8m (M05 £3.1m)
- The most significant un-funded element is the impact of the cost of delivering the additional activity. This points to why the wte numbers are also above plan in M06 and previous months.
- Capitalised staff expenditure is £1.7m adverse to plan YTD in M06 (*M5 £1.0m adv*).

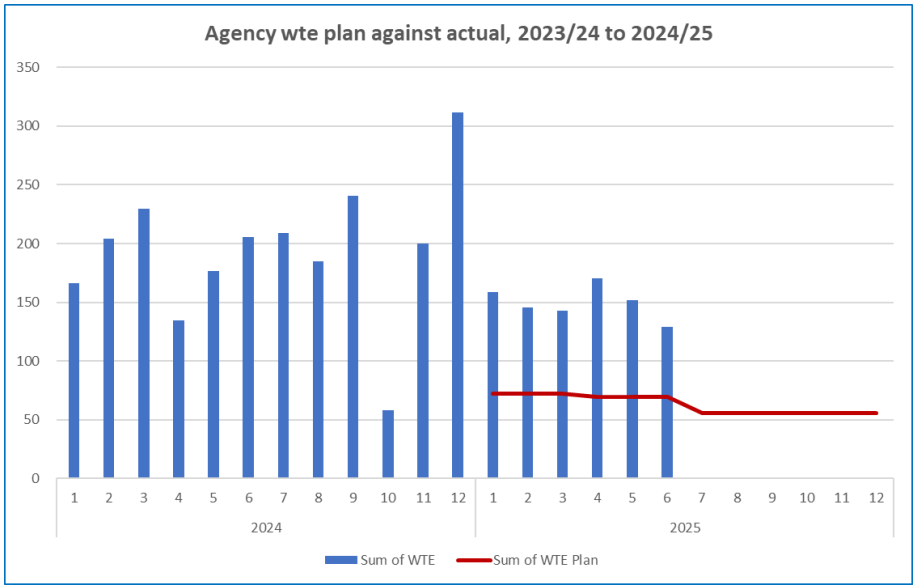
8.4.1 - TSD workforce summary, month 06 (Agency).

Overspend in M06 is £0.3m (*M05 £0.6m*). YTD overspend is £2.7m. WTE numbers are 86% above plan.

Data from month 05 Trust PFR and PWR returns

- Agency expenditure is over plan by £2.7m, or 94% (*M04 110%*). WTE totals are 86% (M05 120%) above plan.
- The forecast has been revised in M06 and now shows an increase to £9.7m against the full year plan of £5.7m
- TSD has identified a number of further initiatives to control staff numbers and new appointments. (see slide 8.4.3). Agency wte and in-month expenditure have reduced in M05 and M06. TSD has commenced its arrangement with NHS Professionals in M06 and expects this to generate improved cost controls and longer-term reduction in reliance on temporary staffing.

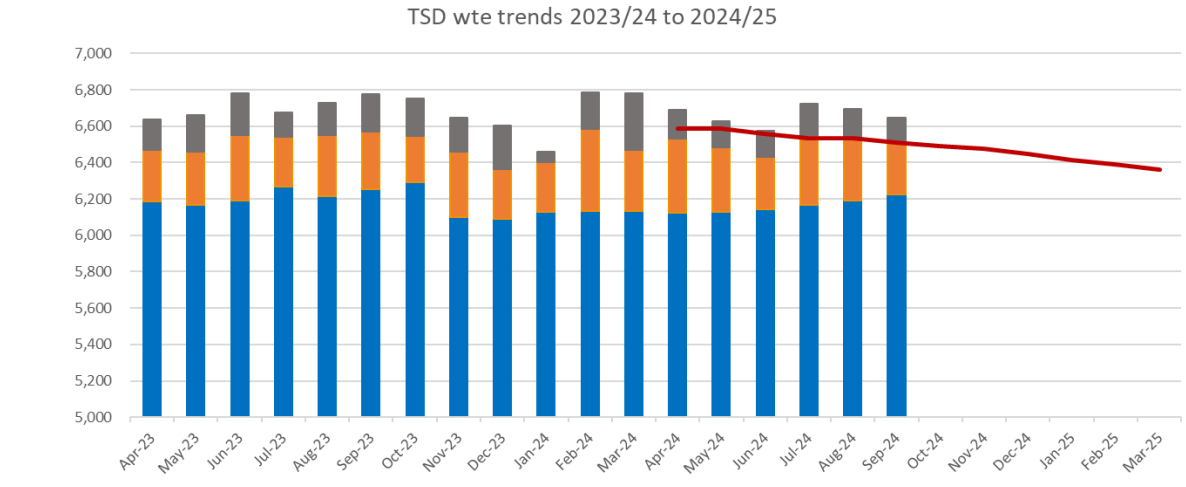




8.4.2 - TSD workforce summary, month 06.

TSD workforce total numbers are planned to fall marginally during 2024/25.

Data from month 06 Trust PWR return



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Agency	166	204	230	135	176	206	209	185	240	58	200	312	159	145	143	170	152	129	0	0	0	0	0	0
Bank	282	289	363	273	337	318	254	360	275	270	451	337	407	355	289	385	353	294	0	0	0	0	0	0
Substantive	6,188	6,168	6,190	6,266	6,213	6,253	6,290	6,100	6,089	6,130	6,134	6,133	6,126	6,126	6,141	6,167	6,189	6,225	0	0	0	0	0	0
Plan													6,586	6,586	6,556	6,531	6,531	6,508	6,493	6,477	6,449	6,413	6,389	6,362

Plan trend

- The TSD workforce plan identifies reduction by 223 wte (-3%) arising from the introduction on enhanced pay controls as set out in slide 8.4.3

Actual trend

- Actual wte numbers are 141 above plan in M06 (*M05 163 wte*). Of this, 80 wte relates to externally funded posts not planned for. This element is offset by income for other funded activity (*slide 8.4*).

8.4.3 - TSD Staff Controls (including agency)

A suite of controls is being is being enhanced to address workforce costs.

Data from TSD

- All planned agency and bank bookings are reviewed and considered by control panels chaired by Executives. Full rational to be made clear why this is required, for how long and the ongoing plan for correction. Additional oversight at the Recovery Group chaired by the CEO, no one will have the approval for any cost pressures outside of this group.
- For bank bookings a 48-hour check point will be in place to validate the gap to make sure mitigation has not been possible. Additional oversight at the Recovery Group chaired by the CEO, no one will have the approval for any cost pressures outside of this group.
- Improvements on substantive staffing has evidenced but additional checks and challenges are now in place to make sure A&C openings have been further challenged around pooling staffing and redeployment of staffing across TSD on critical areas before any approval is released.
- Trust goes live with NHS Professionals (7 October 2024)
- Review of long-term medical locums being undertaken and challenged accordingly making sure we have a robust replacement plan in place
- Review of all other agency workers and challenge why this work cannot be untaken internally including the use of redeployment across TSD and reaching out to the wider 'One Devon' approach
- Termination of all Off-Framework contracts

9.0 - University Hospitals Plymouth NHS Trust summary at month 06

9.1 - Financial reporting and forecast

- UHP has recorded £39.0m NR deficit funding in M06. The plan deficit for the year is revised to £15.6m (M05 £54.6m adverse).
- YTD position is £0.7m adverse, improved due to receipt of funds to cover the costs of industrial action in Q1.due to the impact of industrial action in Q1.
- The forecast is to achieve the plan for the year. Within this, expenditure on healthcare services is forecast to overspend by £21.5m, a significant element of this will be offset by additional healthcare funding.

9.2 - Efficiency programme

- Delivery is £4.7m ahead of plan in M06 YTD, mainly due to non-recurrent utilities CIP and recognition of reserve slippage in M06. The forecast for the year is to achieve the CIP plan in full.
- In M06 UHP has achieved the NHSE target to assess less than 20% of schemes by value as high risk. UHP has assessed 15.2% to be high risk, while 73.9% are assessed and fully developed and low risk.
- The forecast for the CIP programme shows a £8.0m shift from recurrent to non-recurrent savings. This represents a risk to future years' financial planning. UHP reports that the full year effect delivery of identified plans recovers the shortfall in this year's recurrent savings, but this includes delivery risks.

9.3 - Risks and mitigations

- UHP is reporting net unmitigated risk of £16.0m (*M05 £19.9m*).
- The main risks by value are CIP delivery, ERF delivery and cost and activity pressures.

9.4 - Workforce indicators

- YTD expenditure is adverse to plan by £1.1m (*M05 £0.1m adv*).
- UHP is forecasting a £1.4m overspend on pay for the year, mainly in bank expenditure. Agency expenditure is forecast to remain below plan.
- WTE numbers are above plan in M06 by 112 wte.

9.1 - UHP Summary financial performance, month 06.

UHP is reporting a £0.7m adverse position YTD, with a revised forecast to achieve the plan for the year.

Data from month 06 Trust PFR return

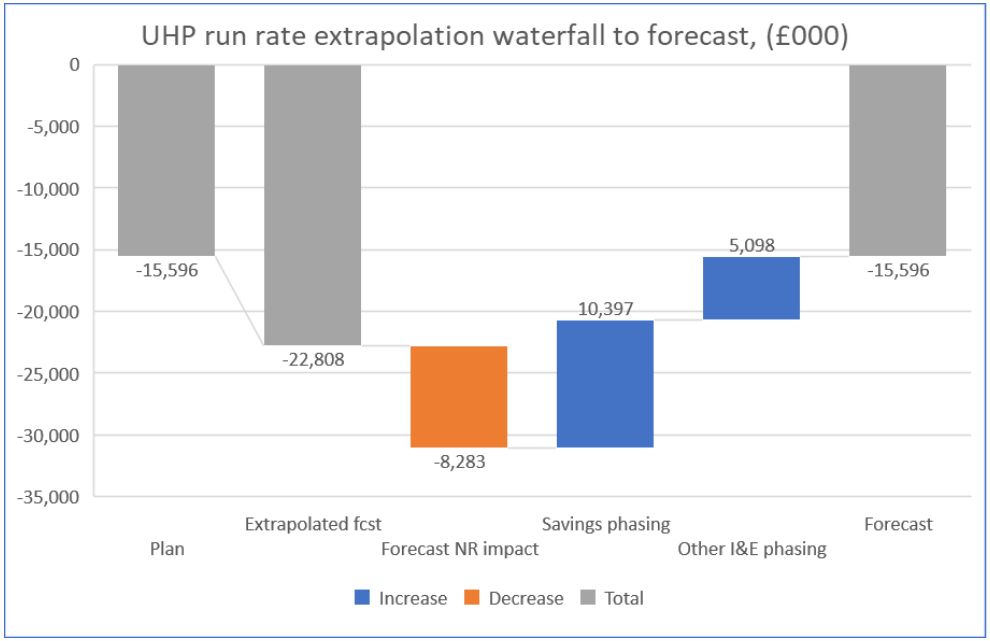
Key indicators

- UHP has recorded £39.0m NR deficit funding in M06. The plan deficit for the year is revised to £15.6m (M05 £54.6m adverse).
- YTD position is £0.7m adverse (*M05 £1.8m adv*). The improvement is because UHP has received funding to cover the costs incurred due to industrial action in Q1.
- Expenditure on healthcare services in £6.1m overspent ytd and forecast to overspend by £21.5m. Most of this increase will be offset by the forecast additional patient care income.
- Expenditure on premises ytd is £4.0m below plan (*M05 £3.9m*) and is forecast to underspend by £8.8m. YTD expenditure on pay is £1.4m above plan (*M05 £0.1m*). The overspend is not forecast to increase significantly.
- The forecast position was revised from plan in M05. The net forecast matches plan, but matching increases in income and expenditure by £14m, circa 1.5%, are included in the forecast to reflect passthrough drugs and devices variance.

Class	Group	Plan ytd £000	Actual ytd £000	Variance fav/(adv) £000	Variance fav/(adv) (%)	FY Plan £000	Forecast £000	Fcst vs Plan fav/(adv) £000	Fcst vs Plan fav/(adv) (%)	Extrapolated run rate £000	Run-rate vs plan fav/(adv) £000	Run-rate vs plan fav/(adv) (%)
Op Inc	Income NHSE PC	-158,056	-155,269	-2,787	-2%	-316,111	-314,511	-1,600	-1%	-310,539	-5,572	-2%
	Income other op	-37,706	-40,755	3,049	8%	-80,177	-79,428	-749	-1%	-81,509	1,332	2%
	Income pat care	-303,517	-303,196	-321	0%	-578,326	-594,783	16,457	3%	-606,393	28,067	5%
Op Inc Total		-499,279	-499,220	-59	**0%**	-974,614	-988,722	14,108	**1%**	-998,441	23,827	**2%**
Op Exp	Healthcare	52,922	59,024	-6,102	12%	95,711	117,171	-21,460	22%	118,048	-22,337	23%
	Social care	0	0	0	0%	0	0	0	0%	0	0	0%
	Pay	285,753	286,895	-1,142	0%	561,180	562,625	-1,445	0%	573,790	-12,610	2%
	S&S Clin	45,863	47,262	-1,399	3%	87,277	87,445	-168	0%	94,524	-7,247	8%
	S&S other	4,932	3,244	1,688	-34%	9,203	5,260	3,943	-43%	6,488	2,715	-30%
	Drugs	54,876	52,119	2,757	-5%	106,482	106,930	-448	0%	104,238	2,244	-2%
	Estab	2,712	3,225	-513	19%	5,224	7,542	-2,318	44%	6,450	-1,226	23%
	Premises	16,996	13,029	3,967	-23%	33,486	24,685	8,801	-26%	26,058	7,428	-22%
	Transport	610	886	-276	45%	1,220	1,895	-675	55%	1,772	-552	45%
	Deprecn	22,392	21,400	992	-4%	44,632	42,675	1,957	-4%	42,801	1,831	-4%
	ClinNeg	10,337	9,601	736	-7%	20,675	19,658	1,017	-5%	19,202	1,473	-7%
	Other	6,392	8,875	-2,483	39%	12,729	17,973	-5,244	41%	17,750	-5,021	39%
Op Exp Total		503,785	505,560	**-1,775**	0%	977,820	993,859	-16,039	2%	1,011,121	-33,301	3%
SoCI	Finance and Other	6,195	5,064	1,131	-18%	12,390	10,459	1,931	-16%	10,128	2,262	-18%
Net Total		**10,701**	**11,404**	**-703**		**15,596**	**15,596**	**-0**		**22,808**	**-7,212**	

9.1.1 – Financial run rate waterfall to plan, month 06.

Data from Trust PFR return M06



Commentary

- The plan and forecast for UHP has been adjusted in M06 to reflect receipt of NR deficit funding
- Key elements of the reconciliation from the extrapolated run-rate calculated at £22.8m deficit to the £15.6m forecast deficit position comprise the following:
  - -£8.3m - Adjustment to NR elements of the ytd position. This includes the impact of the phasing of the NR deficit support income received in M06
  - £10.4m - Impact of phasing of savings growth into H2 of the year.
  - £5.1m – Other phasing impacts, which includes £7.6m risks within the ytd figures. UHP states that this is a net position of risks and mitigations. It is built up from a further £16.4m forecast delivery risks outside the current run rate position, which brings the Trust to a variance of £24m off plan. This is then reduced offset with £8m of identified mitigations to a position of £16m off plan and then unidentified mitigations of £16m to get back to plan. This is in line with the overall net unmitigated position for UHP reported in slide 9.3.

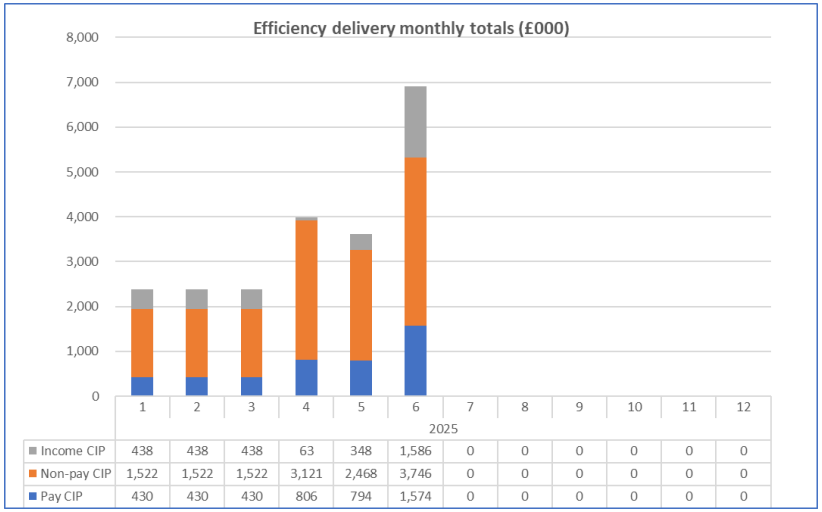
Forecast delivery risks	(£16.4m)
Identified mitigations	£8.0m
Unidentified mitigations	£16.0m
Total	**£7.6m**

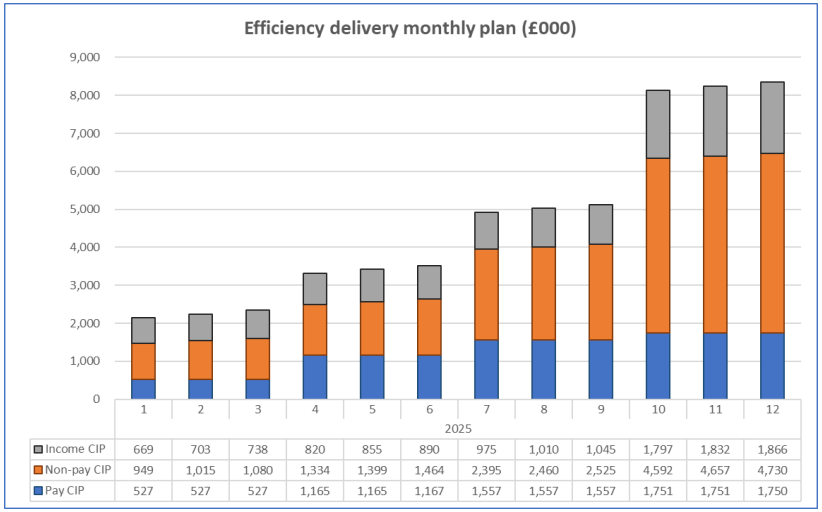
9.2 - UHP efficiency programme.

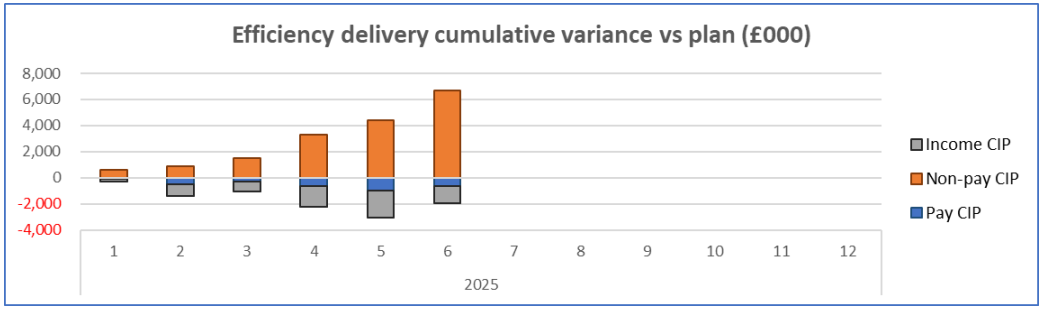
UHP has achieved CIP £4.7m above plan ytd in M06 (M05 £1.3m). The forecast is to deliver the plan.

Data from month 06 Trust PFR return

Organisation	Year to date			Forecast		
	Plan CIP delivery £000	Actual CIP delivery £000	Variance fav / (adv) £000	Plan for the year £000	Forecast £000	Variance fav / (adv) £000
University Hospitals Plymouth NHS Trust	16,994	21,677	4,683	56,801	56,802	1







Year to date and forecast CIP

- Efficiency savings achieved has seen a significant step-up in M06.
- The CIP delivery YTD is £4.7m favourable (*M05 £1.3m fav*) mainly due to non-recurrent utilities CIP and reserve slippage reflected in M06. The forecast is to deliver to plan.
- Non-pay CIP is £6.7m above plan (*M05 £4.4m above*).
- Pay CIP delivery is £0.6m adverse to plan (*M05 £1.0m adv*) and income CIP £1.4m adverse to plan (*M05 £2.1m adv*) ytd.
- The majority of programme is set to deliver in H2.

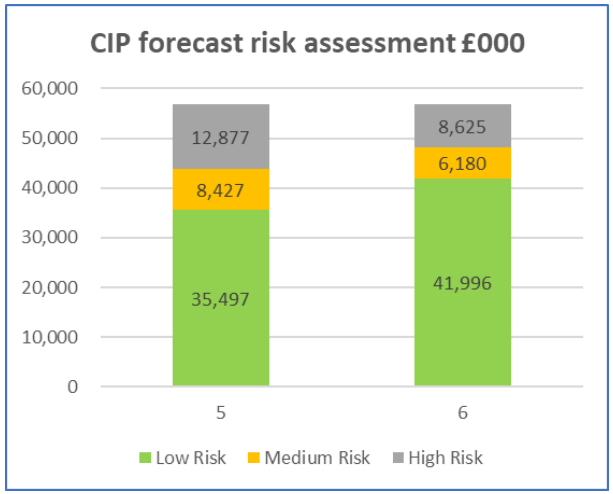
Spread of plan across quarters

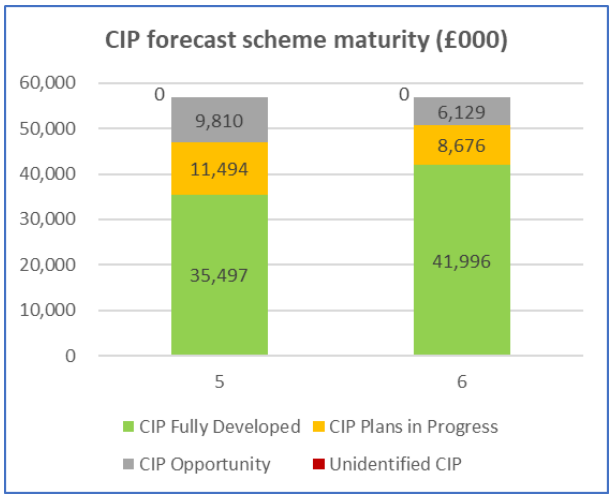
Q1 – 12%
Q2 – 18%
Q3 – 27%
Q4 – 44%

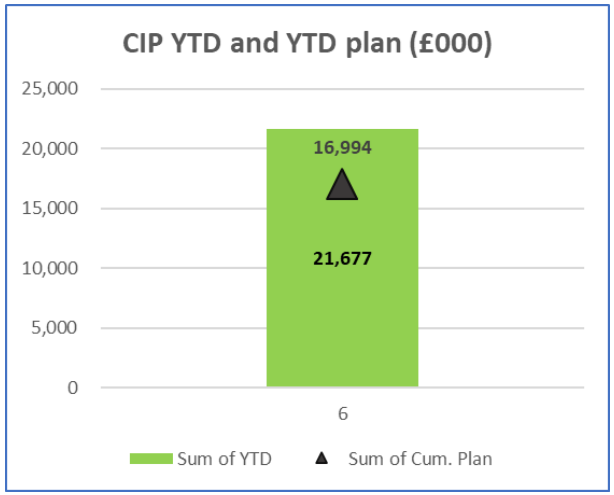
9.2.1 - UHP Efficiency plan delivery, maturity and risk.

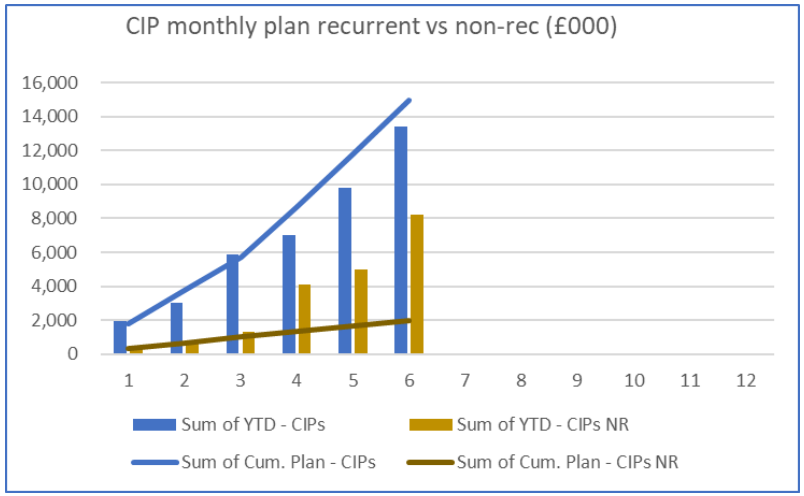
The profile of assessed risk and scheme maturity has improved slightly in M05 over M04, however UHP has not met the NHSE target to limit high risk schemes to less than 20% by 31 August.

Data from month 05 Trust PFR return









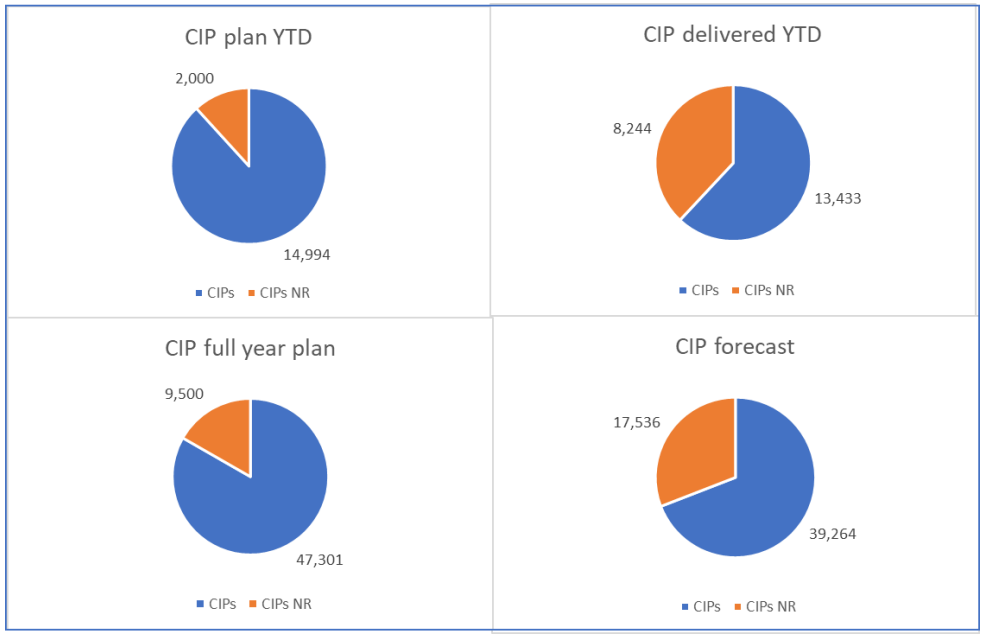
CIP programme risk and maturity profiles

- In M06 UHP has achieved the NHSE target for reducing the value of high risk schemes to below 20% of the programme value. £8.6m (15.2%) of the UHP CIP programme by value is identified as high risk. Low risk schemes have risen to £42.0m, 73.9% of the forecast value.
- The value in fully developed schemes has risen to £42.0m and there has been improvement in the value of schemes at early stages of development.
- Recurrent CIP scheme delivery is behind plan, but has improved to 90% achieved ytd in M06 (*M05 83%*). NR scheme delivery remains ahead of plan.
- UHP identifies that there remain significant risks in a number of the improvement programmes. Work is ongoing to ensure that savings are delivered and maximised but there is risk with a number of high value schemes including the One Plan and the Discharge Assessment Unit. The Trust is formalising plans for bed reductions but increased NEL demand and NRTR pressures are a significant concern.
- There is under achievement on pay savings but there are controls in place and focus on the reduction of bank and agency spend

9.2.2 - UHP Efficiency plan delivery, maturity and risk.

The forecast £7.6m shift of savings from recurrent to NR represents a risk to future years' financial planning.

Data from month 05 Trust PFR return



CIP programme delivery

- The CIP plan includes 17% of NR schemes by value. The YTD plan is for 12% to be NR. The actual achieved ytd is 38% of the CIP achieved.
- NR in the original plan was £9.5m. At M06 the forecast has increased to £17.5m NR (*M05 £17.1m, 30.1%*).
- UHP reports that the full year effect of schemes is forecast to deliver in excess of the financial target with the NR schemes supporting the in-year shortfall. The projected FYE effect is valued at £60m.
- The shift of schemes forecast of £8.0m (*M05 £7.6m*) from recurrent to non-recurrent represents a risk to future years financial planning. UHP reports that elements of the newly identified schemes will be classified as NR whilst plans are developed to confirm their recurrent opportunity.
- UHP reports that the full year effect of schemes is forecast to deliver in excess of the financial target with the NR schemes supporting the in-year shortfall. The projected FYE effect is valued at £60m. Although this still includes delivery risks this is greater than planned. This includes the full benefits current identified plan including the Trust's One Plan.

	Year to date			Forecast		
	Plan CIP delivery £000	**Actual CIP delivery** £000	**Variance** benefit / (adverse) £000	**Plan for the year** £000	**Forecast** £000	**Variance** benefit / (adverse) £000
Recurrent efficiencies	14,994	13,433	(1,561)	47,301	39,264	(8,037)
Non-recurrent efficiencies	2,000	8,244	6,244	9,500	17,536	8,036
Total	**16,994**	**21,677**	**4,683**	**56,801**	**56,800**	**(1)**
Recurrent %	88.2%	62.0%		83.3%	69.1%	
Non-recurrent %	11.8%	38.0%		16.7%	30.9%	

9.3 - UHP financial risks and mitigations position.

UHP is reporting a net risk position of £16.0m in month 06

Data from month 06 Trust PFR

	UHP £000	UHP Prior month £000
Risks		
Commissioning	0	0
Cost pressures & inflation	-9,350	-8,808
Demand volume	0	-2,000
Efficiencies, CIP	-8,000	-18,113
ERF risks	-3,200	-3,776
IA cost & lost activity	-800	2,660
ICB risk share	-800	-974
Income issues	0	-2,050
Other	351	-1,922
Pay award pressures	-2,240	-152
Social Care & CHC	0	0
Total risks	**-24,039**	**-35,135**
Mitigations		
Additional efficiencies	2,300	5,000
Balance sheet flexibilities	0	0
Cost controls	2,000	2,500
ERF mitigations	2,000	4,000
IA additional funding	0	1,900
ICB risk share mitigated	800	186
Income recognition	900	1,600
Other	0	0
Total mitigations	**8,000**	**15,186**
Unmitigated risk per PFR	**-16,039**	**-19,949**

Commentary

- The ICS total net risk reported in the month 6 Integrated Finance Return (IFR) is £35.0m (M05 £41.2m).
- The net unmitigated risk position for UHP is improved from M05 at £16.0m. Identified risks have reduced from £35.1m to £24.0m, mitigations have fallen from £15.2m to £8.0m.
- CIP risk has reduced from £18.1m to £8.0m, mitigations have also reduced, with the net unmitigated position reduced from £13.1m to £5.7m. Although CIP delivery is ahead of plan the net unmitigated risk position reflects that there is risk in delivery of the full CIP plans.
- The mitigations value has been reduced by the exclusion of funding to cover elements of the cost of IA in Q1.
- The position in M06 includes an assessment in the shortfall of the final pay award of £2.2m.

9.4 - UHP workforce summary, month 06.

Payroll expenditure YTD is £1.1m above plan ytd in M06. Temporary staffing requirements are met primarily from bank; agency expenditure ytd is below plan.

Data from month 06 Trust PFR, PWR and narrative returns

Commentary

- Expenditure ytd is £1.1m adverse to plan (*M05 £0.1m adv*). WTE totals are above plan at 112 over (*M05 52 wte over plan*).
- Temporary staffing requirements are met mainly from bank. The overspend of £1.2m is partially offset by underspends in agency expenditure. Agency wte and costs are below plan.
- UHP is forecasting to overspend the plan by £1.4m, through bank expenditure. Agency expenditure is forecast to remain below plan.
- UHP reports that the increase in recruitment to planned developments has been slower than planned. Variance from the financial plan reflects slippage on reserve recruitment for planned investments which to some degree are offset by increased insourcing costs.

		Year to date (excl capitalised)			Full Year (excl capitalised)			WTE current month		
Organisation	**Class**	**Plan** £000	**Actual** £000	**Variance** fav/(adv) £000	**Full Year Plan** £000	**Forecast** £000	**Variance** fav/(adv) £000	**Plan wte**	**Actual wte** (per PWR)	**Variance** fav/(adv)
University Hospitals Plymouth NHST	Substantive	268,431	268,725	-294	529,677	527,330	2,347	10,204	10,105	99
	Bank	14,764	15,960	-1,196	26,630	30,590	-3,960	298	525	-227
	Agency	2,555	2,210	345	4,873	4,705	168	39	24	16
		285,750	286,895	-1,145	561,180	562,625	-1,445	10,542	10,654	-112

Paycost YTD versus budget	**UHP £m**	**UHP prior month £m**
prior month YTD (over)/underspend	*-0.14*	*0.81*
reported YTD (over)/underspend	-1.14	-0.14
Offset by additional funding:		
Industrial Action (funded)	0.58	
Other funded activity	0.33	
Non-funded YTD position (-ve adverse)	**-0.24**	**-0.14**
Recognised unfunded pressures:		
Industrial Action (unfunded)		0.50
CIP slippage/(advance)	0.62	1.02
B2-3 Lump settlement excess of accrual	0.50	
YTD against budget net of pressures	**0.88**	**1.38**

Pay funded and unfunded expenditure against plan

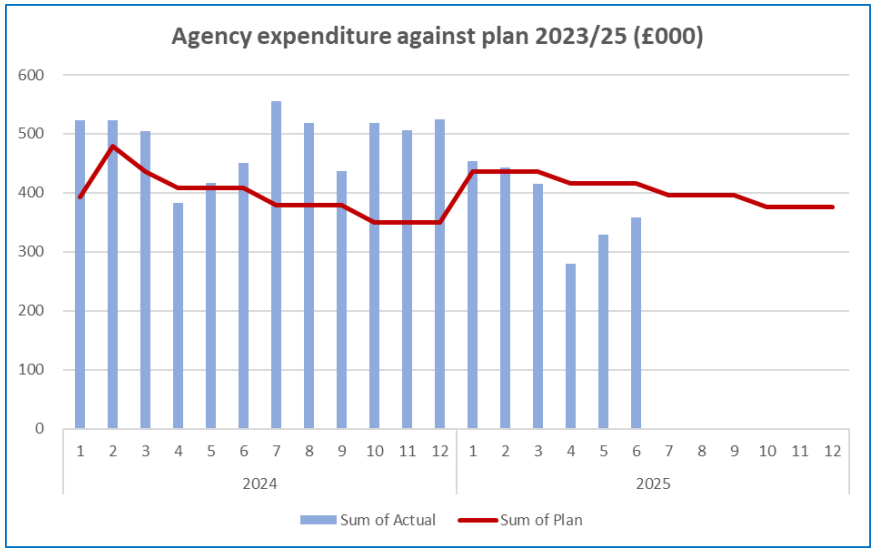
- UHP is reporting an unfunded position ytd of £0.2m adverse to plan
- Funding has been received to offset the costs of industrial action in Q1
- UHP has received funding for additional staffing to deliver NHSE approved schemes in ED
- Slippage on pay CIP schemes ytd and pressures from the band 2/3 settlement are factors identified as having an adverse impact on the pay expenditure totals reported.

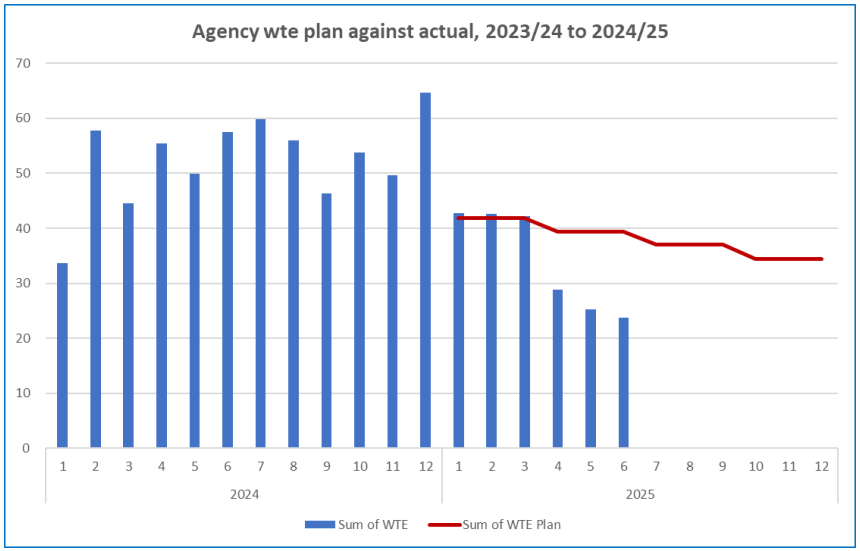
- Capitalised staff pay ytd is £0.3m above plan in M06 (*M05 £0.2m adv*)

9.4.1 - UHP workforce summary, agency month 06.

Data from month 06 Trust PFR and PWR returns

- Agency expenditure and wte remains below plan.
- There is no off-framework agency spend.

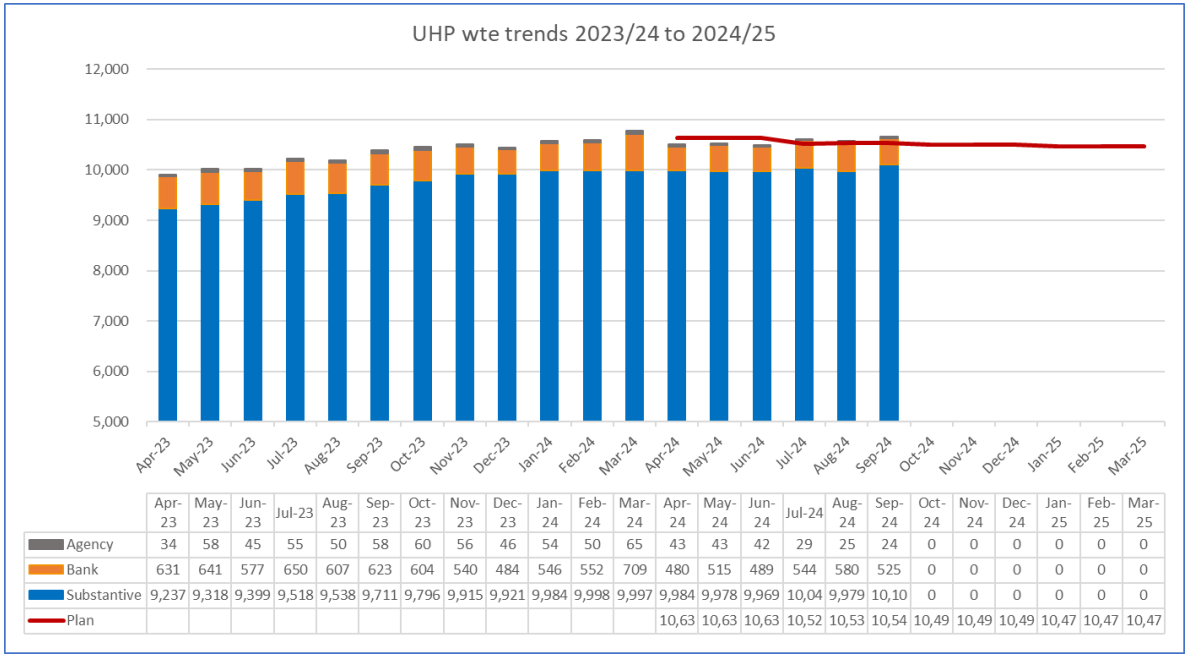




9.4.2 - UHP workforce summary, month 06.

UHP workforce total numbers are planned to reduce marginally during 2024/25.

Data from month 06 Trust PWR return



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Agency	34	58	45	55	50	58	60	56	46	54	50	65	43	43	42	29	25	24	0	0	0	0	0	0
Bank	631	641	577	650	607	623	604	540	484	546	552	709	480	515	489	544	580	525	0	0	0	0	0	0
Substantive	9,237	9,318	9,399	9,518	9,538	9,711	9,796	9,915	9,921	9,984	9,998	9,997	9,984	9,978	9,969	10,04	9,979	10,10	0	0	0	0	0	0
Plan													10,63	10,63	10,63	10,52	10,53	10,54	10,49	10,49	10,49	10,47	10,47	10,47

Plan trend

- The UHP workforce plan identifies reduction by 166 wte (-2%) arising from CIP plans and reduced bank and agency following last year's substantive international recruitment.

Actual trend

- Actual wte numbers are above plan by 112 wte (*M05 52 wte above plan*).
- Substantive staff wte are 99 wte below plan, offset by bank wte 227 wte above plan.

10.0 – NHS Devon Integrated Care Board summary at month 06

10.1 - Financial reporting and forecast

- The ICB is forecasting to deliver against plan. The £0.4m net underspend in commissioned services and £1.0m underspend in ICB running costs are offset within the reserves position.
- Commissioned services in mental health and continuing care are forecast to overspend by £2.4m combined (*M05 £2.1m*). The overspend is forecast to be met from reserves.

10.2 - Efficiency programme

- The ICB CIP plan is heavily weighted to the second half of the financial year (88% in H2)
- The ICB is delivering £0.1m above plan YTD at month 6 and is forecasting full achievement of the CIP plan
- Assessment of scheme risk and maturity has improved significantly in M06. There are no high risk schemes and all schemes have progressed to at least planning stages.

10.3 - Risks and mitigations

- The ICB is reporting no net unmitigated risk in M06, unchanged from M05.

10.1 – NHS Devon ICB summary financial performance, month 06.

Data from month 06 ICB IFR return

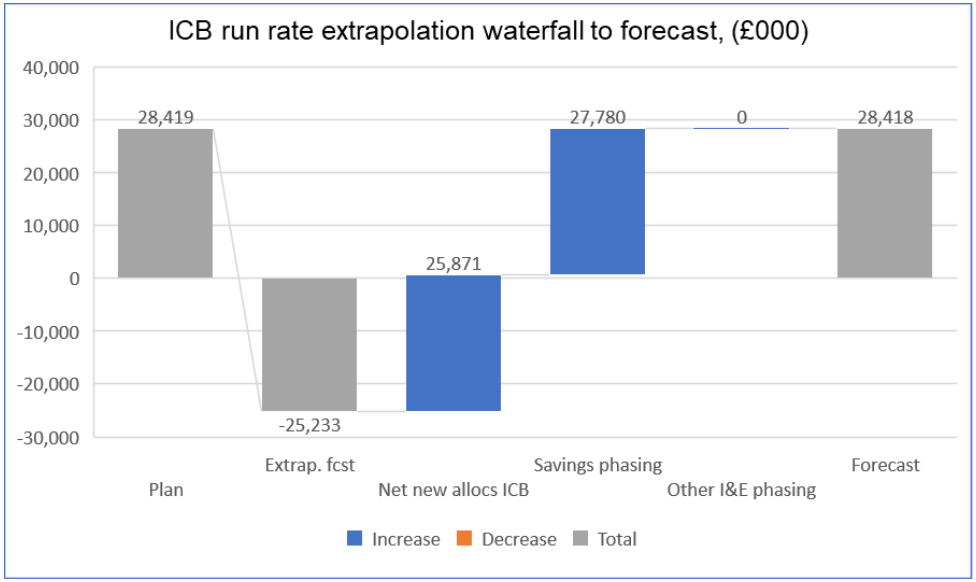
Key indicators

- YTD net position is in line with forecast:
  - Revenue Resource Limit (RRL) plan has been adjusted to reflect receipt of the NR deficit funding for the ICS.
  - Commissioned services expenditure £0.4m favourable (*M05 £0.4m adv*)
  - ICB running costs £1.0m favourable to plan (*M05 £0.8m fav*)
  - Reserves are committed below plan by £1.4m (*M05 £0.4m under-committed*)
- Forecast position is for commissioned services expenditure £1.3m adverse to plan (*M05 £1.8m adv*), funded through reserves, with no change to the RRL. Main overspend forecasts in mental health and continuing care.

Service	YTD Plan £000	YTD Actual £000	YTD variance fav/(adv) £000	Full Year Plan £000	Forecast £000	Fcst variance fav/(adv) £000	Run rate (3 month) projection £000	Run-rate vs plan fav/(adv) £000	Run-rate vs plan fav/(adv) (%)
Commissioned services									
Acute	737,509	736,972	537	1,410,431	1,409,619	812	1,473,944	-63,512	-5%
Mental Health	161,920	162,874	-954	324,429	326,344	-1,915	325,747	-1,318	0%
Community Health	173,889	173,743	146	351,627	351,434	193	347,485	4,142	1%
Continuing Care	83,580	83,849	-269	169,180	169,689	-509	167,698	1,482	1%
Primary Care	142,351	142,279	72	282,582	282,559	23	284,559	-1,977	-1%
Delegated Primary Care	183,651	183,650	1	356,208	356,208	0	367,301	-11,093	-3%
Other Programme Services	17,975	17,111	864	35,950	35,849	101	34,223	1,727	5%
Total Commissioned Services	**1,500,875**	**1,500,478**	**397**	**2,930,408**	**2,931,702**	**-1,294**	**3,000,957**	**-70,549**	**-2%**
ICB Running Costs	9,490	8,490	1,000	18,980	18,980	0	16,980	2,000	11%
Reserves/Contingencies	-9,180	-7,783	-1,397	-670	-1,965	1,295	-15,567	14,897	-2225%
Total Expenditure	**1,501,185**	**1,501,185**	**0**	**2,948,718**	**2,948,717**	**1**	**3,002,370**	**-53,652**	**-2%**
Revenue Resource Allocation	1,515,395	1,515,395	-0	2,977,137	2,977,137	0	2,977,137	0	0%
ICB Net Income	**14,210**	**14,210**	**-1**	**28,419**	**28,420**	**-1**	**-25,233**	**53,652**	

10.1.1 – Financial run rate waterfall to plan, month 06.

Data from ICB IFR return



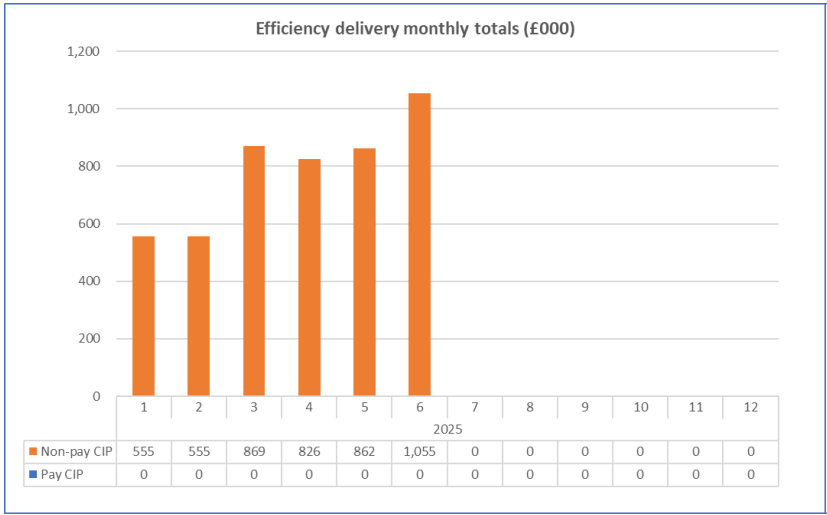
Commentary

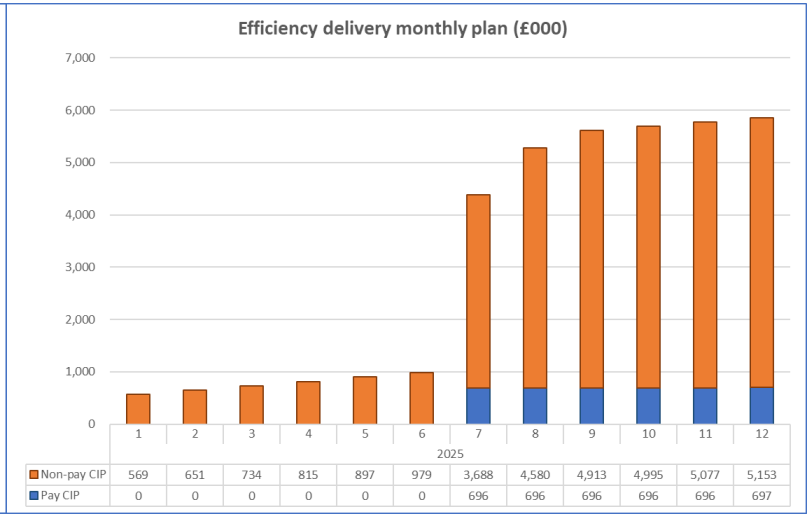
- The plan and forecast for the ICB for the year is £28.4m surplus. The straight-line extrapolated run-rate indicates a £25.2m deficit (note that the revenue resource limit is not extrapolated, but remains at the plan value).
- Key elements of the reconciliation to the £28.4m surplus forecast position comprise the following:
  - £25.9m – Net ICB allocations adjustment to the M01-06 extrapolated total to reflect the impact of non-recurrent benefits and expenditure, comprising mainly the expenditure incurred by the ICB and phasing of (mainly) ERF allocation currently forecast at £125.1m.
  - (£28m) Impact of phasing of savings delivered by the ICB, with the majority planned to be achieved in H2.

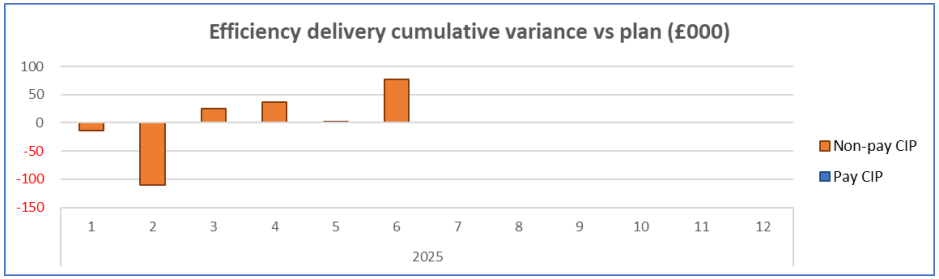
10.2 – NHS Devon ICB efficiency programme.

Data from month 05 ICB IFSE return

Organisation	Year to date			Forecast		
	Plan CIP delivery £000	Actual CIP delivery £000	Variance fav / (adv) £000	Plan for the year £000	Forecast £000	Variance fav / (adv) £000
Devon ICB	4,645	4,722	77	37,228	37,228	(0)







Spread of plan across quarters

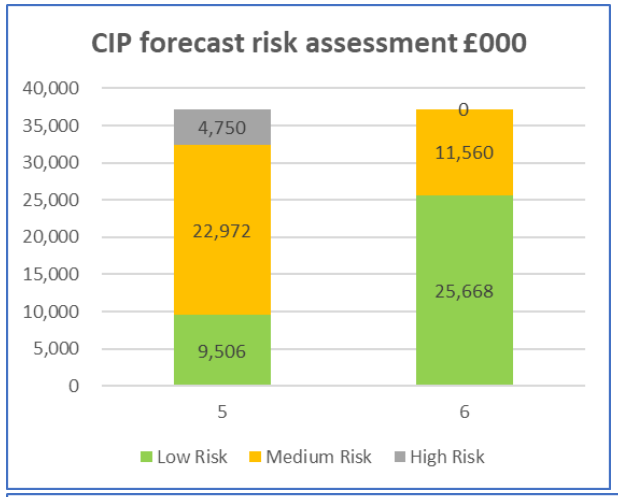
Q1 – 5%
Q2 – 7%
Q3 – 41%
Q4 – 47%

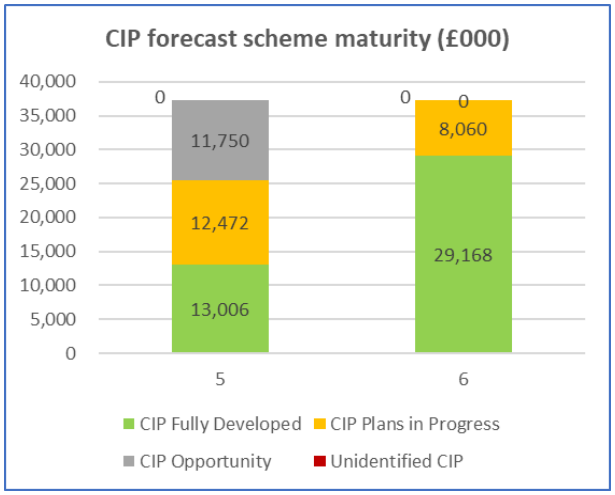
Year to date and forecast CIP

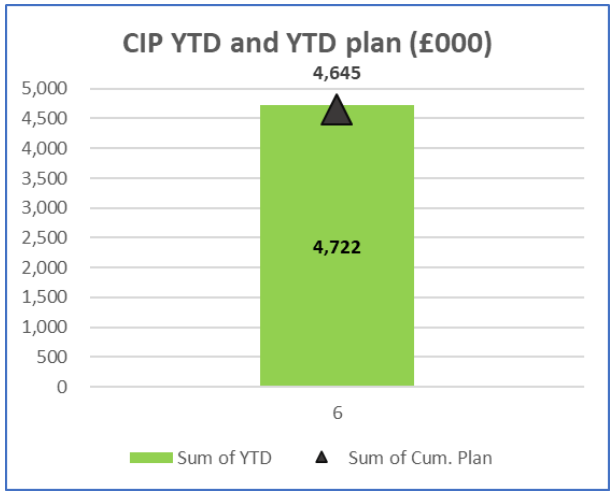
- YTD delivery is £0.1m above plan and forecast is in line with plan.
- The profile of the CIP plan is heavily weighted to the second half of the year.
  - Savings from the ICB restructuring are reflected in H2 and meet the target set by NHSE
- *Note that the ICB's total savings plan of £80.1m includes savings from commissioning with the ICS trusts, which are monitored through the trusts' performance. The remainder of the plan, of £37.2m is considered here.*

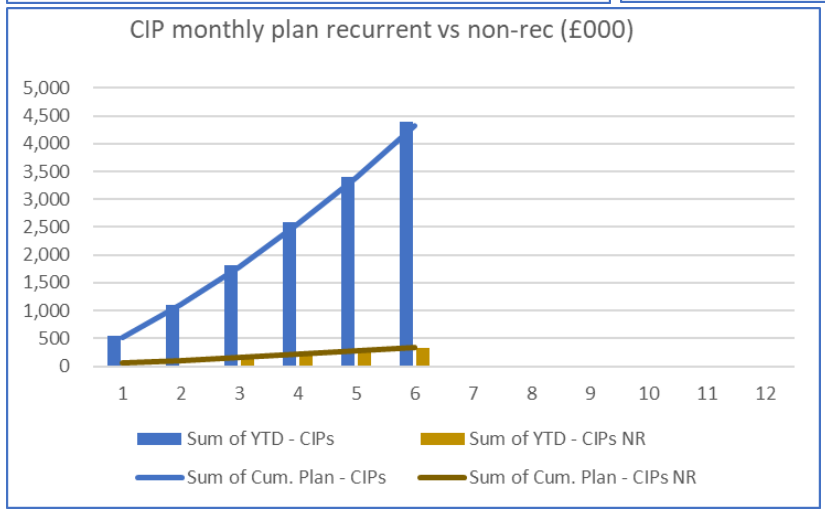
10.2.1 – NHS Devon ICB efficiency plan delivery, maturity and risk.

Data from month 05 IFR return







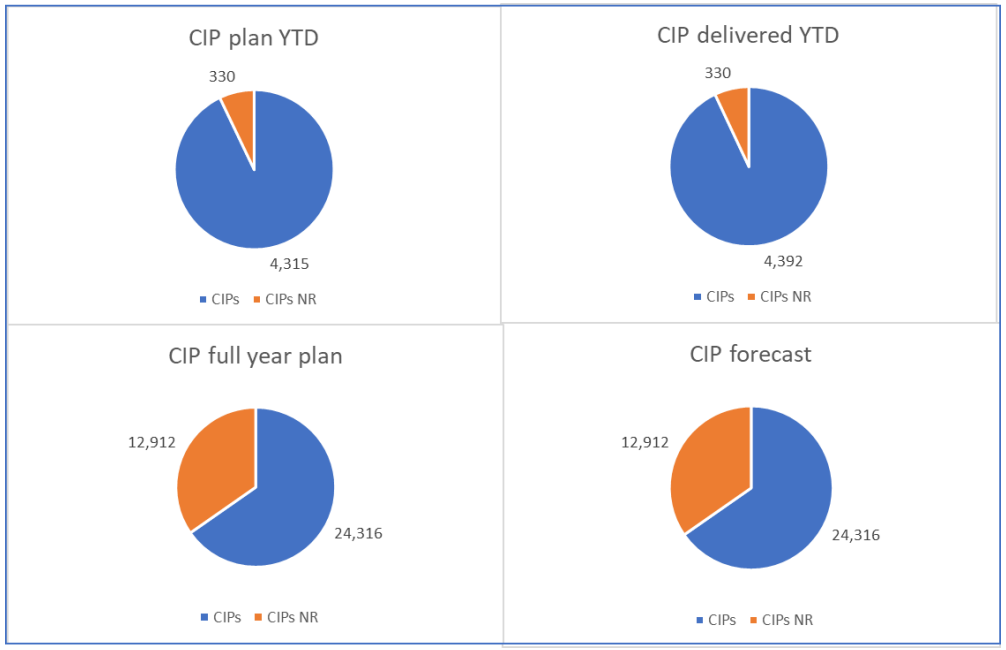


Commentary

- No high risk schemes by M06 (*M05 12.8%*)
- Low risk schemes value is significantly improved from M05, and represents 68.9% of the forecast total. The ICB has introduced enhanced CIP monitoring arrangements and uses monthly budget holder meetings to nail down progress and identify alternative opportunities
- The value of fully developed schemes has improved to £29.2m, 78% of the total programme forecast.

10.2.2 – NHS Devon ICB efficiency plan delivery, maturity and risk.

Data from month 06 IFR return



Commentary

- YTD delivery of CIP is £0.1m above plan.
- No changes to the expected proportions of recurrent and NR savings forecast.

	Year to date			Forecast		
	Plan CIP delivery £000	**Actual CIP delivery** £000	**Variance** benefit / (adverse) £000	**Plan for the year** £000	**Forecast** £000	**Variance** benefit / (adverse) £000
Recurrent efficiencies	4,315	4,392	77	24,316	24,316	(0)
Non-recurrent efficiencies	330	330	0	12,912	12,912	0
Total	**4,645**	**4,722**	**77**	**37,228**	**37,228**	**(0)**
Recurrent %	92.9%	93.0%		65.3%	65.3%	
Non-recurrent %	7.1%	7.0%		34.7%	34.7%	

10.3 – NHS Devon ICB financial risks and mitigations position.

Data from month 06 ICB IFR

	ICB £000	ICB Prior month £000
Risks		
Commissioning	0	-5,000
Cost pressures & inflation	-2,780	-2,780
Demand volume	0	0
Efficiencies, CIP	-9,750	-4,750
ERF risks	0	0
IA cost & lost activity	0	0
ICB risk share	-1,624	-1,624
Income issues	0	0
Other	0	0
Pay award pressures	0	0
Social Care & CHC	-3,200	-3,800
Total risks	**-17,354**	**-17,954**
Mitigations		
Additional efficiencies	8,053	3,053
Balance sheet flexibilities	0	0
Cost controls	2,000	2,000
ERF mitigations	0	0
IA additional funding	0	0
ICB risk share mitigated	310	310
Income recognition	0	0
Other	6,991	12,591
Total mitigations	**17,354**	**17,954**
Unmitigated risk per PFR	**0**	**0**

Commentary

- The ICS total net risk reported in the month 6 Integrated Finance Return (IFR) is £35.0m (M05 £41.2m).
- The ICB is reporting a balanced risk position (*M05 balanced*).
- Total risks and total mitigations are marginally lower than M05.
- The CIP net position is reported as £1.7m net risk (*M05 £1.7m net risk*). The movement in total risk is a reclassification of the £5m commissioning risk in primary care.
- The ICB's element of the £5.4m ICS risk share is recognised at £1.6m, with £0.3m of mitigations identified against it.

NHS Devon Integrated Care Board

NHS Devon Annual Plan – Delivery Assurance

Date of meeting	Date report produced
28 November 2024	31 October 2024

Author(s)		Report approved by	
Name and title:	Sam Wadham-Sharpe Director of Performance and Planning Lucy Pare Deputy Director of Performance, Planning & PMO	**Name and title:**	Bill Shields Chief Finance Officer and Deputy CEO
Phone:		**Date:**	31 October 2024
Email:	s.wadham-sharpe@nhs.net lucy.pare@nhs.net		

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
N/A

Executive summary
This report sets out oversight and assurance for the delivery of the each of the Directorate's objectives against their agreed Annual Plan. It provides details of the objectives by exception which the NHS Devon Programme Management Office (PMO) and Performance team are either not assured or only partially assured on the progress being made to deliver the plan. The content of the report is created through the detail provided by each directorate in their highlight reports and the outputs of the review and assurance process chaired by the Director/Deputy Director of Performance and Planning.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
NHS Devon Executive reviewed this report on 05 November 2024. It was also reviewed at the Finance and Performance Committee and the Quality and Patient Experience Committee meetings on 14 November 2024.

Key recommendations and actions requested
AGREE the assurance ratings relating to the delivery of NHS Devon's 2024/25 Annual Plan objectives
AGREE the proposed amendments to the NHS Devon 2024/25 Annual Plan

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	Positive
Improve services and reduced unwarranted variation	Positive
Make more efficient use of our resources	Positive
Develop our culture and how we operate	Positive

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	All
Health inequalities	
Workforce	
Resources and finance	
Legal	
Digital and Data	
Engagement and consultation	

NHS Devon Annual Plan – Delivery Assurance

Introduction

1. The Annual Plan is a comprehensive set of corporate objectives designed to address NHS Devon's response to all relevant local and national requirements, both internal and external.

2. It directly addresses local needs outlined in the One Devon Integrated Care Strategy, as well as national policy objectives in the NHS Long Term Plan, NHS England's operational planning guidance, and the NHS Oversight Framework.

3. By tracking the delivery of our Annual Plan at a Directorate level and working with our partners at place, we will ensure that NHS Devon is meeting all relevant priorities and requirements, including our performance, oversight, and commissioning responsibilities in relation to NHS providers in Devon.

4. The Annual Plan details what NHS Devon needs to achieve by 31 March 2025 and how we will do it. The plan is built on objectives that have been identified for 2024/25 in response to requirements in the NHS Long Term Plan, the NHS Oversight Framework, NHS England's 2024/25 operational planning guidance and One Devon's local Integrated Care Strategy.

5. The Annual Plan is 'high level' but contains clear deliverables, impact statements and timelines, and supports accountability by linking objectives to Chief Officer portfolios.

Delivering our 2024/25 Annual Plan

6. To deliver our Annual Plan, the Director of Performance and Planning has established monthly NHS Devon Planning and Delivery Meetings with each member of the NHS Devon Senior Leadership Team.

7. These monthly meetings, conducted via the Programme Management Office (PMO) Delivery Room, will focus on the delivery of our 2024/25 Annual Plan and key corporate objectives. They provide oversight of the Board Assurance Framework, track performance improvements against the NOF, and mitigate risks on the corporate and programme risk registers. The PMO has developed highlight reports to support these meetings, so progress can be monitored against key performance indicators (KPIs) and agreed impact metrics. The highlight reports are considered ahead of the delivery review meetings and Key Lines of Enquiry (KLOEs) agreed and shared with SROs.

8. The outputs from these performance meetings have been collated into this month's assurance report for NHS Devon's Executives and Directors. This will enable all directorates to understand corporate delivery against NHS Devon and system priorities, reducing the risk of silo working.

Our Annual Plan 2024/25

9. In summary the total number of objectives has increased to 137 from 129 in last month's report.

10. Of the 137 objectives:

    - 96 (70%) are fully assured.
    - 31 (23%) are partially assured.
    - 1 (1%) have limited assurance.
    - 8 (6%) are new objectives or have not had their status evaluated.

11. The report will provide the following in detail by directorate:

    - Overall directorate status of assurance of delivery (Fully Assured - over 75%, Partially Assured – between 50% and 75% and Not Assured – below 50% of directorate objectives are on track/fully assured.)
    - By exception the details of those objectives not fully/partially assured
    - Highlighted risks and escalations for noting by NHS Devon Executive
    - Appendix 1 provides details of all objectives which are fully assured/on track by Directorate.

12. Following this month's Delivery Review meetings, interdependencies are highlighted between objectives/workstreams within different directorates. These require a matrix style working approach, they are identified within this report and have been shared by the PMO with appropriate Chief Officers.

13. Planning objectives which are proposed to be amended, added or removed within a directorate will be noted within this report and require agreement from the NHS Devon Executive.

14. This month's report includes directorate dashboards which provides a summary of the data (where metrics are available), this shows actual position compared to target, its trend and the assurance level.

15. Appendix 1 includes data charts to provide further information displaying current position against target (as applicable). Where possible, statistical process control charts have been included. These charts will confirm on a statistical basis whether a metric is improving, deteriorating or showing common cause variation (neither improving nor deteriorating).

Chief Nursing Officer

Objective dashboard

	Objective description	Board Assurance Committee	Metric	Latest Target	Latest Actual	Variance	Latest	Trend	On Track?
Quality & Safety	Implement Quality Management System Improvement Process	FPC & QPEC							G
	Safeguarding Improvement •Delivering high standard of compliance with Working Together Safeguard Children (2023) statutory guidance • Delivery of the ICB's duties under The Care Act (2014) with regard to safeguarding adults	FPC & QPEC							G
	Review and enhance the Continuing Health Care (CHC) function to deliver value and improve efficiency	FPC & QPEC							A
Maternity, Neonatal and Women's	Implement the three-year maternity and neonatal delivery plan	FPC & QPEC							G
	Implement the 10 year national Women's Health Strategy in Devon	FPC & QPEC							G
Children and Young People	Develop Family Hub and Early Help models across Devon by 2026	FPC & QPEC							TBC
	Reduce the number of children and young people on long waiting lists for paediatrics acute and surgery procedures to eliminate waits of over 65 weeks for elective care	FPC & QPEC	Over 65 week elective waits for CYP (Apr24 baseline)	122	50	-72	G	G	A
	Implement a neurodiversity offer for children and families with neurodiverse, emotional and communication needs	FPC & QPEC							A
	Improve outcomes for CYP with long term conditions, focussing on a reduction in health inequalities	FPC & QPEC							G
	Prioritise the Special Education Needs and Disabilities (SEND) of children and families across Devon ICS, embedding SEND reforms in line with local inspection findings within mandated timeframes	FPC & QPEC							G
	Develop a comprehensive plan to support the recovery of community services, with a target to reduce the autism pathways waits over 52 weeks by April 2025.	FPC & QPEC	Autism assessment waits over 52 weeks (Apr24 baseline)	1,877	2,514	637	A	A	A
	Address significantly poorer outcomes for care experienced children and young people by tackling access and equity issues in care delivery	PHIC							G
Health Protection	Infection Management System ICBs are responsible for developing integration and collaboration, and for improving population health across the system. Under the Civil Contingencies Act 2004, NHS England and ICBs are identified as Category 1 responders.	QPEC							G
	Vaccination Delivery Improvement	FPC & QPEC							G

Overview of assurance – Partially assured

There are a total of 13 objectives being actively monitored which fall within the CNO directorate of which 69% (9) are fully assured to deliver within the expected timescales and 29% (4) are partially assured.

Objectives by exception

AP Section	Objective	Status	Narrative and comments
Quality & Safety	Review and enhance the Continuing Health Care (CHC) function to deliver value and improve efficiency	Partially assured	Exceptional Executive Committee being organised for mid-October to further discuss outputs of review and set next steps re transformation programme. Partially assured but still expected to deliver in year.
Children & Young People	Reduce the number of children and young people on long waiting lists for paediatrics acute and surgery procedures to eliminate waits of over 65 weeks for elective care.	Partially assured	CYP providers are establishing increased reporting for oversight of recovery actions to reduce 52-104 week waiters. Partially assured - Off track due to complexity of triangulating with regional and tertiary centres.
Children & Young People	Implement a neurodiversity offer for children and families with neurodiverse, emotional and communication needs to improve access and support.	Partially assured	Limited access to data and intelligence means it is difficult to be full assured.
Children & Young People	Support the recovery of community services, with a target to reduce the autism pathways waits over 52 weeks by April 2025.	Partially assured	Limited access to data and intelligence means this objective is partially assured.

Risks and escalations

Workstreams/ Objectives	Risk to delivery	Impact	Mitigation	Is risk recorded on appropriate risk register?
Maternity, Neonatal and Women's Health	Corporate risk 189: LMNS capacity to meet statutory requirements.	Unable to deliver full LMNS programme.	Priority areas of LMNS focus being worked on with existing capacity.	Yes
Maternity, Neonatal and Women's Health	Gap in dedicated BI support to progress maternity system dashboard.	Delay in the maternity system dashboard.	Development of a brief to support the requirement for BI support within Women and Children's team and to prioritise key work areas.	Yes
Maternity, Neonatal and Women's Health	ICB capacity to progress Women's Health Hub development to all 8 core areas of the national service specification.	Unable to meet NHSE requirement for full Women's Health Hub by December 2024.	Priority areas of Women's Health Hub focus being worked on with existing capacity.	Yes
Children and Young People	Gap in dedicated BI support to progress CYP system dashboard.	Delay in the CYP system dashboard	Development of a brief to support the requirement for BI support within Women and Children's team and to prioritise key work areas.	Yes

Chief Medical Officer

Objective dashboard

	Objective description	Board Assurance Committee	Metric	Latest Target	Latest Actual	Variance	Latest	Trend	On Track?
Mental Health	Adults and older adults who need to be admitted to hospital for treatment of a mental illness will be treated in a hospital in Devon whenever it is clinically safe. By March 2025 there will be no more than 2 people inappropriately out of area, for acute care	FPC & QPEC	Out of Area placements	7	9	2	A	A	A
	People and families to get help early in development of perinatal mental health need. A minimum of 1115 will access the service. System recommendations aligned to supporting infant -care giver relationships will be known.	FPC & QPEC	Birthing people accessing MH care	1,115	1,109	-6	G	G	G
	As a minimum 8700 adults and older adults with Severe Mental Illness (on a rolling 12 month period) will have timely access to transformed models of community mental services.	FPC & QPEC	SMI access to community MH services	8,700	16,695	7,995	G	G	G
	Adults and older adults with Severe Mental Illness will get help with their health and social care needs including housing and physical health as close to home as possible.	FPC & QPEC							A
	Enable people of all ages experiencing a mental health crisis to access the necessary help as early as possible without the need to visit A&E.	FPC & QPEC	MH presentations at A&E (ytd vs 2023/24)	4924	5226	302	A	A	G
		FPC & QPEC	Average time (hrs) in A&E (vs same period 23/24)	8.24	7.53	-0.7	G	G	
		FPC & QPEC	999 MH calls (vs same period 23/24)	1273	1,371	98.0	A	A	
		FPC & QPEC	FRS calls	5653	4,588	-1,065	G	G	
	Enhance treatment outcomes for anxiety and depression through improved NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery.	FPC & QPEC	Talking therapies access	8,306	6,302	-2,004	A	A	G
		FPC & QPEC	Talking therapies reliable improvement	67.0%	69.8%	2.8%	G	G	
		FPC & QPEC	Talking therapies reliable recovery	48.0%	50.0%	2.0%	G	G	
	Reduce inequalities in mental health care by increasing the rate of annual physical health checks so that 75% of people with severe mental illness (SMI) are receiving a full annual physical health check, with at least 64% receiving one by March 2025 ensuring appropriate follow-up care for all those who need it.	FPC,QPEC & PHIC	SMI Annual Health Check	5,424	5,525	101	G	G	G
	Provide more timely dementia diagnoses and coordinated care planning by increasing the dementia diagnosis rate to 65% by March 2025.	FPC & QPEC	Dementia diagnosis rate	60.00%	58.70%	-1.30%	A	G	A
	Develop a Devon health and social care Dementia Strategy	QPEC							

	Objective description	Board Assurance Committee	Metric	Latest Target	Latest Actual	Variance	Latest	Trend	On Track?
	More children and young people will have timely, coordinated access to NHS-funded mental health support, care, and treatment, including through mental health support teams in schools. This will mean that at least 15 754 CYPS will access NHS services.	FPC & QPEC	CYP access to MH services	15,754	12,090	-3,664	A	G	G
	Develop alternative community physical health monitoring services for eating disorders patients to enhance outpatient support.	FPC & QPEC							A
	Develop a business case for a community based alternative to hospital admission for individuals with severely disordered eating with atypical features or which is secondary to neurodiversity &/or trauma based issues	FPC & QPEC							R
	Ensure that commissioned mental health services are of high quality, safe, effective and well led.	FPC & QPEC							G
	Establish a framework for quality assuring the standards expected of any digital services that children and young people can access; with a central resource that children and young people can be signposted to	FPC & QPEC							A
	Work to ensure that all acute hospital trusts across the ICB work to the same protocol of medical admissions for “Physiological rescue” admissions with rapid admission and rapid discharge within a 14-21 day time frame and similar criteria for NG feeding, enhanced nursing, restraint, sedation, use of legislation and working with liaison psychiatry	FPC & QPEC							A
Learning Disabilities	Ensure 75% of individuals aged 14 and over on GP learning disability registers receive an Annual Health Check (AHC) by 31 March 2025.	FPC & QPEC	LD annual health checks (YTD)	25%	17%	-8%	G	G	G
	Reduce reliance on mental health inpatient care for people with learning disabilities and autistic individuals, achieving a target of no more than 30 adults and 12–15 under 18s per 1 million population	FPC & QPEC	ICB	20	23	3	A	A	G
		FPC & QPEC	SWPC	8	13	5	A	A	
		FPC & QPEC	CAMHS Tier 4	1	2	1	A	A	
	Test and implement improvements in autism diagnostic assessment pathways, including actions to reduce waiting times by March 2028.	FPC & QPEC							G
	Develop integrated workforce plans for the learning disability and autism workforce to support the delivery of objectives outlined in national Workforce Plan	FPC & PODC							G
	Reduce health inequalities by reducing over-medication through the STOMP and STAMP programmes and taking action to prevent overprescribing.	PHIC							G
	Continue to implement the LeDeR programme to enhancing care, reducing health inequalities, and preventing premature deaths among individuals with learning disabilities and autism.	PHIC	Avoidable deaths						A

	Objective description	Board Assurance Committee	Metric	Latest Target	Latest Actual	Variance	Latest	Trend	On Track?
	Support the delivery and use of the reasonable adjustment digital flag to reduce health inequalities among people with learning disabilities and autistic individuals	PHIC							G
	Develop governance and due diligence with contracting for the Patient Choice pathway for ADHD. Compliant with "Patient Choice" Legislation whilst protecting local delivery and quality.	FPC & QPEC							G
	ADHD Pathway develop access to support closer to home in models of care yet to be designed by clinical group, Engage with the national taskforce and GIRFT	FPC & QPEC	Over 18 week ADHD waits (vs Apr 24)	62.0%	61.2%	-0.8%	G	A	G
	Oliver McGowan Mandatory Training (OMMT) Standardised training developed for the purpose of education health and social care staff on Learning Disability and Autism. Statutory requirement in the Health and care Act 2022regulating service providers in compliance.	FPC & QPEC							G
	REGIONAL CAPITAL INVESTMENT OF 20.5 Million New MH LDA bed capacity for the treatment of our community closer to home of people who are intellectual, disabled or an Autistic Person.	FPC & QPEC							G
Population Health	Support Local Care Partnerships (LCPs) and Provider Collaboratives with evidence-based resources to empower them to make informed decisions and implement change at the local level	PHIC							G
	Implement the national Inclusion Health Framework to ensure health equity and support the needs of the most vulnerable groups.	PHIC							A
	Develop and implement a Population Health Charter to articulate and guide the collective health priorities and strategies across the system.	PHIC							G
	Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025	FPC & QPEC							A
	Increase the % of patients aged 25-84 with a CVD risk score grater than 20% on lipid lowering therapies to 65% by March 2025	FPC & QPEC							A
	Expand and develop High Intensity User (HIU) services and establish system working arrangements to support ongoing learning and development	FPC & QPEC							A
	Develop plans to enhance the ICB's role as an Anchor Organisation by March 2025 to strengthen community ties and improve those factors that contribute to improved prospects for local populations. This is a 2024/25 step towards delivery of the ICS '4th purpose' (to help the NHS support broader social and economic development)	PHIC & FPC							G
Medicine	Delivery of the 16 National Medicines Optimisation Opportunities	FPC							G

	Objective description	Board Assurance Committee	Metric	Latest Target	Latest Actual	Variance	Latest	Trend	On Track?
	Develop the Peninsula Aseptic Hub to centralise and optimise the preparation of sterile medications	FPC							A
	Develop the Peninsula Radiopharmacy Strategy to enhance the provision and distribution of radiopharmaceuticals	FPC							A
	Implement CIP projects in line with national best practice to improve the clinical and cost-effective use of medicines across all sectors in the Devon system.	FPC							A
	Develop the Integrated Medicines Optimisation Committee (IMOC) and associated work programme to oversee and enhance medicines use across the health system	FPC							G
Pharmacy	Develop Community Pharmacy, including improved resilience and the expansion of Pharmacy First services, to enhance accessibility and efficiency of pharmaceutical care.	FPC							G
Research	Continue to contribute to the Peninsula Research and Innovation Programme (PRIP) with partners across the Peninsula to foster collaborative improvements and innovation in healthcare	PHIC							G
	Work with Cornwall and Somerset to implement key deliverables in the Peninsula Research and Innovation Strategy (PRIS), enhancing regional healthcare research and development	PHIC							G
	Continue to support the development of the Research Engagement Network (REN) to increase opportunities for people to participate in health and social care research, including those working in primary care	PHIC							G
System Development	Develop and implement the One Devon Clinical and Care Professional Leadership framework to enhance clinical and care professional leadership and involvement in strategy development and delivery across the system	Executive							G
Acute Services Strategy	Transform acute services to ensure workforce, clinical and financial sustainability	FPC							A
	Stabilise acute services that are fragile	FPC & QPEC							G
Cross Cutting	Within the ICS '4th purpose' (to help the NHS support broader social and economic development), develop the ICB as an Anchor Organisation by March 2025 to strengthen community ties and improve those factors that contribute to improved prospects for local populations	PHIC & FPC							A

Overview of assurance – Partially assured.

There are a total of 45 objectives being actively monitored within the CMO directorate of which 62% (28) are fully assured to deliver within the expected timescales, 35% (16) are partially assured and 2% (1) has limited assurance.

Objectives by exception

AP Section	Objective	Status	Narrative and comments
Mental Health	Adults and older adults with Severe Mental Illness will get help with their health and social care needs including housing and physical health as close to home as possible. By March 2025 there will be no more than 2 people inappropriately out of area, for acute care	Partially assured	Partially on track - Set ambitious target of achieving a very low number of people being placed out area inappropriately. Devon Partnership footprint exceeding the trajectory but Plymouth underachieving against the trajectories, we have more people placed inappropriately out of area. On track for March 2025, increased demand in need for inpatient admissions. Fully assured of delivery by agreed timescale, increased risk to the delivery which is distinct from assurance piece.
Mental Health	Adults and older adults with Severe Mental Illness will get help with their health and social care needs including housing and physical health as close to home as possible.	Partially assured	Partially assured: Not on track with housing recommendations due to the need to need to redirect resources to respond to collective action.
Mental Health	Reduce inequalities in mental health care by increasing the rate of annual physical health checks so that 75% of people with severe mental illness (SMI) are receiving a full annual physical health check, with at least 64% receiving one by March 2025 ensuring appropriate follow-up care for all those who need it.	Partially assured	
Mental Health	Provide more timely dementia diagnoses and coordinated care planning by increasing the dementia diagnosis rate to 65% by March 2025.	Partially assured	Partially assured: Due to redirection of resources/collective action with Primary Care, recommendations are to be considered further and timescale shift from Q3 to Q4 to complete.

AP Section	Objective	Status	Narrative and comments
Mental Health	More children and young people will have timely, coordinated access to NHS-funded mental health support, care, and treatment, including through mental health support teams in schools. This will mean that at least 15 754 CYPS will access NHS services.	Partially assured	
Mental Health	Develop alternative community physical health monitoring services for eating disorders patients to enhance outpatient support.	Partially assured	The number of GP practices giving notice on this service is now causing concern in terms of capacity. Previously recorded on the corporate risk register, now moved to corporate issue. Execs are fully sighted, paper going to DIG in November as next stage for addressing this work.
Mental Health	Develop a business case for a community based alternative to hospital admission for individuals with severely disordered eating with atypical features or which is secondary to neurodiversity &/or trauma based issues	Limited assurance	Piece of work to be done to be clear what eating disorder objectives are for this year. Be clear on objectives for the system in relation to eating disorders.
Mental Health	Establish a framework for quality assuring the standards expected of any digital services that children and young people can access; with a central resource that children and young people can be signposted to	Partially assured	Framework delivery lead has been tasked with the development of the proposal document, outlining delivery in respect to regional leadership changes.
Mental Health	Work to ensure that all acute hospital trusts across the ICB work to the same protocol of medical admissions for “Physiological rescue” admissions with rapid admission and rapid discharge within a 14-21 day time frame and similar criteria for NG feeding, enhanced nursing, restraint, sedation, use of legislation and working with liaison psychiatry.	Partially assured	Actions have been undertaken, not currently meeting the rates we stated in trajectory. Further discussions to be undertaken prior to ensure appropriately objectives have been identified and implemented effectively.

AP Section	Objective	Status	Narrative and comments
Learning Disability and Autism	Continue to implement the LeDeR programme to enhancing care, reducing health inequalities, and preventing premature deaths among individuals with learning disabilities and autism.	Partially assured	Mitigation in place. Recruitment of an 8a post advertised. Shortlisting completed bank reviewers being sort and funding paused in LDA SDF. Actions currently in CNO
Population Health	Implement the national Inclusion Health Framework to ensure health equity and support the needs of the most vulnerable groups.	Partially assured	No ability to progress until resource in place.
Population Health	Increase the percentage of patients with hypertension treated according to NICE guidance to 80% by March 2025	Partially assured	Main issues are funding streams and clarification of matrix working in new structure.
Population Health	Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025	Partially assured	Not meeting objectives, unable to appoint to post to support the work. Inequalities team have picked up with work but there is no one to designated to deliver.
Population Health	Expand and develop High Intensity User (HIU) services and establish system working arrangements to support ongoing learning and development	Partially assured	

AP Section	Objective	Status	Narrative and comments
Medicines Optimisation	Develop the Peninsula Aseptic Hub to centralise and optimise the preparation of sterile medications	Partially assured	Mitigation in place. Nothing more ICB can progress as awaiting NHSE approval of business case.
Medicines Optimisation	Develop the Peninsula Radiopharmacy Strategy to enhance the provision and distribution of radiopharmaceuticals	Partially assured	Mitigation in place. Options appraisal process had to be revised and will extend into Q3.
Medicines Optimisation	Implement CIP projects in line with national best practice to improve the clinical and cost-effective use of medicines across all sectors in the Devon system.	Partially assured	mitigation in place No visibility of CIP plans. But seeing money falling out of position. Relates to finance team analysis, until reviewed info not sure on status. Due to meet finance colleagues in next 2 weeks.
Medicines Optimisation	Develop the Peninsula Aseptic Hub to centralise and optimise the preparation of sterile medications	Partially assured	Not on track but nothing more ICB can progress with regional partners.
Medicines Optimisation	Implement CIP projects in line with national best practice to improve the clinical and cost-effective use of medicines across all sectors in the Devon system.	Partially assured	Not on track but mitigating actions in place. Escalation to SLG regarding visibility of CIP details.
Pharmacy	Develop Community Pharmacy, including improved resilience and the expansion of Pharmacy First services, to enhance accessibility and efficiency of pharmaceutical care.	TBC	
Acute Services Strategy	Stabilise acute services that are fragile	TBC	
Acute Services Strategy	Transform acute services to ensure workforce, clinical and financial sustainability	Partially assured	Final Case for Change agreed and signed off by Boards, however, awaiting national guidance on engagement
Cross-Cutting Objectives	Within the ICS ‘4th purpose’ (to help the NHS support broader social and economic development), develop the ICB as an Anchor Organisation by March 2025 to	Unknown	No further actions planned until Phase 2 capacity is in place

AP Section	Objective	Status	Narrative and comments
	strengthen community ties and improve those factors that contribute to improved prospects for local populations.		

Risks and escalations

Workstreams/ Objectives	Risk to delivery	Impact	Mitigation	Is risk recorded on appropriate risk register?
Learning Disability and Autism	ADHD Patient Choice	The financial costs to the ICB Clinical need has quadrupled "Patient Choice" legislation and compliance impacting on cost of delivery	Accreditation process in place to help manage and contain the cost incurred but the clinical need exasperates financial position	Yes local (requires consideration for Corporate Risk Register)

Chief Operating Officer

Objective dashboard

	Objective description	Board Assurance Committee	Metric	Latest Target	Latest Actual	Variance	Latest	Trend	On Track?
Primary Care and Community Pharmacy	Expand clinical pharmacy services, including Hypertension Case-finding and Oral Contraceptive provision	FPC & QPEC							G
	Increase dental activity by implementing the plan to recover and reform NHS dentistry, improving units of dental activity (UDAs) towards pre-pandemic levels	FPC & QPEC							G
	Support Devon Primary Care Network (PCNs) to adopt an integrated, proactive approach to care and support	FPC & QPEC							A
	Implement personalised care across integrated teams, focusing on the most benefiting groups such as end-of-life, frailty, and dementia.	FPC & QPEC							A
	Expand and innovate the Independent Prescribing (IP) programme within Devon	FPC & QPEC							G
	Improve the sustainability of general practice and increase dedicated urgent primary care capacity through the implementation of a new Same Day General Practice model.	FPC & QPEC	GP contacts (compared to 23/24)	32,432	33,237	805	A	A	G
	Enhance public understanding and access to community-based services	FPC & QPEC							NEW
Urgent and Emergency Care	Increase the proportion of A&E patients seen within four hours to at least 78% by March 2025	FPC & QPEC	All types 4 hour performance	78%	69%	-9%	A	A	G
	Achieve an average response time of 30 minutes for Category 2 ambulance calls during 2024/25	FPC & QPEC	Cat 2 response times	18	44	26	A	G	G
	Standardise UTC provision across Devon and divert attendances from ED and optimise UTCs and MIUs by building resilience into current delivery across UEC within the estates, workforce and funding limits.	FPC & QPEC	UTC closures (compared to 23/24)	73	20	-53	G	G	G
	Establish and deliver a Care Coordination Hub to enhance patient navigation within the Urgent Care System.	FPC & QPEC							G
	Standardise Same Day Emergency Care (SDEC) across One Devon using a Devon-wide, nationally recognised specification to handle up to 40% of acute medical cases at Type 1 organisations, reduce ambulance attendances at ED, and improve ambulance handover times.	FPC & QPEC	Handover delays over 15 minutes (vs 2023/24)	8,915	5,218	-3,697	G	G	G
	Ensure consistent delivery of Virtual Wards across Devon, achieving 80% occupancy and a 4-5 day average Length of Stay (LoS), fully aligned with NHSE recommendations, to maximise existing financial investment.	FPC & QPEC	Virtual ward occupancy rate	80%	69%	-11%	A	G	G

	Objective description	Board Assurance Committee	Metric	Latest Target	Latest Actual	Variance	Latest	Trend	On Track?
	Implement Acute Frailty Services operating 70 hours per week (10 hours per day) at all three acute trust organisations, ensuring alignment with Virtual Wards and community-based services for individuals aged over 65.	FPC & QPEC	Emergency admissions 1+ length of stay (65 years+)	6,756	6,977	221	A	A	TBC
	Standardise Urgent Community Response (UCR) operations to national specifications (8-8, 7 days per week) and increase referrals by 15% monthly to reduce ED attendance.	FPC & QPEC	2 hour UCR contacts	1,905	2,025	120	G	G	G
	Establish consistent proactive clinical care in care homes, aiming for a 20% reduction in unplanned admissions for people aged 65+, 85% coverage of Electronic Treatment Escalation Plans, and improved pathways for End of Life and falls and frailty by 2025.	FPC & QPEC	Daily zero LoS admissions 65+ (vs 2023/24)	52.6	58.5	5.9	A	A	G
	Reduce acute bed occupancy and hospital Length of Stay by ensuring timely discharges and optimal capacity across discharge pathways (P1-P3), supporting the system target of achieving 6.4% NCTR by March 2025 and improving acute hospital flow.	FPC & QPEC	No Criteria to Reside - average daily patients not discharged (vs 2023/24)	266.3	250.4	-15.9	G	G	G
	Ensure that children and young people are included explicitly in the UEC recovery plans, incorporating specific interventions such as paediatric virtual wards and the Paediatric Early Warning System - need to establish exec ownership	FPC & QPEC							TBC
Elective Care	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)	FPC & QPEC	RTT over 65 week waits	378	1,190	812	A	G	A
	Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 103%	FPC & QPEC	Elective IP/DC activity	18,454	18,644	190	G	G	G
	Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25	FPC & QPEC	Outpatient procedures	79,400	99,518	20,118	G	G	A
	Improve performance against the headline 62-day cancer treatment standard to 70% by March 2025	FPC & QPEC	62 day cancer target	70%	71%	1%	G	G	G
	Increase the percentage of cancers diagnosed at stages 1 and 2 to align with the 75% early diagnosis ambition by 2028.	FPC & QPEC							G
	Increase the percentage of patients receiving a diagnostic test within six weeks to 95% by March 2025.	FPC & QPEC	6 week diagnostics	95%	67.70%	-27%	A	A	G
	Improve patient and list management, ensuring at least 90% of patients waiting over 12 weeks are validated at any time	FPC & QPEC	New metric (TBC)						A

	Objective description	Board Assurance Committee	Metric	Latest Target	Latest Actual	Variance	Latest	Trend	On Track?
	Continue to expand patient choice at the point of referral, offering a choice of five providers where appropriate and facilitating access to non-local NHS or independent sector providers to shorten wait times	FPC & QPEC							G
	Make significant improvements towards the 85% day case and 85% theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings	FPC & QPEC							G
	Establish an approach to ensure referrals to secondary care are appropriate, including through increased use of advice and guidance (A&G) to avoid unnecessary referrals	FPC & QPEC							G
	Conduct a review of the neurology headache clinics	FPC & QPEC							G
	Increase diagnostic capacity, including through Community Diagnostic Centres	FPC & QPEC							G
	Complete contract reviews for GP with Extended Roles (GPwER) and Sentinel	FPC & QPEC							A
	Establish an early screening, risk assessment and health optimisation programme for patients waiting extended periods and/or coming from demographics experiencing health inequalities	FPC & QPEC							A
	Consultant to Consultant (C2C)	FPC & QPEC							G
	Evidence Based Interventions (EBI)	FPC & QPEC							G
	Primary Secondary Care Interface	FPC & QPEC							G
	Take on formal delegation of specialised commissioning functions (was moved from CFO)	FPC & QPEC							TBC

Overview of assurance – Partially assured.

There are a total of 32 objectives being actively monitored within the COO directorate of which 78% (25) are fully assured to deliver within the expected timescales, 22% (7) are partially assured, and 4 are new or have not yet been evaluated.

Objectives by exception

AP Section	Objective	Status	Narrative and comments
Primary Care and Community Pharmacy	Support Devon Primary Care Network (PCNs) to adopt an integrated, proactive approach to care and support	Partially assured	The ICB have conditioned a pathway specific approach and are implementing a number of mitigations, although this objective is not fully understood.
Primary Care and Community Pharmacy	Implement personalised care across integrated teams, focusing on the most benefiting groups such as end-of-life, frailty, and dementia.	Partially assured	Mitigations in place. EoL and Frailty in place as part of the wider plan and Dementia sits within the mental health workstream with a primary care element.
Urgent and Emergency Care	Increase the proportion of A&E patients seen within four hours to at least 78% by March 2025	Partially assured	
Urgent and Emergency Care	Achieve an average response time of 30 minutes for Category 2 ambulance calls during 2024/25	Partially assured	
Urgent and Emergency Care	Standardise Same Day Emergency Care (SDEC) across One Devon using a Devon-wide, nationally recognised specification to handle up to 40% of acute medical cases at Type 1 organisations, reduce ambulance attendances at ED, and improve ambulance handover times.	Partially assured	

AP Section	Objective	Status	Narrative and comments
Urgent and Emergency Care	Ensure that children and young people are included explicitly in the UEC recovery plans, incorporating specific interventions such as paediatric virtual wards and the Paediatric Early Warning System - need to establish exec ownership	TBC	UEC team will be meeting with CYP to scope this.
Elective Care	We aim to reduce waiting times for community services, focusing specifically on significant reductions in long waits	Partially assured	
Elective Care	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties).	Partially assured	The ICB have actioned everything possible and is reliant on providers meeting their obligations.
Elective Care	Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25.	Partially assured	The system is currently off track at 40.7% however this is recoverable within this year.
Elective Care	Improve patient and list management, ensuring at least 90% of patients waiting over 12 weeks are validated at any time.	Partially assured	Off track – mitigations in place RDUH - 59% 12ww validated TSDFT - 46% 12ww validated UHP - 98% 12ww validated
Elective Care	Establish an early screening, risk assessment and health optimisation programme for patients waiting extended periods and/or coming from demographics experiencing health inequalities	Partially assured	Off track - Requires identified management support within all Trusts as the clinicians do not have the capacity to do all the work.
Elective Care	13. Complete contract reviews: a) Audiology procurement b) Improving Termination care c) GP with Extended Roles (GPwER) x 13 d) Sentinel x 8 services	Partially assured	On track for a) & b) Partially on track c) Off track for d) – capacity being re-prioritised to support, expected to be on track following capacity and PSR agreement

AP Section	Objective	Status	Narrative and comments
Elective Care	Take on formal delegation of specialised commissioning functions (was moved from CFO)	TBC	

Risks and escalations

Workstreams/ Objectives	Risk to delivery	Impact	Mitigation	Is risk recorded on appropriate risk register?
CRG: Virtual Wards	TSDFT have identified that they are unable to continue to run the Cardiology VW pathway after December 2024. This will mean a reduction in VW beds from between 12-20 beds.	Reduction in VW bed capacity and subsequent deterioration in performance.	None identified – Escalated to CRG Leads and South Locality Director. Requires urgent discussion re equal funding allocation.	Not known

Chief Communications and Corporate Affairs Officer

Objective dashboard

	Objective description	Board Assurance Committee	Metric	Latest Target	Latest Actual	Variance	Latest	Trend	On Track?
Governance	Develop an ICB governance improvement plan, secure approval by the July Board meeting, and make necessary amendments to constitutions, risk frameworks, and terms of reference based on agreed actions	Executive							G
	Implement new System Planning, and Delivery & Assurance Structures for the 2024-25 governance approach within the ICB	Executive							G
System OD	Create a compact to formally articulate the shared vision of system partners and establish a set of reciprocal behaviours for effective delivery, supporting the Devon single operating model	Executive							G
	Develop a system Organisation Development (OD) plan focused on implementing high-impact actions to address challenges identified in ICS maturity assessments, supporting the development of a single operating model for Devon.	Executive							G
Communications	Establish the One Devon Involvement Platform to enhance engagement and participation across the healthcare system	Executive							G
	Integrate Healthwatch into NHS Devon ICB Governance to enhance public accountability and consumer insight.	Executive							G
Equality, Diversity and Inclusion	Work with system partners to agree on shared Equality, Diversity, and Inclusion (EDI) priorities and initiate actions based on the NHS England EDI Improvement Plan's six high-impact areas	Executive							A
	Through the NHS Devon governance review, identify opportunities to incorporate the six high-impact actions from the NHS England EDI Improvement Plan	Executive							G

Overview of assurance – Fully assured.

There are a total of 8 objectives being actively monitored within the CCO directorate of which 88% (7) are fully assured to deliver within the expected timescales and 12% (1) is partially assured. This is the same as position as last month's report.

Objectives by exception

AP Section	Objective	Status	Narrative and comments

Equality, Diversity and Inclusion	Work with system partners to agree on shared Equality, Diversity, and Inclusion (EDI) priorities and initiate actions based on the NHS England EDI Improvement Plan's six high-impact areas	Partially assured	Not currently on track but there are mitigating actions in place.

Risks and escalations

Workstreams/ Objectives	Risk to delivery	Impact	Mitigation	Is risk recorded on appropriate risk register?
None identified for escalation				

Chief People Officer

Objective dashboard

	Objective description	Board Assurance Committee	Metric	Latest Target	Latest Actual	Variance	Latest	Trend	On Track?
System Workforce	Improve management and productivity of workforce resources (WTE and financial) across all System providers, delivering activities aligned with the 6 workforce Financial Recovery Programme (FRP) workstreams.	PODC & FPC							A
	Deliver significant efficiencies and ensure consistency in business processes across Trusts and the ICB through technological and digital advancements, aiming to save £19 million over five years, contributing to system financial recovery	FPC							G
	Implement the One Devon Workforce Strategy and development of case for change to inform a new financially sustainable workforce model and plan to meet local and national objectives and comply with the 10 regulatory requirements of an Integrated Care System (ICS) People function.	PODC & FPC							G
HR	Reduce running costs by 30% while continuing to evolve the ICB's functions and form to effectively meet its strategic and statutory responsibilities	FPC							G
	Develop a workforce with the skills and capability to fulfil the strategic and statutory responsibilities of the ICB in a sustainable and affordable manner	PODC							G
	Improve the working lives of all staff, thereby increasing staff retention and attendance at work -	PODC							G
System Learning and Education	Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan	PODC							G
	Increase the number of Advanced Practice posts across Devon by implementing a governance matrix and enhancing education and recruitment strategies, aiming to recruit 10% new trainees in new and emerging areas of advanced practice.	PODC & FPC	Number of Advanced practitioners in post comparison to previous year	0%	19%	19%	G	G	G
	Increase placement capacity across the system to enable an increase of supply of domestic nursing and AHP. Specifically the aim is to: •Reduce placement under-utilisation by 30% •Increase placement capacity by 20% •Increase range of placement experiences by 30%	PODC & FPC							A

Overview of assurance – Fully assured.

There are a total of 9 objectives being actively monitored which fall within the CPO directorate of which 78% (7) are fully assured to deliver within the expected timescales and 22% (2) are partially assured.

Objectives by exception

AP Section	Objective	Status	Narrative and comments
System Workforce	Improve management and productivity of workforce resources (WTE and financial) across all System providers, delivering activities aligned with the 6 workforce Financial Recovery Programme (FRP) workstreams.	Partially assured	All supporting workstreams are on track however overspend on Operation Plan so further engagement and check challenge is required to increase assurance and grip and control
System Learning and Education	Increase placement capacity across the system to enable an increase of supply of domestic nursing and AHP. Specifically, the aim is to: Reduce placement under-utilisation by 30% Increase placement capacity by 20% Increase range of placement experiences by 30%	Partially assured	Off track recoverable – mitigations in place, this is due to external factors due to downward trend of supply of under graduate places, which is giving back placement capacity. This is recoverable and will be recovered in year. Partially assured until recovered.

Risks and escalations

Workstreams/ Objectives	Risk to delivery	Impact	Mitigation	Is risk recorded on appropriate risk register?
None identified for escalation.				

Chief Finance Officer

Objective dashboard

	Objective description	Board Assurance Committee	Metric	Latest Target	Latest Actual	Variance	Latest	Trend	On Track?
Digital & Data	Support implementation of Electronic Patient Records (EPRs) in TSDFT and UHP by 2026.	FPC							G
	Procure and implement the Peninsula Laboratory Information Management System (LIMS) solution for the clinical network by 2025.	FPC							G
	Support core health and care organisations to implement the Devon and Cornwall Care Record by 2028.	FPC							A
	Rationalise data centres subject to business case approval.	FPC							G
	Undertake contract reviews to achieve non-pay contract savings.	FPC							G
	Increase the number of eligible citizens connected to the NHS App to support the national target of 75% of people registered	FPC							NEW
	Implement the national Digital Inclusion Framework, working in partnership with the population health team, to increase accessibility to digital health resources among underserved populations	FPC							NEW
Finance and Use of Resources	Achieve a balanced net system financial position across all NHS organisations by the end of the 2024/25 financial year.	FPC							G
	Progress shared service arrangements within ICB and across system to increase efficiency and productivity and reduce costs.	FPC							G
	Deliver NHS Devon's 2024/25 recovery and Cost Improvement Programmes (CIP) and performance manage delivery of provider CIPs	FPC							G
	Ensure ICB re-structure allows the organisation to operate within its agreed Running Cost Allowance (RCA)	FPC							G
	Produce the long-term financial plan to achieve sustainable financial balance by system and by organisation.	FPC							G
	Commence reprioritisation of funding upstream towards prevention and health inequalities	FPC							NEW

Overview of assurance – Partially assured.

There are a total of 10 objectives being actively monitored which fall within the CFO directorate of which 90% (9) are fully assured to deliver within the expected timescales. This is a decrease of fully assured objectives from last month's report. There is one objective which is partially assured 10% (1).

There are three additional objectives, their assurance status has not yet been established.

Objectives by exception

There are no objectives to review by exception as fully assured and on track.

AP Section	Objective	Status	Narrative and comments
Digital and Data	Support core health and care organisations to implement the Devon and Cornwall Care Record by 2028	Partially assured	Off track - no mitigations in place. Key target for all NHS organisations to be connected by April 2024.Torbay and RDUH are not connected. Expected to be back on track and delivered by December 2024.

Risks and escalations

Workstreams/ Objectives	Risk to delivery	Impact	Mitigation	Is risk recorded on appropriate risk register?
None identified for escalation.				

Deputy Chief Executive Officer

Objective dashboard

	Objective description	Board Assurance Committee	Metric	Latest Target	Latest Actual	Variance	Latest	Trend	On Track?
Performance and Planning	Develop Annual Plan for 24/25	Executive							G
	Develop a rolling Annual Planning cycle to support the ongoing development, refresh, and alignment of key strategic and operational plans, including necessary annual updates to One Devon's Integrated Care Strategy and NHS Devon's 5-Year Joint Forward Plan, organisational-level Annual Plans, and NHS Operational Planning submissions	Executive							G
	Develop a System Delivery Governance PMO approach, including a PMO Delivery Room to support the delivery of corporate objectives.	Executive							G
	Provide the Strategic Client function for Business Intelligence (BI), developing and agreeing on the ICB requirements of the external BI function	FPC							G
	Work collaboratively with regional ICS teams to develop a regional secure data environment to support future research	FPC							TBC
Estates and Green Plan	Drive collaboration between provider service departments where possible to create resilience, efficiencies, and succession planning. (EFM and SPV are vehicles to deliver)	FPC							G
	Commence delivery of the implementation plans that will support each area of the Estates Strategy	FPC							G
	Deliver agreed Estates recovery and Cost Improvement Programmes (CIP)	FPC							G
	Enhance the patient experience by improving access to primary care facilities.	FPC & QPEC							G
	Refresh the ICS Green Plan by 2025	FPC							G
	Data base line collection	FPC							G

Overview of assurance – Fully assured.

There are a total of 10 objectives being actively monitored which fall within the DCOE directorate of which 100% (10) are fully assured to deliver within the expected timescales. One objective is yet to be evaluated.

Objectives by exception

AP Section	Objective	Status	Narrative and comments
None identified for escalation.			

Risks and escalations

Workstreams/ Objectives	Risk to delivery	Impact	Mitigation	Is risk recorded on appropriate risk register?
Performance and Planning	Finance/BI/Strategy support to ongoing MTFP and system recovery programme	Ability to understand financial impact and benefits realisation of programmes and opportunities	Being addressed through weekly CEO meetings	No

Interdependencies between objectives and directorates

Following this month's Delivery Review meetings there have been interdependencies highlighted between objectives/workstreams within different directorates, these are listed below, these will be shared by the PMO and appropriate Chief Officers:

Directorate	Objective/Workstream	Comments	To be linked to
COO	**UEC: Ensure that children and young people are included explicitly in the UEC recovery plans, incorporating specific interventions such as paediatric virtual wards and the Paediatric Early Warning System - need to establish exec ownership**	Action arising to link James Wenman with Su Smart on the CYP objective including Paediatric Virtual Wards and Paediatric Early Warning System and identify how this will be managed and fed back to the next meeting.	CNO - CYP

Changes to objectives and updates to the Annual Plan

This section will be used to describe any additions, updates and removals to/from the Annual Plan. The Board is asked to agree the proposed changes and note that further objectives may be added throughout the year as new priorities emerge. Any additional objectives or significant material changes to the wording of current objectives will be brought to the Board for approval through this report:

Directorate	Objective/Workstream	Rationale	New Addition / Amendment / Removal
COO	Increase the percentage of patients receiving a diagnostic test within six weeks to 95% by March 2025.	Request to amend wording of objective to: *Increase the percentage of patients receiving diagnostics test within six weeks in line with the agreed trajectory by March 2025*	Amendment
COO	Consultant to Consultant (C2C)	Elective Care – These objectives were previously reported as part of the elective recovery programme, as discussed with Elective leads and supported by COO all recovery workstreams and objectives linked to Elective recovery will be a priority within the directorates annual plan	New Addition
COO	Evidence Based Interventions (EBI)		New Addition

Directorate	Objective/Workstream	Rationale	New Addition / Amendment / Removal
COO	Primary Secondary Care Interface		New Addition
CMO & CFO	Commence reprioritisation of funding upstream towards prevention and health inequalities	Agreement between Chief Officers for assignment of this objective to CFO	Amendment
CMO & CFO	Implement the national Digital Inclusion Framework to increase accessibility to digital health resources among underserves populations	Agreement between Chief Officers for assignment of this objective to CFO	Amendment
CMO	Establish a framework for quality assuring the standards expected of any digital services that children and young people can access; with a central resource that children and young people can be signposted to	Regional involvement in this area of work, but there is no capacity to drive this forward in Mental Health commissioning team at present. Recommendation this work is planned for next year. No immediate risks.	Removal
COO & CMO	Expand and develop High Intensity User (HIU) services and establish system working arrangements to support ongoing learning and development	Agreement between Chief Officers for assignment of this objective to CMO	Amendment
CMO	Develop plans to enhance the ICB's role as an Anchor Organisation by March 2025 to strengthen community ties and improve those factors that contribute to improved prospects for local populations. This is a 2024/25 step towards delivery of the ICS '4th purpose' (to help the NHS support broader social and economic development).	Agreement between Chief Officers for assignment of this objective to remain with CMO	Amendment
COO	Reduce the number of children and young people on long waiting lists for paediatrics acute and surgery procedures to eliminate waits of over 65 weeks for elective care	Agreement between Chief Officers for assignment of this objective to COO	Amendment
COO	Ensure that children and young people are included explicitly in the UEC recovery plans, incorporating specific	Agreement between Chief Officers for assignment of this objective to COO	Amendment

Directorate	Objective/Workstream	Rationale	New Addition / Amendment / Removal
	interventions such as paediatric virtual wards and the Paediatric Early Warning System - need to establish exec ownership		
DCEO	Work collaboratively with regional ICS teams to develop a regional secure data environment to support future research	Agreement between Chief Officers for assignment of this objective to DCEO under Performance & Planning	Amendment
DCEO	Enhance the patient experience by improving access to primary care facilities	Agreement between Chief Officers for assignment of this objective to DCEO under Estates	Amendment
COO	Enhance public understanding and access to community-based services	Agreement between Chief Officers for assignment of this objective to COO	Amendment
CFO	Increase the number of eligible citizens connected to the NHS App to support the national target of 75% of people registered	Agreement between Chief Officers for assignment of this objective to CFO	Amendment
CMO	Increase the % of patients with hypertension treated according to NICE guidance to 80% by March 2025	Agreement between Chief Officers for assignment of this objective to CMO	Amendment
CMO	Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025	Agreement between Chief Officers for assignment of this objective to CMO	Amendment
CMO	Increase the percentage of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies to 65% by March 2025	Agreement between Chief Officers for assignment of this objective to CMO	Amendment
CCO	Develop an ICB Governance Improvement plan, secure approval by the July Board meeting, and make necessary amendments to constitution, risk frameworks, and terms of reference based on agreed actions	Milestones to be amended through the change process to Q3.	Amendment

Directorate	Objective/Workstream	Rationale	New Addition / Amendment / Removal
CCO	Implement new System Planning and Delivery & Assurance Structures for the 2024/25 governance approach within the ICB	Milestones to be amended through the change process to Q3.	Amendment
CFO	Support reduction of total procurement cost by driving 'at scale', cross-system procurement, enabling greater efficiency and minimising unwarranted variation Progress shared service arrangements within ICB and across system to increase efficiency and productivity and reduce costs	Agreement from Chief Officers to merge into one objective	Amendment

Following the receipt of the NHSE letter dated 16 September 2024 regarding Winter and H2 priorities we are expecting additional objectives to be added using the change process for the Annual Plan for next month's report.

Each objective has been allocated to a Board Assurance Committee – see the table. Committee members are asked to review and confirm that they are content with the progress being made in respects of those actions which have been allocated to the Committee.

Recommendations

The NHS Devon Board is asked to:

- **AGREE** the assurance ratings relating to the delivery of NHS Devon's 2024/25 Annual Plan objectives
- **AGREE** the proposed amendments to the NHS Devon 2024/25 Annual Plan

NHS Devon

NHS Devon Integrated Care Board

Board Assurance Framework

Date of Meeting	Date Report Produced
28 November 2024	11 November 2024

Author(s)		Report Approved By	
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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
N/A

Executive Summary
This paper provides the NHS Devon Board with an update on the high-level strategic risks that might impact on the achievement of NHS Devon's strategic objectives in the current financial year.

Committees that have previously discussed / agreed the report, and outcomes of that discussion
The NHS Devon Executive reviewed the report at its meeting on 05 November 2024. The Finance and Performance Committee and the Quality and Patient Experience Committee reviewed extracts of this report at their meetings on 14 November 2024.

Key recommendations and actions requested
APPROVE the content of the latest iteration of the 2024/25 BAF risks to achieving the strategic objectives of NHS Devon.

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	Impacts on all of these areas.
Improve services and reduced unwarranted variation	
Make more efficient use of our resources	
Develop our culture and how we operate	

Outline the implications of matters covered in this report for the following areas	
Area	
Quality of Services	Risk management systems and processes do not in themselves present any quality or safety implications. They capture and report the risks relating to population health outcomes and patient experience in the One Devon Integrated Care System, in order to ensure that they are appropriately mitigated / controlled.
Health Inequalities	None
Workforce	None
Resources and Finance	Risk management systems and processes do not present in themselves any financial implications. They capture and report the strategic financial risks faced by NHS Devon in order to ensure that they are appropriately mitigated / controlled.
Legal	Sound control and assurance mechanisms, including risk management systems are an essential component of internal control processes. NHS organisations are required to sign an annual governance statement to provide reasonable assurance that they have been properly informed about the totality of their risks and can evidence that they have identified the organisational objectives and managed the principal risks to them. There is a mandatory annual internal audit review into aspects of risk management and the BAF each year.

Digital and Data	None
Engagement and Consultation	This is an internal control process, and no patient engagement has taken place with respect to it.

Board Assurance Framework

Introduction and Background

1. NHS Devon is required to prepare public statements to confirm that it has done its reasonable best to maintain a sound system of internal control to manage the risks to achieving its objectives. This is achieved by the Chief Executive providing a signed Annual Governance Statement, which covers the risk management and review processes within the organisation. The evidence to support this Statement is supported by the Board Assurance Framework, referred to hereafter as the BAF.

2. NHS Devon's BAF is based upon the identification of its strategic objectives (in essence, its strategic aims and goals), the principal risks to delivering them, the key controls to minimise these risks, with the key assurances of these controls identified. These are monitored by the NHS Devon Executive to resolve issues or concerns and to improve control mechanisms and overseen by Board Committees.

BAF Approach for 2024/25

Greater alignment to NHS Oversight Framework

3. At its meeting on 26 March 2024, the Board agreed a new approach to the BAF for the 2024/25 financial year, closely aligning it to the six themes as set out in the NHS Oversight Framework:

    - Quality of Care, Access and Outcomes;
    - Preventing Ill-health and Reducing Inequalities;
    - Finance and Use of Resources;
    - People;
    - Leadership and Capability; and
    - Local Strategic Priorities.

4. In addition, the Board also agreed the following BAF risks, covering five out of the six themes set out in the NHS Oversight Framework:

    Quality of Care, Access and Outcomes

    If NHS Devon does not work with system partners to deliver NHS service performance for *'All Age' services* in line with national standards and quality requirements, **then** we will fail to deliver on one of our key statutory purposes

(improve outcomes in population health and healthcare), **resulting in** patients across the One Devon Integrated Care System not receiving the services that they need.

NB: *The wording above is a slight revision (indicated by the words in italics) of the original risk articulation that was agreed by the Board at its meeting on 30 May 2024. Further information about the rationale for this can be found at paragraph 24 below.*

Preventing Ill-health and Reducing Inequalities
If NHS Devon is unable to embed a focus on population health management across all of its *'All Age' services* and activities and those of its partners, **then** we will fail to deliver on of our key statutory purposes (tackle inequalities in outcomes, experience, and access), **resulting in** patients across the One Devon Integrated Care System potentially continuing to suffer health inequalities.

NB: *The wording above is a slight revision (indicated by the words in italics) of the original risk articulation that was agreed by the Board at its meeting on 30 May 2024. Further information about the rationale for this can be found at paragraph 24 below.*

Finance and Use of Resources
If NHS Devon does not work with system partners to deliver financial recovery plans, **then** we will fail to deliver on one of our key statutory purposes (enhance productivity and value for money), **resulting in** patients across the One Devon Integrated Care System potentially not receiving the services that they need.

People
If NHS Devon does not work with system partners to ensure an appropriate NHS workforce, **then** we will not be appropriately resourced to deliver safe and effective services, **resulting in** patients across the One Devon Integrated Care System not receiving the services that they need.

NB: *The wording above is a revision of the original risk articulation that was agreed by the Board at its meeting on 30 May 2024.*

Leadership and Capability
If NHS Devon does not sufficiently develop its own leadership capability and that within system partners (particularly clinical leadership), **then** we will fail to deliver transformational change in relation to service delivery, **resulting in** patients across the One Devon Integrated Care System not receiving the services that they need.

Local Strategic Priorities
No BAF risk has yet been identified in relation to this theme. This will be kept under review during the 2024/25 financial year and a BAF risk added if and when it is deemed appropriate.

Key Headings within the BAF

5. The following table summarises the key headings within the 2024/25 BAF:

Main BAF Headings	Explanation of BAF Headings
NHS Oversight Framework Themes	The NHS Oversight Framework consists of 6 themes: Quality of Care, Access and Outcomes; Preventing Ill-health and Reducing Health Inequalities; Finance and Use of Resources; People; Leadership and Capability; and Local Strategic Priorities.
Principal Risks	The key risks that NHS Devon perceives to achieving its strategic objectives / priorities.
Risk Appetite and Risk Tolerance	The amount and type of risk that NHS Devon is prepared to pursue, retain or take in pursuit of its strategic aims / objectives / priorities.
Inherent Risk Score	The rating assigned to a risk before any mitigations / controls are applied. The likelihood and impact of the risk if it were to be left untreated.
Current Residual Risk Score	The rating assigned to a risk before any mitigations / controls are applied. The likelihood and impact of the risk taking into account the mitigations / controls applied to it.
Current Key Controls	The controls or systems in place that help to prevent the risk from materialising.
Current Key Control Gaps	Where controls or systems are not in place.
Current Assurances	Sources of information (usually documented) which provide evidence that the identified controls are in place and operating effectively.
Current Assurance Gaps	Where there is insufficient evidence that controls are in place and operating effectively.
Mitigating Actions	Actions identified to address the control gaps and assurance gaps.

6. In addition to the above, NHS Devon's BAF also assigns risks to Board Committees to ensure oversight of Executives' management of each of the identified risks.

Risk Appetite Statement for 2024/25

7. Risk appetite is defined as 'the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives' and is key to achieving effective risk management. It represents a balance between the potential benefits of innovation and the threats that change, and improvement inevitably bring. It should be at the heart of the systems and processes in place to manage risk within NHS Devon, as well as how decisions are taken.

8. Following agreement by the NHS Devon Board of the BAF risks for the 2024/25 financial year, it was asked to articulate its risk appetite in relation to each of the four statutory purposes of ICBs, using the following Corporate Governance Institute Framework:

Avoid	Avoidance of risk and uncertainty is a key organisational objective
Minimal	(ALARP) (as little as reasonably possible). Preference for ultra-safe delivery options that have a low degree of inherent risk and only limited reward potential
Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward and Value for Money (VfM)
Seek	Eager to be innovative and choose options offering potentially higher business rewards despite greater inherent risk
Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

9. The agreed risk appetite, that is, the levels and types of risk that the Board is prepared to accept (and not accept) in pursuance of the strategic goals of NHS Devon, will be used to inform the agendas for meetings of the Board and its Committees in 2024/25, as well as to ensure that the mitigations controls being put in place for risks are appropriate.

10. The Board was asked to set specific limits for the levels of risk that NHS Devon is able to tolerate in the pursuit of its strategic aims and objectives.

11. Set out below is the risk appetite statement that was agreed by the Board for the 2024/25 financial year:

NHS Oversight Framework Theme	Risk Appetite	Tolerance Level for Residual Risk
Quality of Care, Access and Outcomes	AVOID	8-12
Preventing Ill-health and Reducing Inequalities	AVOID	8-12
Finance and Use of Resources	OPEN	15
People	SEEK	20-25
Leadership & Capability	SEEK	20-25
Local Strategic Priorities	OPEN	15

12. Each NHS Oversight Framework theme has been allocated to a Board Assurance Committee, which will then receive information about the most significant risks aligned to that statutory purpose.

13. Following the first iteration of the BAF in April 2024, it has become clear that as well as being responsible for providing the Board with assurance with regard to the Finance and Use of Resources and the People BAF risks, the Finance and Performance Committee also needs to have oversight of the actions in relation to the Quality of Care, Access and Outcomes BAF risk. As from June 2024, reports to this Committee also include details in relation to this BAF risk.

14. As discussed at the Board meeting on 30 May 2024, the Risk Appetite Statement should be guiding views as to the actions that are, or are not taken by

the Board. Discussions around risk appetite and tolerance will be developed alongside the content of the BAF during the 2024/25 financial year.

Current Risk Position

15. Individual BAF risks were reviewed with Chief Officers / Director Leads late October 2024 as part of the PMO Delivery Room meetings (see paragraph 22 of this report). The details for each risk are attached at **Annex A** and the scoring methodology at **Annex B** of this report.

16. The table below provides a high-level summary of the current risk position for the 5 strategic risks for the current financial year:

Committee Abbreviations	
ExCo	Executive
QPEC	Quality and Patient Experience Committee
FPC	Finance and Performance Committee
PHIC	Population Health Improvement Committee
ODC	Organisational Development Committee

Key - Movement in Risk Scores		
↑	↔	↓
Increased	No Change	Decreased

			Historical and Current Risk Scores							
NHS Oversight Framework Theme – Risk Entry	**Board Committee**	**Inherent Risk Score**	**April 2024** Residual Risk Score	**June 2024** Residual Risk Score	**August 2024** Residual Risk Score	**October 2024** Residual Risk Score	**Risk Movement** (Residual Risk Score)	**Risk Appetite**	**Target / Tolerance Level** (Residual Risk Score)	**Last Reviewed**
1. Quality of Care, Access and Outcomes	QPEC & FPC	25	12	12	12	12	↔	AVOID	8 - 12	Oct-24
2. Preventing Ill-health and Reducing Health Inequalities	PHIC	25	12	16	16	16	↔	AVOID	8 - 12	Oct-24
3. Finance and Use of Resources	FPC	20	12	12	12	12	↔	OPEN	15	Oct-24
4. People	PODC & FPC	20	12	12	12	12	↔	SEEK	20 - 25	Oct-24
5. Leadership and Capability	EXCO	20	16	12	12	12	↔	SEEK	20 - 25	Oct-24

17. There are no proposed changes following the outcomes of the strategic risk reviews in October 2024 which were reported to the Board at its meeting on 18 September 2024.

18. The Finance and Performance Committee was tasked by the Board at its meeting on 25 July 2024 to consider whether the strategic risk in relation to Finance and Use of Resources was appropriately scored. This was considered

at the Finance and Performance Committee meeting on 12 September 2024. In light of the conversation throughout the meeting and based on the latest financial position, the Committee deemed that no change was needed at the present time although it may revisit this in the future

Heat Map Showing Current Risk Scores

19. The heatmap provides a comprehensive view of the likelihood and impact of NHS Devon's strategic risks. It shows that of the five BAF risks, four are within or below the agreed target / tolerance level in terms of their residual risk score. One risk has a residual risk rating in excess of the target / tolerance level.

Board Assurance Framework Heatmap – Status as at October 2024:

NHS Oversight Framework Theme - Risk Entry	Chief Officer	Assigned Board Committee	Risk Appetite	1-3	4-6	8	9	10	12	15	16	20	25
1. Quality of Care, Access and Outcomes	CNO	QPEC & FPC	AVOID										
2. Preventing Ill-health and Reducing Health Inequalities	CMO	PHIC	AVOID										
3. Finance and Use of Resources	CFO	FPC	OPEN										
4. People	CPO	PODC & FPC	SEEK										
5. Leadership and Capability	CCA & CO	EXCO	SEEK										

Chief Officer Abbreviations:	
CNO	Chief Nursing Officer
CMO	Chief Medical Officer
CFO	Chief Finance Officer
CPO	Chief People Officer
CCA&CO	Chief Corporate Affairs & Communications Officer

Key – Risk Score Symbols and Shapes	
▭	Tolerance Level – Residual Risk
●	Current Residual Risk Score

Developments Since the Last Consideration of the BAF

Mapping of 2024/25 Annual Plan Priorities to BAF Risks

20. As previously reported, the Governance team has completed an exercise to map 2024/25 Annual Plan priorities to BAF risks. The Annual Plan sets out what NHS Devon needs to deliver during the current financial year to continue to improve 'in-year' alongside what it needs to do this year to deliver its longer-term strategic priorities to stay on track and to deliver the 5 Year Joint Forward Plan (JFP). This mapping exercise is informing mitigating actions required to help further minimise materialisation of BAF risks and in addition, is helping inform

and enhance the risk information recorded and tracked at this latest iteration and each future iteration of the BAF in 2024/25.

21. Further work has been undertaken for this latest update of the BAF to link mitigating actions to controls and control gaps and to group actions together into themes in order to reduce the level of information and to make the BAF easier to engage with.

Linking with PMO Delivery Room Meetings

22. Following Board approval of the 2024/25 Annual Plan and the development of the Delivery Plans that underpin this, Directorates have been participating throughout October 2024 in review meetings with the Director of Planning and Performance. Each of these meetings have also be attended by the Governance team. The focus of these meetings has been on obtaining the latest position in terms of delivery against actions, measuring impact against the oversight framework metrics, identification of risks to delivery of key priorities, and on oversight and assurance in terms of NHS Devon's performance and the management of its strategic risks. The outcome from each of these meetings has been used to inform this latest iteration of the BAF, particularly in relation to mitigating actions for each BAF risk.

23. In order to ensure consistency in reporting of the BAF and the Annual Plan, specifically in terms of RAG ratings, the Governance team has adopted the assurance levels used by the PMO and applied these to the mitigating actions section of the BAF at this latest iteration. Assurance levels and their definitions can be found in Appendix B to this report.

BAF Risk Relating to Children and Young People

24. Following feedback from the meeting of the NHS Devon Board on 25 July 2024, discussions have taken place between Governance and the Director of Women, Children and Young People's Services to establish whether a BAF risk should be developed in this area. As a result of these discussions a slight change to the wording of the Quality of Care, Access and Outcomes, and the Preventing Ill Health and Inequalities BAF risks has been made to reflect that they cover "All Age" services. This has been reflected in this latest iteration of the BAF.

Conclusion

25. The Board is asked to **APPROVE** the content of the latest iteration of the 2024/25 BAF risks to achieving the strategic objectives of NHS Devon.

Annex A

NHS Oversight Framework Theme	Chief Officer	Assigned Board Committee	Review Date
1. Quality of Care, Access and Outcomes	Penny Smith - Chief Nursing Officer	Quality & Patient Experience Committee; and Finance & Performance Committee	October 2024

Principal Risk

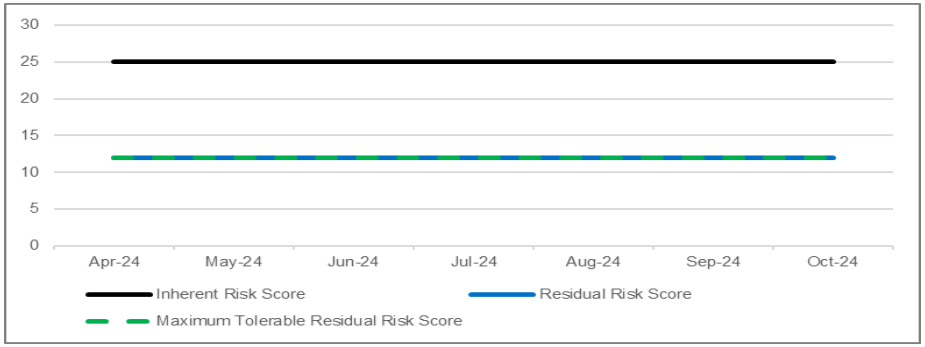
IF NHS Devon does not work with system partners to deliver NHS service performance for 'All Age' services in line with national standards and quality requirements, **THEN** we will fail to deliver on one of our key statutory purposes (improve outcomes in population health and healthcare), **RESULTING IN** patients across the One Devon Integrated Care System not receiving the services that they need.

Risk Appetite	AVOID	Risk Tolerance	8 - 12

Risk Scoring	Likelihood	Impact	Total	Movement
Inherent Risk Score	5	5	25	-
Current Residual Risk Score	3	4	12	↔

Rationale for Amendment to Residual Risk Score:

N/A



	Current Key Controls (what do we have, or what should we have in place to mitigate the risk?)	In Place?
1.	**Quality Strategy** in place articulating current and future ambitions for delivering high quality healthcare aligned to national standards, in line with the needs of the Devon population.	Not in Place
2.	**Quality Management System (QMS)** in place to support delivery of high quality healthcare.	Partially
3.	**2024/25 Annual Plan** priorities agreed and delivery plan in place to ensure achievement of these.	Partially
4.	**NHSE Quality and Accountability Framework** implementation.	Partially

	Current Key Control Gaps
CG1	**Quality Strategy** needs to be developed, in line with proposed priorities set out in the 2024/25 Annual Plan.
CG2	**QMS** – monitoring systems need refinement to include improved visibility of system risks where NHS Devon oversight is required.
CG3	**2024/25 Annual Plan** priorities agreed by the Board at its meeting on 30 May 2024; final iteration approved by the Board on 25 July 2024. Ongoing development / changes to be approved by the Board throughout 2024/25.
CG4	**NHSE Quality and Accountability Framework** published May 2024. A gap analysis is in the process of being undertaken.

Annex A

5.	**Equality and Quality Impact Assessment (EQIA)** framework in place to help inform commissioning decision-making processes, business cases, projects and other business plans.	Partially		CG5	**EQIA** framework in place but is currently being refined to ensure that it is as effective as possible with regular monitoring and updates for Board assurance.
6.	**Mental Health Strategy** in place to ensure delivery of high quality, safe, effective and well commissioned Mental Health Services. This is supported by a Delivery Plan.	Partially		CG6	**Mental Health Strategy and Delivery Plan** needs to be developed, in line with proposed priorities set out in the 2024/25 Annual Plan.
7.	**Dementia Strategy** in place to ensure high quality, safe and effective delivery of Dementia Services. This is supported by a Delivery Plan.	Partially		CG7	**Dementia Strategy and Delivery Plan** needs to be developed, in line with proposed priorities set out in the 2024/25 Annual Plan.
8.	**Eating Disorders and Disordered Eating Strategy** in place to ensure high quality, safe and effective delivery of Eating Disorders and Disordered Eating Services. This is supported by a Delivery Plan.	Partially		CG8	**Eating Disorders and Disordered Eating Strategy and Delivery Plan** needs to be developed, in line with proposed priorities set out in the 2024/25 Annual Plan.
9.	**LD & Neurodiversity Services Strategy** in place to ensure high quality, safe and effective delivery of LD & Neurodiversity Services. This is supported by a Delivery Plan.	Partially		CG9	**LD & Neurodiversity Services Strategy and Delivery Plan** needs to be developed, in line with proposed priorities set out in the 2024/25 Annual Plan.
10.	**Sustainable Acute Hospital Service Delivery Strategy** - The system has a clear strategy for sustainable acute hospital service delivery in the long-term.	Partially		CG10	**Sustainable Acute Hospital Service Delivery Strategy** – NHS Devon needs to ensure that the system has a clear strategy for sustainable hospital service delivery in the long-term.
11.	Fulfilling **Operational Plan Requirements, NOF4 and National Standards** as set by NHSE.	Partially		CG11	**Operational Plan Requirements, NOF4 and National Standards** – Trajectories need to be put in place as not currently addressing Operational Plan requirements and complying with national standards.
12.	**Urgent and Emergency Care (UEC) Strategy and Policy** has been fully and appropriately implemented.	Partially		CG12	**Urgent and Emergency Care (UEC) Strategy and Policy** needs to be fully and appropriately implemented.
13.	**GIRFT** is an enabler to delivery of the Elective Care and UEC strategies.	Partially		CG13	**GIRFT** – Implementation of the GIRFT programme / recommendations to reduce unwarranted variations in services and practices to bring about higher-quality care in hospitals, at lower cost.
14.	**Specialised Commissioning** – There is a clearly defined and agreed approach in place for the formal delegation of specialised commissioning functions from NHSE to NHS Devon.	Partially		CG14	**Specialised Commissioning** – Clarification is needed about the approach to formal delegation of specialised commissioning functions from NHSE to NHS Devon.
15.	**Levelling Up Services Across Devon** – There are consistent service level provided across the One Devon ICS	Partially		CG15	**Levelling Up Services Across Devon -** Certain services require amendment to ensure that a consistent service level is provided across the One Devon ICS.
16.	Fulfilling statutory obligations under **Working Together Safeguarding Children (2023) and the Care Act (2014)**.	Partially		CG16	**Working Together Safeguarding Children (2023) and the Care Act (2014)** – need to ensure full implementation of the Joint Targeted Area Inspection Plan (JTAI).

Annex A

17.	Fully functional **CHC Function** in place to deliver NHS Devon's statutory responsibilities in relation to this service, to deliver value and improve efficiency.	Partially		CG17	**CHC Function** – Organisational change, Phase 2.2 (CHC) requires completion, including the need to recruit to key business critical posts. Digital business case requires discussion at DIG.
18.	There is a clear strategy and plan in place for the system to enable successful delivery and exit from the national **Maternity Safety Improvement Programme**.	Partially		CG18	**Maternity Safety Improvement Programme** – action plan needs to be fully implemented in order to enable successful delivery and exit from the programme.
19.	Fulfilling **Special Educational Needs and Disabilities (SEND) and Wider National Requirements**.	Partially		CG19	**(SEND) and Wider National Requirements** - Trajectories need to be put in place as not currently addressing SEND requirements and complying with national standards.
20.	Effective commissioning of **Child and Adolescent Mental Health Services (CAMHS)** is in place across the One Devon system.	Partially		CG20	**CAMHS** – There is potentially a lack of effective commissioned intermediate care across the One Devon system to meet the need of children and young people (under 18).

Current Assurances **(how do we know that the controls in place are working effectively?)**			**Current Assurance Gaps**	
1.	**System Quality Group (SQG)** in place focused on enabling quality improvement across the One Devon Integrated Care System.		AG1	**SQG** is in existence, but still requires development to become fully effective.
2.	**Quality & Patient Experience Committee (QPEC)** in place providing oversight and assurance to the NHS Devon Integrated Care Board that it is delivering its functions in a way that secures continuous improvement in the quality of services.		AG2	**QPEC** forward plan needs to be informed by 2024/25 Annual Plan priorities once approved.
3.	**Quality Report** is received by the NHS Devon Executive, QPEC and the NHS Devon Board at agreed intervals throughout the year.		AG3	**Quality Report** is being improved to better illustrate risks in the system and report efficacy of mitigation.
4.	**Provider Quality Committees** are in place and attended by representatives of NHS Devon, ensuring that providers have appropriate assurance and oversight mechanisms with regard to quality.		AG4	**System planning and delivery assurance structures** need to be implemented.
5.	**National and NOF4 Reporting Requirements** ensure that all partners within the One Devon Integrated Care System provide assurance about quality metrics to appropriate national bodies.			
6.	**System planning and delivery assurance structures** are clear and in place to ensure oversight of key risks and issues.			

Mitigating Actions **(what do we plan to do to address the control gaps / assurance gaps identified above?)**	**Action Owner**	**Planned Completion Date**	**Assurance Level**	**Update Since Last Review** **(only applicable where assurance level is 'partially assured / 'limited assurance')**
CG1: Quality Strategy needs to be developed.	Penny Smith	Start of Q1 2025/26	Not Yet Due	N/A
CG2: Quality Management System Improvement Process Implementation *(Annual Plan Ref. 1)*	John Trevains	End Q4 2024/25	Fully Assured	N/A

Annex A

CG3: 2024/25 Annual Plan to be approved by the Board *(Annual Plan Ref. 102)*	Sam Wadham-Sharpe	Start Q2 2024/25	Fully Assured	N/A
CG4: Undertake Gap analysis in relation to the **NHSE Quality and Accountability Framework** (Published May 2024).	John Trevains / Natasha Goswell	Start Q3 2024/25	Not Yet Due	N/A
CG5: EQIA framework needs refinement.	Natasha Goswell	End Q3 2024/25	Fully Assured	N/A
CG6: Perinatal Mental Health *(Annual Plan Ref. 50)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG6: Transformed Models of Community Mental Services *(Annual Plan Ref. 51)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG6: Adults and Older Adults with Severe Mental Illness and Support with Health and Social Care Needs *(Annual Plan Ref. 52)*	CMO	End Q4 2024/25	Partially Assured	Due to redirection of resources / collective action within Primary Care, recommendations are to be considered further. Timescale shift from Q3 to Q4 to complete.
CG6: Mental Health Crisis and access to necessary help without the need to visit A&E *(Annual Plan Ref. 53)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG6: Improved **NHS Talking Therapies** for anxiety and depression *(Annual Plan Ref. 54)*	CMO	End Q3 2024/25	Fully Assured	N/A
CG6: High Quality, Safe, Effective and Well Led Commissioned Mental Health Services *(Annual Plan Ref. 61)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG7: More timely **Dementia Diagnosis** *(Annual Plan Ref. 56)*	CMO	End Q4 2024/25	Partially Assured	Actions will be based on Devon Investment Group (DIG) outcome.
CG7: Development of a **Devon Health and Social Care Dementia Strategy** *(Annual Plan Ref. 57)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG8: Develop alternative **Community Physical Health Monitoring Services** for eating disorder patients *(Annual Plan Ref. 59)* *NB: Previously aligned to BAF Risk 2 (Preventing Ill-health and Reducing Inequalities)*	CMO	End Q2 2024/25	Not Assured	Workshops held with relevant provider partners (ongoing). Proposal being collated and business case to be presented to DIG later in October 2024 / early November 2024. Number of GP practices giving notice on this; this is giving cause for concern in terms of capacity.
CG8: Business case development for **Community Based Alternative to Hospital Admission** for individuals with severely disordered eating with atypical features or which is secondary to neurodiversity and / or trauma based issues *(Annual Plan Ref. 60)* *NB: Previously aligned to BAF Risk 2 (Preventing Ill-health and Reducing Inequalities)*	CMO	End Q4 2024/25	Not Assured	Discussions commenced with relevant MHLDN and ICB leads in order to clarify and confirm objectives and implementation.
CG8: Medical Admissions Protocol for 'Physiological Rescue' *(Annual Plan Ref. 63)*	CMO	End Q4 2024/25	Partially Assured	Terms of Reference have been agreed for the working group.

Annex A

CG9: Reliance on Mental Health Inpatient Care (LDA) *(Annual Plan Ref. 65)* *NB: Moved from BAF Risk 2 (Preventing Ill-health and Reducing Inequalities)*	CMO	End Q3 2024/25	Fully Assured	N/A
CG9: Test and implement improvements in **Autism Diagnostic Assessment Pathways** *(Annual Plan Ref. 66)* *NB: Moved from BAF Risk 2 (Preventing Ill-health and Reducing Inequalities)*	CMO	End Q3 2024/25	Fully Assured	N/A
CG9: Develop **Governance and Due Diligence with Contracting for the ADHD Patient Choice Pathway** *(Annual Plan Ref. 71)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG9: ADHD Pathway and Models of Care *(Annual Plan Ref. 72)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG9: Oliver McGowen Mandatory Training (OMMT) *(Annual Plan Ref. 73)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG10: Stabilisation of Fragile Acute Services *(Annual Plan Ref. 90)*	CMO	End Q3 2024/25	Fully Assured	N/A
CG11: Hospital Admissions (Adults and Older Adults) Mental Health *(Annual Plan Ref. 49)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG11: Clinical Pharmacy Services Expansion *(Annual Plan Ref. 15)*	COO	End Q4 2024/25	Fully Assured	N/A
CG11: Improve **Access to Primary Care Facilities** to enhance patient experience *(Annual Plan Ref. 109)*	DCEO	Ongoing	Fully Assured	N/A
CG11: Plan for Recovery and Reform of NHS Dentistry *(Annual Plan Ref. 16)*	COO	End Q4 2024/25	Fully Assured	N/A
CG11: Integrated Approach to Care and Support *(Annual Plan Ref. 17)*	COO	-	Partially Assured	This was identified as a priority 3 area for Primary Care and therefore there is no action to update on this month. There is however synergy with elements of the UEC workstream (e.g. high intensity users). Mitigations in place.
CG11: Implement **Personalised Care** across integrated teams *(Annual Plan Ref. 18)*	COO	-	Partially Assured	This was identified as a priority 3 area for Primary Care and therefore there is no action to update on this month. There is however synergy with elements of the UEC workstream (e.g. frailty and end of life). Mitigations in place.
CG11: Expand and invocate the **Independent Prescribing Programme (IP)** *(Annual Plan Ref.19)*	COO	End Q4 2024/25	Fully Assured	N/A
CG11: Improve the sustainability of **General Practice Sustainability** *(Annual Plan Ref. 20)*	COO	End Q4 2024/25	Fully Assured	N/A
CG11: A&E Response Times *(Annual Plan Ref. 22)*	COO	End Q4 2024/25	Fully Assured	N/A

Annex A

CG11: Category 2 Ambulance Response Times *(Annual Plan Ref. 23)*	COO	End Q4 2024/25	Fully Assured	N/A
CG11: Eliminate **Elective Care Waits** >65 weeks *(Annual Plan Ref. 34)*	COO	End Q4 2024/25	Partially Assured	Deep dive into theatre productivity and utilisation. Discussions with Sulis group in Bath to support Devon orthopaedic long waiters in difficult to clear subspeciality areas. Ongoing collaborative working with RDUH and TSDFT to improve the PTL position for RDUH P2 and long waiters. Ongoing One Devon check and challenge regarding long waiter capacity plans and actions.
CG11: Delivery or exceed **System Specific Activity Targets** *(Annual Plan Ref. 35)*	COO	End Q4 2024/25	Fully Assured	N/A
CG11: Outpatient Attendances *(Annual Plan Ref. 36)*	COO	End Q4 2024/25	Partially Assured	Patient validation work ongoing to support TSD to pick up Netcall activity as well as choice conversation for those eligible for transfer.
CG11: Improve Patient Experience of Choice at Point of Referral *(Annual Plan Ref. 37)*	COO	End Q4 2024/25	Fully Assured	N/A
CG11: Improve performance against **62 Day Cancer Treatment Standard** *(Annual Plan Ref. 38)*	COO	End Q4 2024/25	Fully Assured	N/A
CG11: Increase **Cancer Diagnosis %** *(Annual Plan Ref. 39)*	COO	No Fixed Milestones Set	Fully Assured	N/A
CG11: Increase **Diagnostic Tests %** *(Annual Plan Ref. 40)*	COO	End Q4 2024/25	Fully Assured	N/A
CG11: Improve **Patient and List Management** *(Annual Plan Ref. 41)*	COO	Ongoing (Monitor and Mitigate Against Any Deviation from Plan)	Partially Assured	Validation monitored via speciality improvement programmes. Monitor validation progress in gynaecology for TSD in conjunction with Netcall roll-out.
CG11: Appropriateness of **Referrals to Secondary Care** *(Annual Plan Ref. 44)*	COO	End Q4 2024/25	Fully Assured	N/A
CG11: Increase **Diagnostic Capacity** *(Annual Plan Ref. 46)*	COO	End Q4 2024/25	Fully Assured	N/A
CG11: Complete **GP Contract Reviews** *(Annual Plan Ref. 47)*	COO	End Q4 2024/25	Partially Assured	-
CG11: Reduce **Children and Young People Long Waits** *(Annual Plan Ref. 7)*	CNO	End Q4 2024/25	Partially Assured	Alignment of lengths of waits on children's dashboard is complete to match adults to enable 'like for 'like' reporting.
CG12: Standardise UTC Provision Across Devon *(Annual Plan Ref. 24)*	COO	End Q4 2024/25	Fully Assured	N/A
CG12: Establishment and Delivery of a **Care Coordination Hub** *(Annual Plan Ref. 25)*	COO	End Q4 2024/25	Fully Assured	N/A

Annex A

CG12: Standardise **Same Day Emergency Care (SDEC)** across One Devon *(Annual Plan Ref. 26)*	COO	End Q4 2024/25	Fully Assured	N/A
CG12: Consistent delivery of **Virtual Wards** across Devon *(Annual Plan Ref. 27)*	COO	End Q4 2024/25	Fully Assured	N/A
CG12: Implementation of **Acute Frailty Services** across the 4 acute trusts *(Annual Plan Ref. 28)*	COO	End Q4 2024/25	Fully Assured	N/A
CG12: Standardise **Urgent Community Response (UCR)** operations *(Annual Plan Ref. 29)*	COO	End Q4 2024/25	Fully Assured	N/A
CG12: Establish consistent proactive clinical care in Care Homes *(Annual Plan Ref. 30)*	COO	End Q4 2024/25	Fully Assured	N/A
CG12: Reduce **Acute Bed Occupancy and Length of Stay** *(Annual Plan Ref. 31)*	COO	End Q4 2024/25	Fully Assured	N/A
CG12: Children and Young People Inclusion in UEC Recovery Plans *(Annual Plan Ref. 32)*	COO	End Q4 2024/25	Not Yet Due	UEC team will be meeting with CYP to scope actions.
CG12: Expand and develop **High Intensity User (HIU) Services** *(Annual Plan Ref. 79)*	CMO	End Q4 2024/25	Partially Assured	Business case for HIUs in North approved by Devon Investment Group (DIG) until March 2025.
CG13: Theatre Utilisation using GIRFT *(Annual Plan Ref. 43)*	COO	End Q4 2024/25	Fully Assured	N/A
CG14: Specialised Commissioning *(Annual Plan Ref. 48)*	COO	Not Stated	Fully Assured	N/A
CG15: Review of Neurology Headache Clinics *(Annual Plan Ref. 45)*	COO	End Q4 2024/25	Fully Assured	N/A
CG16: Safeguarding Improvement – Working Together Safeguard Children (2023) and The Care Act (2014) *(Annual Plan Ref. 2)*	CNO	End Q4 2024/25	Fully Assured	N/A
CG17: Review and enhance the **Continuing Health Care (CHC) Function** *(Annual Plan Ref. 3)*	CNO	End Q4 2024/25	Partially Assured	Exceptional NHS Devon Executive meeting being organised for mid-October 2024 to discuss outputs of review and to set the next steps in respect of the transformation programme. New Associate Director for CHC Transformation has now been appointed and is in post.
CG18: System collaboration and implementation of **Maternity, Neonatal and Women's Health (3 Year Plan)** *(Annual Plan Ref. 4)*	CNO	End Q4 2024/25	Fully Assured	N/A
CG18: System collaboration and implementation of **10 Year National Women's Health Strategy** *(Annual Plan Ref. 5)*	CNO	End Q4 2024/25	Fully Assured	N/A
CG19: Implementation of **Neurodiversity Offer for Children and Families** *(Annual Plan Ref. 8)*	CNO	End Q4 2024/25	Fully Assured	N/A
CG19: Improve outcomes for **Children and Young People with Long Term Conditions** *(Annual Plan Ref. 9)*	CNO	End Q4 2024/25	Fully Assured	N/A

Annex A

CG19: Prioritise the **Special Education Needs and Disabilities (SEND)** of children and young families across the Devon ICS *(Annual Plan Ref. 10)*	CNO	End Q4 2024/25	Fully Assured	N/A
CG19: Support **Children and Young People Community Services Recovery** *(Annual Plan Ref. 11)*	CNO	-	Partially Assured	Development of broader community services recovery plan for children created alongside adult community waiting list recovery. Lock-in took place 10 September 2024 to finalise implementation programme for recovery of 52 week waits by the end of March 2025.
CG20: Children and Young People's Timely, Co-ordinated Access to NHS Funded Mental Health Support, and Treatment *(Annual Plan Ref. 58)*	CMO	End Q4 2024/25	Fully Assured	N/A
AG1: SQG requires development to become fully effective.	CNO	Q2 2024/25	Partially Assured	
AG2: QPEC forward plan to be informed by 2024/25 Annual Plan.	CCCAO	End Q2 2024/25	Partially Assured	
AG3: Quality Report is being improved to better illustrate risks in the system and report efficacy of mitigation.	John Trevains	Monthly Updates	Fully Assured	
AG4: System Planning and Delivery Assurance Structures to be agreed and implemented.	CCCAO	End Q2 2024/25	Partially Assured	

Annex A

NHS Oversight Framework Theme	Chief Officer	Assigned Board Committee	Review Date
2. Preventing Ill-Health and Reducing Inequalities	Chief Medical Officer	Population Health Improvement Committee	October 2024

Principal Risk

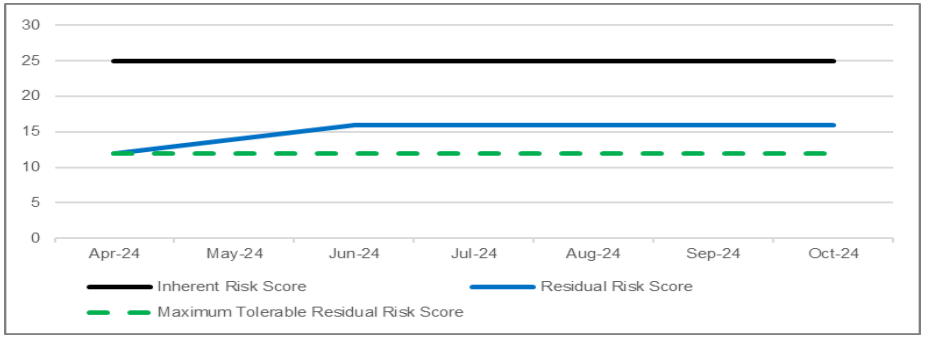
IF NHS Devon is unable to embed a focus on population health management across all of its 'All Age' services and activities and those of its partners, **THEN** we will fail to deliver on our key statutory purposes (improve outcomes in population health and healthcare, tackle inequalities in outcomes, experience and access, and help the NHS support broader social and economic development) **RESULTING IN** patients across the One Devon Integrated Care System potentially continuing to suffer health inequalities.

Risk Appetite	AVOID	Risk Tolerance	8 - 12

Risk Scoring	Likelihood	Impact	Total	Movement
Inherent Risk Score	5	5	**25**	-
Current Residual Risk Score	5	5	**16**	↔

Rationale for Amendment to Residual Risk Score:

N/A



	Current Key Controls (what do we have, or what should we have in place to mitigate the risk?)	In Place?
1.	**Population Health Objectives** are set out within the Joint Forward Plan (JFP).	Fully
2.	**Funding for Population Health** agreed at a level that enables a full programme of work to be established.	Not in Place
3.	**Population Health Programme of Work** agreed and in place in line with available funding.	Not in Place
4.	**Quality and Equality Impact Assessments (QEIAs)** in place to help inform commissioning decision-making processes, business cases, projects and other business plans. *(Links to NHS Oversight Theme 1: Quality of Care, Access and Outcomes*	Partially

	Current Key Control Gaps
CG1	**Funding for Population Health** agreed but at a significantly reduced level (£3.7m from national Health Inequalities budget has been put in bottom line).
CG2	**Population Health Programme of Work** – 2024/25 Annual Plan priorities have been agreed in principle, but the reduction in funding means that they are not fully resourced.
CG3	**Quality and Equality Impact Assessments (QEIAs)** may not be fully effective and / or being monitored.

Annex A

5.	**Clear One Devon PHM Dataset** to which all Primary Care and Voluntary Community and Social Enterprise Sector (VCSE) are signed up to.	Partially		CG4	**Clear One Devon PHM Dataset** - Access to data for PHM limited. Not all of Primary Care and the Voluntary Community and Social Enterprise Sector (VCSE) are signed up to this.
6.	**Health Inequalities Actions** are incorporated into all key service strategies.	Partially		CG6	**Health Inequalities Actions** are not incorporated into all key service strategies.
7.	**Evidence Based Interventions.**	Partially		CG7	**Evidence Based Interventions** – Need to ensure that our intervention are evidence based.
8.	**Infection Control** action plan fully implemented to improve infection prevention and control.	Partially		CG8	**Infection Control** action plan needs to be fully implemented to improve infection prevention and control.
9.	Agreed plan in place and being successfully delivered in order to tackle health inequalities experienced by care experience **Children & Young People**.	Partially		CG9	**Children & Young People Plan** to be implemented and successfully delivered in order to tackle health inequalities of experienced by care CYP.

Current Assurances **(how do we know that the controls in place are working effectively?)**			**Current Assurance Gaps**	
1.	**System Governance and Assurance Structures** are focused on Population Health.		AG1	**System Governance and Assurance Structures** are not fully informed by Population Health perspectives.
2.	**One Devon Population Health Steering Group** in place which is comprised of system partners. This group provides assurance that work is on-going within the system in relation to Population Health.			
3.	**Population Health Improvement (Board Assurance) Committee** in place to provide assurance to the Board that NHS Devon is fulfilling its role to improve outcomes in population health and healthcare and to tackle inequalities in outcomes, experience and access. Provides oversight and challenge.		AG2	**Population Health Improvement (Board Assurance) Committee** Terms of Reference (ToRs) agreed by the NHS Devon Board at its meeting on 24 May 2024. First meeting due to take place in November 2024.
4.	**NHS Devon Annual Report** demonstrates how it has discharged its functions in the previous financial year. NHS England (NHSE) Core20PLUS5 relates specifically to those duties in relation to health inequalities.			

Mitigating Actions **(what do we plan to do to address the control gaps / assurance gaps identified above?)**	**Action Owner**	**Planned Completion Date**	**Assurance Level**	**Update Since Last Review** **(only applicable where assurance level is 'partially assured / 'limited assurance')**
CG1 Funding for Population Health to be explored with the Finance team.	CMO	TBC	TBC	-
CG2 Population Health Programme of Work - Capacity to deliver the agreed Population Health programme of work to be considered through Phase 2 of the organisational change programme.	CMO	TBC	TBC	-

Annex A

CG3 Equality and Quality Impact Assessments (EQIAs) framework needs refinement.	Natasha Goswell	End Q3 2024/25	Fully Assured	N/A
CG3: Develop and implement a **Population Health Charter** *(Annual Plan Ref. 76)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG4 One Devon Dataset to be improved with access to Primary Care and VCSE data.	BI Team / Sam Wadham-Sharpe	TBC	TBC	-
CG6: Mental Health Annual Physical Health Checks *(Annual Plan Ref. 55)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG6: Learning Disability and Autism (LDA) Annual Health Checks *(Annual Plan Ref. 64)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG6: Reduce over-medications through the **STOMP and STAMP** programmes *(Annual Plan Ref. 68)*	CMO	End Q3 2024/25	Fully Assured	N/A
CG6: LeDeR Programme Implementation *(Annual Plan Ref. 69)*	CMO	End Q3 2024/25	Partially Assured	Recruitment of Band 8a to the LeDeR reviewing post currently managed in the Quality & Nursing Directorate. Recovery plan in development with the Deputy Director of Nursing and LDAP team. Mitigations in place to recover the position. Recruitment of a Band 8a post advertised; shortlisting completed, bank reviewers being sort and funding paused in LDA SDF. Actions currently with Chief Nursing Officer.
CG6: Support delivery and use of the **LDA Reasonable Adjustment Digital Flag** *(Annual Plan Ref. 70)*	CMO	End Q3 2024/25	Fully Assured	N/A
CG6: Support LCPs and Provider Collaboratives with **Population Health and Evidence Based Resources** *(Annual Plan Ref. 74)*	CMO	End Q3 2024/25	Fully Assured	N/A
CG6: Implement the **National Inclusion Framework** *(Annual Plan Ref. 75)*	CMO	End Q4 2024/25	Partially Assured	Development of plan for implementation of Inclusion Health Framework. Meeting with Devon County Council (DCC) Public Health Team.
CG7: Continue to contribute to the **Peninsula Research and Innovation Programme (PRIP)** *(Annual Plan Ref. 86)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG7: Implement deliverables in the **Peninsula Research and Innovation Strategy (PRIS)** *(Annual Plan Ref. 87)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG7: Support the development of the **Research Engagement Network (REN)** *(Annual Plan Ref. 88)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG8: Infection Management System *(Annual Plan Ref. 13)*	CNO	End Q4 2024/25	Fully Assured	N/A
CG8: Vaccination Delivery Improvement *(Annual Plan Ref. 14)*	CNO	End Q4 2024/25	Fully Assured	N/A

Annex A

CG9: Address significantly poorer outcomes for care experienced **Children & Young People** *(Annual Plan Ref. 12)*	CNO	End Q4 2024/25	Fully Assured	N/A
AG1 System Governance and Assurance Structures to be reviewed once established to determine the most appropriate method of ensuring that they are appropriately informed by Population Health perspectives.	CCCAO	End Q4 2024/25	-	Structures to be reviewed quarterly and earlier if required. No later than 31 March 2025. Review currently scheduled for December 2024.
AG2 Population Health Improvement (Board Assurance) Committee to be formally established.	Philippa Harding	End Q2 2024/25	Partially Assured	

Annex A

NHS Oversight Framework Theme	Chief Officer	Assigned Board Committee	Review Date
3. Finance and Use of Resources	Bill Shields - Chief Finance Officer	Finance and Performance Committee	October 2024

Principal Risk

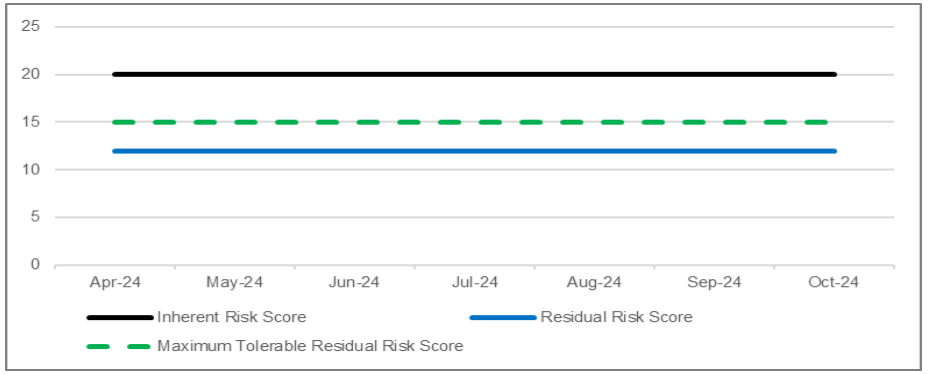
IF NHS Devon does not work effectively with system partners to deliver financial recovery plans, **THEN** we will fail to deliver on one of our key statutory purposes (enhance productivity and value for money), **RESULTING IN** patients across the One Devon Integrated Care System potentially not receiving the services that they need.

Risk Appetite	OPEN	Risk Tolerance	15

Risk Scoring	Likelihood	Impact	Total	Movement
Inherent Risk Score	5	4	20	-
Current Residual Risk Score	4	3	12	↔

Rationale for Amendment to Residual Risk Score:

N/A



	Current Key Controls (what do we have, or what should we have in place to mitigate the risk?)	In Place?
1.	**Financial Plans** in place that underpin the Operating Plan for 2024/25.	Fully
2.	**Medium-Term Financial Plan** in place setting out the scope and scale of challenge to deliver financial balance during the strategic medium-term. MTFP developed locally and understood and owned by all system partners.	Partially
3.	**System Recovery Plan** (which is encapsulated in the 2024/25 operational and financial plans) in place. This is a dynamic plan that continually assesses progress against system-wide savings, identification of new schemes and performance against key finance and performance trajectories.	Fully

	Current Key Control Gaps
CG1	**Medium-Term Financial Plan** requires updating.

Annex A

4.	**Devon Investment Group (DIG)** in place and responsible for ensuring the adoption and application of best practice governance and decision-making for investments by NHS Devon.	Fully			
5.	**Triple Lock Sign-Off Process** in place for all revenue investments above £100k, with sign-off required by the organisation, system and NHS England (NHSE) regional team.	Fully			
6.	**System Vacancy Control Panel (VCP)** in place to prevent an increase in workforce growth and to support a reduction in running costs.	Partially			
7.	**Cost Improvement Programmes (CIPs)** in place that contains cost reduction strategies that aim to identify and implement measures to achieve cost savings and efficiency improvements while maintaining or enhancing the quality of healthcare services provided to patients. *(Annual Plan Ref. 83, 108, 115, 120)*	Fully			
8.	**ICB Programme Management Office (PMO)** established.	Partially		CG4	**ICB PMO** needs to be adequately resourced.
9.	**Information Systems and System Processes** facilitate decisions with respect to the most effective use of resources.	Partially		CG5	**Information Systems and System Processes** need improvement to facilitate decisions with respect to the most effective use of resources.
10.	**Infrastructure Strategy** enables most effective use of resources.	Partially		CG6	**Infrastructure Strategy** - Further work required to ensure Infrastructure Strategy enables most effective use of resources.
11.	**Systems Medicines Strategy** is an enabler to deliver financial savings.	Partially		CG7	**Systems Medicines Strategy** – Further work required to ensure Systems Medicines Strategy enables delivery of financial savings.
12.	**Infrastructure Innovations** enable delivery of financial savings.	Partially		CG8	**Infrastructure Innovations** – Further work required to ensure infrastructure innovations enable delivery of financial savings.
13.	**Service Resilience** is aligned to fragile services.	Partially		CG9	**Service Resilience** needs to be aligned to fragile services.
14.	Fulfilling **Operational Plan Requirements, NOF4 and National Standards** as set by NHSE.	Partially		CG10	**Operational Plan Requirements, NOF4 and National Standards** – Trajectories need to be put in place as not currently addressing Operational Plan requirements and complying with National Standards.
15.	**30% Running Cost Reduction –** Fulfilling the 30% reduction in running costs as set by NHSE.	Partially		CG11	**30% Running Cost Reduction** – Organisational Change Programme to be completed in order to enable the 30% reduction in running costs to be realised.

Current Assurances **(how do we know that the controls in place are working effectively?)**			**Current Assurance Gaps**	
1.	**Weekly Chief Finance Officer (CFO) meetings** take place in relation to system working arrangements. Issues for resolution are discussed and proposals agreed as appropriate.		AG1	**More closely aligned reporting to system financial plans** is needed.

Annex A

2.	**Fortnightly reporting to the Finance and Planning Board (FPB)**. Matters that cannot be resolved here are escalated to the System Recovery Board (SRB).	AG2	**Assurance needed that system level CIPs are being delivered** in provider financial plans.
3.	**NHS Devon Finance and Performance Committee (FPC)** receives system finance reports; these flag issues for escalation to the Board.	AG3	Monthly monitoring of full-time equivalents (FTEs) but **no assurance that system partners have workforce controls in place** or how well they are engaging with workforce controls.
4.	**Additional mandated support** is provided by NHS England (NHSE).	-	-

Mitigating Actions (what do we plan to do to address the control gaps / assurance gaps identified above?)	Action Owner	Planned Completion Date	Assurance Level	Update Since Last Review (only applicable where assurance level is 'partially assured / 'limited assurance')
CG1: Medium-Term Financial Plan to be updated to reflect latest known changes	Kirsty Denwood	End Q2 2024/25	Fully Assured	N/A
CG1: Progress **Shared Service Arrangements** *(Annual Plan Ref. 119)*	CFO	End Q4 2024/25	Fully Assured	N/A
CG1: Produce **Long Term Financial Plan** *(Annual Plan Ref. 122)*	CFO	End Q3 2024/25	Fully Assured	N/A
CG1: Efficiencies and Consistency in Business Processes *(Annual Plan Ref. 94)*	CPO	End Q4 2024/25	Fully Assured	N/A
CG1: Implement **One Devon Workforce Strategy** *(Annual Plan Ref. 95)*	CPO	End Q4 2024/25	Fully Assured	N/A
CG4: Resourcing of ICB PMO to be considered through Phase 2 of the organisational change programme	Sam Wadham-Sharpe	Start Q2 2024/25	TBC	
CG5: Strategic Client Function for Business Intelligence (BI) *(Annual Plan Ref. 105)*	CFO	Discharged Reactively Through 2024/25	Fully Assured	N/A
CG5: Support implementation of **Electronic Patient Records (EPRs)** – TSDFT and UHP *(Annual Plan Ref. 111)*	CFO	End Q3 2024/25	Fully Assured	N/A
CG5: Procure and implement **Peninsula Laboratory Information Management System (LIMS)** *(Annual Plan Ref. 112)*	CFO	End Q3 2024/25	Fully Assured	N/A

Annex A

CG5: Support implementation of **Devon and Cornwall Care Record (DCCR)** *(Annual Plan Ref. 113)*	CFO	End Q4 2024/25	Partially Assured	Electronic Treatment Escalation Plans (eTEP) is live with over 12,000 eTEPS in the DCCR. RDUH were due to connect to DCCR in Q3 but connection is delayed due to lack of Project Manager. Objective off track; no mitigations in place.
CG5: Rationalise **Data Centres** *(Annual Plan Ref. 114)*	CFO	End Q4 2024/25	Fully Assured	N/A
CG5: Cross System Procurement *(Annual Plan Ref. 123)*	CFO	End Q4 2024/25	Fully Assured	N/A
CG6: Estates – deliver collaboration between provider service departments *(Annual Plan Ref. 106)*	CFO	End Q4 2024/25	TBC	-
CG6: Implement **Estates Strategy** *(Annual Plan Ref. 107)*	CFO	-	TBC	NHSE have provided feedback in respect of NHS Devon's submission. Guidance to be released in the next 3 months.
CG7: Delivery of 16 National Medicines Optimisation Opportunities *(Annual Plan Ref. 80)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG7: Develop **Integrated Medicines Optimisation Committee (IMOC)** *(Annual Plan Ref. 84)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG8: Develop **Peninsula Aseptic Hub (PAH)** *(Annual Plan Ref. 81)*	CMO	End Q4 2024/25	Partially Assured	Peninsula Aseptics Hub Programme Board meeting has taken place. Awaiting feedback from NHSE – delay is outside of NHS Devon's control.
CG9: Develop **Peninsula Radiopharmacy Strategy (PRS)** *(Annual Plan Ref. 82)*	CMO	End Q4 2024/25	Partially Assured	Options appraisal templates updated. Consistency check meeting. Options appraisal meeting taken place. Peninsula Radiopharmacy Exec meeting taken place. Delayed due to the need to revise the options appraisal process.
CG9: Acute Services Transformation *(Annual Plan Ref. 91)*	CMO	End Q4 2024/25	Partially Assured	Maternity Services clinical workshops complete with high scenarios developed; moved to modelling. Clinical Reference Groups for detailed modelling of maternity, medical, surgical and paediatric scenarios set-up for October, November and December 2024. Draft case for change socialised with Health & Wellbeing Board. Engagement with staff, patients and the public slowed down to align with national engagement on the Darzi report and 10-year plan. Deep dive undertaken for 3 specialties.

Annex A

CG10: Develop **Community Pharmacy** *(Annual Plan Ref. 85)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG10: Improving management and productivity of **System Workforce Resources** *(Annual Plan Ref. 93)* *NB: Moved from BAF Risk 4 (People)*	CPO	End Q4 2024/25	Partially Assured	All supporting workstreams are on track, however, there is an overspend on the Operating Plan so further engagement and check and challenge is required to increase assurance and grip and control.
CG11: 30% Running Cost Reduction *(Annual Plan Ref. 96 & 121)*	CPO	End Q4 2024/25	Fully Assured	N/A
AG1: Closer Aligned Reporting to System Financial Plans	Kirsty Denwood	Start Q3 2024/25	TBC	
AG2: Assurance on Delivery of System Level CIPs Reporting of progress of CIP workstreams to FPB to provide assurance that system CIPs are being identified and delivered in accordance with submitted provider annual financial plans	Sam Wadham-Sharpe	On-going Through 2024/25	TBC	
AG3: Workforce Controls Assurance required from system partners that workforce controls are in place and are working effectively.	CPO	Ongoing 2024/25	TBC	

Annex A

NHS Oversight Framework Theme	Chief Officer	Assigned Board Committee	Review Date
4. People	Piers Tetley – Chief People Officer	People and Organisational Development Committee Finance and Performance Committee	October 2024

Principal Risk

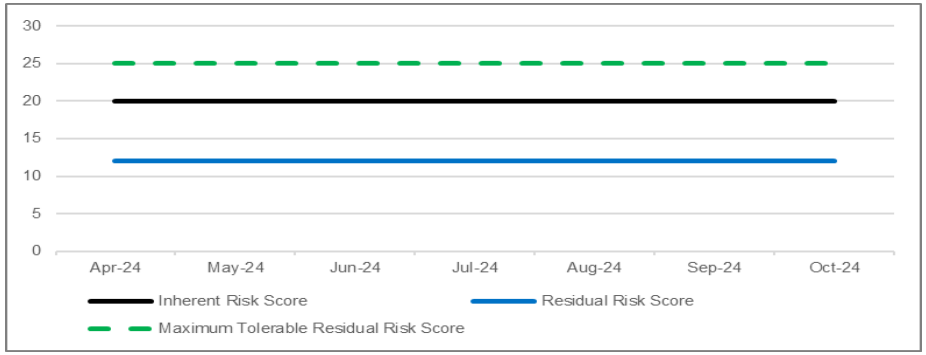
IF NHS Devon does not work with system partners to ensure an appropriate NHS workforce, **THEN** we will not be appropriately resourced to deliver safe and effective services, **RESULTING IN** patients across the One Devon Integrated Care System not receiving the services that they need.

Risk Appetite	SEEK	Risk Tolerance	20 - 25

Risk Scoring	Likelihood	Impact	Total	Movement
Inherent Risk Score	5	4	20	-
Current Residual Risk Score	3	4	12	↔

Rationale for Amendment to Residual Risk Score:

N/A



	Current Key Controls (what do we have, or what should we have in place to mitigate the risk?)	In Place?		Current Key Control Gaps
1.	**Workforce Recovery Programme** - Robust and deliverable workforce recovery programme approved and in place. Workforce controls (including those covering temporary and agency staff, rostering for clinical staff) are part of this.	Fully		
2.	**System Workforce Strategy** designed, approved and in place.	Fully		
3.	**5 Year Workforce Numerical Plan** outlining the size and skill mix of the NHS provider workforce required to meet population demand.	Partially	CG2	**5 Year Workforce Numerical Plan** not yet agreed by System Partners.
4.	**Workforce Programmes** in place to support wider service transformation. These focus on specific services	Fully		

Annex A

	/ areas of greatest concern e.g. Urgent & Emergency Care (UEC) improvement and Peninsula Acute Sustainability Programme (PASP) etc.				
5.	**NHS Devon's Ability to Lead System Partners** – NHS Devon has the required workforce and skill sets in place to lead the work of system partners in ensuring an appropriate NHS workforce to deliver safe and effective services across Devon.	Partially		CG3	**NHS Devon's ability to lead system partners** – Phase 2 of the NHS Devon organisational change process yet to be completed.
6.	**NHS Roles and Careers** are shaped to reflect the future needs and priorities in the NHS Long Term Plan (LTP).	Partially		CG4	**NHS Roles and Careers** need to be shaped to reflect LTP requirements e.g. providing placements and apprenticeship opportunities in order to expand the clinical workforce, providing education and training opportunities, improving staff retention and attendance etc.

Current Assurances **(how do we know that the controls in place are working effectively?)**			**Current Assurance Gaps**	
1.	**Governance Architecture** – Appropriate governance architecture in place to manage delivery of this workstream.		AG1	**Governance Architecture** – first meeting of People and Organisational Development Committee yet to take place (scheduled 26 September 2024)
2.	**System Workforce Dashboard** in place and monitored on a monthly basis. The dashboard includes data relating to staff turnover, staff sickness absence rates etc.			
3.	**Workforce Delivery Group (WDG)** in place, with membership comprising of Chief People Officers (CPOs) and Chief Finance Officers (CFO) from across the Devon system. Considers matters such as plans for efficient use of workforce (e.g. job planning, staff rostering etc.) and work programmes in support of system transformation (e.g. UEC improvements and PASP), reporting to SRB on the latter.			
4.	**National People Plan** – A People Plan specifically for the Devon system has been established.		AG2	**National People Plan for Devon** – System People Board to be established. Proposed to form part of the ToR of the People and Organisational Development Committee.

Mitigating Actions **(what do we plan to do to address the control gaps / assurance gaps identified above?)**	**Action Owner**	**Planned Completion Date**	**Assurance Level**	**Update Since Last Review** **(only applicable where assurance level is 'partially assured / 'limited assurance')**
CG2: 5 Year Workforce Numerical Plan – Skill mix reviews to be complete to inform development of the programme	Mark Sowden	End Q2 2024/25	Partially Assured	Planned completion date has been extended to end of Q3 (December 2024) to enable a One Devon skill mix methodology to be developed. This deliverable now aligned to and overseen by Workforce Transformation FRP workstream to ensure provider engagement in design and delivery of plans. Work on System Workforce Case for Change in progress and will be

Annex A

				launched at same time as skills mix methodology and supporting workforce optimisation suite for maximum benefit.
CG3: NHS Devon's ability to lead system partners – Phase 2 of the NHS Devon organisational change process to be completed	Steve Moore	End Q4 2024/25	Fully Assured	N/A
CG4: Staff Retention and Attendance *(Annual Plan Ref. 98)*	CPO	End Q4 2024/25	Fully Assured	N/A
CG4: Sufficient **Clinical Placements and Apprenticeship Pathways** *(Annual Plan Ref. 99)*	CPO	TBC	Fully Assured	N/A
CG4: Increase **Advanced Practice Posts** *(Annual Plan Ref. 100)*	CPO	End Q4 2024/25	Fully Assured	N/A
CG4: Increase **Placement Capacity** *(Annual Plan Ref. 101)*	CPO	End Q4 2024/25	Partially Assured	Off track as a result of external factors outside of NHS Devon's control. Position is recoverable; mitigating actions are in place.
AG1: Governance Architecture – NHS Devon People and Organisational Development Committee to be established.	Philippa Harding	End Q2 2024/25	Partially Assured	
AG2: National People Plan for Devon – System People Board to be established to oversee the People Plan for Devon	CPO	End Q3 2024/25	Partially Assured	

Annex A

NHS Oversight Framework Theme	Chief Officer	Assigned Board Committee	Review Date
5. Leadership and Capability	Philippa Harding, Interim Chief Communications & Corporate Affairs Officer	NHS Devon Executive	October 2024

Principal Risk

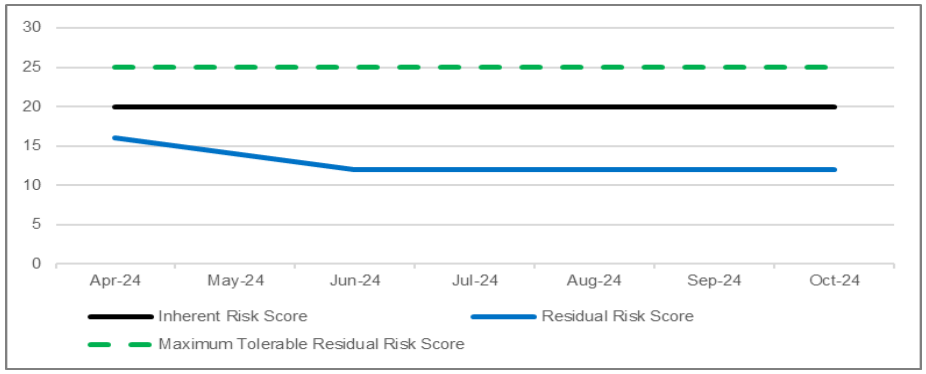
IF NHS Devon does not sufficiently develop its own leadership capability and that within system partners (particularly clinical leadership), **THEN** we will fail to deliver transformational change in relation to service delivery, **RESULTING IN** patients across the One Devon Integrated Care System not receiving the services that they need.

Risk Appetite	SEEK	Risk Tolerance	20 - 25

Risk Scoring	Likelihood	Impact	Total	Movement
Inherent Risk Score	4	5	20	-
Current Residual Risk Score	3	4	12	↔

Rationale for Amendment to Residual Risk Score:

N/A



	Current Key Controls (what do we have, or what should we have in place to mitigate the risk?)	In Place?
1.	**Clear Leadership Structure within NHS Devon** with a coherent vision for the organisation.	Partially
2.	**NHS Devon Leadership to System Partners** – There is a clear vision for how NHS Devon will provide leadership to its system partners.	Partially
3.	**NHS Devon's Ability to Lead System Partners** – NHS Devon has the required workforce and skill sets in place to lead the work of system partners in	Partially

	Current Key Control Gaps
CG1	**NHS Devon Organisational Change Programme** – Phase 1 of the Organisational Change Programme has now been completed. However, there are a number of interim arrangements in place for Chief Officer roles and a number of vacancies amongst key Senior Leadership Team (SLT) roles. Phase 2 of the Organisational Change Programme is due to complete by the end of the 2024 calendar year.
CG2	**Compact and Articulation of Shared Vision for the System** – a Compact needs to be developed and agreed to provide formal articulation of the shared vision of system partners and an explicit set of reciprocal behaviours to deliver this.
CG3	**NHS Devon's ability to lead System partners** – Phase 2 of the NHS Devon organisational change process yet to be completed.

Annex A

	ensuring an appropriate NHS workforce to deliver safe and effective services across Devon.				
4.	**Annual Plan for 2024/25** developed and approved by the NHS Devon Board. This is an enabling function that will ensure the delivery of NHS Devon priorities. *(Annual Plan Ref. 102)*	Fully			
5.	**ICB Governance Improvement Plan** in place and approved, ensuring governance structures are robust, up-to-date, and responsive to evolving organisational needs. *(Annual Plan Ref. 125)*	Fully			
6.	**System Planning, Delivery and Assurance Structures** for the 2024/25 governance approach within the ICB now implemented. *(Annual Plan Ref. 126)*	Fully			
7.	**NHS Devon Programme of Organisational Development Activities** – There is a clear programme of organisational development activities in place for NHS Devon.	Fully			
8.	**System Programme of Organisational Development Activities** – There is a clear programme of organisational development activities for the system.	Partially		CG5	**System Organisation Development Action Plan** – This needs to be developed for the system and signed off via the appropriate governance routes.
9.	**Patient and Public Engagement insights** inform the work of NHS Devon and its Board.	Partially		CG6	**Patient and Public Engagement insights** work programme to be confirmed
10.	**Equality, Diversity and Inclusion** considerations are embedded throughout the work of NHS Devon.	Partially		CG7	**Equality, Diversity and Inclusion** priorities to be identified, agreed and embedded.
11	**Clinical and Professional Leadership Framework** in place and operating effectively.	Partially		CG8	**One Devon Clinical and Care Professional Leadership Framework** to be developed
12	**Annual Planning approach for 2025/26 and beyond** to be agreed and implemented.	Partially		CG9	**Rolling Annual Planning** cycle to be developed and supported by System Delivery Governance PMO approach.

Current Assurances **(how do we know that the controls in place are working effectively?)**			**Current Assurance Gaps**	
1.	**NHS Devon Organisation Change Oversight Group** provides assurance on the organisational change process from a technical and procedural perspective and also touches on the wider determinants.			
2.	**NHS Devon Governance Structure** – Clear governance structure in place to provide robust assurance on the measures being taken to improve and develop leadership capability in NHS Devon.			

Annex A

3.	**System Planning and Delivery Assurance Structures** are clear and in place to ensure oversight of key risks and issues.			
4.	**NHS Oversight Framework (NOF)** – Ongoing work with NHSE regional colleagues to ensure that NHS Devon has the appropriate senior capacity and capability to deliver the priorities set out in NHS planning guidance, the overall aims of the NHS Long Term Plan (LTP), and the NHS People Plan, as well as the shared local ambitions and priorities of the One Devon Integrated Care System.			

Mitigating Actions (what do we plan to do to address the control gaps / assurance gaps identified above?)	Action Owner	Planned Completion Date	Assurance Level	Update Since Last Review (only applicable where assurance level is 'partially assured / 'limited assurance')
CG1: Organisation Change Programme and developing the workforce *(Annual Plan Ref. 97)*	Steve Moore	End Q4 2024/25	Fully Assured	N/A
CG2: Create a **Compact and Articulation of Shared Vision for the System** *(Annual Plan Ref. 127)*	CCCAO	End Q2 2024/25	Fully Assured	N/A
CG5: Development of **System Organisation Development Action Plan** *(Annual Plan Ref. 128)*	Katy Kerley	End Q3 2024/25	Fully Assured	N/A
CG6: Establishment of **One Devon Involvement Platform** *(Annual Plan Ref. 129)*	Nicola Bonas	End Q4 2024/25	Fully Assured	N/A
CG6: Integrate Healthwatch into NHS Devon ICB Governance *(Annual Plan Ref. 130)*	Nicola Bonas	End Q3 2024/25	Fully Assured	N/A
CG7: Agree on **Shared Equality, Diversity and Inclusion (EDI) Priorities** *(Annual Plan Ref. 131 & 132)*	CCCAO	End Q3 2024/25	Partially Assured	People and Organisational Development Committee meeting due to take place 26 September 2024 was stood down. Discussion now due to take place at the next meeting of the Committee on 07 November 2024. EDI Working Group to be established in November 2024, following the aforementioned Committee meeting. Annual Plan Objective Ref. 132 is complete. EDI actions incorporated into the Governance Improvement Plan Workplan.
CG8: Development of **One Devon Clinical and Care Professional Leadership Framework** *(Annual Plan Ref. 89)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG9: Development of **Rolling Annual Planning Cycle** *(Annual Plan Ref. 103)*	DCEO	Q4 2024/25 ('Process Live')	Fully Assured	N/A
CG9: Development of **System Delivery Governance PMO Approach** *(Annual Plan Ref. 104)*	DCEO	End Q4 2024/25	Fully Assured	N/A

Annex B

Assessing and Scoring Risks:

Current risks are scored using a combined assessment of both the likelihood and impact of the risk materialising, as summarised in the matrix below. Further information on the definition of the likelihood and impact categories can be found in NHS Devon's Risk Management Policy.

The inherent risk score is the rating assigned to a risk before any mitigations / controls are applied; the current risk score is the rating assigned to a risk that takes account of the mitigations / controls applied to it.

Risk Scoring Approach = Impact / Consequence x Likelihood (I x L)						
		Likelihood				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Impact / Consequence	5 Catastrophic	**5**	**10**	**15**	**20**	**25**
	4 Major	**4**	**8**	**12**	**16**	**20**
	3 Moderate	**3**	**6**	**9**	**12**	**15**
	2 Minor	**2**	**4**	**6**	**8**	**10**
	1 Negligible	**1**	**2**	**3**	**4**	**5**

For grading risk, the scores obtained from the risk matrix are assigned as follows:

Colour	Risk Score Range	Risk Grading
	1 to 6	Low Risk
	8 to 10	Moderate Risk
	12	High Risk
	15 to 25	Extreme Risk

BAF Controls and Mitigating Action Status - Colour Keys:

Annex B

Control - In Place?
Not in Place *(No Control)*
Partially *(Control in Place BUT Concerns Over Effectiveness of Control)*
Fully *(Control In Place)*

Assurance Levels	
Not Assured	▪ **A significant delay in schedule** ▪ **Metrics are falling below acceptable thresholds**
Partially Assured	▪ **Some delay in schedule** ▪ **Metrics that are borderline or trending negatively**
Fully Assured	▪ **Project is on schedule** ▪ **Metrics that meet or exceed expectations**

Risk Appetite:

Risk appetite is defined as “the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic aims and objectives” and is key to achieving effective risk management.

Good Governance Institutes Framework Definitions:

Risk Appetite	Risk Appetite Level Description
Avoid	The avoidance and uncertainty is a key organisational objective
Minimal	(ALARP - As Little As Reasonably Possible) - The preference for ultra-safe delivery options that have a low degree of inherent risk and only for a limited reward potential
Cautious	The preference for safe delivery options that have a low degree of inherent risk and may only have a limited potential for reward
Open	Willing to consider all potential delivery options and chose while also providing an acceptable level of reward and Value for Money (VfM)
Seek	Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk
Mature	Confident in setting higher levels of risk appetite because controls, forward scanning and responsiveness systems are robust

NHS Devon’s Risk Appetite Statement (Board Approved: 26 March 2024):

Annex B

NHS Devon's Risk Appetite Statement documents the delegation of risk taking from the Board to senior management. It specifies the overall risk levels that the Board is willing to accept whilst operating in full compliance with regulatory and legal requirements:

NHS Oversight Framework Theme	Risk Appetite	Tolerance Level for Residual Risk
Quality of Care, Access and Outcomes	AVOID	8 to 12
Preventing Ill-health and Reducing Inequalities	AVOID	8 to 12
Finance and Use of Resources	OPEN	15
People	SEEK	20 to 25
Leadership and Capability	SEEK	20 to 25
Local Strategic Priorities	OPEN	15

NHS
Cornwall and
Isles of Scilly

Paper number ICB2425/132

Board meeting of the Integrated Care Board (ICB)

Agenda item: ICB chief executive update

Date of meeting: 14 November 2024
Meeting section: Public session (part 1)
For: Assurance
Author: Kate Shields, chief executive

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1. Executive summary

The chief executive's update is a regular feature of each board meeting. The report focuses on highlighting emerging issues and significant developments that are not otherwise covered on the board agenda. It helps ensure members are aware of key areas of work happening within the Cornwall and Isles of Scilly integrated care system (ICS). A verbal update on other key areas may also be given.

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2. Recommendations

The ICB Board is asked to receive the updates and enquire further, as necessary.

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3. Main report

3.1 NHS 10-year plan engagement

The Department for Health and Social Care and NHS England have started an engagement exercise that will help shape the government's 10 Year Health Plan, which runs from October 2024 - March 2025. This is described as 'the biggest national conversation about the future of the NHS since its birth', as set out in '*Change NHS: help build a health service fit for the future'*.

The NHS 10 plan will be underlined by three big shifts in healthcare:

- hospital to community
- analogue to digital
- sickness to prevention.

Members of the public, as well as NHS staff and experts are being invited to share their experiences, views and ideas using online Change NHS national engagement platform and available via the NHS App.

NHS Cornwall and Isles of Scilly Integrated Care Board
Call us on 01726 627 800
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Bodmin, PL31 2FR
Chair: John Govett
Chief executive officer: Kate Shields

There are 3 phases, with the aim of having the 10-year plan published by Spring 2025:

- Phase 1 - Asking for experiences and challenges
- Phase 2 - Looking at the priorities
- Phase 3 – Asking about the shared objectives for the plan

Over the coming months, Integrated Care Boards have been asked to help codesign this plan by sharing views and experiences from staff, stakeholders and people and communities. The government is committed to providing transparency to the policy making process and targeting those whose voices often go unheard. Integrated Care Boards will utilise their local community networks making sure everyone has an opportunity to feed into the process.

The Cornwall and Isles of Scilly approach for the 10 year plan engagement approach

We are planning to implement a three-stage process to support engagement:

1. Encourage staff, stakeholders, networks, people and communities to share their views and experiences via the Change the NHS online portal.
2. Using the 'workshop in a box' toolkit we will hold local engagement events with groups of staff, people, communities and stakeholders.
3. Provide an ICB response to the engagement and share existing insights we have gathered across the Cornwall and Isles of Scilly system as part of past work to inform our Integrated Care Partnership Strategy and Five Year Joint Forward Plan.

Working across the Integrated Care System we will:

- Ensure as many people and stakeholders as possible, across Cornwall and Isles of Scilly, take part in the NHS 10 year online survey and engagement opportunities
- Make extra effort to involve and engage our Core20PLUS5 adult and young people audiences working with our trusted partners and stakeholders
- Encourage sign-up for continuous engagement in Cornwall and Isles of Scilly, to increase public involvement now and in the future
- Work as part of a team of teams with our regional and national ICS comms and engagement teams, especially with our regional and NHS Devon ICB.

We will use our engagement framework to ensure representation from across Cornwall and Isles of Scilly with a consistent engagement approach for populations on county boundaries, key partners to collaborate with are:

- Healthwatch Cornwall and Healthwatch Isles of Scilly, Healthwatch Devon, Plymouth and Torbay
- Healthwatch **Partnerships Boards**
- The voluntary, charity and social enterprise (VCSE) sector including their **Thematic alliances**
- Cornwall's **community area partnerships**
- People and communities engagement network which includes communications and engagement colleagues from across ICS, neighbouring ICBs and NHS providers
- ICS wide staff and staff networks

3.2 Action to strengthen patient safety

Patient safety across health and social care is set to be bolstered as the Government works to improve the effectiveness and efficiency of key patient safety organisations. This came as a major review of the CQC's operational effectiveness was published in full. The report, led by Dr Penny Dash, Chair of the North West London Integrated Care Board, identified significant internal failings at the regulator, hampering its ability to identify poor performance at hospitals, care homes and GP practices. Its interim conclusions, published in July, prompted the Health and Social Care Secretary to order immediate action to restore public confidence in the effectiveness of health and social care regulation.

The report provides seven specific recommendations for improvement. This includes recommending that the CQC formally pauses the implementation of its assessments of Integrated Care Systems as it works to restore public confidence in health and care regulation. This will allow the CQC to focus on getting the basics right when assessing the organisations it regulates. This has been agreed, with the pause in place for a six-month period.

The Health and Social Care Secretary has asked Dr Dash to conduct two further reviews moving her focus from operational effectiveness to patient safety and quality. The first review will examine the roles and remits of six key organisations and make recommendations on whether patient safety could be bolstered through a different approach. These are:

- Care Quality Commission (CQC) including the maternity programme (MNSI)
- National Guardian's Office (NGO)
- Healthwatch England (HWE) and the Local Healthwatch (LHW) network.
- Health Services Safety Investigation Body
- Patient Safety Commissioner
- NHS Resolution (quality and safety functions only)

A further review will focus on quality and its governance. This will guide the Government's next steps as it continues its drive for positive cultural change across health and social care. All findings will also inform the Government's 10-Year Health Plan to transform the NHS and social care and make them fit for the future.

3.3 Publication of the Care Quality Commission's State of Care Report

In October, the Care Quality Commission (CQC) published its State of Care report. This is its annual assessment of health and social care in England. The report looks at trends, shares examples of good and outstanding care and highlights where care needs to improve.

This year's report describes issues with access to and quality of care and the impact on people who use health and care services – with particular focus on the many children and young people who are not getting the care they need when they need it.

Other areas of national focus are as follows:

a) Primary care

The report highlights that more people are struggling to get appointments to see a GP, and the number of people registered with a GP has increased. Pressures from demand and capacity on NHS primary dental services contribute to problems in access to care and deterioration in people's oral health. Schoolchildren living in the most deprived areas of England were more than twice as likely to experience tooth decay than those living in the least deprived areas. These are areas being addressed locally by our primary care strategy on the Board's agenda today.

b) Adult Social Care

The CQC continue to see a supply of social care not always keeping pace with need, including impacting on people whose discharge from hospital is delayed. Locally, discharge arrangements remain under significant scrutiny across health and care with a recognised need for improvements in this area, and action plans in place to deliver this at pace.

c) Mental Health

The demand for mental health services, for adults and more increasingly for children, continues to grow. Access to these services continues to be a challenge for many people. Those who live in deprived areas, women and people from 'other' ethnic minority groups are more likely to attend urgent and emergency care departments. The CQC found evidence of people experiencing significant delays for treatment in the community. The mental health workforce has grown, but problems with staffing and skill mix remain.

Locally, mental health commissioning intentions respond to these issues in the context of local priorities, with alternatives to ED for those in crisis being worked up, and new service models that will improve the timeliness of access to services.

Nationally, the safety of mental health wards continues to be a concern in some areas. Lack of resources, ageing estates and poorly designed facilities can lead to issues around privacy and dignity for patients, as well as compromising the safety of both patients and staff. Our estates strategy sets out priorities for improvement, with work being prioritised locally in respect of fire safety issues at Bodmin Community Hospital.

d) Secondary Care

The CQC report highlights the high demand for services and ongoing pressure nationally that means many people, including children, are struggling to get the care they need leading to a deterioration in people's health conditions, which then need more intensive support and treatment, and results in longer stays in hospital. They raise concern that long waits for diagnostic tests and treatment are becoming normalised. Locally our commissioning intentions set out significant channel shift which will support our acute services in improving the timeliness of care. Performance improvement trajectories will also be an important part of our operating plan – in year and next year.

e) Deprivation of Liberty Safeguards (DoLS)

The CQC report that nationally people are waiting too long for Deprivation of Liberty Safeguards (DoLS) authorisation, despite the efforts by local authorities to reduce backlogs and ensure sustainable improvements.

The ICB are aware of the delays being experienced and to ensure all persons who are ICB funded in nursing homes settings are having their Mental Capacity Act (MCA) statutory rights upheld, the MCA team are:

- visiting the homes to confirm that they have completed their initial DoLs application to the council and have the obligatory 12 monthly reviewed capacity assessment for residency and care provision and consequent Best Interest Outcome.
- If the homes have not completed any aspect of this process the MCA team are providing support and training to each home and in some cases completing the assessments as a benchmark for consequent reviews.
- In the process of setting up a quality assurance meeting (via the MCA Professional Lead) with all systems to gain further understanding and implementing inter agency support for each system and the challenges they are facing within the MCA arena.

The ICB and Adult Social Care teams work very well with all the joint funded persons who require a welfare application to the Court of Protection.

f) Integrated Care Systems

The CQC conclude that nationally finance, joint forward planning and workforce depletion are some of the main challenges for integrated care boards while people struggle to access care, with particular system challenges around urgent and emergency care. They note the importance of ICBs understanding their population, but variability in capability to address local health inequalities.

Nationally they also describe challenges and barriers around data and analysis skills, governance and accountability, and capacity and capability in the system.

Locally, the ICB redesign has addressed capacity and capability issues, with some appointments in response to this still taking place, for example to build system capacity and capabilities in BI. ICB governance was reviewed in September, and system workforce planning continues to develop. **Board members are asked to comment as to whether they feel sufficiently assured on the work being undertaken to address health inequalities.**

The CQC also notes the vital role played by carers and the importance of work needed to identify carers, promote carers' entitlement to an assessment and services to support them in their role. The CQC notes that local authorities have taken steps to address inequalities and understand the demographics of local populations, but there is a need for better engagement with the voluntary sector and community groups.

g) Areas of Specific Concern, including Children and Young People

Areas of specific national concern highlighted in this year's CQC report involve issues around safety, quality, workforce, and inequalities, including:

- Too many women still not receiving the quality of maternity care they deserve.
- Concerns that children and young people are not always able to access services in a timely way.
- A decline in the number of health visitors by 45% over the last 9 years.
- Only around a quarter of people with a learning disability recorded on the disability register.
- Waiting times to start an assessment for an autism diagnosis
- People in Black or Black British ethnic groups over 3 and a half times more likely to be detained under the Mental Health Act than people in white ethnic groups.

It is suggested that we benchmark ourselves against these areas in our next Integrated Performance Report where not already included, initially as a one-off, and understand areas where further scrutiny may be required. I would also like to suggest that we have a Board focus on children over the next few months, recognising their particular and specific needs, and the importance of this not being overshadowed by some of the challenges we face in other services. This will include a Board Deep Dive on neurodiversity. In the meantime, I am providing more information on local services for children, given the priority placed on this in the national CQC report, as set out below:

Maternity
Royal Cornwall Hospitals Trust has worked closely with the ICB and the Local Maternity and Neonatal System Board to ensure that women's voice is heard in the development of quality care. Our equity and equality strategy has been developed with our Maternity and Neonatal Voices Partnership who have been working with a wide range of community groups to change the way we deliver perinatal parenting support to reach all our communities – the principles within "Kernow Parenting Journey" have been adopted by all advice and education providers within our area, including our maternity teams. We recognise we still have work to do to meet the needs of some of our most vulnerable women and are looking to expand the development of our Women's hubs to work with a wider group of services.

Mental Health
The significant rise in the prevalence of mental health difficulties for children is a core focus within COIS. As well as increasing funding to our specialist mental health and crisis teams, we have secured a joint approach to crisis with the local authority to ensure we can address wider concerns within the family and circumstances of the young people. We have also funded our VCSE and independent sector partners to develop digital responses and open access drop

in provision in a wide variety of settings, including targeting our neighbourhoods of deprivation and vulnerable cohorts such as our LGBT community. Our services continue to be challenged by demand but are finding collaborative and innovative ways to support children and young people, such as implementing evidence based single therapy sessions and working more collaboratively together to ensure young people get the best response for them.

Elective Care
We closely monitor our elective care waits to ensure under 18-year-olds are prioritised and have been working alongside our southwest clinical network to review how we better risk assess those waiting to consider developmental impact of waiting in childhood.

Child Development
Our largest challenge relates to our services for children with child developmental needs and conditions, such as speech and language, Autism and ADHD. Increase in service demand and capacity to meet this increase poses significant resource challenges. We have developed a wide range of tools to support these children whilst they wait for appointments and diagnosis, including training staff in schools and community, developing a website resource for parents and staff to support the ability to understand need, provide support and adjust to meet need.

Finally, the Integrated Care Partnership Board was delighted to hear at its recent meeting that the Inspecting Local Authority Children's Services (ILACS) short inspection undertaken in July 2024 achieved the following grades:

Judgement	**Grade**
The impact of leaders on social work practice with children and families	Good
The experiences and progress of children who need help and protection	Good
The experience and progress of children in care	Good
The experience and progress of care leavers	Outstanding
Overall effectiveness	Good

Inspectors highlighted a number of strengths across a wide range of services, including recognising the enormous progress made in collaborating more creatively, and working together more effectively across children's social care, education and children's community health.

Inspectors identified 4 areas that needed to improve, which are being addressed through the ILACS action plan:

- The timeliness of child protection strategy meetings
- The effectiveness of pre-proceedings work, particularly for children living in long-term neglectful situations, so that children come into care at the right time
- The quality of Public Law Outline letters
- The day-to-day monitoring of arrangements for children living in unregistered children's home

3.4 Council's White Paper progress through Government

Cornwall Council leaders, together with Cornwall's MPs have called for a devolution deal that will help 'unleash' Cornwall's potential.

As presented to a previous Board meeting, the Cornwall White Paper sets out proposals which include Cornwall forming part of the membership of the Government's Council of Nations and Regions. This request was amplified in a letter from Cornwall Council's Group leaders to the Prime Minister in July.

Last month, Ben Maguire MP, spoke in Prime Ministers Questions to call for a Cornish Assembly to recognise the county's unique culture and language. This followed Perran Moon MP's appeal in his maiden speech last month, advocating for Cornwall to have a devolution arrangement akin to Wales.

In response the Prime Minister has agreed to meet with all six Cornish MPs to discuss devolution, including a Cornish assembly. His response also noted the devolution agreement for Devon and Torbay and encouraged local authorities to work with their neighbours to pursue wider and deeper devolution for their area.

The Council are also awaiting the upcoming English Devolution White Paper which will set out more detail on the government's devolution plans.

3.5 Parliamentary Award

I am very proud to report that the ground-breaking work of health, care and community services in Cornwall and the Isles of Scilly have been recognised with a win at the national NHS Parliamentary Awards. The national awards are organised by NHS England, with nominations invited from all English MPs.

The ceremony in London highlighted the collaborative approach across the local integrated care system, which sees NHS and social care teams work with community and voluntary partners, at scale, to support residents to stay independent in their own homes by providing support that avoids hospital admission or enables earlier discharge.

Full press release at Appendix A.

3.6 Performance

The Urgent and Emergency Care system has remained challenged particularly over the past couple of weeks with the Acute Trust reporting OPEL 4 for a sustained period leading to increased ambulance waits and high numbers of patients within the Emergency Department. Our local system is under considerable national scrutiny, given its outlier status.

A number of actions were taken to support the system on the back of a system dynamic risk assessment meeting. This had a focus on reducing ambulance response times, ambulance handover delays and generating a clinically led dynamic risk review to support the use of alternative (to acute care) capacity in the system and flow through our hospitals where this is in the best interests of individuals and the wider cohort of patients experiencing delays.

They included:

- Enhanced support for clinicians regarding level of risk, and system pressures to support clinical decision making.

- Single Point of Access enhanced offer with standing up of senior clinical support (acute GP) to be put in place immediately, ahead of planned go-live of 11 November 2024.

- All ED and Assessment area patients awaiting admission to have had consultant level review for community alternatives, including clarification that each patient requires bedded care in an acute hospital.

- RCHT deputy medical director linked with the clinical lead for virtual ward (VW) to ensure expediting the VW process and utilisation of a briefing to be produced for all clinicians outlining the services available with capacity for out of hospital services.

- Adult Social Care Brokerage team to focus solely on flow to support pull out of hospital.

- Mobilisation of the home together approach to be coordinated through the Integrated Transfer of Care Hub (ITOCH) and Heads of Flow. This will provide oversight of referrals across Steps, Chaos, Home First and Humans to coordinate at pace.

- RCHT to drive the 'SHOP' model, using risk assessment to discharge lower risk patient safety using community services available.

- Integrated Urgent Care Service (IUCS) to support in reach into ED with staff sent to the ED department to pull out patients who are suitable for community hospital avoidance pathways.

- ICB chief medical officer and community nursing teams on site at RCHT front door from 29th October to support pulling patients into the community and promoting learning.

- A refresh and launch of the system communications to staff and public.

- A review of purchasing vacant care home capacity at pace.

- Reviewing the procurement of additional P1 capacity at ICB level.

These actions are tracked through the SCC daily processes with 'Impact on a page for data' to understand the benefits/obstacles, and via daily System oversight, daily system tactical, clinical executive twice weekly calls and weekly system executive calls.

An end-to-end pathway review meeting took place with ICB and system partners on 22 October where a 'discharge charter' was agreed; these included recommendations around staff training, use of discharge co-ordinators, and challenging whether individuals require bedded care or could be discharged to 'home

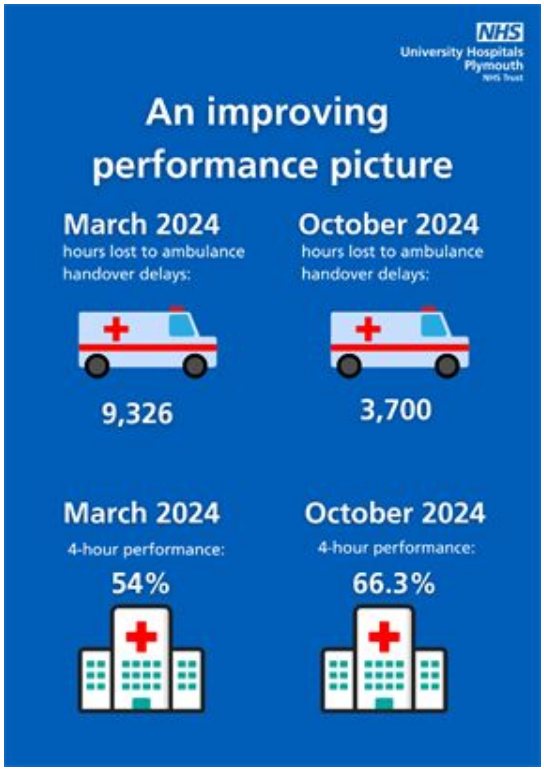
first pathways. A number of actions are now underway with RCHT, CFT and Adult Social Care that will support a system-wide discharge event in week of 25th November.

The whole system remains focused on delivering improvements on behalf of the communities we serve, and an update on progress will be provided at the Board meeting.

3.7 Urgent and Emergency Care at University Hospitals Plymouth

Earlier this month, the Care Quality Commission published a report following their inspection of Urgent and Emergency Care (UEC), Same Day Emergency Care and the Discharge Lounge, over 2 days in March 2024. At the time, the CQC arrived during a Critical Incident and saw the reality of a crowded busy Emergency Department with significant numbers of ambulances waiting, speaking to both staff and patients. The CQC subsequently served UHP with a Warning Notice under section 29A of the Health and Social Care Act 2008 with improvements to be made in streaming patients away from ED to other pathways more rapidly by 21 July. It is important to add that the CQC gave feedback at the time about the improvement in culture at the Trust and, as in previous inspections, were exceptionally complementary about the care and compassion patients received. The Warning Notice has now expired, and the CQC rated UHP 'Requires Improvement' for Urgent and Emergency Care.

The Board has been kept abreast of the clinically-led improvements being driven with a forensic focus by UHP, and the channel shift they are effecting. including creating new pathways away from the Emergency Department, investing in more Same Day Emergency Care and working with our partners on community initiatives. This has resulted in the following improvements



The Trust recognises that there are further improvements required, as set out and being taken forward through their One Plan. I would like to put on record my recognition of the improvements made on behalf of our local patients. I know only too well the relentless work required to make and sustain such improvements. We have taken a number of opportunities to share their learning and see how it can be applied more widely across Cornwall.

APPENDIX A

Cornwall and Isles of Scilly take gold for ‘Excellence in Healthcare’ at the NHS Parliamentary Awards

The ground-breaking work of health, care and community services in Cornwall and the Isles of Scilly have been recognised with a win at the national NHS Parliamentary Awards.

The ceremony in London highlighted the collaborative approach across the local integrated care system, which sees NHS and social care teams work with community and voluntary partners, at scale, to support residents.

Nominees were able to show “individuals or teams who go above and beyond to improve outcomes and experiences for patients living with and beyond these major health conditions or work to prevent them.”

The national awards are organised by NHS England, with nominations invited from all English MPs.

John Govett, Chair of NHS Cornwall and Isles of Scilly Integrated Care Board said: “I am incredibly proud of our collaborative work here in Cornwall and the Isles of Scilly and delighted that it is receiving the national recognition it so richly deserves. We will continue working together as one system to increase our support for people to have the care they need in the comfort and safety of their own homes.”

Kate Shields, Chief Executive Officer, NHS Cornwall and Isles of Scilly Integrated Care Board said: “I am absolutely delighted and proud of our win in the 'Excellence in Healthcare’ Parliamentary Award which celebrates the collaborative approach between NHS, social care teams, community and voluntary partners and provides well deserved recognition for the amazing teams who put local people’s needs at the heart of the services they deliver every day.

“We are committed to making personalised care the universal model for how we provide health and care services across Cornwall and the Isles of Scilly, and I look forward to seeing this award-winning approach flourish across our work in the future.”

Among the partners involved in this work are disAbility Cornwall and Isles of Scilly, Home First, Age UK Cornwall, Volunteer Cornwall, CHAOS Group, Pentreath and Humans Cornwall, Short Term Enablement and Planning Services (STEPS), Cornwall Voluntary Sector Forum (CVSF) and NHS Cornwall and Isles of Scilly Integrated Care Board.

Together they are helping people to stay independent in their own homes by providing support that avoids hospital admission or enables earlier discharge. This includes:

- the Community Gateway helpline; which took 48,000 calls and provided 7,000 personal support plans over 1 year, and is open 365 days a year

- the network of more than 50 community hubs; which has supported roughly 1 in 4 people in Cornwall
- Penhallow ‘Home from Home’; which offers step down care for people leaving hospital
- The Home Together Reablement Collaborative; which supports 56 people a week to leave hospital

Ian Jones MBE, Chief Executive, Volunteer Cornwall said: “To win the national NHS Parliamentary Award is incredible. The work in Cornwall by teams across the public and voluntary sector is starting to be truly transformative. We are working together to meet people’s needs and to support their aspirations. The task now is to keep this change and improvement going.”

Emma Rowse, Chief Executive, Cornwall Voluntary Sector Forum said: “This award is a testament to the power of collaboration. As a voluntary and community sector, we know we’re able to deliver the best services when we work together and that also means working in partnership with our commissioners.”

Jane Johnson MBE, Chief Executive, disAbility Cornwall and Isles of Scilly added: “We are thrilled with the recognition for this incredible programme of work, which sees providers transcending boundaries to align their services for seamless provision, ensuring people receive the right support, in the right place and at the right time.

“This collaborative spirit is delivering high-quality wraparound care, leveraging a wide range of resources to address and overcome the root causes of inequalities.”

Local residents, who have been helped by these services include James, who was helped with transport to appointments following a stroke, Margaret, who had food shopping after her hospital stay, and Bill, who was introduced to his local community hub after the loss of his wife.

When Cornwall and Isles of Scilly won the regional award earlier this year, the judges said “This shows the huge potential of integrating community support into health and care services. A model that could potentially be emulated across the country.”

They commented on “a terrific example of what can be achieved by working with more than 60 voluntary organisations to make a real difference to people across Cornwall” and noted that “tens of thousands have been helped to stay well and to get home quicker after hospital treatment.”

NHS Devon

NHS Devon Integrated Care Board

Committee Chair's Report – Quality and Patient Experience Committee

Date of meeting	Date of committee covered in this report
28 November 2024	14 November 2024

Chair	
Name and title:	Thandiwe Hara, Independent Non-Executive Member for Citizen and Community Involvement

Board Assurance Framework (BAF) updates or escalation
The Committee received the report which informed it of the current position regarding those Board Assurance Framework (BAF) Risks for which the Committee has been identified as responsible for oversight.

Risk register review updates/escalation
None

Assurance Updates
Quality Report **(i) Primary Care Deep Dive** **(ii) Urgent and Emergency Care Deep Dive** **(iii) Children and Young People's Service Deep Dive Performance Report**

One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

The Committee **AGREED** the overall assurance level relating to the quality position of the One Devon Integrated Care System as satisfactory and that adequate plans were in place to mitigate the quality risks.

As requested by the NHS Devon Board, the Committee considered the "waiting well" offer for children awaiting an autism diagnosis as part of the Children and Young People's Service Deep Dive Performance Report.

System Quality Group Report

The Committee **TOOK FULL ASSURANCE** from the contents of the report regarding NHS Devon fulfilling the mandate to lead and facilitate system level quality assurance and improvement and **NOTED** that this report is submitted to NHSE Regional Quality Group.

Annual Plan - Delivery Assurance

The Committee **NOTED** the assurance ratings relating to the delivery of NHS Devon 2024/25 Annual Plan was work in progress and to remedy the definitions and criteria for levels of assurance and **NOTED** the proposed amendments to the NHS Devon 2024/25 Annual Plan.

Reports received, discussed, and noted

Regulatory issues update

The Committee **NOTED** the contents of this report for information and **TOOK ASSURANCE** that NHS Devon is suitably engaged with regulatory activity in Health and Social Care services with Devon.

Committee decisions

None

Escalation to the Board – for information

Ongoing oversight of context and information in mortality figures are currently suggestive of an increase but it is not clear that this is cause for concern. Committee would like further exploration.

Ongoing review of EQIA issues were raised regarding how the Committee is cited in data reporting and clarity of categorisation (e.g. red vs. green ratings).

Collaboration and cross Committee work in regular reporting were highlighted between this Committee, the Finance and Performance Committee, and the People and Organisational Development Committee.

Acknowledgment from System Quality Group to track organisations in escalation (DPT, TSD and UHP).

Continued emphasis on improving how data is reported and ensuring consistent definitions and interpretations across Committees and reports.

Escalation to the Board – for action

None

Recommendations for the Board

None

Recommendations for other committees

The Quality and Patient Experience Committee to collaborate cross Committee work with the Finance and Performance Committee and People and Organisational Development Committee on various issues arising.

Terms of reference or other committee effectiveness issues

None

Please note that all reports considered by Board Assurance Committees are available to Board Members on request.

NHS Devon

NHS Devon Integrated Care Board

Committee Chair's Report – Finance and Performance Committee

Date of meeting	Date of committee covered in this report
28 November 2024	10 October 2024

Chair	
Name and title:	Kevin Orford, Acting Chair and Chair of the Finance and Performance Committee

BAF updates or escalation

The Committee received the report informing them of the current position regarding the Board Assurance Framework (BAF) risks for which the Committee had been identified as responsible for oversight.

The Committee suggested consideration be given to the impact of the development of a national ten year plan for the NHS on local transformation plans.

The Committee **TOOK ASSURANCE** from the current content of the BAF.

Risk register review updates/escalation

None

Assurance Updates

NHS Devon 2024/25 Annual Plan Delivery
The Committee **NOTED** the assurance report summary and assurance levels for each directorate.

Progress report on the requirements of the NHS Oversight Framework
The Committee **AGREED** the assurance ratings relating to progress against each of the NOF4 exit criteria for One Devon Integrated Care System and **AGREED** that adequate plans were in place to mitigate the risks relating to the delivery NOF4 exit identified in Locality Planning and Delivery Meetings, and System Leadership Group.

Integrated Quality, Performance and Finance Report
The Committee **AGREED** the assurance ratings relating to current performance position against the Key Performance Indicators measured through the IQPR.

Reports received, discussed, and noted

NHS Devon (ICB) Finance Report M5
The Committee AGREED the overall assurance level relating to the financial position of NHS Devon of satisfactory assurance and AGREED that adequate plans were in place to mitigate the risks relating to the delivery of planned savings and efficiencies and to the management of the financial risks identified at plan stage.

One Devon (ICS) Finance Report M5
The Committee supported the approach of basing forecasts on the best available information to date and **AGREED** the overall assurance level relating to the financial position of the One Devon Integrated Care System as satisfactory and agreed that adequate plans were in place to mitigate the risks relating to the delivery of planned savings and efficiencies and to the management of the financial risks identified at plan stage.

National Recovery Support Funding
The Committee **NOTED** the letter confirming Recovery Support Funding to be provided and the conditions attached to this and agreed distribution of the funds.

Devon Investment Group Report Q2 2024/25
The Committee **NOTED** the investments that had been reviewed by the Devon Investment Group, together with the resulting actions and approvals.

Committee decisions

None

Escalation to the Board – for information

None

Escalation to the Board – for action

None

Recommendations for the Board

None

Recommendations for other committees

None

Terms of reference or other committee effectiveness issues

None

Please note that all reports considered by Board Assurance Committees are available to Board Members on request.

NHS Devon Integrated Care Board

Committee Chair's Report – Finance and Performance Committee

Date of meeting	Date of committee covered in this report
28 November 2024	14 November 2024

Chair	
Name and title:	Kevin Orford, Acting Chair and Chair of the Finance and Performance Committee

BAF updates or escalation

The Committee received the report informing them of the current position regarding the BAF risks for which the Committee had been identified as responsible for oversight.

The Committee **TOOK ASSURANCE** from the current content of the BAF.

Risk register review updates/escalation

None

Assurance Updates

Progress Report on the Requirements of the NHS Oversight Framework – Segment 4
The Committee **AGREED** the assurance ratings relating to each of the NOF4 progress positions of the One Devon Integrated Care System as satisfactory.

Annual Plan 2024/25 – Delivery Assurance

The Committee **AGREED** the assurance ratings relating to the delivery of NHS Devon's 2024/25 Annual Plan objectives and **NOTED** the proposed amendments to the NHS Devon 2024/25 Annual Plan. The Committee **NOTED** the rising risk of delivery to Pharmacy objectives. The Committee agreed that for assurance of delivery of the 25/26 plan, there should be clarity of resources required.

Annual Planning Cycle 2025/26

The Committee **TOOK SATISFACTORY ASSURANCE** from the process for agreeing the 2025/26 Annual Plan.

Reports received, discussed, and noted

Medium Term Financial Plan

The Committee **NOTED** the information and assurances presented to NHS England on 17th October. The Committee asked that when the detailed provider plans are developed, there should also be a plan relating to Primary Care.

System Provider Financial Risk

The Committee **NOTED** the oral update relating to emergent financial risk and supported the approach to provide further support to system partners in mitigation.

NHS Devon (ICB) Finance Report M6

The Committee **AGREED** the overall assurance level relating to the financial position of NHS Devon of satisfactory assurance and **AGREED** that adequate plans were in place to mitigate the risks relating to the delivery of planned savings and efficiencies and to the management of the financial risks identified at plan stage.

One Devon (ICS) Finance Report M6

The Committee **AGREED** the overall assurance level relating to the financial position of the One Devon Integrated Care System of satisfactory and **AGREED** that adequate plans were in place to mitigate the risks relating to the delivery of planned savings and efficiencies and to the management of the financial risks identified at plan stage.

Forward Plan

The Committee **NOTED** the draft workplan.

Committee decisions

None

Escalation to the Board – for information

- The Committee supported the targeted approach in terms of the intervention at relating to emergent financial risk in the System.
- The Committee suggested linking resources to 2025/2026 Annual Plan.
- Overall satisfied assurance of the MTFP however, further assurance on detailed provider financial plans including Primary Care was requested by the Committee.

Escalation to the Board – for action

None

Recommendations for the Board

None

Recommendations for other committees

None

Terms of reference or other committee effectiveness issues

None

Please note that all reports considered by Board Assurance Committees are available to Board Members on request.

NHS Devon Integrated Care Board

Chair's Report - Primary Care Commissioning Transitional Committee

Date of meeting	Dates of committee covered in this report
28 November 2024	21 November 2024

Chair	
Name and title:	Judy Hargadon Independent Non-Executive Member for Primary Care

BAF updates or escalation
None

Risk register review updates/escalation
Risks continue to be reviewed and considered, there is little movement in mitigation of high risks. There is ongoing work regarding the uptake in use of the new oversight framework.

Integrated Quality, Performance and Finance Report (please provide summary of discussion for Board assurance)
The **Finance Report** updated the meeting on the details of the dental finance plan, and contingency funding being used to support a South Devon group of practices. The **Quality report** highlighted updates in matters concerning a warning notice from Care Quality Commission (CQC) served to a Devon practice and the work being done by the NHS Devon team to receive compliance assurance from the practice.

Reports received, discussed, and noted

The **Director's Report** noted good progress being made in filling roles within the Primary Care team, although there are still some outstanding.

The meeting was updated as to the progress of General Practice **Strategic Metrics** which show Devon as now being above 80% (and above national average) for its two- week patient access numbers.

The **Contracting and Resilience Report** highlighted improvement in resilience rating within general practice, 115 out of the 118 Devon practices are rated by CQC as good or outstanding. 2 practices are being supported by the Primary Care team to deal with short-term concerns, one of lapsed registration and one of workload backlog.

The meeting was updated on **Workforce** priorities including helping Practices identify different models of staffing, recruitment successes at national events, and work on improving recruitment and retention of administration and practice manager roles in General Practice.

The meeting received an update regarding the progress and actions of the **Devon Collaborative Board** who are electing new Chair and deputy chair officers, giving General Practice clinical and managerial representation to 5 key system meetings, becoming involved in procurement and commissioning services planning. They were pleased to have been asked to present to the Board.

Committee decisions

Members of the committee discussed a paper which gave a detailed recommendation for **future Primary Care Commissioning decision governance assurance.** The meeting agreed with the recommendation to move the decision ratification to a Commissioning Group. Feedback was given regarding some areas requiring clarity and suggestions were given regarding some of the wording of the terms of reference for that group.

An update was given to the meeting on the progress being made in **Dental service commissioning.** The meeting reviewed and discussed a paper recommending closure of the Devon Dental waiting list. **The PCCTC agreed** to **accept** the closure of the Devon waiting list to new entrants, on the basis that all other areas do not have a waiting list, with the caveat that clear communications for patients and other healthcare practitioners are ready to go before the closure; this to be done within a month. **The PCCTC agreed** to the development of a detailed options appraisal following the assessment of all risks for those patients already on the list and relevant mitigation. The meeting reviewed the paper regarding changes/rebasing of Units of Dental Activity UDA rates. **PCCTC endorsed the decision** made by the Primary Care Senior Leadership Team to approve the changes to UDA charges as laid out in the paper.

A paper was presented updating PCCTC on the **Community Pharmacy service** The committee reviewed and discussed the recently finalised Devon Community Pharmacy Strategy and **agreed to give formal support** for the vision, mission and strategic aims and objectives of the Devon Community Pharmacy strategy.

Escalation to the Board – for information

None

Escalation to the Board – for action

The Committee would ask the Board to consider reviewing the work of the new Executive Commissioning Group once established as part a wider corporate governance framework review, including the exercise of delegated powers.

Recommendations for the board

None

Recommendations for other committees

None

Terms of reference or other committee effectiveness issues

None

Please note that all reports considered by Board Assurance Committees are available to Board Members on request.

NHS Devon Integrated Care Board

Committee Chair's Report – People and Organisational Development Committee

Date of meeting	Date of committee covered in this report
28 November 2024	07 November 2024

Chair	
Name and title:	Judy Hargadon, Chair of the People and Organisational Development Committee

BAF updates or escalation
The Committee received the report informing them of the current position regarding the Board Assurance Framework (BAF) risks for which the Committee had been identified as responsible for oversight. The Committee **TOOK ASSURANCE** from the current content of the BAF but noted that they wished to review this after the next meeting when they would receive an update on progress with the various pillars for action from the ICB/ICS's people plans, as agreed over the last two years.

Risk register review updates/escalation
None

Assurance Updates

As this was the first meeting of the Committee, it did not receive any assurance reports.

Reports received, discussed, and noted

Approach to People and Organisational Development
The report provided detail on NHS Devon's functions, accountability, and responsibility regarding people and organisational development and the frameworks to be delivered.

The Committee **NOTED** the content of the national guidance provided.

Equality, Diversity and Inclusion (EDI)
The report outlined NHS Devon's responsibilities relating to EDI, an update on the various workstreams under the EDI portfolio; and proposals of how this work could be delivered in the future.

The Committee **TOOK PARTIAL ASSURANCE** from the proposed model of an EDI Working Group for the co-ordination and delivery of EDI activities within NHS Devon and across the One Devon Integrated Care System, noting that the question of whether there was sufficient resource for this work would be kept under review. The Committee was grateful to staff who have kept this work going during organisational change.

Forward Plan
Work had progressed in the development of a Forward Plan for the Committee. This would be presented at the next meeting. Discussions throughout the meeting had shaped much of what would be included in the future Forward Plan.

Committee decisions

None

Escalation to the Board – for information

None

Escalation to the Board – for action

None

Recommendations for the Board

The Committee has raised the importance of addressing EDI more often with the Board. The Acting Chair has offered to lead action on this.

Recommendations for other committees

None

Terms of reference or other committee effectiveness issues

Terms of reference and future operation of the Committee
The report presented the Terms of Reference (ToR) of the People and Organisational Development Committee that had been approved by the Board on 25 July 2024. The Committee was asked to comment on the responsibilities and membership outlined in the report.

The Committee **NOTED** People and Organisational Development Committee's ToR, in particular the responsibilities of the Committee. There will be further discussions about appropriate membership, for recommendation to the Board.

Please note that all reports considered by Board Assurance Committees are available to Board Members on request.