NHS Devon

NHS Devon Integrated Care Board (ICB) Extraordinary Meeting

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

28 August 2025

15.00 – 16:30

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 Deputy Chair
b) At least two Executive Directors
c) At least two Non-Executive Members
d) At least two of either the Partner Members, the Mental Health Member or the VCSE Member

1.		Introductory Items	Lead	Action	Time
1.1	ICB25-049	Welcome, introduction and apologies for absence	Kevin Orford, Chair	Discussion	15:00
1.2	ICB25-50	Declarations of interest	Kevin Orford, Chair	Information	
1.3	ICB25-051	Minutes of the meeting held on 31 July 2025	Kevin Orford, Chair	Approval	
1.4	ICB25-052	Action Register	Kevin Orford, Chair	Approval	
2.		**For Approval and Endorsement**	**Lead**	**Action**	**Time**
2.1	ICB25-053	Establishing Cluster Governance Arrangements	Philippa Harding, Director of Governance and Interim Communications and Corporate Affairs Officer	Approval	15:10
3.		**Governance and Assurance**	**Lead**	**Action**	**Time**
3.1	ICB25-054	NHS Devon 2024/25 Annual Report and Accounts	Philippa Harding, Director of Governance and Interim Communications and Corporate Affairs Officer	Information	15:50
4.		**Closing Items**	**Lead**	**Action**	**Time**
4.1	ICB25-055	Questions from members of the public	Kevin Orford, Chair	Discussion	16:10
4.2	ICB25-056	Any Other Business	Kevin Orford, Chair	Discussion	16:20
5.		**Close**			

NHS Devon Board Register of Interest Report - 28 August 2025

Employee	Role	Interest Type	Date Ended / Active	Interest Description	Interest Category	Mitigating Actions
Kevin Orford	Chair, NHS Devon	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.
Salma Ali	Independent Non-Executive Member	Declaration of Interest	Active	Non- Executive Director and Vice Chair for Birmingham Community Health Care Foundation Trust.	Financial	To be managed in line with the Conflict of Interest Policy and Corporate Governance advice
				Director- SKSN Consultancy & Advice which supports the NHS with bespoke pieces of work. The company is currently dormant. It did not trade during 2024/25 and there are now plans for it to do so now or going forward.	Financial	To be managed in line with the Conflict of Interest Policy and Corporate Governance guidance.
				Trustee of Black County Women's Aid with no Executive responsibilities..	Non-Financial Professional	To be managed in line with the Conflict of Interest Policy and Corporate Governance guidance.
Mary Aspinall	Health and Wellbeing Chair - Plymouth	Declaration of Interest	Active	Elected member of Plymouth City Council and Chair of The Plymouth Health and Wellbeing Board	Financial	To be managed in line with the Conflict of Interest Policy and Governance advice.
Kaye Bentley	Independent Non-Executive Member	Declaration of Interest	Active	Provision of consultancy and advice services to the NHS via KB consulting, a sole trader	Financial	Each assignment to be considered on a case by case basis to ensure there are no conflicts of interest with Devon INEM role. No work will be undertaken in the Devon system
				Independent Chair of the South West specialised services committee. Payment via Somerset ICB to KB consulting	Financial	Committee members representing the 7 ICBs in the South West and NHSE representatives on the committee have considered and agreed there is no conflict as the Chair is not a voting member of the committee.
				Trustee of The Budleigh Salterton Hospital League of Friends, also known as the Budleigh Fund	Non-Financial Personal	Remove from any decision making involving the Budleigh Fund or Seachange.
				Working with the NHSE national finance team on a fixed term contract providing support to the NHS financial reset	Financial	To be managed in line with the Conflict of Interest Policy and Governance advice.
Graham Clarke	Independent Non-Executive Member	Declaration of Interest	Active	Non-Executive Director of Medicine Discovery Catapult	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.

NHS Devon Board Register of Interest Report - 28 August 2025

Employee	Role	Interest Type	Date Ended / Active	Interest Description	Interest Category	Mitigating Actions
Graham Clarke (Cont'd)	Independent Non-Executive Member	Declaration of Interest	Active	Non Executive Member at the Department of Health & Social Care	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.
				Trustee and Treasurer of the Cornwall Community Foundation	Non-Financial Professional	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.
				Spouse is CEO of Cornwall Partnership Foundation Trust	Indirect	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.
				Spouse is a Board Member of Cornwall & Isles of Scilly ICB	Indirect	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.
				Member, Institute of Cancer Research.	Non-Financial Professional	To be managed in line with the Standards of Business Conduct Policy.
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
Mark Cooke	Managing Director (Strategy, Oversight & Regulation)	Declaration of Interest	Active	Non paid Director National Centre for Rural Health and Care	Non-Financial Professional	Declare when necessary
				Director non-paid Bristol City Robins Foundation	Non-Financial Personal	Declaration when appropriate
			Ended 23/06/2025	Director/trustee Quantock Education Trust	Non-Financial Personal	Declare when appropriate
Kirsty Denwood	Interim Chief Finance Officer	Nil Declaration	Active	N/A	N/A	N/A
John Finn	Acting Chief Operating Officer	Declaration of Interest	Active	Daughter employed by Royal Devon University Hospital as resident Doctor from August 1st 2025	Indirect	none

NHS Devon Board Register of Interest Report - 28 August 2025

Employee	Role	Interest Type	Date Ended / Active	Interest Description	Interest Category	Mitigating Actions
Philippa Harding	Director of Governance	Declaration of Interest	Active	Founding Director of Harding Advisory Ltd, a professional services company providing corporate governance expertise.	Financial	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
				Interim Company Secretary for Cornwall and Isles of Scilly ICB as a secondary contract	Financial	Will provide impartial, independent advice and guidance on areas relating to governance for both Devon and Cornwall ICBs, ensuring professional integrity at all times when working closely with the Chairs of both organisations in line with UKCGI Code of Professional Ethics and Conduct as well as each organisations Standards of Business Conduct and Conflict of Interest Policies.
Thandiwe Hara	Independent 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 interest at any meeting that may result in them being considered for service provision and leave
				I am a lay representative on the new Structure SWP RRDN which has superseded the SW CRN	Non-Financial Professional	To declare this should I be involved in anything that might be relevant to CoI
			Ended 30/03/2025	Member on the NIHR SW Clinical Research Network Board.	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 interest at any meeting that may result in them being considered for service provision and leave
Sam Higginson	NHS Trust and Foundation Trusts Partner Member	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 - General Charity of the Royal Devon University Healthcare NHS Foundation Trust	Non-Financial Professional	To be managed in line with the Standards of Business Conduct and Conflicts of Interest Policies
				Chief Executive Officer Royal University Hospitals Devon	Financial	To be managed in line with the Standards of Business Conduct and Conflicts of Interest Policies.

NHS Devon Board Register of Interest Report - 28 August 2025

Employee	Role	Interest Type	Date Ended / Active	Interest Description	Interest Category	Mitigating Actions
Donna Manson	Local Authority Partner Member	Declaration of Interest	Active	Chief Executive Officer 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.
Phillip Mantay	Mental Health Partner Member	Declaration of Interest	Active	Employed as Chief Executive Officer of Devon Partnership Trust since June 2024	Financial	Declaration of relationship prior to offering opinion or recommendation.
				Children and Family Health Devon delivered services for Devon Partnership NHS Trust of which I am Chief Executive Officer	Financial	To be managed in line with the conflict of interest policy and guidance from Corporate governance
Steve Moore	Chief Executive Officer	Nil Declaration	Active	N/A	N/A	N/A
Francis O'Kelly	Primary Medical Services Partner Member	Declaration of Interest	Active	GP Partner at Amicus Health Group. As well as providing the full range of Primary Care Services the practice is also a provider of Surgical Services (dermatology, carpal tunnel, vasectomies and minor ops) and Dermatology Services. Part of the merged practice is also dispensing.	Financial	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
				Blundell's School Lead Doctor	Financial	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
				Member of the National Armed Forces Reference Group	Non-Financial Professional	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
				Attends Tiverton High School Welfare Meeting fortnightly	Non-Financial Professional	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
				Contributor to FASD Forum	Non-Financial Professional	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
				5 adopted children, 2 with recognised learning difficulties both receiving PIP and with residential or supported living in Devon	Financial	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
				Wife is a book-keeper for STEER Education	Financial	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
				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) merged with the Mid Devon Medical Practice on 1.10.24 - 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

NHS Devon Board Register of Interest Report - 28 August 2025

Employee	Role	Interest Type	Date Ended / Active	Interest Description	Interest Category	Mitigating Actions
Francis O'Kelly (Cont'd)	Primary Medical Services Partner Member	Declaration of Interest	Active	Member of the SW People Board	Non-Financial Professional	To be managed in line with the conflicts of interest policy
				Amicus Health of which I am a partner, employs General Practitioners with a Special Interest (GPSI) in both dermatology and surgery. We provide dermatology and surgery services in the community and employ additional GPSIs in both these services. We have GP registrars who are doing specialist modules in the practice in both these specialties.	Non-Financial Professional	To be managed in line with the Conflict of Interest Policy and guidance from the Governance Team
			Ended 05/05/2025	Son is being assessed for Continuing Healthcare.	Financial	Conflict will be managed in line with the Conflict of Interest Policy and advise from the Governance Team. 5.5.25 - I am not certain of the exact date but this is no longer happening.
Lopa Patel	Independent Non-Executive Member	Declaration of Interest	Active	My daughter is undertaking a research-based PhD funded by AstraZeneca PLC, a supplier to the healthcare sector.	Indirect	Will seek advice from the Chair / step out of the room if there are commissioning decisions related to AstraZeneca PLC
				Currently there are 12 members of my family, including my sister, nephews and nieces who work as doctors, dentists and pharmacists in the NHS, although none currently in the NHS Devon ICB commissioning region.	Indirect	Will seek the advice from the Chair and declare any direct interests if they arise.
				Currently Chair of equality charity, Diversity UK which is focusing on addressing inequalities, particularly for women and ethnic minorities. As a charity, Diversity UK, may receive donations from companies, organisation or individuals to help it deliver its mission. Donations are declared as per Charity Commission guidelines.	Financial	Will seek the advice from the Chair and declare any direct interests if they arise.
				Board Member, Enterprising Women Programme at Murray Edwards College, University of Cambridge. The programme is sponsored by a number of companies, philanthropists and private donors including AstraZeneca UK, C Hoare & Co Private Bank, Innovate UK and others. The purpose of the programme is to create spin-outs from the University of Cambridge created by female postgraduates, researchers and staff. The programme currently does not accept under-graduates but this may change in the future.	Non-Financial Professional	I will excuse myself from any discussions related to the NHS or NHS Devon.

NHS Devon Board Register of Interest Report - 28 August 2025

Employee	Role	Interest Type	Date Ended / Active	Interest Description	Interest Category	Mitigating Actions
Lopa Patel (Cont'd)	Independent Non-Executive Member	Declaration of Interest	Active	I have been a judge for the The King's Awards for Enterprise Innovation Panel since 27 November 2017. This work is carried out with The King's Awards Office, part of the Department for Business & Trade (DBT) under a confidentiality agreement with recommendations from the innovation panel being put forward to the Prime Minister's Advisory Committee. However, I have recently been asked to promote the awards on social media with text and video clips. I have also previously been asked by DSIT/DBT & the Lord Lieutenancy to take part in online and in-person events to promote the awards.	Non-Financial Professional	Although I do not foresee any conflict of interest, there may be business applicants from the Devon area for whom I may have to declare an interest at panel (if they are a supplier to NHS Devon ICB) to ensure impartiality at the judging stage.
Libby Ryan-Davies	Chief Strategic Commissioning and Planning Officer	Nil Declaration	Active	N/A	N/A	N/A
Lincoln Sargeant	Local Authority Partner Member	Nil Declaration	Active	N/A	N/A	N/A
Kate Shields	Chief Executive Officer, Cornwall and Isles of Scilly ICB	Declaration of Interest	Active	Chief Executive Officer, Cornwall and Isles of Scilly ICB	Non-Financial Professional	To be managed in line with Governance Advice and Policies.
Penny Smith	Chief Nursing Officer	Nil Declaration	Active	N/A	N/A	N/A
Piers Tetley	Chief People Officer	Nil Declaration	Active	N/A	N/A	N/A

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 Thursday 29 May 2025 between 09:30 and 14:00	
Name	*Title and organisation*
Board Members:	
Kevin Orford	Chair, NHS Devon
Steve Moore	Chief Executive Officer, NHS Devon
Salma Ali	Independent Non-Executive Member, NHS Devon
Kaye Bentley	Independent Non-Executive Member, NHS Devon
Graham Clarke	Non-Executive Member, Audit and Risk, NHS Devon
Dr Peter Collins	Chief Medical Officer, NHS Devon
Kirsty Denwood	Interim Chief Finance Officer, NHS Devon
Dr Thandiwe Hara	Non-Executive Member, Citizen and Community Involvement, NHS Devon
Sam Higginson	Partner Member for NHS Trusts and Foundation Trusts, Chief Executive of Royal Devon University Healthcare NHS Foundation Trust
Phill Mantay	Partner Member for Mental Health, Chief Executive, Devon Partnership NHS Trust
Dr Frank O'Kelly	Partner Member for Primary Medical Services Providers, Amicus Health
Lopa Patel	Independent Non-Executive Member, NHS Devon
Penny Smith	Chief Nursing Officer, NHS Devon
Dr Lincoln Sargeant	Partner Member, Local Authorities (Population Health and Prevention), Director of Public Health, Torbay
Also in attendance:	
Councillor Mary Aspinall	Chair, One Devon Integrated Care Partnership
Helen Braid	Governance & Assurance Manager and Board Secretary
Mark Cooke	Managing Director (Strategy, Oversight & Regulation), NHS England South West
Philippa Harding	Director of Governance and Interim Chief Communications & Corporate Affairs Officer, NHS Devon
Libby Ryan-Davies	Chief Strategic Commissioning and Planning Officer
Piers Tetley	Chief People Officer, NHS Devon
Allison Williams	System Recovery Director, NHS England
Apologies for absence:	
John Finn	Acting Chief Operating Officer, NHS Devon
Donna Manson	Partner Member, Local Authorities, Chief Executive, Devon County Council
Kate Shields	Chief Executive Officer, NHS Cornwall and the Isles of Scilly

Item	Ref	Discussion
1.		**Introductory Items**
1.1	ICB25-024	**Welcome, Introductions and Apologies** Kevin Orford, NHS Devon Chair, welcomed Board members to the meeting. It was noted that apologies for absence had been received from Donna Manson, John Finn and Kate Shields. The Chair welcomed Councillor Mary Aspinall, Mark Cooke and Allison Williams to the meeting and confirmed that Steve Darling, MP for Torbay was expected to join members of the public in attendance at the meeting later in the morning. It was confirmed that a meeting in private would be held later in the day to consider progress relating to the redesign of the role and purpose of ICBs and progress against the National Oversight Framework Segment 4 exit criteria, with this being referenced in the Chair's Report on this agenda and also in the CEO report. The meeting was deemed quorate.
1.2	ICB25-025	**Declarations of Interest** The Board **noted** the Register of Interests.
1.3	ICB25-026	**Minutes of Previous Meeting** The minutes of the Board meeting in public held on 29 May 2025 were **approved** as a correct record.
1.4	ICB25-027	**Action Register** Chief Medical Officer, Peter Collins (PC), provided an update in respect of Action ICB25-015 with it being noted that a discussion had taken place with Independent Non-Executive Member Salma Ali in respect of the Mental Health Assertive and Intensive Outreach Action Plan and agreement had been reached as to the metrics to be included in future update reports. The Board: • **Agreed** the closure of actions ICB24-111 and ICB25-006 and 015. • **Noted** the updates in respect of actions ICB25-008 and 009.
1.5	ICB25-028	**Fit for the Future: 10 Year Health Plan for England** Chief Executive Officer, Steve Moore (SM), introduced the report which summarised the engagement approach in Devon, across the south-west and nationally in respect of the 10 Year Health Plan for England. The report set out the key local, regional and national findings and how these findings would be used to inform the development of the NHS Devon Health and Care Strategy. It was noted that the 10 Year Plan would likely result in changes in the future, for example the ambition that a third of outpatients will receive care in community settings or receive care digitally. During the consultation period, it had become evident that people would be empowered by having the information they needed to help themselves and this ambition would be built into the Devon strategy. Thanks were extended to the Communications and Engagement Team for leading the consultation exercise across Devon and also to those members of the public who had given their time to provide feedback. The Board: • **Noted** Fit for the future: 10 Year Health Plan for England;

		• **Noted** the key findings from the Devon 10 Year Plan engagement programme; and • **Took satisfactory assurance** from the proposed approach to using the findings to inform local priorities and programmes of work.
2.		**Leadership Reports**
2.1	ICB25-029	**Chairs Report** The Chair introduced his report which included an update on Integrated Care Board (ICB) clustering and leadership and the NHS mandated amendment of the NHS Devon Constitution It was noted that the 'clustering' of NHS Devon with NHS Cornwall and Isles of Scilly had been approved by NHS England (NHSE), with a formal merger being possible between April 2026 and April 2027. The cluster arrangement required both the NHS Devon Board and the NHS Cornwall and Isles of Scilly Board to formally delegate authority to a new Joint Committee of the two organisations and an extraordinary meeting of the Board in public would be held to enable this authority to be delegated. To enable there to be a single CEO of the cluster, NHSE had mandated an amendment to the NHS Devon Constitution to enable the CEO to hold that post in more than one ICB. The Board **noted** the content of the report.
2.2	ICB25-030	**Chief Executive Officer's Report** The Chief Executive Officer introduced the report which provided updates on key events that had taken place since the last meeting of the Board including the commissioning intention to review community urgent care provision, the NHS Pulse Survey for staff, Trade Union recognition and the Dash patient safety review. The following points were highlighted during consideration of this item: • The impact on staff of the ongoing uncertainty around the clustering timescales was considerable and this would be one of the issues that would be monitored through the Pulse Survey to enable a greater understanding of staff experience at present. • Although the future of Healthwatch remained uncertain in the new health and social care landscape, they would be included within NHS Devon's plans and work with them would continue. Part of the new cluster design process would include consideration as to how feedback from service users would be obtained once Healthwatch had been abolished. • The Chief Medical Officer had co-ordinated the system's response to the most recent round of industrial action by junior doctors with the efforts of all staff in NHS Devon and providers to ensuring services remained safe during this time was acknowledged. The indications were that the activity stood down as a result of the action was less than during previous rounds of industrial action and exact numbers would be made available as soon as this analysis had been completed. • The successful collaboration across organisations and sectors which had resulted in the opening of "The Brook" Regional Learning Disability and Neurodiversity which would make a significant difference to those who needed support. • Having declared a personal interest as a parent to five adopted children, Dr Frank O'Kelly referred to the Care Leaver Covenant and suggested that the scheme should not be limited to those were under 18 but rather opened up to any individual who had been in care, acknowledging that the implications and scale of such an expansion would need to be investigated. The Board **noted** the content of the report.

3.		For Approval and Endorsement
3.1	ICB25-036	**Updating the 2025/26 Annual Plan** Libby Ryan-Davies (LRD), Chief Strategic Commissioning and Planning Officer, introduced the report which provided the updated 2025/26 Annual Plan for approval, together with supporting delivery and enabling plans. The report also presented a proposed de-prioritisation process to identify and manage activities that no longer align with core priorities. The following points were highlighted during consideration of this item: • When reviewing the Plan, a balance had to be struck between delivering in-year targets and longer-term ambitions. Links to the commissioning plan and alignment with performance and contract management arrangements was also essential. • The consolidation of objectives did not change the workload, so identifying what activities no longer aligned with priorities was important. A framework had been developed to support de-prioritisation discussions across the system and prevent the "shunting" of work from one organisation to another. • The Annual Plan was laying the groundwork to move to a better position next year where strategic commissioning intentions and transformation was possible. • The System Leadership Group had oversight of what was being de-prioritised or proposed for re-allocation so that any issues could be considered at a strategic level. • Challenges remained in respect of software and digital progress with providers which need to be worked through, and a cluster view would also have to be taken, as digital was a significant enabler for strategic commissioning. • SM was a member of the national Innovation and Technology Working Group that was supporting the 10 Year Plan, so was appraised of developments in the area of digital for the NHS. • Concern as to whether there was enough of a community focus during strategy development discussions as the shift from hospital to community would need to begin next year. • Whether strategy work undertaken this year would need to be re-visited in light of the clustering arrangements and it being acknowledged that it would be easier to bring two strategies together rather than producing a single strategy from scratch. It was also noted that colleagues across the two organisations were already working together in this respect. • Some terminology used in the document should be reviewed. **Actions**: • The Annual Plan to be reviewed in response to points raised by Board members before finalisation of the document The Board • **Approved** the six revised and consolidated Annual Plan objectives. • **Approved** the updated Annual Plan and the supporting delivery and enabling plans. • **Endorsed** the de-prioritisation process for pausing, delaying or stopping activities that no longer align with current organisational priorities.
4.		**Performance Oversight**
4.1	ICB25-031	**2025/26 NHS Oversight Framework** Director of Governance and Interim Communication and Corporate Affairs Officer, Philippa Harding (PH) introduced the report which provided a brief overview of the new NHS Oversight Framework (NOF), which set out a revised approach to

		assessing Integrated Care Boards (ICBs), NHS trusts and foundation trusts for 2025/26. The 2025/26 NOF replaced the version published in June 2022 and emphasised system working, with its goals being to enhance public accountability for performance and improve the identification of providers that require support to improve. The following points were highlighted during consideration of this item: • Due to the current complexities around clustering of some ICBs at present, they would not be allocated to segments within the new NOF in 2025/26. • Segmentation for providers had been delayed and detailed modelling and metrics are expected by the end of August 2025 so that 2025/26 Q1 data could be taken into account. • While the previous NOF had emphasised partnership working across systems, the new framework was organisationally focused with sovereign Boards being held accountable. However, it was acknowledged that the solutions for a number of organisational issues would be found at a system level. • Recovery Support Programme (RSP) support to organisations would also be different going forward. Where previously RSP teams had been embedded within organisations, it was now anticipated that CEOs would be encouraged to look at how system assets can be used to provide support where specific delivery challenges were being experienced. • The new NOF provided clarity around roles and responsibilities with ICBs having responsibility for holding providers to account for the delivery of their commissioned contracts, with NHS England (NHSE) would hold ICBs to account for their commissioning capability. • Any freedoms awarded under the new regime would be dependent upon where an organisation was in terms of meeting its plans. The more successful they were, the more freedom they would have from regulation and interventions. • For Devon, there would now be a period of change during the transition to the new NOF and whilst organisations were allocated to their new segments, dependent upon the progress that had been made to date. The Board **noted** the 2025/26 NHS Oversight Framework.
4.2	ICB25-032	**Delivery Management Outcome Report** Chief Strategic Commissioning and Planning Officer, Libby Ryan-Davies (LRD) introduced the report which set out the escalations arising from the NHS Devon Delivery Management process. The following points were highlighted during consideration of this item: • The delivery management process currently being developed was the first step for NHS Devon becoming a more proactive contract manager. • The balance of information contained within the report still required refinement so that it combined a high-level overview of the current position while the detail provided all of the supporting information required to escalate where required and illustrate the actions being taken to course correct. • The Board should be focused on the strategic level information contained within the report, with Assurance Committees having the remit to review the operational detail. • The current approach had been developed in response to the operational plan but would be refined to incorporate strategic aims and as work in this area matured, it was hoped that the dependencies between the various metrics could be understood. • The process was now established and the work to be completed during August would result in future reporting clearly illustrating the impact of any escalations and providing assurance on delivery.

		• It was important to ensure that consistent language and definitions were used to prevent any misunderstandings as to the current position and actions being taken. **Action:** • Discussions to take place with Assurance Committee Chairs regarding the level of detail required in reporting and how this was presented. The Board **took satisfactory assurance** from the Delivery Management Process.
4.3	ICB25-035	**Approach to Winter Planning** Consideration was given to the report which set out the approach to winter planning, setting out the NHS England timeline, system-wide priorities, and NHS Devon's key contributory programmes. It also detailed the next steps and provided recommendations to ensure coordinated and effective delivery across the system The following points were highlighted during consideration of this item: • From a provider perspective, while there had been improvements in ambulance handovers and Urgent and Emergency performance, winter would still be challenging and planning had already commenced. • Learning from last year would result in mutual aid and governance processes being strengthened with the System Control Centre providing real time indicators of how the system was performing and on-call managers being clear as to expectations. • Each provider had been asked to nominate a Winter Director this year so that there were clear points of contact across the system • A successful vaccination programme was required for both staff and the wider public with this being achieved through increasing confidence in the value and safety of vaccines. • In light of climate change and the increased periods of high temperatures being experienced, consideration should be given to seasonal planning rather than just winter planning and Public Health colleagues could support in developing approaches to this. • The risk of further industrial action over winter was being incorporated into planning with this being led by the national team. • While it was accepted that the focus was on reducing hospital attendances, consideration was required as to exactly which cohorts were being targeted. The system already had high see and treat rates and high numbers of primary care appointments. Current Primary Care Network trials had recently delivered an extra 24,000 appointments but this had not impacted significantly on hospital attendances. Careful targeting actions should be considered. **Actions**: • Discussions to take place with the Directors of Public Health in respect of improving vaccination programme take up and also planning for increasingly high temperatures. The Board: • **Took satisfactory assurance f**rom the planning for winter and the proposed leadership model, including the approach to the appointment of an ICB Winter Director. • **Agreed** to consider and approve the final Winter Plan in correspondence during August 2025.
4.4	ICB25-034	**Developing a case for change for cardiovascular disease, cardiology and cardiac surgery services**

		Chief Strategic Commissioning and Planning Officer, Libby Ryan-Davies (LRD) and Chief Medical officer, Peter Collins (PC) introduced the report which summarised the process, timeline and governance in place to develop a draft case for change for cardiovascular disease (CVD), cardiology and cardiac surgery services in Devon; alongside in-year activity to improve performance. Prior to further consideration of the report, the Chair welcomed Steve Darling, MP for Torbay and took the question that he had submitted to the Board in respect of this item. ***Question:*** *Please provide more detail into how exactly clinicians will be engaged with as part of this process.* ***Response:*** *As part of the development of the case for change for cardiovascular disease, cardiology, and cardiac surgery services, clinician engagement will be central to ensuring the process is credible, inclusive, and informed by frontline expertise. Specifically:* • *Senior clinical leaders from across the system will be directly involved from the outset to shape and guide the work.* • *A structured stakeholder mapping process will identify the right clinical voices to involve, ensuring a broad range of perspectives, including those with direct experience of delivering cardiac care.* • *Dedicated joint working sessions will be established to bring clinicians together to define shared objectives, service standards, and opportunities for improvement.* • *We will take a proactive approach to understanding and addressing any barriers to collaboration by listening to clinicians' concerns and using this insight to shape the process.* • *Where appropriate, independent facilitation will be used to support open, constructive dialogue and ensure all voices are heard.* • *Throughout, we will maintain a focus on co-producing realistic, patient-centred solutions that reflect clinical evidence and local population needs.* • *In addition, a Clinical Reference Group will be established to ensure clinical insights remain central to the development of a case for change.* The following points were then highlighted during consideration of this item: • Engagement in respect of the case for change would commence formally in September. • The case for change would not include any proposals for the future but rather sets out why a change was needed for the service to meet the needs of the population of Devon. • While the case for change was one aspect of work being undertaken to improve service provision, in-year improvements were taking place to maximise current capacity to ensure patients that are waiting for interventional procedures are prioritised with providers collaborating to ensure that this happens. • Clinical engagement would be essential in developing the case for change, with there needing to be an understanding that this was about the needs of the entire Devon population rather than just those individuals who currently need to access services. • The case for change would be developed with the future direction of travel for healthcare services in mind such as the move from hospital to community, analogue to digital and from treatment to prevention. Definitions of success would need to be articulated and agreed. • Due to a variety of factors, the programme was now expected to take longer than originally anticipated, with the case for change and proposals for the future provision of services expected to be available in approximately 11 months.

		• Productivity and value for money evaluations would be incorporated within the case for change, with it being essential that data and costings were at the necessary level of detail for informed decisions to be taken. • In the longer term, this would be a Peninsula issue with all providers involved in service development across the two counties. • The experience of Cornwall in moving to neighbourhood models will be of benefit to Devon, particularly in respect of the longer-term developments required. • A three-year approach might see year one focussing on building a neighbourhood team, year two identifying how shifts in provision can be made and year three seeing full implementation. At some point, it may be necessary to double run to maintain services, with the impact of prevention not being seen until further into the future. • The way in which this work had commenced had created concern across the system and this was regretted. The revised approach was the way that NHS Devon wanted to work as commissioners going forward, with experts, patients and clinicians all being involved in developing solutions. The Board: • **Endorsed** the process to develop a case for change. • **Noted** the additional activity underway to be delivered in year.
3.3	ICB25-033	**Children and Young People** Chief Nursing Officer, Penny Smith (PS), introduced three reports which provided an update on the regulatory position in respect of services for Children and Young People across the One Devon System. In introducing the reports, PS set out the context in which services were provided and the complex statutory and regulatory position Devon was in with ratings ranging from good to inadequate across local authority areas. The Chair referred to the following question that had been submitted by the MP for Torbay: ***Question:*** *Why did no representative from Devon ICB attend the Continuous Improvement meeting for young people in Torbay on 14th July?* ***Response****: Unfortunately, no one from the ICB was able to attend the Continuous Improvement meeting with Torbay Council on 14 July. While it was intended for someone from the ICB to be there, some urgent internal operational priorities came up that day that had to be addressed, and we had to give our apologies for the meeting.* *However, we have worked with Torbay Council to set up an extraordinary meeting instead as quickly as possible to ensure we could participate, and this is due to take place tomorrow (31 July).* *Penny Smith, Chief Nursing Officer, and Hannah Pugliese, Director of Women, Children & Young People's Services, will be attending the meeting.* The following points were highlighted in respect of the three reports presented: **Inspection of Local Authority Children's Services (ILACS), Devon County Council** • A response to the inspection findings would be submitted to the Secretary of State for Education in September, with one of the options to them being to place the services into a Child's Trust. All partners were working together to prevent this option being progressed.

- NHS Devon contributed the health response to inspection.
- There had been much learning from all multi agency partners. A fully integrated improvement plan was being developed by the Children's Commissioner. However, prior to the inspection, work had been undertaken in respect of the Multi Agency Safeguarding Hub, the front door to accessing safeguarding services.
- NHS Devon had commissioned a review of the health component of the Multi Agency Safeguarding Hub to ensure that there was sufficient capacity and also productive ways of working and worked with providers to ensure that there was a prioritised approach to staffing the Hub as no further funding was available to increase staffing levels.
- It was acknowledged that the report did not set out in detail the range of issues that had been identified or the mitigations in place to improve the position. This information contained within an action plan would provide the Board with a greater level of assurance than it could take at present.
- While local ownership for local children was the right approach, this was the third children's commission, and the focus needed to be on getting it right for children rather than the institutions involved.

The Board:

- **Noted** the enhanced regulatory focus on Devon County Council's Children's Services including reporting to the Secretary of State.
- **Took limited assurance** regarding the health component of the plan and remitted this to the Quality and Patient Experience Committee for further review.

Torbay Ofsted and CQC Area Special Educational Needs and Disabilities (SEND)

- If children don't receive the appropriate interventions early on in life, the impact on their development was significant.
- The feedback indicated that it was appreciated that health had developed a strategy and that there was greater partnership working and much improved relationships across the system; however, the gains that had been made were not sufficient to prevent an inadequate rating.
- A significant challenge was the perception that a label or diagnosis was required to enable support to be accessed. An approach which provided support based on need as opposed to final diagnosis was more favourably looked upon by inspectors. This would give the Devon system a way forward.
- Managing waiting lists was important in terms of how children and families with SEND were supported and this was for services across the board.
- The action plan in response to the findings had to be realistic given that tangible impacts needed to be achieved within 18 months.
- 3.8% of the state school population in Tiverton was in home education, with many of these cases related to SEND.
- Going forward, how could prioritisation be given to getting it right for children and how could the right governance be implemented by an ICB with fewer staff when three local authority areas needed to be covered.
- National guidance as to future responsibilities around SEND and safeguarding was imminent, and this would support the future structure of the ICB team leading in this area of work.

The Board:

- **Noted** the findings of the SEND inspection for Torbay Local Area including identified areas of improvement for the Health System.
- **Took limited assurance** on the approach being taken to the remedial action plan and remitted it to the Quality and Patient Experience Committee for further review.

		Reducing Neurodiversity Waiting (incorporating Autism) Lists for Children and Young People • While the ambition to reduce the waiting lists had not been met as yet, pace had been kept with the increased levels of referrals across the system. • Commissioning levers have been implemented and a rapid improvement plan has been put in place; however, it was recognised that whilst attempts could be made to performance manage the current model this would not resolve the challenges being faced and new innovative approaches were required. • There has been a significant increase in the referrals from education. • It would be helpful to understand the processes in place to identify those on waiting lists where was the potential for deterioration for the family as well as the child and to also understand how that intelligence and insight was shared. • Whether learning from list management in the acute setting could be applicable to these waiting list in terms of demand and capacity planning, referral protocols and quality improvement methodologies. • Children on these waiting lists were disadvantaged as the lists did not attract elective recovery funding. The Board: • **took limited assurance** regarding the impact of remedial work being led by NHS Devon for neurodiversity recovery, noting improvements made and continued improvement plans; • **remitted** the report to the Quality and Patient Experience Committee for further review.
5.		**Governance and Assurance Reports**
5.1	ICB25-037	**Board Assurance Framework (BAF)** PH introduced the report which provided information in respect of the high-level strategic risks that might impact on the achievement of NHS Devon's strategic objectives in the current financial year. The following points were highlighted during consideration of this item: • The BAF now included two risks in relation to the requirements for NHS Devon reduce running costs by 50%. • This was an interim report which used the previous National Oversight Framework to set out strategic risks. As the objectives of the Health and Care Strategy were developed work would be undertaken to articulate the risks to achieving those objectives. • The risk score in respect of Finance had now increased to 16 in light of the underlying position, with the agreement of a Medium Term Financial Plan by September 2025 being a mitigation. • A review of risk appetite would form part of the development of the new BAF. The Board **approved** the content of the latest iteration of the 2025/26 Board Assurance Framework risks to achieving the strategic objectives of NHS Devon
5.2	ICB25-038	**Quality Report** PS introduced the report which provided a summary of key quality information, in the format of both quantitative and qualitative data with sources ranging from NHS Devon data collection including patient experience; and direct from NHS Devon Nursing and Quality Directorate teams being embedded in partner meetings, groups, quality committees and other key forums. The report sought to evidence the triangulation of quality information around key issues identified through quality governance process. The following points were highlighted during consideration of this item:

		• There had been improvements in patient safety in Urgent and Emergency Care due in part to improved ambulance handover times. • Approaches to patient experienced aligned to the Penny Dash quality work were being developed and included strengthened links with the complaints team and increasing their capacity to deal with complaints relating to audiology and dental services. • The Equality and Quality Impact Assessment process was now largely aligned with national guidance and would be subject to internal audit. • The reporting system in respect of incidents no longer enabled the detail of all reported incidents to be viewed and the classification of incidents was down to local discretion. With regard to the never events reported at University Hospitals Plymouth NHS Trust (UHP) it could not be confirmed whether these were dispersed or concentrated but due to their open reporting culture this number would also include near misses as well as actual incidents. • Whilst UHP's coding in respect of the Summary Hospital-level Mortality Indicator (SHMI) was improving, it could take up to a year for an improved position to be seen. However, a further deep dive in respect of this was to be undertaken. • The Quality Report was being refined with an updated format to be available in the near future. The Board **took satisfactory assurance** from the content of the report and that there was satisfactory focus and actions in place to mitigate risks and support improvements in relation to quality.
5.3	ICB25-039	**Committee Chair's Report: Quality and Patient Experience Committee – 12 June 2025** Chair of the Quality and Patient Experience Committee, Thandiwe Hara (TH) introduced the report which provided an overview of the issues considered by the Quality and Patient Experience Committee at its meeting of 12 June 2025. The Board: • **Took assurance** from the Chair's report of the meeting of the Quality and Patient Experience Committee on 12 June 2025; and • **Noted** the recommendation that EQIAs would an appropriate area of work to be considered by a joint Committee of the Finance and Performance and Quality and Patient Experience.
5.4	ICB25-040	**Finance Report – Month 02 2025/26** The Interim Chief Finance Officer, Kirsty Denwood (KD), introduced the report which sought to provide the necessary assurance on the financial position relating to the One Devon Integrated Care System (ICS) financial plan for the year ending 31 March 2026. The report detailed the ICS financial position for the period ended 31 May 2025 against the finance plan submitted for the financial year 2025/26 on the 30 April 2025. The Board **took limited assurance** from the financial position of the One Devon Integrated Care System and NHS Devon as at Month 2 2025/26.
5.5	ICB25-041	**Chair's Report: Finance and Performance Committee – 12 June and 10 July 2025** Chair of the Finance and Performance Committee, Kaye Bentley (KB), introduced the reports which provided an overview of the issues considered by the Finance and Performance Committee at its meetings on 12 June and 10 July 2025. Points highlighted during consideration of this item included: • The Committee had endorsed the One Devon System Cash Risk Policy and taken assurance from the Cash Risk Review, noting that measures had been

		taken to secure the cash position of each provider organisation through the first half of the financial year but that further decisions would be required later in the year. • The Committee had taken only limited assurance in respect of the NHS Devon financial position due to the scale of the deficit and that it had not decreased between Month 01 and Month 02. The Board: • **Took assurance** from the Committee Chair's Reports of the Finance and Performance Committee held on 12 June and 10 July 2025; and • **Noted** the escalations in respect of limited assurance regarding the ICS' financial position, as the underlying position appeared to be deteriorating, and the way in which cash was being managed across the system.
6.		**Other Committee Chair Reports**
6.1	ICB25-042	**Remuneration Committee – 16 June 2025** Chair of the Remuneration Committee, Kaye Bentley (KB), presented this report which provided an overview of the items considered by the Remuneration Committee at its meeting held on 16 June 2025. It was noted that the purpose of this meeting had been to review the Remuneration and Staff Report for the 2024/25 Annual Report and Accounts, which had been recommended for inclusion. The Board **took assurance** from the Committee Chair's Report of the meeting of the Remuneration Committee held on 16 June 2025.
6.2	ICB25-043	**Audit and Risk Committee – 19 June 2025** The Chair of the Audit and Risk Committee, Graham Clarke (GC), introduced the report which provided an overview of the work undertaken by the Audit and Risk Committee at its meeting on 19 June 2025. The following points were highlighted during consideration of this item: • The purpose of the meeting had been to receive the Annual Report and Accounts. • The Head of Internal Audit Opinion for 2024/25 was one of satisfactory assurance, which was an improvement on the limited assurance opinion received for the two previous financial years. • The Value for Money element of the external auditor's work had highlighted concern as to the Cost Improvement Programme position as the delivery profile was different to that which had been anticipated. • The Committee had recommended that the Health Inequalities Statement contained within the Annual Report be referred to the Population Health Improvement Committee for review. The Board **took assurance** from the Committee Chair's Report of the meeting of the Audit and Risk Committee held on 19 June 2025.
6.3	ICB25-044	**People and Organisational Development Committee – 23 June 2025** Chair of the People and Organisational Development Committee, Salma Ali (SA), introduced the report which provided an overview of the issues considered by the Committee at its meeting on 23 June 2025. It was noted that the government decision to de-fund Level 7 apprenticeships would not only impact on advanced practice expansion but also the number of apprentices coming into the NHS which would have an impact on future workforce availability.

		The Board: • **took assurance** from the Committee Chair's Report of the meeting of the People and Organisational Development Committee held on 23 June 2025; and • **noted** the impact on advanced practice expansion on clinical and leadership educational programmes the government decision to defund Level 7 apprenticeships will have.
6.4	ICB25-045	**Population Health Improvement Committee – 9 July 2025** Chair of the Population Health Improvement Committee, Lopa Patel (LP), introduced the report which provided an overview of the issues considered by the Committee at its meeting on 9 July 2025. It was noted that the Committee issues regarding Population Health Management data had been identified and as a result consideration of an item in respect of Population Health Functional Mapping had been withdrawn from the agenda and would be considered at a later date. The Board **took assurance** from the Committee Chair's Report of the meeting of the Populational Health Improvement Committee held on 9 July 2025.
7.		**Partnership Working**
7.1	ICB25-046	**One Devon Integrated Care Partnership Update** Chair of the One Devon Integrated Care Partnership (ICP), Councillor Mary Aspinall (MA), introduced the report which provided an overview of the issues considered by the ICP at its workshops on 13 June and 24 July 2025. The Board **noted** the Chair's report of the workshops of the One Devon Integrated Care Partnership held on 13 June and 24 July 2025.
8.		**Closing Items**
8.1	ICB25-047	**Questions from Members of the Public** No questions had been received from members of the public with the exception of those from Steve Darling MP, two of which had been considered as part of Agenda Items 4.4 and 4.5, the final question and answer was as follows: ***Question:*** *What consideration does the Board take of 'place-shaping' & the impact on local economies of health activities, not just immediate costs and clinical outcomes (i.e. a more holistic approach)?* ***Response:*** *The Devon Integrated Care System (ICS) is in the early stages of developing its place-shaping strategy, aimed at delivering integrated, community-based care that meets the needs of local populations. This approach is aligned with commitments in the NHS Long Term Plan and 10 Year Health Plan and reflects a shift toward more holistic, locally driven models of health and wellbeing.*
8.2	ICB25-048	**Any Other Business** None
		Meeting Closed

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**
ICB25-008	29.05.2025	Mark Cooke to be invited to a future Board Development Session to speak about the new NHS Oversight Framework.	30.09.2025	Philippa Harding	21.07.2025 - In light of propsed cluster arrangements consideration is being given to the plan for Board development sessions. A revised approach for the proposed joint peninsula committee will be confirmed in September.	In progress
ICB25-009	29.05.2025	A session in respect of the Decommissioning Schedule to be included in a future Board Development Session.	30.09.2025	Libby Ryan-Davies		In progress
ICB25-009i	29.05.2025	A session in respect of Population Health Management to be included in a future Board Development Session.	30.09.2025	Peter Collins		In progress
ICB25-009ii	29.05.2025	The Commissioning Plan to be considered at a Board seminar at the same time as the new National Oversight Framework to support understanding of the connections that had been made.	30.09.2025	Libby Ryan-Davies		In progress
ICB25-036	31.07.2025	The Annual Plan to be reviewed in response to points raised by Board members before finalisation of the document	30.09.2025	Libby Ryan-Davies	13.08.2025 - This will be considered as part of the development of the strategy and resulting work.	In progress
ICB25-032	31.07.2025	Discussions to take place with Assurance Committee Chairs regarding the level of detail required in in the Delivery Management Outcome Reoprt and how this was presented.	30.09.2025	Libby Ryan-Davies	13.08.2025 - This is being confirmed	In progress
ICB25-035	31.07.2025	Discussions take place with the Directors of Public Health in respect of improving vaccination programme take up and also planning for increasingly high temperatures.	30.09.2025	Peter Collins	22.08.2025 - No update as yet.	In progress

NHS Devon Integrated Care Board

Establishing Cluster Governance Arrangements

Date of meeting	Date report produced
28 August 2025	22 August 2025

Author(s)		Report approved by	
Name and title:	Philippa Harding, Company Secretary and Interim Chief Communications & Corporate Affairs Officer	**Name and title:**	n/a
Phone:		**Date:**	
Email:	philippa.harding4@nhs.net		

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

Executive summary
Following approval from NHS England (NHSE) for the cluster arrangement between NHS Cornwall and Isles of Scilly (CIOS) and NHS Devon Integrated Care Boards (ICBs), the Boards of each ICB now need to agree to the establishment of a Joint Committee/Board (Joint Committee) and arrangements for the governance and oversight of the Cluster until the point of formal merger which is currently anticipated April 2027. This paper sets out the proposed joint governance arrangements that each Board is being asked to approve to come into effect from 1 September 2025, which will

enable both ICBs to come together as a Cluster. An outline of the details is provided within a Transition Agreement, together with an overview of delegation of authority required from each sovereign Board and proposed Terms of Reference for the Joint Committee for approval. A shared Scheme of Reservation and Delegation (SoRD) and proposed updates to the Constitution of each sovereign organisation are also presented for approval.

To support the effective operation of Board Committees as Committees in Common, revised Terms of Reference for the respective Audit Committee and Remuneration Committee are presented together with an overview of the way in which Sub-Committees will be established. Draft documentation was circulated to all Board members for comment, and feedback has been considered within the final draft documents.

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

Board meeting in private – 31 July 2025.
The Board discussed the establishment of the Joint Peninsula Committee.

Key recommendations and actions requested

APPROVE:

- The Terms of Reference for the South West Peninsula Board (Annex Ai), for implementation when the Cluster Chair appointment is confirmed;
- The dis-establishment of all existing Board Assurance Committees from 01 September and the establishment of the new assurance groups for the Cluster (Annex Aii) once the aligned NEMs are appointed.
- The proposed amendments to the current ICB Constitution (Annex B) for submission to NHS England for approval;
- The revised, single Scheme of Reservation and Delegation (Annex C);
- That the current Chair and Chief Executive can sign the Transition Agreement (Annex D) on behalf of the Board;
- The revised Terms of Reference for the Audit Committee (Annex E); and
- The revised Terms of Reference for the Remuneration Committee (Annex F).
- The Board is asked to delegate to the Cluster Chair (once appointed) authority to approve any modifications to these arrangements that are aligned with this direction of travel and supported by the NHS England South West Regional Team.

NOTE the Terms of Reference for the Transition Steering Group (Annex G).

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	
Health inequalities	
Workforce	
Resources and finance	All
Legal	
Digital and Data	
Involvement, Engagement and consultation	

Establishing cluster governance arrangements

Introduction

1. Following approval from NHS England (NHSE) for the cluster arrangement between NHS Cornwall and Isles of Scilly (CIOS) and NHS Devon Integrated Care Boards (ICBs), the Boards of each ICB now need to agree to the establishment of a Joint Committee/Board (Joint Committee) and arrangements for the governance and oversight of the Cluster.

2. This paper sets out the proposed joint governance arrangements that each Board is asked to approve to come into effect from 1 September 2025, which will enable both ICBs to come together as a Cluster.

3. The paper also outlines details of a Transition Agreement that each Board is also being asked to approve. This will provide a robust structure for the working relationship between the two ICBs whilst working together as a Cluster.

Implementing a Joint Committee arrangement

4. Both ICBs will continue to be individual sovereign legal entities until the point of formal merger (expected April 2027). In order to ensure effective and cohesive governance oversight of the Cluster arrangements, both ICBs need to agree to delegate their current Board's responsibilities into a Joint Committee arrangement.

5. Joint Committees arise where NHS bodies agree to form a single committee with a membership drawn from each of the constituent bodies to exercise specific functions which are delegated to it by each of those constituent bodies. A Joint Committee operates under an agreed single set of Terms of Reference, with a shared Scheme of Reservation and Delegation (SoRD) and Collaboration Agreement to provide greater detail on governance arrangements. Decisions of the Joint Committee are, subject to any specific provisions in the delegation or Terms of Reference, binding on all those who are members of the Committee and no further recourse to individual constituent members or Boards is usually required for decisions to be made and implemented.

6. The NHS Cornwall and Isles of Scilly and NHS Devon Joint Committee/Board would be established under sections 65Z5 and 65Z6 of the National Health Service Act 2006 as amended ('the NHS Act'). In accordance with Section 65Z5 of the NHS Act, ICBs can establish and maintain joint working arrangements to jointly exercise their commissioning functions, with Section 65Z6 giving the power to establish a joint committee.

7. To give full effect to the cluster arrangements envisaged, all the functions of each ICB would be exercised jointly through the Joint Committee with the exception of those functions that must remain reserved to each sovereign Board:

   Statutory functions that cannot be delegated

   - Decision making in respect of NHS Continuing Healthcare and NHS funded nursing care functions
   - Annual accounts preparation and approval
   - Constitutional compliance matters specific to each ICB
   - Individual ICB statutory reporting requirements
   - Functions that are required by NHS England to remain with individual ICBs
   - Such other functions as are determined to be non-delegable by an ICB

   Corporate governance functions

   - Approval of changes to each ICB's constitution
   - Approval of ICB Operational Scheme of Delegation
   - Approval of ICB Standing Financial Instructions

8. It is proposed that the first meeting of the Joint Committee takes place once the Chair of the Cluster has been confirmed. At that point each current Board would no longer be required to meet separately, other than when required to transact the business set out at paragraph 7 above. It is proposed that there should be two scheduled ICB Board meetings per financial year until at such time a merger is effected.

9. It must be emphasised that the establishment of the Joint Committee, whilst it enables NHS Devon and NHS Cornwall and Isles of Scilly to align under a shared "South West Peninsula Board", does not replace the ICBs as separate sovereign legal entities. It is the first step towards an anticipated merger; however, each ICB will continue, initially, to have their own separate Accountable Officer and Executives as well as their separate organisational structures. Confirmation of the appointment of a single Chair and Chief Executive Officer for the cluster is awaited. Both of these individuals will be appointed to both ICBs. Once both of these posts have been confirmed the Cluster will then look to move to implementing an organisational change programme that replaces the two Executive teams with a single set of Executives for the cluster, again these individuals will be appointed to both ICBs. This process will cascade down through the organisational structure of both ICBs until there is one clear organisational structure to support the Cluster. There is then a formal process to be entered into in order to effect a merger.

10. The proposed Terms of Reference for the Joint Committee (known as the South West Peninsula Board) are attached as Annex Ai to this report. The proposed sub-groups of the South West Peninsula Board are attached as Annex Aii to this report.

Changes to the Constitution and Scheme of Reservation and Delegation

Constitution

11. In order to give effect to the proposed Joint Committee arrangement the current Constitutions and Board Schemes of Reservation and Delegation (SoRD) of each ICB will need to be amended.

12. Proposed consequential changes to the ICB's Constitution are set out in tracked changes at Annex B to this report. These changes do the following:-

- Amend the voting membership of the Board so that it now has six non-executive members;
- Remove provisions that reference the appointment of an other ordinary member;
- Make some minor and other drafting changes:

    - that NHS England have required all ICBs to make in an update to the model constitution, including (1) allowing a chief executive to also be the chief executive of another ICB, (2) updates relating to the provider selection regime, and (3) updates in relation to the development of the Joint Forward Plan
    - that enable the two Constitutions of the NHS Cornwall and Isles of Scilly and NHS Devon to be better aligned to facilitate closer working whilst in a cluster arrangement.

13. It should be noted that further amendment of the Constitutions of both NHS Devon and NHS Cornwall and the Isles of Scilly will be required with respect to the naming of the executive members of the Board. As these roles will be subject to consultation as part of a formal organisational change programme, it is proposed that the Board agrees that these proposed changes should be agreed in correspondence.

14. Once agreed by the Board, changes to the Constitution will also need to be agreed by NHS England. It is anticipated that this agreement will be secured swiftly.

15. The proposed amendments to the Constitutions of NHS Devon and NHS Cornwall and the isles of Scilly will enable the non-executive membership of both Boards to be aligned. This will facilitate the next step towards the cluster, pending the first meeting of the Joint Committee, which requires the appointment of the Cluster Chair to be approved.

Scheme of Reservation and Delegation

16. In addition to the constitutional changes, it is proposed that a single, consistent Board Scheme of Reservation and Delegation (SoRD) is agreed for use by each Board. This scheme, set out at Annex C to this report, sets out the matters that

are delegated from each Board to the Joint Committee, those matters delegated to the cluster executive team, and those matters reserved to each Board.

17. The delegations also give the appointed Cluster Chief Executive the ability to agree a single operational scheme of delegation (which sets out the financial and other delegations below executive level) and standing financial instructions for the cluster at a future point post consultation and officer appointments. Executive committee arrangements would be for the Cluster Chief Executive to determine on appointment, with the support of the Cluster Chair as part of the wider board and committee governance arrangements.

18. Each ICB's Governance Handbook will need to be updated to reflect these changes and it is proposed this is done once the executive and senior leadership structure for the Cluster is in place.

Adopting a Transition Agreement

19. In order to support effective working between the two ICBs as they move into cluster arrangements, it is proposed that each Board agrees to sign up to a Transition Agreement.

20. The draft Transition Agreement sets out the (1) design principles that have informed the design of the cluster arrangements and (2) the behaviours and ways of working expected from each ICB. It also confirms the principle that the Joint Committee will not be able to unpick any of the budgetary or planning decisions made by each Board in agreeing its 2025/26 operating and financial plan other than with the explicit agreement of both Boards.

21. It then sets out a number of protocols that should govern working arrangements between the two ICBs covering the following:-

- Employment and management of change processes and associated costs;
- Risk management;
- Management of assets and liabilities;
- Information governance; and
- Due diligence in relation to a future merger.

22. The draft Transition Agreement can be found at Annex D to this report.

Board Committees and Sub-Committees of the Joint Committee

23. Each ICB is required to have its own Audit Committee and Remuneration Committee.

24. It is envisaged that the respective Audit Committees and Remuneration Committees of NHS Cornwall and Isles of Scilly and NHS Devon will generally wish to meet as Committees in Common. In light of this a review of their terms of Reference has been undertaken to ensure that these are aligned to facilitate

this approach to operation. The proposed revised Audit Committee Terms of Reference are attached at Annex E to this report. The proposed revised Remuneration Committee Terms of Reference are attached at Annex F.

25. With the exception of the Audit Committee and the Remuneration Committee, all other existing ICB Board Committees will be dis-established as of 01 September 2025.

26. Once the proposed amendments of the Constitutions of both NHS Devon and NHS Cornwall and the Isles of Scilly have been approved and the non-executive membership of both boards aligned, it is proposed that certain key new sub-groups of the Joint Committee should begin meeting, even if the Joint Committee itself has not formally met. This is to ensure that the Cluster arrangement between the two ICBs is in effect during the crucial period when ICBs are required to work through their commissioning intentions and operational planning and does not rely upon the confirmation of the Cluster Chair appointment.

27. In order to ensure that the risks and issues being addressed by current ICB Board Committees are not lost in the transition to the cluster arrangement. The Non-Executive Chair of each current Board Committee (supported by the relevant lead executive and Corporate Governance lead) would be required to develop and sign off a full handover report to the new joint sub-committees covering key issues, risks, outstanding actions and current forward plans.

28. This handover documentation would inform the draft workplans for the new joint sub-committees. Where current non-executive members are not appointed to the new cluster governance arrangements, they will be offered (and where accepted) engaged as transition advisors until 31 October 2025 to facilitate this handover.

29. In addition to the new joint sub-committees, the Model ICB Blueprint requires each ICB to establish a Transition Committee to be Chaired by the Cluster Chair. The Terms of Reference for the Transition Steering Group are attached at Annex G to this report.

Recommendations

30. The Board is asked to **APPROVE**:

- The Terms of Reference for the South West Peninsula Board (Annex Ai), for implementation when the Cluster Chair appointment is confirmed;
- The dis-establishment of all existing Board Assurance Committees from 01 September and the establishment of the new assurance groups for the Cluster (Annex Aii) once the aligned NEMs are appointed.
- The proposed amendments to the current ICB Constitution (Annex B) for submission to NHS England for approval;
- The revised, single Scheme of Reservation and Delegation (Annex C);
- That the current Chair and Chief Executive can sign the Transition Agreement (Annex D) on behalf of the Board;

- The revised Terms of Reference for the Audit Committee (Annex E); and
- The revised Terms of Reference for the Remuneration Committee (Annex F).
- The Board is asked to delegate to the Cluster Chair (once appointed) authority to approve any modifications to these arrangements that are aligned with this direction of travel and supported by the NHS England South West Regional Team.

31. The Board is asked to **NOTE** the Terms of Reference for the Transition Steering Group (Annex G).

South West Peninsula Board

Terms of Reference

1. Introduction and purpose

1.1. The South West Peninsula Board (the SWPB) has been established by NHS Cornwall and the Isles of Scilly Integrated Care Board and NHS Devon Integrated Care Board (the Partner ICBs) pursuant to sections 65Z5 and 65Z6 of the National Health Service Act 2006 as amended ('the NHS Act'). In accordance with Section 65Z5 of the NHS Act, Integrated Care Boards (ICBs) can establish and maintain joint working arrangements to jointly exercise their commissioning functions, with Section 65Z6 giving the power to establish a joint committee.

1.2. The purpose of the SWPB is to enable the Partner ICBs to enact their Cluster arrangement and take decisions as one in the best interests of the populations of Devon, Cornwall and the Isles of Scilly and fulfill the four core purposes of Integrated Care Systems (ICSs):

- improve outcomes in population health and healthcare
- tackle inequalities in outcomes, experience and access
- enhance productivity and value for money
- help the NHS support broader social and economic development

2. Responsibilities

2.1 The SWPB shall be responsible for the key decisions previously reserved to the Boards of both partners, with the exception of those which cannot be delegated, as summarised below:

Statutory functions that cannot be delegated

2.1.1 Decision making in respect of NHS Continuing Healthcare and NHS funded nursing care functions
2.1.2 Annual accounts preparation and approval
2.1.3 Constitutional compliance matters specific to each ICB
2.1.4 Individual ICB statutory reporting requirements
2.1.5 Functions that are required by NHS England to remain with individual ICBs

2.1.6 Such other functions as are determined to be non-delegable by an ICB

Corporate governance functions

2.1.7 Approval of changes to each ICB's constitution
2.1.8 Approval of ICB Operational Scheme of Delegation
2.1.9 Approval of ICB Standing Financial Instructions

3. Membership

3.1 Members of the SWPB shall be appointed by the Partner ICBs and cannot be varied without the agreement of both the Partner ICBs' Boards.

Chair & Deputy Chair

3.2 The SWPB will be chaired by the single Chair of the Partner ICBs' Boards, as appointed by NHS England, with the approval of the Secretary of State for Health and Social Care (also known as the Cluster Chair).

3.3 The SWPB Chair will appoint a Deputy Chair from amongst the membership of the SWPB. This must be a Non-Executive Member of the Partner ICBs' Boards, who has the requisite skills and experience to act in that capacity.

3.4 The Chair of the SWPB will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these Terms of Reference, in line with the Standing Orders of both Partner ICBs.

Membership

3.5 The membership of the SWPB shall be constituted as follows:

- Cluster Chair
- Non-Executive Members (x6)
- NHS Cornwall and Isles of Scilly: Partner Member – Providers of Primary Care Medical Services
- NHS Devon: Partner Member – Providers of Primary Medical Services
- NHS Cornwall and Isles of Scilly: Partner Member – NHS Providers
- NHS Cornwall and Isles of Scilly: Partner Member – NHS Providers (mental health)
- NHS Devon: Partner Member – NHS Trusts and Foundation Trusts
- NHS Cornwall and Isles of Scilly: Partner Member - Local Authorities
- NHS Devon: Partner Member – Local Authorities
- NHS Devon: Mental Health Member
- Cluster Chief Executive Officer
- Cluster Executive Members (N.B. the Cluster Executive Member roles are subject to consultation and are expected to be confirmed in September. It is anticipated that there will be 5 of these roles)

3.6 At the establishment of the SWPB, whilst the executive level of the Partner ICBs' revised organisational structures is being consulted upon and appointed to, the executive membership of the SWPB shall include the Partner ICBs' existing Executive Teams (see Appendix A). These individuals will have voting rights as SWPB members.

Other participants

3.7 Only members of the SWPB have the right to attend and vote at SWPB meetings; however, meetings of the SWPB will also include the following participants who are not members:

- Director of Public Health, from one of Cornwall Council or Council for Isles of Scilly
- Director of Public Health, from one of Devon County Council, Plymouth City Council, or Torbay Council
- Representative of the VCSE within Cornwall and Isles of Scilly
- Representative of the VCSE within Devon
- GP Collaborative Board Chair, Cornwall and Isles of Scilly
- Devon GP Collaborative Board Chair
- Cluster Corporate Governance lead

3.8 Other attendees may be invited to attend all or part of any meeting as and when the Chair of the SWPB considers they have expertise that would be relevant to the responsibilities of the SWPB.

3.9 The Chair of the SWPB may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Attendance

3.10 Members of the SWPB may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair of the SWPB. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are normally expected to attend at least 75% of meetings during the year.

Conflicts of Interest

3.11 Members' conflicts of interests to be held by their respective organisations and made available on organisations' websites.

3.12 All potential conflicts of interest pertinent to agenda items must be declared and recorded at the start of each meeting.

4. Quorum, Decisions and Voting

Quorum

4.1. The quorum for meetings of the SWPB will be members, including:

a) Chair or Deputy Chair
b) At least two Executive Members
c) At least three Non-Executive Members
d) At least two of either the Partner Members or the Mental Health Member

4.2. If any member of the SWPB is unable to participate in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

4.3. If the quorum has not been reached, then the meeting may proceed informally if those attending agree, but no decisions may be taken.

Decision Making and Voting

4.4. In line with the Standing Orders of each of the Partner ICBs, it is expected that decisions will be reached by consensus. Should this not be possible, each member of the SWPB will have one vote, the process for which is set out below:

a) All members of the SWPB who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the SWPB are set out at paragraph 3.5; attendees and observers do not have voting rights).

b) Absent members may not vote by proxy. Absence is defined as not being present at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so.

c) A resolution will be passed if more votes are cast for the resolution than against it.

d) If an equal number of votes are cast for and against a resolution, then the Chair of the SWPB (or in their absence, the Deputy Chair) will have a second and casting vote.

e) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

4.5. At the establishment of the SWPB, whilst the top (executive) level of the Partner ICBs' revised organisational structures is being consulted upon and appointed to, as the executive membership of the SWPB includes the Partner

ICBs' existing Executive Teams, the SWPB will require a majority of the Non-Executive Members in attendance including the Chair of the SWPB (or in their absence, the Deputy Chair) to support any executive recommendations before it becomes a formal decision.

4.6. For urgent issues, the Chair of the SWPB may call a meeting at a notice of 5 days, setting out the reason for the urgency and the issue to be addressed.

5. Ways of Working

5.1 All members of the SWPB will have due regard to and operate within the Constitutions of the Partners, their Standing Orders, Standing Financial Instructions and other financial procedures.

5.2 Members of the SWPB will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

5.3 Members of the SWPB must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

5.4 A Register of Interests will be reviewed at each SWPB meeting. Those in attendance will be asked by the Chair of the SWPB to declare any interests at the beginning of each meeting. If a member of the SWPB feels compromised by any agenda item, they should declare a conflict of interest and agreement reached as the action to be taken as set out in the Partner ICBs' Conflicts of Interest Policy.

5.5 If necessary, the SWPB may draw on third-party support to assist it in resolving any disputes, such as peer review or support from NHS England.

6. Reporting Arrangements

6.1 The SWPB is accountable to the Partner ICBs' Boards and shall report to the Boards at least annually on how it discharges its responsibilities.

6.2 The SWPB shall undertake an annual self-assessment of its own performance against its annual programme of business, membership and Terms of Reference.

7. Meetings and Administration

Frequency of Meetings

7.1 The SWPB will meet in public and in private every other month (with the exception of August).

7.2 The SWPB will meet formally in private in the alternate months (with the exception of August).

7.3 The Chair of the SWPB may ask the SWPB to convene further meetings to discuss particular issues they consider pertinent.

7.4 Arrangements and notice for calling meetings are set out in the Partner ICBs' Standing Orders.

7.5 Whilst in person attendance is expected at most meetings, when an urgent meeting is called members of the Committee may participate by telephone, video or by other electronic means where they are available and with the prior agreement of the Cluster Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting.

Publication of notices, minutes and papers

7.6 The Chair of the SWPB shall see that a notice of any public meeting of the SWPB, together with an agenda listing the business to be conducted and supporting documentation, is published one week (or, in the case of a special meeting, two days) prior to the date of the meeting.

7.7 The proceedings and decisions taken by the SWPB shall be recorded in minutes, and those minutes circulated in draft form within two weeks of the date of the meeting. The SWPB shall confirm those minutes at its next meeting.

Administration

7.8 The SWPB shall be supported by an administrator from within the Partner ICBs' Corporate Governance team. Their duties in this respect will include:

a) Agreement of agendas with the Chair and attendees.
b) Preparation, collation and circulation of papers in good time.
c) Ensuring that those invited to each meeting attend, highlighting any concerns to Chair (including interests of members that may conflict with an agenda item).
d) Taking the minutes and helping the Chair to prepare any necessary reports to the Partners' Boards.
e) Keeping a record of matters arising and issues to be carried forward.
f) Maintaining records of members' appointments and renewal dates.
g) Ensuring that action points are taken forward between meetings.
h) Ensuring that members receive the development and training they need.
i) Providing appropriate support to the Chair and members.

7.9 Following each meeting of the SWPB, the administrator will also:

a) Maintain an attendance log and follow up as appropriate after each meeting to ensure the SWPB adheres to the required frequency of attendance by members; and
b) Maintain a decisions log of reporting arrangements into each formal

meeting of the SWPB.

8. Review of Terms of Reference

8.1 These Terms of Reference will be reviewed at least annually and earlier if required. Any proposed amendments will be submitted to the Partner ICBs' Boards for approval.

Appendix A

NHS Devon Executive Team

Chief Executive Officer – Steve Moore
Chief Finance Officer – Kirsty Denwood (interim)
Chief Medical Officer – Peter Collins
Chief Nursing Officer – Penny Smith
Chief People Officer – Piers Tetley
Chief Communications and Corporate Affairs Officer – Philippa Harding (interim)
Chief Strategic Commissioning and Planning Officer – Libby Ryan-Davies

NHS Cornwall and the Isles of Scilly Executive Team

Chief Executive Officer – Kate Shields
Chief Finance Officer – Simon Gittoes-Davies
Chief Medical Officer – Chris Reid
Chief Nursing Officer & Chief Operating Officer – Susan Bracefield
Chief People Officer – Patrick Weir
Chief Information Officer and System Digital Lead – Kelvyn Hipperson
Chief of Staff – Tracey Lee

Document Control

Document Reference	JPC ToR
Version	V.0.1
Senior Responsible Officer	Philippa Harding, Director of Governance, NHS Devon Terry Willows, Company Secretary, NHS Cornwall and the Isles of Scilly
Approval by	NHS Devon Board NHS Cornwall and the Isles of Scilly Board
Date last reviewed/ approved	NHS Cornwall and the Isles of Scilly – 28 August 2025 NHS Devon – 28 August 2025
Next review date	Before 31 March 2026

Change Record

Date	Change	Comments

NHS Devon
Integrated Care Board

CONSTITUTION

Version	Date approved by the ICB	Effective date
V1.0	01 July 2022	01 July 2022
V1.2	18 October 2022	18 October 2022
V2	27 March 2025	08 May 2025
V2.1	~~To be considered on 31 July 2025~~N/A	11 July 2025 (instructed by NHSE)
V3	To be considered on 28 August 2025	

Commented [PH1]: To be updated once proposed revisions are approved

1. Introduction

1.1 Background/ Foreword

1.1.1 NHS England has set out the following as the four core purposes of Integrated Care Systems (ICSs):

a) improve outcomes in population health and healthcare
b) tackle inequalities in outcomes, experience and access
c) enhance productivity and value for money
d) help the NHS support broader social and economic development.

1.1.2 The Integrated Care Board (ICB) will use its resources and powers to achieve demonstrable progress on these aims, collaborating to tackle complex challenges, including:

- improving the health of children and young people
- supporting people to stay well and independent
- acting sooner to help those with preventable conditions
- supporting those with long-term conditions or mental health issues
- caring for those with multiple needs as populations age
- getting the best from collective resources so people get care as quickly as possible.

1.2 Name

1.2.1 The name of this Integrated Care Board is NHS Devon Integrated Care Board (the ICB).

1.3 Area Covered by the Integrated Care Board

1.3.1 The area covered by the ICB is co-terminus with the administrative boundaries of the following local authorities:

a) Devon County Council
b) Torbay Council
c) Plymouth City Council

1.3.2 The area covered by the ICB is coterminous with the areas of the District of East Devon, City of Exeter, District of Mid Devon, District of North Devon, City of Plymouth, District of South Hams, District of Teignbridge, Borough of Torbay, District of Torridge and the Borough of West Devon.

1.4 Statutory Framework

1.4.1 The ICB is established by order made by NHS England under powers in the 2006 Act.

1.4.2 The ICB is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England and is an NHS body for the purposes of the 2006 Act.

1.4.3 The main powers and duties of the ICB to commission certain health services are set out in sections 3 and 3A of the 2006 Act. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the 2006 Act).

1.4.4 In accordance with section 14Z25(5) of, and paragraph 1 of Schedule 1B to, the 2006 Act the ICB must have a Constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its Constitution (section 14Z29). This Constitution is published here.

1.4.5 The ICB must act in a way that is consistent with its statutory functions, both powers and duties. Many of these statutory functions are set out in the 2006 Act but there are also other specific pieces of legislation that apply to ICBs. Examples include, but are not limited to, the Equality Act 2010 and the Children Acts. Some of the statutory functions that apply to ICBs take the form of general statutory duties, which the ICB must comply with when exercising its functions. These duties include but are not limited to:

a) having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 2009 and section 14Z32 of the 2006 Act)
b) exercising its functions effectively, efficiently and economically (section 14Z33 of the 2006 Act)
c) duties in relation children including safeguarding, promoting welfare etc (including the Children Acts 1989 and 2004, and the Children and Families Act 2014)
d) adult safeguarding and carers (the Care Act 2014)
e) equality, including the public-sector equality duty (under the Equality Act 2010) and the duty as to health inequalities (section 14Z35)
f) information law, (for instance, data protection laws, such as the UK General Data Protection Regulation 2016/679 and Data Protection Act 2018, and the Freedom of Information Act 2000)
g) provisions of the Civil Contingencies Act 2004

1.4.6 The ICB is subject to an annual assessment of its performance by NHS England which is also required to publish a report containing a summary of the results of its assessment.

1.4.7 The performance assessment will assess how well the ICB has discharged its functions during that year and will, in particular, include an assessment of how well it has discharged its duties under—

a) section 14Z34 (improvement in quality of services)
b) section 14Z35 (reducing inequalities)
c) section 14Z38 (obtaining appropriate advice)
d) section 14Z40 (duty in respect of research)

e) section 14Z43 (duty to have regard to effect of decisions)
f) section 14Z45 (public involvement and consultation)
g) sections 223GB to 223N (financial duties)
h) section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies)

1.4.8 NHS England has powers to obtain information from the ICB (section 14Z60 of the 2006 Act) and to intervene where it is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so (section 14Z61).

1.5 Status of this Constitution

1.5.1 The ICB was established on 01 July 2022 under The Integrated Care Boards (Establishment) Order 2022, which made provision for its Constitution by reference to this document.

1.5.2 Changes to this Constitution will not be implemented until, and are only effective from, the date of approval by NHS England.

1.6 Variation of this Constitution

1.6.1 In accordance with paragraph 15 of Schedule 1B to the 2006 Act this Constitution may be varied in accordance with the procedure set out in this paragraph. The Constitution can only be varied in two circumstances:

a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; or
b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).

1.6.2 The procedure for proposal and agreement of variations to the Constitution is as follows:

a) The ICB's Audit and Risk Committee will lead an annual review of this Constitution. Any proposed amendments shall be considered and approved by the Board of the ICB, for application to NHS England for variation.
b) In addition to the annual review by the Audit and Risk Committee, the Chief Executive Officer or Chair may also propose amendments to this Constitution, which shall be considered and approved by the Board of the ICB, for application to NHS England for variation.
c) In considering and approving any proposed changes to this Constitution, and where proportionate to the proposed variation, the Board of the ICB will wish to engage with relevant stakeholders (in line with any applicable guidance issued by NHS England) ahead of any final application to NHS England.
d) Proposed amendments to this Constitution will not be implemented until an application to NHS England for variation has been approved.

1.7 Related Documents

1.7.1 This Constitution is also supported by a number of documents which provide further details on how governance arrangements in the ICB will operate.

1.7.2 The following are appended to the Constitution and form part of it for the purpose of clause 1.6 and the ICB's legal duty to have a Constitution:

a) Standing orders– which set out the arrangements and procedures to be used for meetings and the processes to appoint the ICB committees.

1.7.3 The following do not form part of the Constitution but are required to be published.

a) The Scheme of Reservation and Delegation (SoRD)– sets out those decisions that are reserved to the board of the ICB and those decisions that have been delegated in accordance with the powers of the ICB and which must be agreed in accordance with and be consistent with the Constitution. The SoRD identifies where, or to whom, functions and decisions have been delegated to.

b) Functions and Decision Map- a high level structural chart that sets out which key decisions are delegated and taken by which part or parts of the system. The Functions and Decision Map also includes decision making responsibilities that are delegated to the ICB (for example, from NHS England).

c) Standing Financial Instructions – which set out the arrangements for managing the ICB's financial affairs.

d) The ICB Governance Handbook– this brings together all the ICB's governance documents, so it is easy for interested people to navigate. It includes:

- The above documents a) – c)
- Terms of reference for all committees and sub-committees of the board that exercise ICB functions.
- Delegation arrangements for all instances where ICB functions are delegated, in accordance with section 65Z5 of the 2006 Act, to another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one of those organisations in accordance with section 65Z6 of the 2006 Act.
- Terms of reference of any joint committee of the ICB and another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body; or to a joint committee of the ICB and one or those organisations in accordance with section 65Z6 of the 2006 Act.

- The up-to-date list of eligible providers of primary medical services under clause 3.7.2

e) Key policy documents - these shall be included in the Governance Handbook or linked to it. They include the following, as amended, supplemented or updated from time to time by the Board of the ICB:

- Standards of Business Conduct Policy
- Conflicts of Interest Policy
- Policy for Public Involvement and Engagement
- Policy for the Development of Procedural Documents

2 Composition of the Board of the ICB

2.1 Background

2.1.1 This part of the Constitution describes the membership of the ICB. Further information about the criteria for the roles and how they are appointed is in section 3 of this Constitution.

2.1.2 Further information about the individuals who fulfil these roles can be found on our website.

2.1.3 In accordance with paragraph 3 of Schedule 1B to the 2006 Act, the membership of the ICB (referred to in this Constitution as "the Board" and members of the ICB are referred to as "Board Members") consists of:

a) a Chair
b) a Chief Executive (known as the Chief Executive Officer)
c) at least three Ordinary Members.

2.1.4 The membership of the ICB (the Board) shall meet as a unitary board and shall be collectively accountable for the performance of the ICB's functions.

2.1.5 NHS England Policy, requires the ICB to appoint the following additional Ordinary Members:

a) three Executive Members, namely:
   - Director of Finance (known as Chief Finance Officer)
   - Medical Director (known as Chief Medical Officer)
   - Director of Nursing (known as Chief Nursing Officer)
b) at least two Non-Executive Members

2.1.6 The Ordinary Members include at least three members who will bring knowledge and a perspective from their sectors. These members (known as Partner Members) are nominated by the following, and appointed in accordance with the procedures set out in section 3 below**:**

- NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description

- the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description
- the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.

2.1.7 While the Partner Members will bring knowledge and experience from their sector and will contribute the perspective of their sector to the decisions of the Board, they are not to act as delegates of those sectors.

2.2 Board Membership

2.2.1 The ICB has ~~4~~ 3 Partner Members

a) 1 Partner Member NHS Trusts and Foundation Trusts
b) 1 Partner Member - Primary Medical Services
c) ~~2~~ 1 Partner Member~~s~~ - Local Authorities

2.2.2 In addition to the expectations set out in 2.1.3 and 2.1.6, ~~The~~ the ICB ~~has~~ will also appoint~~ed~~ the following further Ordinary Members to the Board:

a) At least ~~2~~ 3 and up to ~~3~~ 4 additional Non-Executive Members
~~b)~~ 1 member who brings the perspective of Mental Health services (known as the Mental Health member)

2.2.3 The Board is therefore composed of the following members:

a) Chair
b) Chief Executive Officer
c) 1 Partner Member - NHS Trusts and Foundation Trusts
d) 1 Partner Member - Primary Medical Services
e) ~~2~~ 1 Partner Member~~s~~ - Local Authorities
f) Mental Health Member
~~g) VCSE Member~~
~~i)~~h) Director of Finance (known as Chief Finance Officer)
~~j)~~i) Medical Director (known as Chief Medical Officer)
~~k)~~j) Director of Nursing (known as Chief Nursing Officer)

2.2.4 The Chair will exercise their function to approve the appointment of the ordinary members with a view to ensuring that at least one of the Ordinary Members will have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

2.2.5 The Board will keep under review the skills, knowledge, and experience that it considers necessary for members of the Board to possess (when taken together) in order for the Board effectively to carry out its functions and will take such steps as it considers necessary to address or mitigate any shortcoming.

2.3 Regular Participants and Observers at Board Meetings

Commented [PH2]: This corrects an error in consistency within the Constitution - it does not increase the number of INEMs

Commented [PH3]: Proposed ICB Executive Member roles provided separately and subject consultation and NHSE approval

2.3.1 At the discretion of the Chair, the Board may invite specified individuals to be participants, attendees and observers at its meetings to inform its decision-making and the discharge of its functions as it sees fit.

2.3.2 Participants are invited regularly to actively contribute to the public sessions Board meetings. They will be included in circulation lists and receive advance copies of the agenda and papers. They may, for example, be executive or non-executive members of the ICB or partner organisations. They do not have a vote.

2.3.3 The Chair may invite individuals from the following groups to be regular participants at its board meetings:

a) Director of public health for Devon County Council, Plymouth City Council or Torbay Council.
b) Other non-executive members and senior executives from ICS partner organisations that will include (but not limited to) the Voluntary, Community and Social Enterprise (VCSE) Assembly.

2.3.4 Attendees are people who are invited to attend the whole, or part of, the Board meeting for example, a representative of the Local Medical Committee. They may attend regularly or on an ad hoc basis, for example to present reports or provide expert opinion or advice. They may be invited, at the discretion of the Chair, to contribute to discussions while they are present but may not vote.

2.3.5 Observers are people who join Board meetings which are held in public, such as members of the public or staff. They will be able to access the Board agenda and papers through the ICB website. They are unable to contribute unless specifically invited to by the Chair, for example as part of an agenda item on questions raised by the public. They do not have a vote.

2.3.6 Participants, attendees and/or observers may be asked to leave the meeting by the Chair in the event that the Board passes a resolution to exclude the public as per the standing orders.

2.3.7 At the discretion of the Chair, participants and attendees may be invited to join the closed session of the Board meeting.

Commented [PH4]: Proposed amendment to align to NHS CIOS Constitution

~~The Board may invite up to two Associate Non-Executive Members and other specified individuals to be Participants or Observers at its meetings in order to inform its decision-making and the discharge of its functions as it sees fit.~~

3 Appointments Process for the Board

3.1 Eligibility Criteria for Board Membership

3.1.1 Each member of the ICB must:

a) comply with the criteria of the “fit and proper person test”
b) be committed to upholding the Seven Principles of Public Life (known as the Nolan Principles)
c) fulfil the requirements relating to relevant experience, knowledge, skills and attributes set out in a role specification.

3.2 Disqualification Criteria for Board Membership

3.2.1 Individuals of the following descriptions are automatically disqualified from membership of the Board

a) A Member of Parliament.

b) A person whose appointment as a Board member (“the candidate”) is considered by the person making the appointment as one which could reasonably be regarded as undermining the independence of the health service because of the candidate’s involvement with the private healthcare sector or otherwise.

c) A person who, within the period of five years immediately preceding the date of the proposed appointment, has been convicted—

- in the United Kingdom of any offence, or
- outside the United Kingdom of an offence which, if committed in any part of the United Kingdom, would constitute a criminal offence in that part, and, in either case, the final outcome of the proceedings was a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine.

d) A person who is subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order under Schedule 4A to the Insolvency Act 1986, Part 13 of the Bankruptcy (Scotland) Act 2016 or Schedule 2A to the Insolvency (Northern Ireland) Order 1989 (which relate to bankruptcy restrictions orders and undertakings).

e) A person who, has been dismissed within the period of five years immediately preceding the date of the proposed appointment, otherwise than because of redundancy, from paid employment by any Health Service Body.

f) A person whose term of appointment as the chair, a member, a director or a governor of a Health Service Body, has been terminated on the grounds:

- that it was not in the interests of, or conducive to the good management of, the Health Service Body or of the health service that the person should continue to hold that office
- that the person failed, without reasonable cause, to attend any meeting of that Health Service Body for three successive meetings,

- that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest, or
- of misbehaviour, misconduct or failure to carry out the person's duties;

g) A Health Care Professional, meaning an individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002, or other professional person who has at any time been subject to an investigation or proceedings, by any body which regulates or licenses the profession concerned ("the regulatory body"), in connection with the person's fitness to practise or any alleged fraud, the final outcome of which was:

- the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
- the person's erasure from such a register, where the person has not been restored to the register
- a decision by the regulatory body which had the effect of preventing the person from practising the profession in question, where that decision has not been superseded, or
- a decision by the regulatory body which had the effect of imposing conditions on the person's practice of the profession in question, where those conditions have not been lifted.

h) A person who is subject to:

- a disqualification order or disqualification undertaking under the Company Directors Disqualification Act 1986 or the Company Directors Disqualification (Northern Ireland) Order 2002, or
- an order made under section 429(2) of the Insolvency Act 1986 (disabilities on revocation of administration order against an individual).

i) A person who has at any time been removed from the office of charity trustee or trustee for a charity by an order made by the Charity Commissioners for England and Wales, the Charity Commission, the Charity Commission for Northern Ireland, the Scottish Charity Regulator or the High Court, on the grounds of misconduct or mismanagement in the administration of the charity for which the person was responsible, to which the person was privy, or which the person by their conduct contributed to or facilitated.

j) A person who has at any time been removed, or is suspended, from the management or control of any body under:

- section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or

- section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

3.3.1 The ICB Chair is to be appointed by NHS England, with the approval of the Secretary of State for Health and Social Care.

3.3.2 In addition to criteria specified at 3.1, this member must be independent.

3.3.3 Individuals will not be eligible if:

a) They hold an ongoing role in another health and care organisation within the same ICS footprint
b) Any of the disqualification criteria set out in 3.2 apply

3.3.4 Subject to NHS England's national policy and requirements and as set out in the letter of appointment to the role, the term of office for this role will be a maximum 3 years in duration and the maximum number of terms which may be served is 3.

3.4 Deputy Chair and Senior Non-Executive Member

3.4.1 The Deputy Chair is to be appointed from amongst the Non-Executive Members by the Board subject to the approval of the Chair.

3.4.2 No individual shall hold the position of Chair of the Audit and Risk Committee and Deputy Chair at the same time.

3.4.3 The Senior Non-Executive Member is to be appointed from amongst the Non-Executive Members by the Board, subject to the approval of the Chair.

3.5 Chief Executive Officer

3.5.1 The Chief Executive Officer will be appointed by the Chair of the ICB in accordance with any guidance issued by NHS England.

3.5.2 The appointment will be subject to approval of NHS England in accordance with any procedure published by NHS England.

3.5.3 In addition to the eligibility criteria specified at 3.1, the Chief Executive Officer must be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.5.4 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply

b) Subject to clause 3.5.3, they hold any other employment or executive role other than Chief Executive of another Integrated Care Board.

3.6 Partner Member - NHS Trusts and Foundation Trusts

3.6.1 This Partner Member is jointly nominated by the NHS Trusts and Foundation Trusts that provide services for the purposes of the health service within the ICB's Area and meet the Forward Plan Condition or (if the Forward Plan Condition is not met) the Level of Services Provided Condition:

a) Royal Devon University Healthcare NHS Foundation Trust
b) Torbay and South Devon NHS Foundation Trust
c) Devon Partnership NHS Trust
d) University Hospitals Plymouth NHS Trust
e) South Western Ambulance Service NHS Foundation Trust

3.6.2 This member must fulfil the eligibility criteria set out at 3.1 and also be an executive director of one of the NHS Trusts or Foundation Trusts within the ICB's Area.

3.6.3 Individuals will not be eligible if any of the disqualification criteria set out in 3.2 apply.

3.6.4 This member will be appointed by the ICB Board Appointments Panel, subject to the approval of the Chair.

3.6.5 The appointment process will be as follows:

a) Joint nomination:
- The ICB will provide a role description for partner members.
- One of the two NHS partner members must have significant knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness. This requirement is built into one of the role descriptions.
- When a vacancy arises, each eligible organisation listed at **Error! Reference source not found.**~~3.6.1~~ will be invited to make 2 nominations per vacancy.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement.
- For clarity, rejection or agreement is of the whole list not of any single nomination.
- If all eligible organisations agree with the list, the list will be put forward to step b) below.
- Any 1 nominating organisation cannot veto or cancel another eligible organisation's valid nomination. If an eligible organisation disagrees with the list, the ICB will endeavour to resolve any

concerns and the nomination process will be re-run until majority acceptance is reached on the nominations put forward with non-responders counted as in agreement.

b) Assessment, selection, and appointment subject to approval of the chair under c)

- The full list of nominees will be considered by a panel convened by the chief executive which includes the chair.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause **Error! Reference source not found.**~~3.6.2~~ and **Error! Reference source not found.**~~3.6.3~~
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval

- The chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.6.6 The term of office for these partner members will be 2 years. There is no maximum number of terms. One term may be extended by up to one year, subject to the approval of the chair.

3.6.7 In line with good governance and board effectiveness, these partner members will be subject to an annual review. A summary of this will be reported in accordance with the remuneration committee terms of reference.

3.6.8 In advance of completion of the term of office a nomination and appointment process shall be undertaken in accordance with **Error! Reference source not found.**~~3.6.5~~. Previous partner members may be re-nominated.

3.6.9 In the event of the nomination of a previous partner member, their reappointment will be informed by the reviews outlined in 3.6.7.

Commented [PH5]: Proposed amendment to align to NHS CIOS Constitution

~~The ICB will create a role description for the role, which will set out the requirements associated with the role including the expected skills, knowledge, time commitment and term of office.~~

3.7 Partner Member - Providers of Primary Medical Services.

3.7.1 This Partner Member is jointly nominated by providers of primary medical services for the purposes of the health service within the ICB's Area, and that are primary medical services contract holders responsible for the provision of essential services, within core hours to a list of registered persons for whom the ICB has core responsibility.

3.7.2 The list of relevant providers of primary medical services for this purpose is published as part of the Governance Handbook and can be found here. The list will be kept up to date but does not form part of this Constitution.

3.7.3 This member must fulfil the eligibility criteria set out at 3.1 and also be a registered medical practitioner, performing primary medical services for one of the providers set out at section 3.7.1 of this Constitution.

3.7.4 Individuals will not be eligible if any of the disqualification criteria set out in 3.2 apply.

3.7.5 This member will be appointed by the ICB Board Appointments panel, subject to the approval of the Chair.

3.7.6 The appointment process will be as follows:

a) Joint nomination
- The ICB will provide a role description for this partner member.
- When a vacancy arises, each eligible organisation described at **Error! Reference source not found.**~~3.7.1~~ and listed in the governance handbook will be invited to make 1 nomination.
- The nomination of an individual must be seconded by 2 other eligible organisations.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement.
- For clarity, rejection or agreement is of the whole list not of any single nomination.
- If all eligible organisations agree with the list, the list will be put forward to step b) below.

  Any 1 nominating organisation cannot veto or cancel another eligible organisation's valid nomination. If an eligible organisation disagrees with the list, the ICB will endeavour to resolve any concerns and the nomination process will be re-run until majority acceptance is reached on the nominations put forward with non-responders counted as in agreement.

b) Assessment, selection and appointment subject to approval of the chair under c)
- The full list of nominees will be considered by a panel convened by the chief executive which includes the chair.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause **Error! Reference source not found.**~~3.7.3~~ and **Error! Reference source not found.**~~3.7.4~~

- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval
- The chair will determine whether to approve the appointment of the most suitable nominee as identified under b).

3.7.7 The term of office for this partner member will be 2 years. There is no maximum number of terms. One term may be extended by up to one year, subject to the approval of the chair.

3.7.8 In line with good governance and board effectiveness, this partner member will be subject to an annual review, which may take place part way through the term of office. A summary of this will be reported in accordance with the remuneration committee terms of reference.

3.7.9 In advance of completion of the term of office a nomination and appointment process shall be undertaken in accordance with **Error! Reference source not found.**~~3.7.6~~. Previous partner members may be re-nominated.

3.7.10 In the event of the nomination of a previous partner member, their reappointment will be informed by the reviews outlined in 3.7.8.
~~The ICB will create a role description for the role, which will set out the requirements associated with the role including the expected skills, knowledge, time commitment and term of office.~~

Commented [PH6]: Proposed amendment to align to NHS CIOS Constitution

3.8 Partner Member~~s~~ - Local Authorities

3.8.1 ~~These~~ This Partner Member~~s~~ ~~are~~ is jointly nominated by the following local authorities whose areas coincide with, or include the whole or any part of, the ICB's Area:

a) Devon County Council
b) Torbay Council
c) Plymouth City Council

3.8.2 ~~These~~ This member~~s~~ will fulfil the eligibility criteria set out at 3.1, and also the following additional eligibility criteria:

a) Be the Chief Executive Officer or hold a relevant executive level role within of one of the local authorities listed at 3.8.1.
b) Have skills and experience such that they can bring the perspective of local government
~~At least one member will have skills and experience such that they can bring the perspective of Population Health and Prevention~~

3.8.3 Individuals will not be eligible if any of the disqualification criteria set out in 3.2 apply.

3.8.4 ~~These~~ This member~~s~~ will be appointed by the ICB Board Appointments Panel, subject to the approval of the ICB Chair.

3.8.5 The appointment process will be as follows:

a) Joint nomination
- The ICB will provide a role description for this partner member.
- When a vacancy arises, each eligible organisation described at **Error! Reference source not found.**~~3.8.1~~ and listed in the governance handbook will be invited to make 2 nominations.
- Eligible organisations may nominate individuals from their own organisation or another organisation.
- All eligible organisations will be requested to confirm whether they jointly agree to nominate the whole list of nominated individuals, with a failure to confirm within 5 working days being deemed to constitute agreement.
- For clarity, rejection or agreement is of the whole list not of any single nomination.
- If all eligible organisations agree with the list, the list will be put forward to step b) below.
- Any 1 nominating organisation cannot veto or cancel another eligible organisation's valid nomination. If an eligible organisation disagrees with the list, the ICB will endeavour to resolve any concerns and the nomination process will be re-run until a majority acceptance is reached on the nominations put forward (with non-responders counted as agreement).

b) Assessment, selection and appointment subject to approval of the chair under c)
- The full list of nominees will be considered by a panel convened by the chief executive which includes the chair.
- The panel will assess the suitability of the nominees against the requirements of the role (published before the nomination process is initiated) and will confirm that nominees meet the requirements set out in clause 3.8.2 and 3.8.3.
- In the event that there is more than one suitable nominee, the panel will select the most suitable for appointment.

c) Chair's approval
- The chair will determine whether to approve the appointment of the most suitable nominee as identified under b)

3.8.6 The term of office for this partner member will be 2 years. There is no maximum number of terms. One term may be extended by up to one year, subject to the approval of the chair.

3.8.7 In line with good governance and board effectiveness, this partner member will be subject to an annual review. A summary of this will be reported in accordance with the remuneration committee terms of reference.

3.8.8 In advance of completion of the term of office a nomination and appointment process shall be undertaken in accordance with **Error! Reference source not found.**~~3.8.4~~. Previous partner members may be re-nominated.

3.8.9 In the event of the nomination of a previous partner member, their reappointment will be informed by the reviews outlined in 3.8.7.
~~The ICB will create role descriptions for the roles, which will set out the requirements associated with the roles including the expected skills, knowledge, time commitment and term of office.~~

Commented [PH7]: Proposed amendment to align to NHS CIOS Constitution

3.9 Mental Health Member

3.9.1 This member must fulfil the eligibility criteria set out at 3.1 and shall have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

3.9.2 Individuals will not be eligible for this role if any of the disqualification criteria set out in 3.2 apply.

3.9.3 This member will be appointed by the ICB Board Appointments Panel, subject to the approval of the Chair.

3.9.4 The appointment process will be as follows:

a) The ICB will create a role description for the role, which will set out the requirements associated with the role including the expected skills, knowledge, time commitment and term of office.
b) Expressions of interest for the role will be sought from partners within the ICS as determined by the ICB Board Appointment Panel.
c) Appointment will be made as a result of a formal assessment against the eligibility and disqualification criteria for Board membership as set out above, and to ensure the individual has the ability to contribute effectively to the overall functioning of the Board. The ICB Board Appointments Panel will make a recommendation to the Chair of the ICB, for approval.
d) The Chair of the ICB will determine whether to approve the appointment and report the appointment decision to the next meeting of the Board of the ICB.
e) Should no individual be appointed, then the process described above shall be repeated.
f) Any re-appointment at the end of a term will follow the process as described in 3.9.4 a to d.
g) An individual will only be eligible for reappointment if they continue to meet the relevant eligibility and disqualification criteria outlined above.

3.9.5 The term of office for this member will be 3 years.

~~**VCSE Member**~~

3.10 Chief Medical Officer

Commented [PH8]: Proposed ICB Executive Member roles provided separately and subject consultation and NHSE approval

3.10.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Medical Practitioner

3.8.2 Individuals will not be eligible if any of the disqualification criteria set out in 3.2 apply.

3.8.3 This member will be appointed by the Chief Executive Officer, subject to the approval of the Chair.

3.11 Chief Nursing Officer

Commented [PH9]: Proposed ICB Executive Member roles provided separately and subject consultation and NHSE approval

3.11.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a registered Nurse

3.11.2 Individuals will not be eligible if any of the disqualification criteria set out in 3.2 apply.

3.11.3 This member will be appointed by the Chief Executive Officer, subject to the approval of the Chair.

3.12 Chief Finance Officer

Commented [PH10]: Proposed ICB Executive Member roles provided separately and subject consultation and NHSE approval

3.12.1 This member will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act
b) Be a qualified accountant with full membership of a relevant professional body

3.12.2 Individuals will not be eligible if any of the disqualification criteria set out in 3.2 apply.

3.12.3 This member will be appointed by the Chief Executive Officer, subject to the approval of the Chair.

3.13 Non-Executive Members

3.13.1 The ICB will appoint at least five and up to six Non-Executive Members with a diverse range of skills, experiences and backgrounds who can understand the needs of patients and reflect the communities it serves.

3.13.2 These members will be appointed by the ICB Board Appointments Panel, subject to the approval of the Chair.

3.13.3 These members will fulfil the eligibility criteria set out at 3.1 and also the following additional eligibility criteria:

a) Not be employee of the ICB or a person seconded to the ICB
b) Not hold a role in another health and care organisation within the same ICS or an organisation with which the ICB has a material financial or contractual relationship
c) One shall have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Audit and Risk Committee
d) Another should have specific knowledge, skills and experience that makes them suitable for appointment to the Chair of the Remuneration Committee

3.13.4 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) They hold a role in another health and care organisation within the same ICS

3.13.5 The term of office for a Non-Executive Member is a maximum of ~~4~~ 3 years. Non-Executive Members may serve ~~a further~~up to three term~~s~~ (all~~both~~ terms must not exceed ~~8~~9 years in total) after which they will no longer be eligible for re-appointment.

3.13.6 Initial appointments may be for a shorter period in order to avoid all non-executive members retiring at once. Thereafter, new appointees will ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity

3.13.7 Subject to a satisfactory attendance record and annual appraisal, conducted in accordance with the relevant ICB policy, the Chair may approve the re-appointment of a Non-Executive Member up to the maximum number of years permitted for their role.

3.14 Board Members: Removal from Office

3.14.1 Arrangements for the removal from office of Board Members is subject to the term of appointment, and application of the relevant ICB policies and procedures.

3.14.2 With the exception of the Chair, Board Members shall be removed from office if any of the following occur:

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance
b) If they fail to attend a minimum of 60% of the meetings to which they are invited unless agreed with the Chair in extenuating circumstances
c) If they are deemed to not meet the expected standards of performance (e.g. at their annual appraisal)
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the reputation and/or interest of the ICB and is likely to bring the ICB into disrepute. This includes but is not limited to breach of the ICB's human resources policies; dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise
e) If they are deemed to have failed to uphold the Nolan Principles of Public Life
f) If they are subject to disciplinary proceedings by a regulator or professional body
g) If they have persistently failed to abide by the terms of this Constitution.
h) If they have persistently failed to respond to requests in relation to the provisions of the Constitution made by the ICB.
i) If they have repeatedly refused to comply with, or engage with, activities decided by the ICB.
j) If they have persistently behaved in a way that jeopardises the reputation of the ICB.
k) If they have attempted or committed fraud against the ICB.
l) If they have failed to adhere to any other conditions set out in national guidance or regulations.
m) If any partner member fails to put the interests of the ICB ahead of their own organisational interests.

Commented [PH11]: Proposed amendment to align to NHS CIOS Constitution

3.14.3 Members may be suspended pending the outcome of an investigation into whether any of the matters referenced in section 3.14.2 of this Constitution apply.

3.14.4 Executive Directors (including the Chief Executive Officer) will cease to be Board Members if their employment in their specified role ceases, regardless of the reason for termination of the employment.

3.14.5 The Chair of the ICB may be removed by NHS England, subject to the approval of the Secretary of State for Health and Social Care.

3.14.6 If NHS England is satisfied that the ICB is failing or has failed to discharge any of its functions or that there is a significant risk that the ICB will fail to do so, it may:

a) terminate the appointment of the ICB's Chief Executive Officer; and
b) direct the Chair of the ICB as to which individual to appoint as a replacement and on what terms.

3.15 Terms of Appointment of Board Members

3.15.1 With the exception of the Chair and the Non-Executive Members arrangements for remuneration and any allowances for Board Members of the ICB will be agreed by the Remuneration Committee in line with the ICB Remuneration Policy and any other relevant policies published on our ICB website and any guidance issued by NHS England or other relevant body.

3.15.2 Terms of appointment and remuneration of the Chair will be determined by NHS England.

3.15.3 Remuneration for Non-Executive Members will be determined by the Non-Executive Remuneration Panel.

4 Arrangements for the Exercise of our Functions

4.1 Good Governance

4.1.1 The ICB will, at all times, observe generally accepted principles of good governance. This includes the Seven Principles of Public Life (the Nolan Principles) and any governance guidance issued by NHS England.

4.2 General

4.2.1 The ICB will:

a) comply with all relevant laws including but not limited to the 2006 Act and the duties prescribed within it and any relevant regulations;
b) comply with directions issued by the Secretary of State for Health and Social Care
c) comply with directions issued by NHS England
d) have regard to statutory guidance including that issued by NHS England
e) take account, as appropriate, of other documents, advice and guidance issued by relevant authorities, including that issued by NHS England
f) respond to reports and recommendations made by local Healthwatch organisations within the ICB area

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this Constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

4.3.1 The ICB is accountable for exercising its statutory functions and may grant authority to act on its behalf to:

a. any of its members or employees
b. a committee or sub-committee of the ICB

4.3.2 Under section 65Z5 of the 2006 Act, the ICB may arrange with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB. Where the ICB and other body enters such arrangements, they may also arrange for the functions in question to be exercised by a joint committee of theirs and/or for the establishment of a pooled fund to fund those functions (section 65Z6). In addition, under section 75 of the 2006 Act, the ICB may enter partnership arrangements with a local authority under which the local authority exercises specified ICB functions or the ICB exercises specified local authority functions, or the ICB and local authority establish a pooled fund.

4.3.3 Where arrangements are made under section 65Z5 or section 75 of the 2006 Act the Board must authorise the arrangement, which must be described as appropriate in the SoRD.

4.4 Scheme of Reservation and Delegation (SoRD)

4.4.1 The ICB has agreed a Scheme of Reservation and Delegation (SoRD) which is published in full in the ICB Governance Handbook and available on the ICB website here.

4.4.2 Only the Board may agree the SoRD and amendments to the SoRD may only be approved by the Board.

4.4.3 The SoRD sets out:

a) those functions that are reserved to the Board
b) those functions that have been delegated to an individual or to committees and sub committees
c) those functions delegated to another body or to be exercised jointly with another body, under section 65Z5 and 65Z6 of the 2006 Act.

4.4.4 The ICB remains accountable for all of its functions, including those that it has delegated. All those with delegated authority are accountable to the board for the exercise of their delegated functions.

4.5 Functions and Decision Map

4.5.1 The ICB has prepared a Functions and Decision Map which sets out at a high level its key functions and how it exercises them in accordance with the SoRD.

4.5.2 The Functions and Decision Map is published here.

4.5.3 The map includes:

a) Key functions reserved to the Board of the ICB
b) Commissioning functions delegated to committees and individuals
c) Commissioning functions delegated under section 65Z5 and 65Z6 of the 2006 Act to be exercised by, or with, another ICB, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body
d) functions delegated to the ICB (for example, from NHS England).

4.6 Committees and Sub-Committees

4.6.1 The ICB may appoint committees and arrange for its functions to be exercised by such committees. Each committee may appoint sub-committees and arrange for the functions exercisable by the committee to be exercised by those sub-committees.

4.6.2 All committees and sub-committees are listed in the SoRD.

4.6.3 Each committee and sub-committee established by the ICB operates under terms of reference agreed by the Board. All terms of reference are published in the Governance Handbook.

4.6.4 The Board remains accountable for all functions, including those that it has delegated to committees and sub-committees and therefore, appropriate reporting and assurance arrangements are in place and documented in terms of reference. All committees and sub-committees that fulfil delegated functions of the ICB, will be required to operate within their terms of reference, and both committees and sub-committees must undertake regular performance evaluations and report to the Board on the fulfilment of their activities, drawing attention to any significant risks.

4.6.5 Any committee or sub-committee established in accordance with clause 4.6 may consist of, or include, persons who are not ICB Members or employees.

4.6.6 All members of committees and sub-committees that exercise the ICB commissioning functions will be approved by the Chair. The Chair will not approve an individual to such a committee or sub-committee if they consider that the appointment could reasonably be regarded as undermining the independence of the health service because of the candidate's involvement with the private healthcare sector or otherwise.

4.6.7 All members of committees and sub-committees are required to act in accordance with this Constitution, including the Standing Orders as well as the Standing Financial Instructions and any other relevant ICB policy.

4.6.8 The following committees will be maintained:

a) **Audit and Risk Committee:** This committee is accountable to the Board and provides an independent and objective view of the ICB's compliance with its statutory responsibilities. The committee is responsible for arranging appropriate internal and external audit.

The Audit and Risk Committee will be chaired by a Non-Executive Member (other than the Chair and Deputy Chair of the ICB) who has the qualifications, expertise or experience to enable them to express credible opinions on finance and audit matters.

b) **Remuneration Committee:** This committee is accountable to the Board for matters relating to remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the ICB.

The Remuneration Committee will be chaired by a Non-Executive Member (other than the Chair of the ICB or the Chair of Audit and Risk Committee).

Remuneration for Non-Executive Members will be determined by the Non-Executive Member Remuneration Panel.

4.6.9 The terms of reference for each of the above committees are published in the Governance Handbook.

4.6.10 The Board has also established a number of other committees to assist it with the discharge of its functions. These committees are set out in the SoRD and further information about these committees, including terms of reference, are published in the Governance Handbook.

4.7 Delegations made under section 65Z5 of the 2006 Act

4.7.1 As per 4.3.2 the ICB may arrange for any functions exercisable by it to be exercised by or jointly with any one or more other relevant bodies (another ICB, NHS England, an NHS trust, NHS foundation trust, local authority, combined authority or any other prescribed body).

4.7.2 All delegations made under these arrangements are set out in the ICB SoRD and included in the Functions and Decision Map.

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled fund. The power to approve delegation arrangements made under this provision will be reserved to the Board.

4.7.4 The Board remains accountable for all the ICB's functions, including those that it has delegated and therefore, appropriate reporting and assurance mechanisms are in place as part of agreeing terms of a delegation and these

are detailed in the delegation arrangements, summaries of which will be published in the Governance Handbook

4.7.5 In addition to any formal joint working mechanisms, the ICB may enter into strategic or other transformation discussions with its partner organisations on an informal basis.

5 Procedures for Making Decisions

5.1 Standing Orders

5.1.1 The ICB has agreed a set of standing orders which describe the processes that are employed to undertake its business. They include procedures for:

- conducting the business of the ICB
- the procedures to be followed during meetings
- the process to delegate functions.

5.1.2 The Standing Orders apply to all committees and sub-committees of the ICB unless specified otherwise in terms of reference which have been agreed by the Board.

5.1.3 A full copy of the Standing Orders is included in Appendix 2 and form part of this Constitution.

5.2 Standing Financial Instructions (SFIs)

5.2.1 The ICB has agreed a set of Standing Financial Instructions (SFIs) which include the delegated limits of financial authority set out in the SoRD.

5.2.2 A copy of the SFIs is published in the Governance Handbook

6 Arrangements for conflict of interest management and standards of business conduct

6.1 Principles

6.1.1 In discharging its functions the ICB will abide by the following principles:

a) The Nolan Principles
b) Ensuring clear policy guidance is provided to all those performing a role on behalf of the ICB
c) Monitoring compliance in accordance with published guidance
d) Ensuring interests are proactively declared at the point individuals become involved in decision making
e) Adopting a proportionate, common sense approach to the management of conflicts of interest
f) Keeping an audit trail of actions taken.

6.2 Conflicts of Interest

6.2.1 As required by section 14Z30 of the 2006 Act, the ICB has made arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the ICB will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of the ICB's decision-making processes.

6.2.2 The ICB has agreed policies and procedures for the identification and management of conflicts of interest which are published on the website.

6.2.3 All Board, committee and sub-committee members, and employees of the ICB, will comply with the ICB policy on conflicts of interest, and the ICB Standards of Business Conduct Policy, in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by the ICB.

6.2.4 All delegation arrangements made by the ICB under Section 65Z5 of the 2006 Act will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures comparable with those of the ICB.

6.2.5 Where an individual, including any individual directly involved with the business or decision-making of the ICB and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the ICB considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Constitution, the Conflicts of Interest Policy and the Standards of Business Conduct Policy.

6.2.6 The ICB has appointed the Audit and Risk Committee Chair to be the Conflicts of Interest Guardian. In collaboration with the ICB's governance lead, their role is to:

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest
c) Support the rigorous application of conflict of interest principles and policies
d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation
e) Provide advice on minimising the risks of conflicts of interest.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

a) Members of the ICB
b) Members of the Board's committees and sub-committees
c) Its employees

6.3.2 In accordance with section 14Z30(2) of the 2006 Act registers of interest are published on the ICB website and are available to view.

6.3.3 All relevant persons as per 6.1.3 and 6.1.5 must declare any conflict or potential conflict of interest relating to decisions to be made in the exercise of the ICB's commissioning functions.

6.3.4 Declarations should be made as soon as reasonably practicable after the person becomes aware of the conflict or potential conflict and in any event within 28 days. This could include interests an individual is pursuing. Interests will also be declared on appointment and during relevant discussion in meetings.

6.3.5 All declarations will be entered in the registers as per 6.3.1

6.3.6 The ICB will ensure that, as a matter of course, declarations of interest are made and confirmed, or updated at least annually.

6.4 Standards of Business Conduct

6.4.1 Board members, employees, committee and sub-committee members of the ICB will at all times comply with this Constitution and be aware of their responsibilities as outlined in it. They should:

a) act in good faith and in the interests of the ICB

b) follow the Seven Principles of Public Life; set out by the Committee on Standards in Public Life (the Nolan Principles)

c) comply with the ICB Standards of Business Conduct Policy, and any requirements set out in the policy for managing conflicts of interest.

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be written into their contract for services and is also outlined in the ICB's Standards of Business Conduct Policy.

7 Arrangements for ensuring Accountability and Transparency

7.1.1 The ICB will demonstrate its accountability to local people, stakeholders and NHS England in a number of ways, including by upholding the requirement for transparency in accordance with paragraph 12 (2) of Schedule 1B to the 2006 Act.

7.2 Principles

7.21. In order to achieve maximum accountability and transparency, the ICB will implement the following principles when establishing its accountability frameworks:

a) Comprehensive and joined up
b) Economical of time and money
c) Clear and transparent
d) Rigorous
e) Stable and consistent.

7.3 Meetings and publications

7.3.1 Board and committee meetings composed entirely of Board Members or which include all Board Members, will be held in public, except where a resolution is agreed to exclude the public on the grounds that it is believed to not be in the public interest.

7.3.2 Papers and minutes of all meetings held in public will be published.

7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

7.3.5 The ICB will comply with the Freedom of Information Act 2000 and with the Information Commissioner's Office requirements regarding the publication of information relating to the ICB.

7.3.6 Information will be provided to NHS England as required.

7.3.7 The Constitution and Governance Handbook will be published as well as other key documents including but not limited to:

- Registers of interests
- Conflicts of Interest Policy and procedures
- Standards of Business Conduct Policy.

7.3.8 The ICB will publish, with its partner NHS trusts and NHS foundation trusts, a plan at the start of each financial year that sets out how the ICB proposes to exercise its functions during the next 5 years (the "Joint Forward Plan"). The plan will:

a) describe the health services for which the ICB proposes to make arrangements in the exercise of its functions
b) explain how the ICB proposes to discharge its duties under sections 14Z34 to 14Z45 (general duties of integrated care boards) and sections 223GB and 223N (financial duties)

c) propose steps to implement the joint local health and wellbeing strategies and integrated care strategy
d) set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25
e) set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

7.4 Scrutiny and Decision Making

7.4.1 At least three Non-Executive Members will be appointed to the Board including the Chair; and all of the Board and committee members will comply with the Nolan Principles and meet the criteria described in the Fit and Proper Person Test.

7.4.2 Healthcare services will be arranged in a transparent way, and decisions around who provides services will be made in the best interests of patients, taxpayers and the population, in line with the rules set out in the NHS Provider Selection Regime (PSR), including the PSR statutory guidance. In particular, this shall include the ICB:

a) publishing online an annual summary of its contracting arrangements for the provision of relevant health care services
b) publishing online an annual report of its monitoring of compliance with the regime
c) taking appropriate measures to effectively prevent, identify and remedy conflicts of interest arising in the conduct of procurement processes under the regime
d) where it considers appropriate, seeking or otherwise receiving independent expert advice when making decisions in accordance with the regime

7.4.4 The ICB will comply with local authority health overview and scrutiny requirements.

7.5 Annual Report

7.5.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and that sets out how it has discharged its functions and fulfilled its duties in the previous financial year. An annual report must in particular:

a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)
b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)
c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest

statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised)

d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

8 Arrangements for Determining the Terms and Conditions of Employees

8.1.1 The ICB may appoint employees, pay them remuneration and allowances as it determines and appoint staff on such terms and conditions as it determines.

8.1.2 The Board has established a Remuneration Committee which is chaired by a Non-Executive Member other than the Chair or Audit and Risk Committee Chair.

8.1.3 The membership of the Remuneration Committee is determined by the Board. No employees may be a member of the Remuneration Committee, but the Board ensures that the Remuneration Committee has access to appropriate advice by:

a) Ensuring that the Chief Executive Officer, ICB governance lead and senior human resources advisers are in attendance

b) Authorising it to obtain legal/and or other independent professional advice, and to secure the attendance of anyone with relevant experience and expertise, if it considers this necessary.

8.1.4 The Board may appoint independent members or advisers to the Remuneration Committee who are not members of the Board.

8.1.5 The Chair or specific members of the committee must recuse themselves from committee meetings, if during the discussion on any agenda item that benefits them personally, to ensure that there is no real or perceived conflict of interest in the decisions being made.

8.1.6 The main purpose of the Remuneration Committee is to exercise the functions of the ICB regarding remuneration included in paragraphs 18 to 20 of Schedule 1B to the 2006 Act. The terms of reference agreed by the board are published in the Governance Handbook.

8.1.7 The duties of the Remuneration Committee are set out in its Terms of Reference and include:

a) Setting the ICB pay policy (or equivalent) and standard terms and conditions

b) Making arrangements to pay employees such remuneration and allowances as it may determine
c) Setting remuneration and allowances for members of the Board
d) Setting any allowances for members of committees or sub-committees of the ICB who are not members of the Board.

8.1.8 The ICB may make arrangements for a person to be seconded to serve as a member of the ICB's staff.

9 Arrangements for Public Involvement

9.1.1 In line with section 14Z45(2) of the 2006 Act, the ICB has made arrangements to secure that individuals to whom services which are, or are to be, provided pursuant to arrangements made by the ICB in the exercise of its functions, and their carers and representatives, are involved (whether by being consulted or provided with information or in other ways) in:

a) the planning of the commissioning arrangements by the ICB
b) the development and consideration of proposals by the ICB for changes in the commissioning arrangements where the implementation of the proposals would have an impact on the manner in which the services are delivered to the individuals (at the point when the service is received by them), or the range of health services available to them
c) decisions of the ICB affecting the operation of the commissioning arrangements where the implementation of the decisions would (if made) have such an impact.

9.1.2 In line with section 14Z54 of the 2006 Act, when preparing the Joint Forward Plan or revising the plan in a way they consider significant, the ICB together with its partner NHS trusts and NHS foundation trusts will take appropriate steps to ensure that they involve the Health and Wellbeing Boards and consult its population.

9.1.3 The ICB has adopted the 10 principles set out by NHS England for working with people and communities:

a) put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS
b) start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions
c) understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect
d) build relationships with excluded groups – especially those affected by inequalities
e) work with Healthwatch and the voluntary, community and social enterprise sector as key partners
f) provide clear and accessible public information about vision, plans and progress to build understanding and trust

g) use community development approaches that empower people and communities, making connections to social action
h) use co-production, insight and engagement to achieve accountable health and care services
i) co-produce and redesign services and tackle system priorities in partnership with people and communities
j) learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

9.1.4 These principles will be used when developing and maintaining arrangements for engaging with people and communities.

9.1.5 The NHS Devon Integrated Care Board People and Communities Strategy (known as the People and Communities Framework) is available to view in the ICB Governance Handbook. The strategy sets out how NHS Devon will;

a) Use the 10 principles when working with people and communities across Devon
b) Work with partners across the ICS to develop arrangements for ensuring that the Integrated Care Partnership (ICP) and place-based partnerships have appropriate representation from local people and communities in priority-setting and decision-making forums
c) Gather intelligence about the experience and aspirations of people who use care and support and have clear approaches to using these insights to inform decision-making and quality governance.

Appendix 1: Definitions of Terms Used in this Constitution

2006 Act	National Health Service Act 2006, as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022
Area	The geographical area that the ICB has responsibility for, as defined in clause 1.3 of this Constitution
Associate Non-Executive Member	An individual who is appointed by the ICB Board Appointments Panel (subject to the approval of the Chair) to bring a level of independence and oversight to the ICB's decision-making akin to a Non-Executive Member. An Associate Non-Executive Member may be a member of the ICB's Committees or Sub-Committees, but is not a member of the ICB's Board and as such may not vote at Board meetings.
Committee	A committee created and appointed by the ICB Board.
Director of Finance	Within NHS Devon ICB this role is known as Chief of Finance
Director of Nursing	Within NHS Devon ICB this role is known as Chief of Nursing
Forward Plan Condition	The 'Forward Plan Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Health Care Professional	An individual who is a member of a profession regulated by a body mentioned in section 25(3) of the National Health Service Reform and Health Care Professions Act 2002
Health Service Body	Health service body as defined by section 9(4) of the NHS Act 2006 or an NHS foundation trust.
ICB Board	Members of the ICB
ICB Board Appointments Panel	A panel of senior ICB employees, convened by the Chief Executive Officer with the purpose of making recommendations on certain Board appointments.
Integrated Care Partnership	The joint committee for the ICB's area established by the ICB and each responsible local authority whose area coincides with or falls wholly or partly within the ICB's Area.

Level of Services Provided Condition	The 'Level of Services Provided Condition' as described in the Integrated Care Boards (Nomination of Ordinary Members) Regulations 2022 and any associated statutory guidance.
Medical Director	Within the NHS Devon ICB this role is known as Chief Medical Officer
Non-Executive Member Remuneration Panel	A panel convened when required for the special purpose of considering the remuneration of the Non-Executive Members of the ICB. This is because some of the non-executives are members of the ICB's Remuneration Committee and, consistently with the ICB's processes and national expectations for managing conflicts of interest, the Board is required to have a suitable mechanism for ensuring that no individual is involved is discussion or decision-making relating to their own pay. The panel will be convened the Chair, and constituted of at least two of either the Partner Members or the Mental Health Member ~~or VCSE Member~~.
Ordinary Member	The Board of the ICB will have a Chair and a Chief Executive Officer plus other members. All other members of the Board are referred to as Ordinary Members.
Partner Members	Some of the Ordinary Members will also be Partner Members. Partner Members bring knowledge and a perspective from their sectors and are and appointed in accordance with the procedures set out in Section 3 having been nominated by the following**:** • NHS trusts and foundation trusts who provide services within the ICB's area and are of a prescribed description • the primary medical services (general practice) providers within the area of the ICB and are of a prescribed description • the local authorities which are responsible for providing Social Care and whose area coincides with or includes the whole or any part of the ICB's area.
Place-Based Partnership	Place-based partnerships are collaborative arrangements responsible for arranging and delivering health and care services in a locality or community. They involve the ICB, local government and providers of health and care services, including the voluntary, community and social enterprise sector, people and communities, as well as primary care provider leadership, represented by Primary Care Network clinical directors or other relevant primary care leaders.

Sub-committee	A group created and appointed by and reporting to a committee of the ICB.

Appendix 2: Standing Orders

1. Introduction

1.1. These Standing Orders have been drawn up to regulate the proceedings of NHS Devon Integrated Care Board (ICB) so that the ICB can fulfil its obligations as set out largely in the 2006 Act (as amended). They form part of the ICB's Constitution.

2. Amendment and review

2.1. The Standing Orders are effective from 01 July 2022.

2.2. Standing Orders will be reviewed on an annual basis or sooner if required.

2.3. Amendments to these Standing Orders will be made as per clause 1.6 of this Constitution.

2.4. All changes to these Standing Orders will require an application to NHS England for variation to the ICB Constitution and will not be implemented until the Constitution has been approved.

3. Interpretation, application and compliance

3.1. Except as otherwise provided, words and expressions used in these Standing Orders shall have the same meaning as those in the main body of the ICB Constitution and as per the definitions in Appendix 1.

3.2. These Standing Orders apply to all meetings of the Board, including its committees and sub-committees unless otherwise stated. All references to board are inclusive of committees and sub-committees unless otherwise stated.

3.3. All members of the Board, members of committees and sub-committees and all employees, should be aware of the Standing Orders and comply with them. Failure to comply may be regarded as a disciplinary matter.

3.4. In the case of conflicting interpretation of the Standing Orders, the Chair, supported with advice from the governance lead, will provide a settled view which shall be final.

3.5. All members of the Board, its committees and sub-committees and all employees have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive Officer as soon as possible.

3.6. If, for any reason, these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next

formal meeting of the Board for action or ratification and the Audit and Risk Committee for review.

4. Meetings of the Integrated Care Board

4.1. Calling Board Meetings

4.1.1 Meetings of the Board of the ICB shall be held at regular intervals at such times and places as the ICB may determine.

4.1.2 In normal circumstances, each member of the Board will be given not less than one month's notice in writing of any meeting to be held. However:

a) The Chair may call a meeting at any time by giving not less than ~~14~~ 10 calendar days' notice in writing.

b) One third of the members of the Board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting.

c) In emergency situations the Chair may call a meeting with ~~one~~ two working days' notice by setting out the reason for the urgency and the decision to be taken.

Commented [PH12]: Proposed amendment to align to NHS CIOS Constitution

4.1.3 A public notice of the time and place of the meetings to be held in public and how to access the meeting shall be given by posting it at the offices of the ICB body and electronically at least three clear days before the meeting or, if the meeting is convened at shorter notice, then at the time it is convened.

4.1.4 The agenda and papers for meetings to be held in public will be published electronically in advance of the meeting excluding, if thought fit, any item likely to be addressed in part of a meeting is not likely to be open to the public.

4.2 Chair of a meeting

4.2.1 The Chair of the ICB shall preside over meetings of the Board.

4.2.2 If the Chair is absent or is disqualified from participating by a conflict of interest, the Deputy Chair will preside over the meeting.

4.2.3 If both the Chair and Deputy Chair are absent or disqualified from participating by a conflict of interest, the senior Independent Non-Executive Member shall chair or the assembled members shall appoint a temporary

deputy from amongst the Non-Executive Members for the purpose of chairing the meeting.

4.2.4 The Board shall appoint a Chair to all committees and sub-committees that it has established. The appointed committee or sub-committee Chair will preside over the relevant meeting. Terms of reference for committees and sub-committees will specify arrangements for occasions when the appointed Chair is absent.

4.3 Agenda, supporting papers and business to be transacted

4.3.1 The agenda for each meeting will be drawn up and agreed by the Chair of the meeting.

4.3.2 Except where the emergency provisions apply, supporting papers for all items must be submitted to the corporate office for coordination at least ~~ten working~~seven calendar days before the meeting takes place. The agenda and supporting papers will be circulated to all members of the board at least five calendar days before the meeting.

4.3.3 Agendas and papers for meetings open to the public, including details about meeting dates, times and venues, will be published on the ICB's website.

4.4 Petitions

4.4.1 Where a valid petition has been received by the ICB it shall be included as an item for the agenda of the next meeting of the Board in accordance with the ICB policy as published in the Governance Handbook.

4.5 Nominated Deputies

4.5.1 In exceptional circumstances and with the advance permission of the person presiding over the meeting, the executive directors and the partner members of the board may nominate a named deputy to attend a meeting of the board that they are unable to attend. The deputy may speak and vote on their behalf.

4.5.2 In considering agreement to attendance by nominated deputies, the person presiding over the meeting will pay due regard to the eligibility criteria set out in section 3 of the Constitution.

4.5.3 The decision of the person presiding over the meeting regarding authorisation of nominated deputies is final.

4.5.4 The accountabilities and liabilities associated with the board member role may not be delegated to a deputy.

~~With the permission of the person presiding over the meeting, the Executive Directors and the Partner Members of the Board may nominate a deputy to attend a meeting of the Board that they are unable to attend. The deputy may speak but will not have a vote if one is called in the meeting.~~

4.6 Virtual attendance at meetings

4.6.1 The Board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means, unless the terms of reference prohibit this.

~~4.6.1~~4.6.2 Where all or part of a meeting which is to be held virtually is required to be held in public, this will be facilitated by the provision of information and support to the public on how to join the meeting virtually.

4.7 Quorum

4.7.1 The quorum for meetings of the Board will be at least 50% of its members, including:

a) Chair or Deputy Chair
b) At least two Executive Directors
c) At least two Non-Executive Members
d) At least two of either the Partner Members or~~,~~ the Mental Health Member~~ or the VCSE Member~~

4.7.2 For the sake of clarity:

a) No person can act in more than one capacity when determining the quorum.
b) An individual who has been disqualified from participating in a discussion on any matter and/or from voting on any motion by reason of a declaration of a conflict of interest, shall no longer count towards the quorum.
c) A nominated deputy appointed in accordance with Standing Order 4.5 will count towards quorum for meetings of the Board~~,~~ ~~but will not be entitled to vote at the meeting~~

4.7.3 For all committees and sub-committees, the details of the quorum for these meetings and status of deputies are set out in the appropriate terms of reference.

4.8 Vacancies and defects in appointments

4.8.1 The validity of any act of the ICB is not affected by any vacancy among members or by any defect in the appointment of any member.

4.8.2 In the event of vacancy or defect in appointment the following temporary arrangement for quorum will apply:

- Unless 4.8.3 below applies, the total number of board members from which 50% must be present shall be reduced by the equivalent number of member vacancies (or defects in appointment).

4.8.3 An individual who has been formally appointed to act up for a board member during a period of incapacity or temporarily to fill a board member vacancy shall be entitled to exercise the voting rights of the board member.

~~Where quoracy cannot be achieved due to the defect or vacancy, the meeting will be considered quorate when at least 5 members are present including:~~

4.9 Decision making

4.9.1 The ICB has agreed to use a collective model of decision-making that seeks to find consensus between system partners and make decisions based on unanimity as the norm, including working though difficult issues where appropriate.

4.9.2 Generally, it is expected that decisions of the ICB will be reached by consensus. Should this not be possible then a vote will be required. The process for voting, which should be considered a last resort, is set out below:

a) All members of the Board who are present at the meeting will be eligible to cast one vote each.
b) In no circumstances may an absent member vote by proxy. Absence is defined as being absent at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from participating in the meeting, including exercising their right to vote if eligible to do so.
c) For the sake of clarity, any additional Participants and Observers (as detailed within paragraph 2.3 of the Constitution) will not have voting rights.
d) A resolution will be passed if more votes are cast for the resolution than against it.
e) If an equal number of votes are cast for and against a resolution, then the Chair (or in their absence, the person presiding over the meeting) will have a second and casting vote.
f) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

Disputes

4.9.3 Where helpful, the Board may draw on third party support to assist them in resolving any disputes, such as peer review or support from NHS England.

Urgent decisions

4.9.4 In the case urgent decisions and extraordinary circumstances, every attempt will be made for the Board to meet virtually. Where this is not possible the following will apply:

a) The powers which are reserved or delegated to the Board, may for an urgent decision be exercised by the Chair and Chief Executive Officer (or relevant lead director in the case of committees) subject to every effort having made to consult with a minimum of two Non-Executive Members in the given circumstances

b) The exercise of such powers shall be reported to the next formal meeting of the Board for formal ratification and the Audit and Risk Committee for oversight

4.10 Minutes

4.10.1 The names and roles of all members present shall be recorded in the minutes of the meetings.

4.10.2 The minutes of a meeting shall be drawn up and submitted for agreement at the next meeting where they shall be signed by the person presiding at it.

4.10.3 No discussion shall take place upon the minutes except upon their accuracy or where the person presiding over the meeting considers discussion appropriate.

4.10.4 Where providing a record of a meeting held in public, the minutes shall be made available to the public.

4.11 Admission of public and the press

4.11.1 In accordance with Public Bodies (Admission to Meetings) Act 1960 all meetings of the Board and all meetings of committees which are comprised of entirely Board Members or include all Board Members at which public functions are exercised, will be open to the public.

4.11.2 The Board may resolve to exclude the public from a meeting or part of a meeting where it would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

4.11.3 The person presiding over the meeting shall give such directions as they thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption.

4.11.4 As permitted by Section 1(8) Public Bodies (Admissions to Meetings) Act 1960 as amended from time to time) the public may be excluded from a meeting to suppress or prevent disorderly conduct or behaviour.

4.11.5 Matters to be dealt with by a meeting following the exclusion of representatives of the press, and other members of the public shall be confidential to the members of the Board.

5 Suspension of Standing Orders

5.1 In exceptional circumstances, except where it would contravene any statutory provision or any direction made by the Secretary of State for Health and Social Care or NHS England, any part of these Standing Orders may be suspended by the Chair in discussion with at least 2 other members,

5.2 A decision to suspend Standing Orders together with the reasons for doing so shall be recorded in the minutes of the meeting.

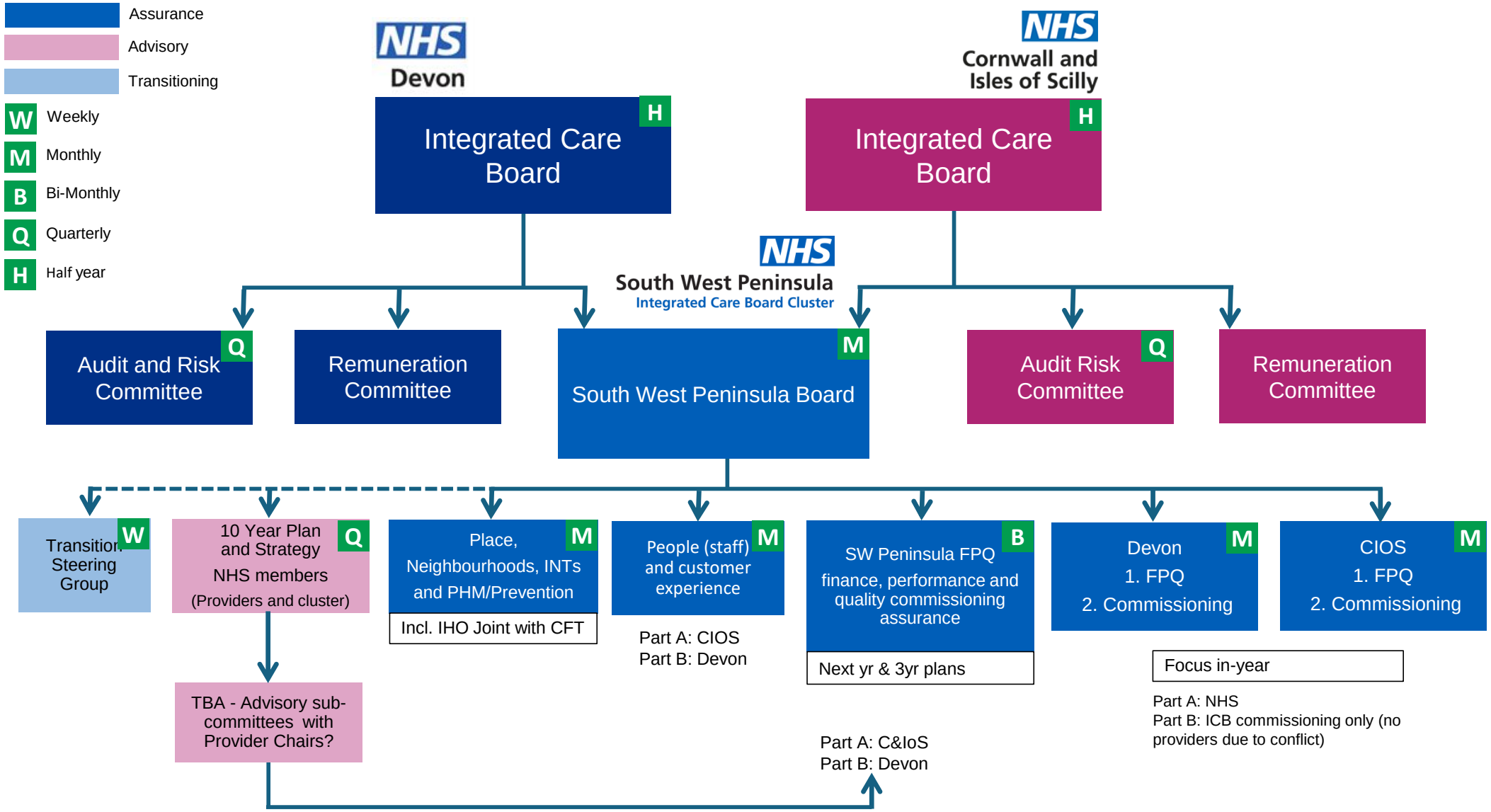
5.3 A separate record of matters discussed during the suspension shall be kept. These records shall be made available to the Audit and Risk Committee for review of the reasonableness of the decision to suspend Standing Orders.

6 Use of seal and authorisation of documents.

6.1 The ICB will have a seal for executing documents where necessary. This will be used subject to the approval limits set out in the Use of the Seal Standard Operating Procedure and Scheme of Delegation and Reservation, which is held in the ICB Governance Handbook and reviewed by the Chief Finance Officer no less than once a year.

6.2 The Chief Executive Officer shall ensure that a register of the sealing of every document is maintained and presented to the Audit and Risk Committee no less than once a year.

END


Assurance
Advisory
Transitioning
W Weekly
M Monthly
B Bi-Monthly
Q Quarterly
H Half year
NHS Devon
Integrated Care Board
H
NHS Cornwall and Isles of Scilly
Integrated Care Board
H
NHS South West Peninsula Integrated Care Board Cluster
Audit and Risk Committee
Q
Remuneration Committee
South West Peninsula Board
M
Audit Risk Committee
Q
Remuneration Committee
Transition Steering Group
W
10 Year Plan and Strategy
NHS members
(Providers and cluster)
Q
Place, Neighbourhoods, INTs and PHM/Prevention
M
Incl. IHO Joint with CFT
People (staff) and customer experience
M
Part A: CIOS
Part B: Devon
SW Peninsula FPQ
finance, performance and quality commissioning assurance
B
Next yr & 3yr plans
Devon
1. FPQ
2. Commissioning
M
Focus in-year
Part A: NHS
Part B: ICB commissioning only (no providers due to conflict)
CIOS
1. FPQ
2. Commissioning
M
TBA - Advisory sub-committees with Provider Chairs?
Part A: C&IoS
Part B: Devon

NHS Cornwall and Isles of Scilly, and NHS Devon Integrated Care Boards

Joint Scheme of Reservation and Delegation

---

1. Introduction

This Scheme of Reservation and Delegation establishes the framework for the Cluster arrangement between NHS Cornwall and Isles of Scilly Integrated Care Board and NHS Devon Integrated Care Board, operating through the Joint Committee/Board established under sections 65Z5 and 65Z6 of the NHS Act 2006.

Summary: All functions of each Integrated Care Board (ICB) are delegated to the Joint Committee/Board except those specifically reserved below.

---

2. Functions reserved to each ICB Board

Annex A sets out the detailed scheme of matters reserved to the individual Boards. The below is meant as a high-level summary of matters reserved and delegated to the Joint Committee/Board and should be read in conjunction with the detailed scheme at Annex A.

2.1 Statutory functions that cannot be delegated

- Decision making in respect of NHS Continuing Healthcare and NHS funded nursing care functions
- Annual accounts preparation and approval
- Constitutional compliance matters specific to each ICB
- Individual ICB statutory reporting requirements
- Functions that are required by NHS England to remain with individual ICBs

- Such other functions as are determined to be non-delegable by an ICB

2.2 Corporate governance functions

- Approval of changes to each ICB's constitution
- Approval of ICB Operational Scheme of Delegation
- Approval of ICB Standing Financial Instructions

2.3 Individual ICB Board meetings

The Board should meet annually as a minimum, or as required for reserved functions.

---

3. Functions Delegated to Joint Committee/Board

3.1 All other ICB functions

All ICB functions not specifically reserved above are delegated to the Joint Committee/Board, including but not limited to:

- Strategic planning and commissioning
- Financial planning and budget approval
- Service commissioning and contracting
- Performance management
- Quality oversight
- Partnership working
- System transformation

3.2 Joint Committee/Board authority to establish sub-committees and working groups

The Joint Committee/Board is delegated authority to:

- Establish such sub-committees and non-decision-making working groups as it considers necessary
- Determine sub-committee and non-decision-making working group terms of reference, which must be reviewed annually
- Delegate functions to sub-committees as appropriate
- Appoint sub-committee members
- Receive reports and assurance from sub-committees

3.3 Joint Committee/Board decision-making authority

The Joint Committee/Board has full authority to make binding decisions on behalf of both ICBs for all delegated functions, subject to:

- Compliance with statutory requirements
- Operating within agreed financial frameworks
- Reporting to individual ICB Boards on reserved matters
- During 2025/26 not taking any decisions that would materially change the operational plan that has been agreed by each Board without the explicit approval of that individual Board

---

4. Functions delegated to individual ICB Audit Committees

4.1 Each ICB retains its own audit committee with authority for:

- Internal audit arrangements (appointment, oversight, planning)
- External audit liaison for each individual ICB

- Individual ICB risk management oversight
- Individual ICB counter fraud arrangements
- Individual ICB information governance compliance
- Review of individual ICB annual accounts
- Oversight of individual ICB losses and special payments
- Individual ICB Operational Scheme of Delegation consideration and recommendation to the Board

4.2 Coordination

Individual ICB Audit Committees may meet "in common" to consider cluster-wide issues while retaining separate decision-making authority for individual ICB matters.

---

5. Functions delegated to individual ICB Remuneration Committees

5.1 Each ICB retains its own remuneration committee with authority for:

- Individual ICB Board member remuneration
- Individual ICB specific employment arrangements
- Individual ICB pay policies (where not harmonised through the Joint Committee/Board)
- Performance management of individual ICB specific roles
- Terms and conditions for individual ICB specific appointments

5.2 Coordination

Individual ICB Remuneration Committees may meet "in common" to consider cluster-wide employment matters while retaining separate decision-making authority for individual ICB matters.

---

6. Operational Arrangements

6.1 Individual ICB Operational Schemes

Each ICB retains its own Operational Scheme of Delegation for:

- Day-to-day operational decisions
- Financial authorisation limits
- Procurement authorities
- Staff employment decisions
- Routine administrative matters

6.2 Individual ICB Standing Financial Instructions

Each ICB retains its own Standing Financial Instructions covering:

- Financial controls and procedures
- Banking and treasury management
- Budget management processes
- Financial reporting requirements
- Value for money arrangements

6.3 Coordination and harmonisation

The Joint Committee/Board may develop cluster-wide policies and procedures for delegated functions, which may inform updates to individual ICB operational schemes and standing financial instructions.

---

7. Conflict Management

7.1 Process for managing conflicts

Where potential conflicts arise between ICB interests:

- Issues must be identified in papers to the Joint Committee/Board
- The Joint Committee/Board Chair may permit separate ICB Board consultation
- Final decisions rest with the Joint Committee/Board incorporating both ICB perspectives
- Formal record of conflict management approach required

---

8. Review and Amendment

8.1 Annual Review

This scheme shall be reviewed annually by both ICB Boards and updated as necessary to reflect:

- Changes in statutory requirements
- Evolution of cluster arrangements
- Lessons learned from operation

8.2 Amendment Process

Changes to this scheme require approval by both individual ICB Boards.

9. Definitions

Joint Committee/Board: Joint Committee established under s65Z5 and s65Z6 of the NHS Act 2006

Individual ICB Boards: NHS Cornwall and Isles of Scilly ICB Board and NHS Devon ICB Board

Reserved Functions: Functions that cannot be delegated to joint committee arrangements

Delegated Functions: Functions exercised jointly through the JPC on behalf of both ICBs

---

Effective Date: [To be confirmed following ICB Board approvals] **Review Date:** Annual **Approval Authority:** Both ICB Boards

---

This scheme provides the high-level framework for the NHS Cornwall and Isles of Scilly and NHS Devon Cluster governance while preserving individual ICB sovereignty for statutory reserved functions and operational arrangements.

Annex A – detailed scheme of reservations

1. **Decisions and functions reserved to NHS England**
1.1 The power to establish ICB
1.2 The power to obtain information from the ICB and intervene where NHS England is satisfied that the ICB is failing, or has failed, to discharge any of its functions or that there is a significant risk that it will fail to do so
1.3 Appointment and removal of the ICB Chair
1.4 Terminate the appointment of the Chief Executive and direct the Chair as to the appointment of a replacement where NHSE is satisfied that the ICB is failing or has failed to discharge any of its functions or there is a significant risk that the ICB will fail to do so
1.5 Approval of the ICB Constitution and any changes made to it
1.6 Variation of the ICB Constitution other than on application by the ICB a) where the ICB applies to NHS England in accordance with NHS England's published procedure and that application is approved; and b) where NHS England varies the Constitution of its own initiative, (other than on application by the ICB).
1.7 Remuneration of ICB Chair

2. **Decisions and functions reserved to the ICB Board**
2.1 Determination of the governance arrangements which allow decisions to be delegated to provider collaboratives, joint committees and/or other statutory bodies
2.2 Determination of the governing arrangements of the ICB, ensuring meetings are held in public (except where the ICB considers it would not be in the public interest in relation to all or part of a meeting).
2.3 Establishment together with each responsible local authority an integrated care partnership (ICP) which includes members appointed by the ICB and each relevant authority, ensuring meetings are held in public in accordance with standing orders
2.4 Consideration and approval of applications to NHS England on any matter concerning changes to the ICB's Constitution, including the Standing Orders
2.5 Require and receive the declaration of interests from members of the ICB Board

2.6 Receive reports from committees that the ICB is required by statute or other regulation to establish and take action upon those reports as necessary
2.7 Approve the ICBs overarching scheme of reservation and delegation, which sets out those decisions of the ICB reserved to the Board and those delegated to the • committees and any joint committees of the ICB, or • its employees
2.8 Approve Standing Financial Instructions (SFIs)
2.9 Approve Functions and Decisions Map
2.10 Appoint and dismiss committees of the ICB that are directly responsible to the Board
2.11 Establish Terms of Reference and reporting arrangements for all of the committees of the Board
2.12 Receive reports from committees of the ICB including those which the ICB is required by its Constitution, or by NHS England, or the Secretary of State or by any other legislation, regulations, directions or guidance to establish and to take appropriate action
2.13 Delegate executive powers to be exercised by any of its members or employees
2.14 Approval of the ICB's Annual Report and Accounts
2.15 Approval of the ICB's arrangements for the management of risk
2.16 Approval of a comprehensive system of internal control, including budgetary control, that underpins the effective, efficient and economic operation of the ICB.
2.17 Approve arrangements with another ICB, an NHS trust, NHS foundation trust, NHS England, a local authority, combined authority or any other body prescribed in Regulations, for the ICB's functions to be exercised by or jointly with that other body or for the functions of that other body to be exercised by or jointly with the ICB.
2.18 Approve arrangements for the functions to be exercised by a joint committee and/or for the establishment of a pooled fund to fund those functions (section 65Z6).
2.19 Endorse the ICB internal audit charter and annual audit plan on the recommendation of the ICB Accountable Officer and audit and risk committee

3. **Decisions and functions reserved to the ICB Chair**
3.1 Appointment of the Chief Executive (subject to approval of NHS England in accordance with any procedure published by NHS England)
3.2 Approval of appointment of partner members of the ICB Board
3.3 Appointment of Non-Executive members of the ICB Board
3.4 Approval of appointment of Executive members of the ICB Board
3.5 Approval of appointment of Mental Health Ordinary Member
3.6 Ensure that the members of the Board possess the skills, knowledge and experience necessary for the Board to effectively carry out its functions

Dated: 2025

Transition Agreement is agreed between the following parties:

(1) NHS CORNWALL AND ISLES OF SCILLY INTEGRATED CARE BOARD.

(2) NHS DEVON INTEGRATED CARE BOARD.

Table of contents Clause heading and number Page number

THIS AGREEMENT is made on the of **2025 BETWEEN:**

(1) NHS Cornwall and the Isles of Scilly Integrated Care Board.

(2) NHS Devon Integrated Care Board.

Individually each ICB will be referred to as an "ICB Partner" and together form the “SW ICB Partners”.

BACKGROUND

(A) The SW ICB Partners have statutory and delegated functions to make arrangements for the provision of services for the purposes of the NHS in their areas, apart from those commissioned directly by NHS England.

(B) Pursuant to section 65Z5 of the NHS Act and relevant delegation agreements, each ICB Partner is able to establish and maintain joint arrangements in respect of the discharge of their commissioning and other functions.

(C) The SW ICB Partners have agreed that they will exercise certain functions, as specified in Clause 4, jointly and for that purpose have created a joint committee in accordance with sections 65Z5 and 65Z6 of the NHS Act.

(D) This Agreement sets out the arrangements that will apply between the SW ICB Partners in relation to the joint exercise of commissioning and such other functions as they determine to exercise through the joint committee.

(E) This Agreement is intended to govern the relationship between the SW ICB Partners.

IT IS HEREBY AGREED as follows:

1. COMMENCEMENT AND DURATION

This Agreement has effect from the date of this Agreement and will remain in force for the Initial Term unless terminated in accordance with Clause 21 (Termination & Default) below.

2. PRINCIPLES AND AIMS

The SW ICB Partners acknowledge that, in exercising their obligations under this Agreement, each ICB Partner must comply with the statutory duties set out in the NHS Act and other applicable legislation, and must:

2.1 Consider how it can meet its legal duties to involve patients and the public in shaping the provision of services, including by working with local communities, under-represented groups and those with protected characteristics for the purposes of the Equality Act 2010.

2.2 Consider how, in performing its obligations, it can address health inequalities.

2.3 At all times exercise functions effectively, efficiently and economically.

2.4 Act at all times in good faith towards each other.

2.5 Improve access to treatment, especially for those with the worst health outcomes (e.g. relating to inequalities others who currently struggle to access treatment).

2.6 Look to shift resource towards more early intervention and prevention, and facilitate transformational changes generating efficiencies.

2.7 Build closer relationships and alliances with other commissioners and providers of services within and outside South West England who service our population.

2.8 Work in collaboration to implement the aims and objectives of the 10 Year Health Plan.

2.9 Enable SW ICB Partners to review and discuss Reserved Functions and Retained Services.

3. SCOPE OF THE ARRANGEMENTS

3.1 This Agreement sets out the arrangements through which the SW ICB Partners will work together to commission services and exercise other functions jointly.

3.2 In respect of functions held by SW ICB Partners which they determine should be exercised jointly the following will apply:

3.2.1 Establishment of a Joint Committee as described in Schedule 2 – Governance Arrangements.

3.2.2 The purpose and scope of the Joint Committee, any sub-committees and/or working groups will need to be confirmed by the Joint Committee at its first meeting and subsequently on establishment of sub-committees and/or working groups thereafter.

3.3 At the Commencement Date the SW ICB Partners will agree the purpose and scope of the Joint Committee as set out in its Terms of Reference and this Agreement.

4. FUNCTIONS

4.1 The purpose of this Agreement is to establish a framework through which the SW ICB Partners can secure the commissioning of health services in accordance with the terms of this Agreement.

4.2 This Agreement shall include such commissioning, and such other functions as shall be agreed from time to time by the SW ICB Partners.

5. JOINT COMMITTEE

5.1 The SW ICB Partners will form a statutory Joint Committee which will offer strategic leadership and oversight of all functions exercised through it and ensure that decisions are made collectively across the SW ICB Partners, rather than taken independently. The arrangements are set out in Schedule 2 (Governance Arrangements).

5.2 The Joint Committee or any properly established sub-committee of it will exercise functions which each ICB Partner has delegated to it.

6. GOVERNANCE

6.1 Overall strategic oversight of partnership working between the SW ICB Partners shall be as set out in Schedule 2 (Governance Arrangements).

6.2 Each ICB Partner has secured internal reporting arrangements to ensure the standards of accountability and probity required by each ICB Partner's own statutory duties and organisation are complied with.

6.3 Each ICB Partner will have overall oversight and approval of variations to each function exercised through the Joint Committee.

7. RISK SHARING

7.1 The SW ICB Partners will establish and implement a risk sharing agreement in 2025/26 in respect of such functions as they all delegate to the Joint Committee.

7.2 The risk sharing agreement shall be agreed by no later than 1 October 2025 and shall apply as though agreed at the date this Agreement came into force.

8. REVIEW

8.1 Save where the SW ICB Partners agree alternative arrangements (including alternative frequencies) the ICBs shall undertake a review after six months of the operation of this Agreement.

8.2 After that, unless the SW ICB Partners agree on other arrangements, including alternative frequencies, the ICBs shall undertake an annual review of the operation of this Agreement.

8.3 Reviews shall be conducted in good faith.

9. COMPLAINTS

Complaints received shall be processed in accordance with the Local Authority, Social Services and National Health Service Complaints Regulations 2009 and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and reported back to the respective ICB Partner, and where relevant as set out within any Delegation Agreement.

10. FINANCES

10.1 The financial arrangements shall be as agreed between the SW ICB Partners and summarised in Schedule 3 (Financial Arrangements for the Delegated ICB Functions).

10.2 Unless expressly provided otherwise in this Agreement or otherwise agreed in advance in writing by the SW ICB Partners, each ICB Partner shall bear its own costs as they are incurred.

11. VARIATION

11.1 The SW ICB Partners acknowledge that the scope of the Arrangements may be reviewed and amended from time to time.

11.2 This Agreement may be varied by the agreement of the SW ICB Partners at any time in writing in accordance with their internal decision-making processes.

11.3 No variations to this Agreement will be valid unless they are recorded in writing and signed for and on behalf of each ICB Partner and approved at the Joint Committee.

11.4 The following approach shall, unless otherwise agreed, be followed by the SW ICB Partners:

11.4.1 On receipt of a request from one ICB Partner to vary the Agreement, the SW ICB Partners will first undertake an impact assessment and identify the likely impact of the variation on all parties.

11.4.2 The SW ICB Partners will agree any action to be taken as a result of the proposed variation. This shall include consideration of whether any Service Contracts affected by the proposed variation should continue, be varied or terminated, taking note of the Service Contract terms and conditions and ensuring that the ICB Partner holding the Service Contract/s is not put in breach of contract; its statutory obligations or financially disadvantaged.

11.4.3 Wherever possible agreement will be reached to reduce the level of funding in the Service Contract(s) in line with any reduction in budget, and

11.4.4 should this not be possible and one ICB Partner is left financially disadvantaged as a result of the proposed variation, then the financial risk will, unless otherwise agreed, be shared equally between the ICBs.

12. DATA PROTECTION

12.1 The SW ICB Partners must ensure that all Personal Data processed by or on behalf of them is processed in accordance with the relevant ICB Partner's obligations under Data Protection Legislation and Data Guidance, and the SW ICB Partners must assist each other as necessary to enable each other to comply with these obligations.

12.2 Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need-to-Know basis. If any ICB Partner:

12.2.1 becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

12.2.2 becomes aware of any security breach, in respect of the Relevant Information

it shall promptly notify the Joint Committee. The SW ICB Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable.

12.3 In processing any Relevant Information further to this Agreement, each ICB Partner shall at all times comply with their own policies and any Regulatory or Supervisory Body's policies and guidance on the handling of data.

12.4 Any information governance breach must be responded to in accordance with Data Security and the Protection Incident Reporting tool. If any ICB Partner is required under Data Protection Legislation to notify the Information Commissioner's Office or a Data Subject of an information governance breach, then, as soon as reasonably practical and in any event on or before the first such notification is made, the relevant ICB Partner must fully inform the Joint Committee of the information governance breach. This clause does not require the relevant ICB Partner to provide information which identifies any individual affected by the information governance breach where doing so would breach Data Protection Legislation.

12.5 Whether or not a ICB Partner is a Data Controller or Data Processor will be determined in accordance with Data Protection Legislation and any Data Guidance from a Regulatory or Supervisory Body. The SE ICB Partners acknowledge that a ICB Partner may act as both a Data Controller and a Data Processor.

12.6 The SW ICB Partners will share information to enable joint service planning, commissioning, and financial management subject to the requirements of law, including in particular the Data Protection Legislation in respect of any Personal Data.

12.7 Other than in compliance with judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise required by any Law, no information will be shared with any other ICB Partner save as agreed by the SW ICB Partners in writing.

13. IT INTER-OPERABILITY

13.1 The SW ICB Partners will work together to ensure that all relevant IT systems operated by the SW ICB Partners in respect of the Joint Functions are inter-operable and that data may be transferred between systems securely, easily and efficiently.

13.2 The SW ICB Partners will use their respective reasonable endeavours to help develop initiatives to further this aim.

14. FURTHER ARRANGEMENTS

The SW ICB Partners must give due consideration to whether any of the Joint Functions should be exercised collaboratively with other NHS bodies or Local Authorities including, without limitation, by means of arrangements under section 65Z5 and section 75 of the NHS Act. The SW ICB Partners must comply with any Guidance around the commissioning of delegated functions by means of arrangements under section 65Z5 or 75 of the NHS Act.

15. FREEDOM OF INFORMATION

15.1 Each ICB Partner acknowledges that the other is a public authority for the purposes of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

15.2 Each ICB Partner may be statutorily required to disclose further information about the Agreement and the Relevant Information in response to a specific request under FOIA or EIR, in which case:

15.2.1 each ICB Partner shall provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR.

15.2.2 each ICB Partner shall consult the other regarding the possible application of exemptions in relation to the information requested; and

15.2.3 each ICB Partner acknowledges that the final decision as to the form or content of the response to any request is a matter for the ICB Partner to whom the request is addressed.

15.3 Each ICB Partner is aware and recognises that NHS England may, from time to time, issue a FOIA or EIR protocol or update a protocol previously issued relating to the dealing with and responding to of FOIA or EIR requests in relation to the Delegated Functions and that the SW ICB Partners shall comply with such FOIA or EIR protocols.

16. CONFLICTS OF INTEREST AND TRANSPARENCY ON GIFTS AND HOSPITALITY

16.1 The SW ICB Partners must and must ensure that, in delivering the Functions, all Staff comply with the law and with Managing Conflicts of Interest in the NHS and other Guidance, including complying with good practice, in relation to gifts, hospitality and other inducements and actual or potential conflicts of interest.

16.2 Each ICB Partner must maintain a register of interests in respect of all persons involved in decisions concerning the Functions. This register must be publicly available. For the purposes of this clause, an ICB may rely on an existing register of interests rather than creating a further register.

16.3 Where any member of the Joint Committee or any sub-committee has an actual or potential conflict of interest in relation to any matter under consideration by the Joint Committee or any sub-committee, that member must not participate in meetings (or parts of meetings) in which the relevant matter is discussed or make a recommendation in relation to the relevant matter. The relevant appointing body may send an alternative representative to take the place of the conflicted member in relation to that matter.

17. CONFIDENTIALITY

17.1 Except as this Agreement otherwise provides, Confidential Information is owned by the disclosing ICB Partner and the receiving ICB Partner has no right to use it.

17.2 Subject to Clause 17.3, the receiving ICB Partner agrees:

17.2.1 to use the disclosing ICB Partner's Confidential Information only in connection with the receiving ICB Partner's performance under this Agreement.

17.2.2 not to disclose the disclosing ICB Partner's Confidential Information to any third party or to use it to the detriment of the disclosing ICB Partner; and

17.2.3 to maintain the confidentiality of the disclosing ICB Partner's Confidential Information.

17.3 The receiving ICB Partner may disclose the disclosing ICB Partner's Confidential Information:

17.3.1 in connection with any Dispute Resolution Procedure.

17.3.2 to comply with the Law.

17.3.3 to any appropriate Regulatory or Supervisory Body.

17.3.4 to its staff, who in respect of that Confidential Information will be under a duty no less onerous than the Receiving ICB Partner's duty under Clause 17.2;

17.3.5 to NHS Bodies for the purposes of carrying out their functions.

17.3.6 as permitted under any other express arrangement or other provision of this Agreement.

17.4 The obligations in Clause 17 will not apply to any Confidential Information which:

17.4.1 is in or comes into the public domain other than by breach of this Agreement.

17.4.2 the receiving ICB Partner can show by its records was in its possession before it received it from the disclosing Party; or

17.4.3 the receiving ICB Partner can prove it obtained or was able to obtain from a source other than the disclosing ICB Partner without breaching any obligation of confidence.

17.5 This Clause 17 does not prevent NHS England making use of or disclosing any Confidential Information disclosed by an ICB where necessary for the purposes of exercising its functions in relation to that ICB.

17.6 This Clause 17 will survive the termination of this Agreement for any reason for a period of 5 years.

17.7 This Clause 17 will not limit the application of the Public Interest Disclosure Act 1998 in any way whatsoever.

17.8 The above shall also apply to such confidential information as is created and shared between the ICB Partners and NHS England in respect of any delegated functions, with each ICB Partner noting the application of clause 17.5.

18. LIABILITIES

18.1 Subject to Clause 18.2, and 18.3, if an ICB Partner ("First ICB") incurs a loss arising out of or in connection with this Agreement as a consequence of any act or omission of the other ICB Partner ("Other ICB") which constitutes negligence, fraud or a breach of contract in relation to this Agreement or any Services Contract then the Other ICB shall be liable to the First ICB for that loss.

18.2 Clause 18.1 shall only apply to the extent that the acts or omissions of the Other ICB contributed to the relevant loss. Furthermore, it shall not apply if such act or omission occurred as a consequence of the Other ICB acting in accordance with the instructions or requests of the First ICB or the Joint Committee.

18.3 If any third party makes a claim or intimates an intention to make a claim against any ICB Partner, which may reasonably be considered as likely to give rise to liability under this Clause 18, the First ICB that may claim against the Other ICB will:

18.3.1 as soon as reasonably practicable give written notice of that matter to the Other ICB specifying in reasonable detail the nature of the relevant claim.

18.3.2 not make any admission of liability, agreement or compromise in relation to the relevant claim without the prior written consent of the Other ICB (such consent not to be unreasonably conditioned, withheld or delayed);

18.3.3 give the Other ICB and its professional advisers reasonable access to its premises and personnel and to any relevant assets, accounts, documents and records within its power or control so as to enable the Indemnifying ICB Partner and its professional advisers to examine such premises, assets, accounts, documents and records and to take copies at their own expense for the purpose of assessing the merits of, and if necessary defending, the relevant claim.

18.4 Each ICB Partner shall at all times take all reasonable steps to minimise and mitigate any loss for which one party is entitled to bring a claim against the other pursuant to this Agreement.

18.5 Unless expressly agreed otherwise, nothing in this Agreement shall affect:

18.5.1 the liability of NHS England to any person in respect of NHS England's Commissioning Functions; or

18.5.2 the liability of any of the ICBs to any person in respect of that ICB's Commissioning Functions.

19. DISPUTE RESOLUTION

19.1 Where any dispute arises between the SW ICB Partners in connection with this Agreement, they must use their best endeavours to resolve that dispute.

19.2 Where any dispute is not resolved under clause 19.1 on an informal basis then the dispute will be referred to a meeting of the relevant ICB Partner Chief Executive Officer and Chair to attempt to resolve the dispute.

19.3 Where any dispute is not resolved under clause 19.2 then any ICB may refer the matter to the Joint Committee for resolution.

19.4 Should the dispute relate to any delegated function from NHS England then the matter may be referred to the South West Regional Leadership Team of NHS England for resolution should clauses 19.1 and 19.2 not lead to a resolution of the dispute.

20. BREACHES OF THE AGREEMENT

20.1 If any ICB Partner ("Relevant ICB Partner") fails to meet any of its obligations under this Agreement, the other ICB Partner may by notice require the Relevant ICB Partner to take such reasonable action within a reasonable timescale as the other ICB Partner may specify to rectify such failure. Should the Relevant ICB Partner fail to rectify such failure within such reasonable timescale, the matter shall be referred for resolution in accordance with Clause 19 ("Dispute Resolution").

20.2 Without prejudice to Clause 20.1, if any ICB Partner does not comply with the terms of this Agreement (including if any ICB Partner exceeds its authority under this Agreement), the other ICB Partner may at their discretion agree to:

20.2.1 waive their rights in relation to such non-compliance.

20.2.2 terminate this Agreement in accordance with Clause 21 *(Termination and Default)* below.

20.2.3 exercise the dispute resolution procedure in accordance with Clause 19, *(Dispute Resolution).*

20.2.4 agree to put in place a variation, under Clause 11, including ratifying a decision with remaining ICB Partners.

20.3 For the avoidance of doubt, there is no provision in this Clause 20 that enables the agreement to be terminated upon breach by any ICB.

20.4 This clause shall also apply as between the ICB Partners, the SW ICB Partners and NHS England in respect of any breaches of the Agreement that arise from the exercise of any delegated functions.

21. TERMINATION & DEFAULT

21.1 If an ICB wishes to end its participation in this Agreement, the relevant ICB must provide at least 12 months' formal and written notice to the other ICB Partner of its intention to end its participation in this Agreement. Such notification shall only take effect from the end of 31 March in any calendar year.

21.2 Should clause 21.1 be activated by an ICB Partner this will end their joint exercise of any delegated functions with other ICB Partners then the relevant ICB Partner must obtain the prior agreement of NHS England and make arrangements for their exercise of the delegated functions that are acceptable to NHS England.

21.3 The termination shall only take effect where alternative arrangements for the provision of the Delegated Services and effective exercise of the delegated functions are in place for the period immediately following termination. This will enable the ICB Partners and NHS England to work together to ensure that there are suitable alternative arrangements in place in relation to the exercise of the Delegated Functions.

22. CONSEQUENCES OF TERMINATION

22.1 Upon termination of this Agreement (in whole or in part), for any reason whatsoever, the following shall apply:

22.1.1 the SW ICB Partners agree that they will work together and co-operate to ensure that the winding down of these arrangements is carried out smoothly and with as little disruption as possible to patients, employees, the ICB Partners and third parties, so as to minimise costs and liabilities of each ICB Partner in doing so.

22.1.2 where a ICB Partner has entered into a Service Contract in exercise of the Functions of any other ICB Partner which continues after the termination of this Agreement, any ICB

Partner for whom that contract shall continue shall contribute to the Contract Price in accordance with the agreed contribution for that Service prior to termination and will enter into all appropriate legal documentation required in respect of this.

22.1.3 termination of this Agreement shall have no effect on the liability of any rights or remedies of any ICB Partner already accrued, prior to the date upon which such termination takes effect.

22.2 The provisions of Clauses 12 (Data Protection), 15 (Freedom of Information), 17 (Confidentiality), 18 (Liabilities) and 22 (Consequences of Termination) shall survive termination or expiry of this Agreement.

22.3 The termination provisions relating to any delegated functions are as set out in clause 21.3 and 21.4.

23. PUBLICITY

The ICB Partners shall use reasonable endeavours to consult one another before making any public announcements concerning the subject matter of this Agreement.

24. EXCLUSION OF PARTNERSHIP OR AGENCY

24.1 Nothing in this Agreement shall create or be deemed to create a legal partnership under the Partnership Act 1890 or the relationship of employer and employee between the Partners or render any Partner directly liable to any third party for the debts, liabilities or obligations of any Partner.

24.2 Save as specifically authorised under the terms of this Agreement, no Partner shall hold itself out as the agent of any other Partner.

25. THIRD PARTY RIGHTS

The Contracts (Rights of Third Parties) Act 1999 shall not apply to this Agreement and accordingly each ICB Partner to this Agreement does not intend that any third party should have any rights in respect of this Agreement by virtue of that Act.

26. NOTICES

26.1 Any notices given under this Agreement must be sent by e-mail to the relevant Authorised Officers or their nominated deputies.

26.2 Notices by e-mail will be effective when sent in legible form, but only if, following transmission, the sender does not receive a non-delivery message.

27. ASSIGNMENT AND SUBCONTRACTING

This Agreement, and any right and conditions contained in it, may not be assigned or transferred by an ICB Partner, without the prior written consent of the other SW ICB Partner, except to any statutory successor to the relevant function.

28. SEVERABILITY

If any term, condition or provision contained in this Agreement shall be held to be invalid, unlawful or unenforceable to any extent, such term, condition or provision shall not affect the validity, legality or enforceability of the remaining parts of this Agreement.

29. WAIVER

No failure or delay by a ICB Partner to exercise any right or remedy provided under this Agreement or by law shall constitute a waiver of that or any other right or remedy, nor shall it prevent or restrict the further exercise of that or any other right or remedy. No single or partial exercise of such right or remedy shall prevent or restrict the further exercise of that or any other right or remedy.

30. STATUS

The SW ICB Partners acknowledge that they are health service bodies for the purposes of section 9 of the NHS Act. Accordingly, this Agreement shall be treated as an NHS contract and shall not be legally enforceable.

31. ENTIRE AGREEMENT

This Agreement constitutes the entire agreement and understanding of the SW ICB Partners and supersedes any previous agreement between the ICB Partners and NHS England relating to the subject matter of this Agreement.

32. GOVERNING LAW AND JURISDICTION

Subject to the provisions of Clause 19 (Dispute Resolution) and Clause 30 (Status), this Agreement shall be governed by and construed in accordance with English Law, and the SE ICB Partners and NHS England irrevocably agree that the courts of England shall have exclusive jurisdiction to settle any dispute or claim that arises out of or in connection with this Agreement.

33. FAIR DEALINGS

The SW ICB Partners recognise that it is impracticable to make provision for every contingency which may arise during the life of this Agreement and they declare it to be their intention that this Agreement shall operate between them with fairness and without detriment to the interests of either of them and that, if in the course of the performance of this Agreement, unfairness to either of them does or may result, then the other shall use its reasonable endeavours to agree upon such action as may be necessary to remove the cause or causes of such unfairness.

34. COUNTERPARTS

This Agreement may be executed in one or more counterparts. Any single counterpart or a set of counterparts executed, in either case, by all SW ICB Partners shall constitute a full original of this Agreement for all purposes.

This Agreement has been entered into on the date stated at the beginning of it.

SIGNED by ....

for and on behalf of **NHS Cornwall and Isles of Scilly Integrated Care Board** (Signature)

.....

(Date)

SIGNED by ....

for and on behalf of **NHS Devon Integrated Care Board** (Signature)

.....

(Date)

SCHEDULE 1: DEFINITIONS AND INTERPRETATIONS

DEFINITIONS AND INTERPRETATION

In this Agreement, unless the context otherwise requires, the following words and expressions shall have the following meanings:

"Agreement"	this agreement between the ICB Partners comprising these terms and conditions together with all schedules attached to it;
"Aligned Commissioning"	means a mechanism by which the ICB Partners agree to commission a Service in a co-ordinated and collaborative manner. For the avoidance of doubt, an aligned commissioning arrangement does not involve the delegation of any functions between ICBs;
"Annual Review"	Means the annual review of the arrangements under this Agreement by the Partners;
"Area"	means the geographical area covered by the ICBs;
"Arrangements"	means the joint working and delegation arrangements set out in this Agreement;
"Assurance Processes"	has the meaning in Paragraph 8 of Schedule 3 (Oversight and Assurance);
"Authorised Officer"	the individual(s) appointed as Authorised Officer in accordance with the agreed Terms of Reference;
"Change in Law"	a change in Law that is relevant to the arrangements made under this Agreement, which comes into force after the Commencement Date;
"Claim"	means for or in relation to the Commissioning Functions (a) any litigation or administrative, mediation, arbitration or other proceedings, or any claims, actions or hearings before any court, tribunal or the Secretary of State, any governmental, regulatory or similar body, or any department, board or agency or (b) any dispute with, or any investigation, inquiry or enforcement proceedings by any governmental, regulatory or similar body or agency;
"Clinical Commissioning Policies"	a nationally determined clinical policy sets out the commissioning position on a particular clinical treatment issue and defines accessibility (including a not for routine commissioning position) of a medicine, medical device, diagnostic technique, surgical procedure or intervention for patients with a condition requiring a specialised service;
"Clinical Reference Groups"	means a group consisting of clinicians, commissioners, public health experts, patient and public voice representatives and professional associations, which offers specific knowledge and expertise on the best ways that Specialised Services should be provided;
"Collaborative Commissioning Agreement"	means an agreement under which NHS Commissioners set out collaboration arrangements in respect of commissioning Specialised Services Contracts;
"Commencement Date"	means 1 September 2025;
"Commissioning Functions"	the respective statutory functions of the ICB Partners in arranging for the provision of services as part of the health service;

"Confidential Information"	means information, data and/or material of any nature which any ICB Partner may receive or obtain in connection with the operation of this Agreement, or arrangements made pursuant to it and: (a) which comprises Personal Data or which relates to any patient or his treatment or medical history. (b) the release of which is likely to prejudice the commercial interests of a ICB Partner; or (c) which is a trade secret;
"Contracting Standard Operating Procedure"	means the Contracting Standard Operating Procedure produced by NHS England in respect of the Joint Specialised Services;
"Core Membership"	means the voting membership of the Joint Committee as set out in the Terms of Reference;
"Data Controller"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Processor"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Guidance"	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement regarding information governance, confidentiality, privacy or compliance with Data Protection Legislation to the extent published and publicly available or their existence or contents have been notified to the ICB by NHS England and/or any relevant Regulatory or Supervisory Body. This includes but is not limited to guidance issued by NHS Digital, the National Data Guardian for Health & Care, the Department of Health and Social Care, NHS England, the Health Research Authority, the UK Health Security Agency and the Information Commissioner;
"Data Protection Legislation"	means the UK General Data Protection Regulation, the Data Protection Act 2018, the Regulation of Investigatory Powers Act 2000, the Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (SI 2000/2699), the Privacy and Electronic Communications (EC Directive) Regulations 2003 (SI 2426/2003), the common law duty of confidentiality and all applicable laws and regulations relating to the processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner;
"Data Protection Officer"	shall have the same meaning as set out in the Data Protection Legislation;
"Data Security and Protection Incident Reporting tool"	the incident reporting tool for data security and protection incidents, which forms part of the Data Security and Protection Toolkit available at https://www.dsptoolkit.nhs.uk/;
"**Delegated Commissioning Group**" **"DCG"**	means a group hosted by NHS England whose terms shall include providing an assurance role in compliance with the Assurance Processes;
"Delegation Agreement(s)"	Means the Delegation Agreements under which NHS England delegate NHS England Commissioning Functions to each ICB;
"Delegated Functions"	Means Commissioning Functions of NHS England delegated to each ICB under a Delegation Agreement;
"Delegated Services"	Means those services commissioned in exercise of the Delegated Functions

"Dispute Resolution Procedure"	the procedure set out in Clause 20 (Dispute Resolution);
“Finance Guidance”	guidance, rules and operating procedures produced by NHS England that relate to these Joint Working Arrangements, including but not limited to the following: - Commissioning Change Management Business Rules. - Contracting Standard Operating Procedure. - Cashflow Standard Operating Procedure. - Finance and Accounting Standard Operating Procedure. - Service Level Framework Guidance;
“Flexibilities”	Mean the flexibilities that the ICB Partners may use to work in a coordinated manner as set out at Clause []
"FOIA"	the Freedom of Information Act 2000 and any subordinate legislation made under it from time to time, together with any guidance or codes of practice issued by the Information Commissioner or relevant government department concerning this legislation;
“Guidance”	means any applicable guidance, guidelines, direction or determination, framework, code of practice, standard or requirement to which the ICB Partners have a duty to have regard (and whether specifically mentioned in this Agreement or not), to the extent that the same are published and publicly available or the existence or contents of them have been notified by any relevant Regulatory or Supervisory Body;
“Governance Arrangements”	Means the governance arrangements in respect of the Arrangements agreed by the ICB Partners and as set out in Schedule [4]
“High-Cost Drugs”	Means medicines not reimbursed though national prices and identified on the NHS England high-cost drugs list;
“ICB Functions”	the Commissioning Functions of an ICB;
“ICB Reserved Functions”	Where there is any delegation of ICB Functions or further delegation of Delegated Functions, those functions that remain reserved to each ICB
“Individual Scheme”	Means a scheme which has been agreed by the ICB Partners to be included within this Agreement;
"Information"	has the meaning given under section 84 of FOIA;
“Indemnity Arrangement”	mean either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
"Information Sharing Agreement"	any information sharing agreement entered into in accordance with Schedule 5 (Further Information Governance and Sharing Provisions).
“Indemnity Arrangement”	means either: (i) a policy of insurance; (ii) an arrangement made for the purposes of indemnifying a person or organisation; or (iii) a combination of (i) and (ii);
“Initial Term”	Means 2 years

"Joint Committee"	means the joint committee(s) established under this Agreement on the terms set out in the Terms of Reference;
"Joint Functions"	any Functions that are delegated to a Joint Committee
"Law"	means: (a) any statute or proclamation or any delegated or subordinate legislation. (b) any guidance, direction or determination with which the ICB Partner(s) or relevant third party (as applicable) are bound to comply to the extent that the same are published and publicly available or the existence or contents of them have been notified to the ICB Partner(s) or relevant third party (as applicable); and (c) any judgment of a relevant court of law which is a binding precedent in England;
"Lead Commissioning Arrangements"	means the arrangements by which one ICB Partner commissions Services in relation to an Individual Scheme on behalf of another ICB Partner or ICB Partners in exercise of the Commissioning Functions of the ICB Partners;
"Lead ICB Partner"	means the ICB Partner responsible for commissioning an Individual Service under a Lead Commissioning Arrangement;
"Mandated Guidance"	means any protocol, policy, guidance, guidelines, framework or manual relating to the exercise of Delegated Functions and issued by NHS England from time to time as mandatory;
"National Standards"	means the service standards for each Specialised Service, as set by NHS England and included in Clinical Commissioning Policies or National Specifications;
"National Specifications"	the service specifications published by NHS England in respect of Specialised Services;
"Need to Know"	has the meaning set out in Schedule 5;
"NHS Act"	the National Health Service Act 2006;
"NHS England Functions"	NHS England's statutory functions exercisable under or by virtue of the NHS Act;
"NHS England Reserved Functions"	those aspects of the Specialised Commissioning Functions for which NHS England retains commissioning responsibility;
"Non-Personal Data"	means data which is not Personal Data;
"Non-Pooled Funds"	means the budget detailing the financial contributions of the ICB PartnerICB ICB Partners which are not included in a Pooled Fund in respect of a particular Service as set out in the relevant Scheme Specification
"**Oversight Framework**"	means the NHS Oversight Framework, as may be amended or replaced from time to time, and any relevant associated Guidance published by NHS England;
"ICB Partners"	the parties to this Agreement;
"Personal Data"	has the meaning set out in the Data Protection Legislation;

"Pooled Funds"	means any pooled fund established and maintained by the ICB Partners as a pooled fund
"Population"	means the population for which an ICB or all of the ICBs have the responsibility for commissioning health services;
"Provider Collaborative"	a group of Providers who have agreed to work together to improve the care pathway for one or more Services;
"Provider Collaborative Arrangements"	Means the contracting arrangements entered into in respect of a Provider Collaborative;
"Provider Collaborative Guidance"	Means any guidance published by NHS England in respect of Provider Collaboratives;
"Regional Quality Group"	A group set up to act as a strategic forum at which regional ICB Partners from across health and social care can share, identify and mitigate wider regional quality risks and concerns as well as share learning so that quality improvement and best practice can be replicated;
"Regulatory or Supervisory Body"	means any statutory or other body having authority to issue guidance, standards or recommendations with which the relevant Party and/or Staff must comply or to which it or they must have regard, including: (i) CQC. (ii) NHS England. (iii) the Department of Health and Social Care. (iv) NICE. (v) Healthwatch England and Local Healthwatch. (vi) the General Medical Council. (vii) the General Dental Council. (viii) the General Optical Council. (ix) the General Pharmaceutical Council. (x) the Healthcare Safety Investigation Branch; and (xi) the Information Commissioner;
"Relevant Information"	means the Personal Data and Non-Personal Data processed under this Agreement, and includes, where appropriate, "confidential patient information" (as defined under section 251 of the NHS Act), and "patient confidential information" as defined in the 2013 Report, The Information Governance Review – "*To Share or Not to Share?*");
"Request for Information"	has the meaning set out in the FOIA;
"Reserved Functions"	Means NHS England Reserved Functions or ICB Reserved Functions
"**Relevant Clinical Networks"**	means those clinical networks identified by NHS England as required to support the commissioning of Specialised Services for the Population;
"Retained Services"	means those Specialised Services for which NHS England shall retain commissioning responsibility, as set out the Delegation Agreement;

"Risk Sharing"	means an agreed arrangement for risk and benefit sharing between the ICB Partners;
"Shared Care Arrangements"	these arrangements support patients receiving elements of their care closer to home, whilst still ensuring that they have access to the expertise of a specialised centre and that care is delivered in line with the expectation of the relevant National Specification;
"Single Point of Contact"	the member of Staff appointed by each relevant ICB Partner in accordance with Paragraph 14 of Schedule 5;
"Special Category Personal Data"	has the meaning set out in the Data Protection Legislation;
"Specialised Commissioning Budget"	means the budget identified by NHS England in respect of each ICB for the purpose of exercising the Delegated Functions;
"Specialised Commissioning Functions"	means the statutory functions conferred on NHS England under Section 3B of the NHS Act 2006 and Regulation 11 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996 (as amended or replaced);
"Specified Purpose"	means the purpose for which the Relevant Information is shared and processed to facilitate the exercise of the Joint Functions and Reserved Functions
"Specialised Services"	means the services commissioned in exercise of the Specialised Commissioning Functions;
"Specialised Services Contract"	a contract for the provision of Specialised Services entered into in the exercise of the Specialised Commissioning Functions;
"Specialised Services Provider"	a provider party to a Specialised Services Contract;
"Specialised Services Staff"	means the Staff carrying out the Specialised Services Functions;
"Staff"	means the ICB Partners' employees, officers, elected members, directors, voluntary staff, consultants, and other contractors and sub-contractors acting on behalf of any ICB Partner (whether or not the arrangements with such contractors and sub-contractors are subject to legally binding contracts) and such contractors' and their sub-contractors' personnel;
"System quality group"	means a group set up to identify and manage concerns across the local system. The system quality group shall act as a strategic forum at which ICB Partners from across the local health and social care footprint can share issues and risk information to inform response and management, identify and mitigate quality risks and concerns as well as share learning and best practice;
"Term"	the Initial Term, as may be varied by: (a) any extensions to this Agreement that are agreed under Clause 1.1 (Commencement and Duration); or (b) the earlier termination of this Agreement in accordance with its terms;

“Terms of Reference”	means the Terms of Reference for the Joint Committee agreed between the ICB Partners at the first meeting of the Joint Committee, a draft of which is included at Schedule 2 (Joint Committee;
“Triple Aim”	the duty on each of the ICB ICB Partners in making decisions about the exercise of their functions, to have regard to all likely effects of the decision in relation to: (a) the health and well-being of the people of England. (b) the quality of services provided to individuals by the NHS. (c) efficiency and sustainability in relation to the use of resources by the NHS;
“UK GDPR”	means Regulation (EU) 2016/679 of the European Parliament and of the Council of 27th April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (General Data Protection Regulation) as it forms part of the law of England and Wales, Scotland and Northern Ireland by virtue of section 3 of the European Union (Withdrawal) Act 2018;
"Working Day"	any day other than Saturday, Sunday, a public or bank holiday in England.

Notes

1. References to statutory provisions shall be construed as references to those provisions as respectively amended or re-enacted (whether before or after the Commencement Date) from time to time.
2. The headings of the Clauses in this Agreement are for reference purposes only and shall not be construed as part of this Agreement or deemed to indicate the meaning of the relevant Clauses to which they relate. Reference to Clauses is Clauses in this Agreement.
3. References to Schedules are references to the schedules to this Agreement and a reference to a Paragraph is a reference to the paragraph in the Schedule containing such reference.
4. References to a person or body shall not be restricted to natural persons and shall include a company, corporation or organisation.
5. Words importing the singular number only shall include the plural.
6. Use of the masculine includes the feminine and all other genders.
7. Where anything in this Agreement requires the mutual agreement of the ICB Partners, then unless the context otherwise provides, such agreement must be in writing.
8. Any reference to the ICB Partners shall include their respective statutory successors, employees and agents.
9. In the event of a conflict, the conditions set out in the Clauses to this Agreement shall take priority over the Schedules.
10. Where a term of this Agreement provides for a list of items following the word "including" or "includes", then such list is not to be interpreted as being an exhaustive list.

SCHEDULE 2: GOVERNANCE ARRANGEMENTS FOR THE CLUSTER

Commented [PH1]: Structure chart to be included once finalised

SCHEDULE 3: FINANCIAL ARRANGEMENTS FOR THE CLUSTER

1 Financial Delegation Conditions

1.1 The SW ICB Partners must adhere to two key delegation conditions related to the future financial framework:

- During 2025/26, ICBs must implement a Risk Share arrangement for the Cluster. This is a critical measure to address broader financial challenges and mitigate the impact of the long-term convergence rate.

1.2 These conditions shall be subject to review in accordance with Clause 8 (Review).

2 Financial allocations

2.1 The ICBs have agreed **not** to establish and maintain pooled funds for revenue expenditure.

2.2 The financial allocation for 2025/26 shall be as set out by the NHSE for each Partner ICB. Growth funding will be applied in accordance with national guidance for baseline levels. Any discretionary growth funding allocated nationally will be agreed by ICBs for consistent application into risk and investment reserves held by each Partner ICB.

2.3 Given the complexity of clustering, it may be necessary to agree a redistribution of allocations where discrepancies come to light during the setting of 2025/26 plans or by exception in year.

2.4 The running costs allowance (RCA) will be taken into account in determining how each Partner ICB will operate and work in the Cluster.

3 Risk share arrangements, Overspends and Underspends

General principle

3.1 Whilst CIOS ICB and Devon ICB remain individual statutory entities, it is the general intention to ensure separate management of the respective financial positions, to ensure financial reporting integrity and maintain a separation of system financial positions. As such, no large scale risk-sharing is anticipated between the two entities. Notwithstanding this principle, both ICBs recognise that the specific costs of transition towards a clustered ICB ('transition costs') should be managed jointly, as a single process and budget between the parties. The arrangements for the management of transition costs will be as set out below in paras [x.xx to y.yy]

3.2 Any reference to the Joint Committee in this schedule may be replaced by a reference to a nominated sub-committee, where the Joint Committee chooses to delegate these responsibilities to that sub-committee.

Transition costs

3.3 Prior to committing to any material transition costs, the CFOs of the statutory ICBs shall present a funding statement to the Joint Committee that sets out the agreed resources to meet the projected costs.

3.4 The actual costs of the transition shall fall to whichever ICB it most clearly relates in accounting terms (e.g. the employer in the event of a redundancy), regardless of the overall funding arrangements.

3.5 Once final costs are established, and periodically up to that point based on latest available figures (including at year-end), the two ICBs shall move allocations between the parties to mirror the actual costs incurred, to ensure that funding allocated by ICB matches actual costs i.e. the intention is that both parties 'breakeven' on the costs allocated to them.

3.6 The CFOs shall provide regular updates on the actual and projected costs of the transition for both ICBs to the Joint Committee.

3.7 The CFOs may at any time propose to the Joint Committee a revised funding statement for the relevant costs, provided that the proposed revised funding statement fully meets the latest projected costs of the transition.

3.8 In the event of an underspend against projected costs, the uncommitted resources from the total funding statement shall be retained by each party in proportion to their initial contributions, unless explicitly agreed to the contrary by the Joint Committee.

3.9 In the event of an overspend being anticipated, the CFOs shall take an updated funding statement to the next available Joint Committee demonstrating continued overall affordability within existing ICB resources: that shall re-set the funding agreement for that element of the transition.

3.10 Costs should not be committed above and beyond the latest agreed funding statement level at any point.

3.11 In the event that a single officer is acting as statutory CFO for both ICBs, they shall determine and present the proposed funding statement across the parties (or any subsequent revisions to that statement) across the parties to the Joint Committee.

Other issues

3.12 The general intention to have separate management of the financial positions of the two statutory ICBs is in no way intended to obstruct or impair delivery of effective joint working across the combined area on issues of efficiency or other financial improvement, where benefits will accrue to both ICBs.

3.13 Where joint teams are established for individual projects, or as part of the delivery of consolidated ICB staffing structures, CFOs responsible for each statutory ICB shall agree and document a reasonable approach to the sharing of those costs between the two statutory ICBs. This will enable a fair share of costs between the parties and retention of a full audit trail to satisfy governance requirements. Unless otherwise agreed in the context of specific projects, it is expected that the default share for joint costs between the statutory ICBs will be the weighted population shares as used by NHS England in determining the cap on future staffing and other administrative costs of each ICB.

3.14 Any material decisions taken by officers in respect of these risk sharing arrangements shall be reported to the next available Joint Committee for ratification, to ensure transparency and corporate assurance of the approaches being taken.

3.15 In the event that a single officer is acting as statutory CFO for both ICBs, they shall determine the approach to the sharing of costs between the parties, but with any material decisions still requiring ratification by the Joint Committee as set out above.

3.16 Any proposals to change the terms of this risk sharing agreement will require approval by [xxxx], as it would constitute a variation to the Transition Agreement

4 Capital Expenditure

Unless agreed by each ICB Partner, no funds shall normally be applied towards any one-off expenditure on goods and/or services, which would historically have been funded from the capital budgets of one of the ICBs. If a need for capital expenditure is identified for any service, this must be agreed by the SW ICB Partners.

Appendix 1 - Risk Share Agreement

SCHEDULE 4: FURTHER INFORMATION GOVERNANCE AND SHARING PROVISIONS

1. Introduction

1.1. This Schedule sets out the scope for the secure and confidential sharing of information between the SW ICB Partners on a Need-to-Know basis, in order to enable each ICB Partner to exercise their functions in pursuance of this Agreement.

1.2. References in this Schedule *(Further Information Governance and Sharing Provisions)* to the Need to Know basis or requirement (as the context requires) should be taken to mean that the Data Controllers' Staff will only have access to Personal Data or Special Category Personal Data if it is lawful for such Staff to have access to such data for the Specified Purpose in paragraph 2.1 and the function they are required to fulfil at that particular time, in relation to the Specified Purpose, cannot be achieved without access to the Personal Data or Special Category Personal Data specified.

1.3. This Schedule and the Data Sharing Agreements entered into under this Schedule are designed to:

1.3.1. provide information about the reasons why Relevant Information may need to be shared and how this will be managed and controlled by each ICB Partner;

1.3.2. describe the purposes for which the SW ICB Partners have agreed to share Relevant Information;

1.3.3. set out the lawful basis for the sharing of information between the SW ICB Partners, and the principles that underpin the exchange of Relevant Information;

1.3.4. describe roles and structures to support the exchange of Relevant Information between the SW ICB Partners;

1.3.5. apply to the sharing of Relevant Information relating to Service Providers and their Staff;

1.3.6. apply to the sharing of Relevant Information whatever the medium in which it is held and however it is transmitted;

1.3.7. ensure that Data Subjects are, where appropriate, informed of the reasons why Personal Data about them may need to be shared and how this sharing will be managed;

1.3.8. apply to the activities of the SW ICB Partners' Staff; and

1.3.9. describe how complaints relating to Personal Data sharing between the SW ICB Partners will be investigated and resolved, and how the information sharing will be monitored and reviewed.

2. Purpose

2.1. The Specified Purpose of the data sharing is to facilitate the exercise of the Joint Functions.

2.2. Each ICB Partner must ensure that they have in place appropriate Data Sharing Agreements to enable data to be received from any third-party organisations from which the SW ICB Partners must obtain data in order to achieve the Specified Purpose. Where necessary specific and detailed purposes must be set out in a Data Sharing Agreement that complies with all relevant Legislation and Guidance.

3. Benefits of information sharing

3.1. The benefits of sharing information are the achievement of the Specified Purpose, with benefits for service users and other stakeholders in terms of the improved delivery of the Commissioned Services.

4. Lawful basis for sharing

4.1. The ICB Partners shall comply with all relevant Data Protection Legislation requirements and good practice in relation to the processing of Relevant Information shared further to this Agreement.

4.2. The ICB Partners shall ensure that there is a Data Protection Impact Assessment ("DPIA") that covers processing undertaken in pursuance of the Specified Purpose. The DPIA shall identify the lawful basis for sharing Relevant Information for each purpose and data flow.

4.3. Where appropriate, the Relevant Information to be shared shall be set out in a Data Sharing Agreement.

5. Restrictions on use of the Shared Information

5.1. Each ICB Partner shall only process the Relevant Information as is necessary to achieve the Specified Purpose and, in particular, shall not use or process Relevant Information for any other purpose unless agreed in writing by the Data Controller that released the information to the other. There shall be no other use or onward transmission of the Relevant Information to any third party without a lawful basis first being determined, and the originating Data Controller being notified.

5.2. Access to, and processing of, the Relevant Information provided by a ICB Partner must be the minimum necessary to achieve the Specified Purpose. Information and Special Category Personal Data will be handled at all times on a restricted basis, in compliance with Data Protection Legislation requirements, and the ICB Partners' Staff should only have access to Personal Data on a justifiable Need to Know basis.

5.3. Neither the provisions of this Schedule nor any associated Data Sharing Agreements should be taken to permit unrestricted access to data held by any of the ICB Partners.

5.4. Neither ICB Partner shall subcontract any processing of the Relevant Information without the prior consent of the other ICB Partner. Where a ICB Partner subcontracts its obligations, it shall do so only by way of a written agreement with the sub-contractor which imposes the same obligations as are imposed on the Data Controllers under this Agreement.

5.5. The ICB Partners shall not cause or allow Data to be transferred to any territory outside the United Kingdom without the prior written permission of the responsible Data Controller.

5.6. Any particular restrictions on use of certain Relevant Information should be included in a Personal Data Agreement.

6. Ensuring fairness to the Data Subject

6.1. In addition to having a lawful basis for sharing information, the UK GDPR generally requires that the sharing must be fair and transparent. In order to achieve fairness and transparency to the Data Subjects, the SW ICB Partners will take the following measures as reasonably required:

6.1.1. amendment of internal guidance to improve awareness and understanding among Staff;

6.1.2. amendment of respective privacy notices and policies to reflect the processing of data carried out further to this Agreement, including covering the requirements of articles 13 and 14 UK GDPR and providing these (or making them available to) Data Subjects;

6.1.3. ensuring that information and communications relating to the processing of data is clear and easily accessible; and

6.1.4. giving consideration to carrying out activities to promote public understanding of how data is processed where appropriate.

6.2. Each ICB Partner shall procure that its notification to the Information Commissioner's Office, and record of processing maintained for the purposes of Article 30 UK GDPR, reflects the flows of information under this Agreement.

6.3. The SW ICB Partners shall reasonably cooperate in undertaking any DPIA associated with the processing of data further to this Agreement, and in doing so engage with their respective Data Protection Officers in the performance by them of their duties pursuant to Article 39 UK GDPR.

6.4. Further provision in relation to specific data flows may be included in a Personal Data Agreement between the SW ICB Partners.

7. Governance: Staff

7.1. The SW ICB Partners must take reasonable steps to ensure the suitability, reliability, training and competence, of any Staff who have access to Personal Data, and Special Category Personal Data, including ensuring reasonable background checks and evidence of completeness are available on request.

7.2. The SW ICB Partners agree to treat all Relevant Information as confidential and imparted in confidence and must safeguard it accordingly. Where any of the ICB Partners' Staff are not healthcare professionals (for the purposes of the Data Protection Act 2018) the employing ICB Partners must procure that Staff operate under a duty of confidentiality which is equivalent to that which would arise if that person were a healthcare professional.

7.3. The SW ICB Partners shall ensure that all Staff required to access Personal Data (including Special Category Personal Data are informed of the confidential nature of the Personal Data. The SW ICB Partners shall include appropriate confidentiality clauses in employment/service contracts of all Staff that have any access whatsoever to the Relevant Information, including details of sanctions for acting in a deliberate or reckless manner that may breach the confidentiality or the non-disclosure provisions of Data Protection Legislation requirements, or cause damage to or loss of the Relevant Information. Each Party shall provide evidence (further to any reasonable request) that all personnel that have any access to the Relevant Information whatsoever are adequately and appropriately trained to comply with their responsibilities under Data Protection Legislation and this Agreement.

7.4. The SW ICB Partners shall ensure that:

7.4.1. only those Staff involved in delivery of the Agreement use or have access to the Relevant Information; and

7.4.2. that such access is granted on a strict Need to Know basis and shall implement appropriate access controls to ensure this requirement is satisfied and audited. Evidence of audit should be made freely available on request by the originating Data Controller; and

7.4.3. specific limitations on the Staff who may have access to the Information are set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8. Governance: Protection of Personal Data

8.1. At all times, the SW ICB Partners shall have regard to the requirements of Data Protection Legislation and the rights of Data Subjects.

8.2. Wherever possible (in descending order of preference), only anonymised information, or strongly or weakly pseudonymised information will be shared and processed by the SW ICB Partners. The SW ICB Partners shall cooperate in exploring alternative strategies to avoid the use of Personal Data in order to achieve the Specified Purpose. However, it is accepted that some Relevant Information shared further to this Agreement may be Personal Data or Special Category Personal Data.

8.3. Processing of any Personal Data or Special Category Personal Data shall be to the minimum extent necessary to achieve the Specified Purpose, and on a Need-to-Know basis.

8.4. If any SW ICB Partner:

8.4.1. becomes aware of any unauthorised or unlawful processing of any Relevant Information or that any Relevant Information is lost or destroyed or has become damaged, corrupted or unusable; or

8.4.2. becomes aware of any security vulnerability or breach in respect of the Relevant Information, it shall promptly, within 48 hours, notify the other ICB Partner. The SW ICB Partners shall fully cooperate with one another to remedy the issue as soon as reasonably practicable, and in making information about the incident available to the Information Commissioner and Data Subjects where required by Data Protection Legislation.

8.5. In processing any Relevant Information further to this Agreement, the SW ICB Partners shall process the Personal Data and Special Category Personal Data only:

8.5.1. in accordance with the terms of this Agreement and otherwise (to the extent that it acts as a Data Processor for the purposes of Article 27-28 GDPR) only in accordance with written instructions from the originating Data Controller in respect of its Relevant Information;

8.5.2. to the extent as is necessary for the provision of the Specified Purpose or as is required by law or any regulatory body;

8.5.3. in accordance with Data Protection Legislation requirements, in particular the principles set out in Article 5(1) and accountability requirements set out in Article 5(2) UK GDPR; and not in such a way as to cause any other Data Controller to breach any of their applicable obligations under Data Protection Legislation.

8.6. The SW ICB Partners shall act generally in accordance with Data Protection Legislation requirements. This includes implementing, maintaining and keeping under review appropriate technical and organisational measures to ensure and demonstrate that the processing of Personal Data is undertaken in accordance with Data Protection Legislation, and in particular to protect the Personal Data (and Special Category Personal Data) against unauthorised or unlawful processing, and against accidental loss, destruction, damage, alteration or disclosure. These measures shall:

8.6.1. take account of the nature, scope, context and purposes of processing as well as the risks, of varying likelihood and severity for the rights and freedoms of Data Subjects; and

8.6.2. be appropriate to the harm which might result from any unauthorised or unlawful processing, accidental loss, destruction or damage to the Personal Data and Special Category Personal Data and having the nature of the Personal Data (and Special Category Personal Data) which is to be protected.

8.7. In particular, each ICB Partner shall:

8.7.1. ensure that only Staff as provided under this Schedule have access to the Personal Data and Special Category Personal Data;

8.7.2. ensure that the Relevant Information is kept secure and in an encrypted form, and shall use all reasonable security practices and systems applicable to the use of the Relevant Information to prevent and to take prompt and proper remedial action against, unauthorised access, copying, modification, storage, reproduction, display or distribution, of the Relevant Information;

8.7.3. obtain prior written consent from the originating ICB Partner in order to transfer the Relevant Information to any third party;

8.7.4. permit any other ICB Partner or their representatives (subject to reasonable and appropriate confidentiality undertakings), to inspect and audit the data processing activities carried out further to this Agreement (and/or those of its agents, successors or assigns) and comply with all reasonable requests or directions to enable each ICB Partner to verify and/or procure that the other is in full compliance with its obligations under this Agreement; and

8.7.5. if requested, provide a written description of the technical and organisational methods and security measures employed in processing Personal Data.

The SW ICB Partners shall adhere to the specific requirements as to information security set out in any Data Sharing Agreement entered into in accordance with this Schedule.

8.8. The SW ICB Partners shall use best endeavours to achieve and adhere to the requirements of the NHS Digital Data Security and Protection Toolkit.

8.9. The SW ICB Partners' Single Points of Contact set out in paragraph 13 will be the persons who, in the first instance, will have oversight of third-party security measures.

9. Governance: Transmission of Information between the ICB Partners

9.1. This paragraph supplements paragraph 8 of this Schedule.

9.2. Transfer of Personal Data between the SW ICB Partners shall be done through secure mechanisms including use of the N3 network, encryption, and approved secure (NHS.net or gcsx) e-mail.

9.3. Wherever possible, Personal Data should be transmitted and held in pseudonymised form, with only reference to the NHS number in 'clear' transmissions. Where there are significant consequences for the care of the patient, then additional data items, such as the postcode, date of birth and/or other identifiers should also be transmitted, in accordance with good information governance and clinical safety practice, so as to ensure that the correct patient record / data is identified.

9.4. Any other special measures relating to security of transfer should be specified in a Data Sharing Agreement entered into in accordance with this Schedule.

9.5. Each ICB Partner shall keep an audit log of Relevant Information transmitted and received in the course of this Agreement.

9.6. The SW ICB Partners' Single Point of Contact notified pursuant to paragraph 13 will be the persons who, in the first instance, will have oversight of the transmission of information between the SW ICB Partners.

10. Governance: Quality of Information

The SW ICB Partners will take steps to ensure the quality of the Relevant Information and to comply with the principles set out in Article 5 UK GDPR.

11. Governance: Retention and Disposal of Shared Information

11.1. A non-originating ICB Partner shall securely destroy or return the Relevant Information once the need to use it has passed or, if later, upon the termination of this Agreement, howsoever determined. Where Relevant Information is held electronically, the Relevant Information will be deleted and formal notice of the deletion sent to the that shared the Relevant Information. Once paper information is no longer required, paper records will be securely destroyed or securely returned to the ICB Partner they came from.

11.2. Each ICB Partner shall provide an explanation of the processes used to securely destroy or return the information, or verify such destruction or return, upon request and shall comply with any request of the Data Controllers to dispose of data in accordance with specified standards or criteria.

11.3. If an ICB Partner is required by any law, regulation, or government or regulatory body to retain any documents or materials that it would otherwise be required to return or destroy in accordance with this Schedule, it shall notify the other ICB Partners in writing of that retention, giving details of the documents or materials that it must retain.

11.4. Retention of any data shall comply with the requirements of Article 5(1)(e) GDPR and with all good practice including the Records Management NHS Code of Practice, as updated or amended from time to time.

11.5. The SW ICB Partners shall set out any special retention periods in a Data Sharing Agreement where appropriate.

11.6. The SW ICB Partners shall ensure that Relevant Information held in paper form is held in secure files, and, when it is no-longer needed, destroyed using a cross-cut shredder or subcontracted to a confidential waste company that complies with European Standard EN15713.

11.7. Each ICB Partner shall ensure that, when no longer required, electronic storage media used to hold or process Personal Data are destroyed or overwritten to current policy requirements.

11.8. Electronic records will be considered for deletion once the relevant retention period has ended.

11.9. In the event of any bad or unusable sectors of electronic storage media that cannot be overwritten, the ICB Partner shall ensure complete and irretrievable destruction of the media itself in accordance with policy requirements.

12. Governance: Complaints and Access to Personal Data

12.1. The SW ICB Partners shall assist each other in responding to any requests made under Data Protection Legislation made by persons who wish to access copies of information held about them ("**Subject Access Requests**"), as well as any other exercise of a Data Subject's rights under Data Protection Legislation or complaint to or investigation undertaken by the Information Commissioner.

12.2. Complaints about information sharing shall be reported to the Single Points of Contact and the Joint Committee. Complaints about information sharing shall be routed through each ICB Partners' own complaints procedure unless otherwise provided for in the Joint Working Arrangements or determined by the Joint Committee.

12.3. The SW ICB Partners shall use all reasonable endeavours to work together to resolve any dispute or complaint arising under this Schedule or any data processing carried out further to it.

12.4. Basic details of the Agreement shall be included in the appropriate log under each ICB Partner's Publication Scheme.

13. Governance: Single Points of Contact

The ICB Partners each shall appoint a Single Point of Contact to whom all queries relating to the particular information sharing should be directed in the first instance.

14. Monitoring and review

The ICB Partners shall monitor and review on an ongoing basis the sharing of Relevant Information to ensure compliance with Data Protection Legislation and best practice. Specific monitoring requirements must be set out in the relevant Data Sharing Agreement.

Audit and Risk Committee

Terms of Reference

1. Constitutional Obligations

1.1. The Audit and Risk Committee (the Committee) is established by the Integrated Care Board for Devon (known and referred to as NHS Devon) as a Committee of the Board in accordance with its Constitution, Standing Orders and Scheme of Reservation and Delegation.

1.2. These Terms of Reference (ToR) which must be published on the ICB website set out the membership, remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the NHS Devon Board.

1.3. The Committee is a Non-Executive Committee of the NHS Devon Board and its members, including any who are not members of the NHS Devon Board, are bound by the Constitution, Standing Orders and Scheme of Reservation and Delegation and other policies of NHS Devon.

1.4. The Committee is authorised by the NHS Devon Board to:

a) Investigate any activity within its ToR;
b) Seek any information it requires within its remit, from any employee or member of NHS Devon (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these ToR;
c) Commission any reports it deems necessary to help fulfil its obligations;
d) Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by NHS Devon for obtaining legal or professional advice;
e) Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and ToR of any such task and finish sub-groups in accordance with NHS Devon's Constitution, Standing Orders and Scheme of Reservation and Delegation, but may /not delegate any decisions to such groups.

1.5. For the avoidance of doubt the Committee will comply with the, ~~in the event of any conflict,~~ NHS Devon's Standing Orders, Standing Financial

Instructions and Scheme of Reservation and Delegation ~~will prevail over these ToR~~.

2. Purpose and Responsibilities

Purpose

2.1 The purpose of the Committee is to contribute to the overall delivery of NHS Devon's objectives by providing oversight and assurance to the NHS Devon Board on the adequacy of governance, risk management and internal control processes within the organisation.

2.2 The duties of the Committee will be driven by NHS Devon's objectives and the associated risks. An annual programme of business will be agreed at the start of each financial year ~~with the NHS Devon Board~~; however, this programme of business will be flexible to new and emerging priorities and risks.

~~2.2~~2.3 The Committee has no executive powers other than those specified in these terms of reference.

Responsibilities

~~2.3~~2.4 The responsibilities of the Committee are as follows:

Integrated governance, risk management and internal control

~~2.4~~2.5 To review the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of NHS Devon's activities that support the achievement of its objectives, and to highlight any areas of weakness to the NHS Devon Board.

~~2.5~~2.6 To ensure that financial systems and governance are established which facilitate compliance with Department of Health and Social Care's (DHSC's) Group Accounting Manual (GAM).

~~2.6~~2.7 To review the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of NHS Devon's objectives, the effectiveness of the management of principal risks.

~~2.7~~2.8 To have oversight of system risks where they relate to the achievement of NHS Devon's objectives.

~~2.8~~2.9 To ensure that NHS Devon acts consistently with the principles and guidance established in His Majesty's Treasury's (HMT's) Managing Public Money.

~~2.9~~2.10 To seek reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

~~2.10~~2.11 To identify opportunities to improve governance, risk management and internal control processes across NHS Devon.

Internal audit

~~2.11~~2.12 To ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the NHS Devon Board. This will be achieved by:

a) Considering the provision of the internal audit service and the costs involved;
b) Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework;
c) Considering the major findings of internal audit work, including the Head of Internal Audit Opinion, (and management's response), and ensure coordination between the internal and external auditors to optimise the use of audit resources;
d) Ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation; and
e) Monitoring the effectiveness of internal audit and carrying out an annual review.

External audit

~~2.12~~2.13 To review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

a) Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit;
b) Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan;
c) Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee; and
d) Reviewing all external audit reports, including to those charged with governance (before its submission to the NHS Devon Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

Other assurance functions

~~2.13~~2.14 To review the findings of assurance functions in NHS Devon, and to consider the implications for the governance of NHS Devon.

~~2.14~~2.15 To review the work of other committees in NHS Devon, whose work can provide relevant assurance to the Committee's own areas of responsibility.

~~2.15~~2.16 To review the assurance processes in place in relation to financial performance across NHS Devon, including the completeness and accuracy of information provided.

~~2.16~~2.17 To review the findings of external bodies and consider the implications for governance of NHS Devon. These will include, but will not be limited to:

- Reviews and reports issued by arm's length bodies or regulators and inspectors: e.g. National Audit Office, Select Committees, NHS Resolution, Care Quality Commission (CQC); and
- Reviews and reports issued by professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges and accreditation bodies).
- Reviews and reports relating to governance and board effectiveness that are periodically commissioned by the ICB

2.18 To assure the Board that internal governance processes fit for purpose for the purposes of maintaining a sound system of internal control and are operating effectively, through both management assurance annually, ahead of the annual governance statement sign-off) and Internal Audit assessment (annual).

2.19 To review the annual governance and compliance arrangements (including joint commissioning arrangements).

Counter fraud

~~2.17~~2.20 To assure itself that NHS Devon has adequate arrangements in place for counter fraud, bribery and corruption (including cyber security) that meet NHS Counter Fraud Authority's (NHSCFA) standards and shall review the outcomes of work in these areas.

~~2.18~~2.21 To review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans, provide direct access and liaison with those responsible for counter fraud, review annual reports on counter fraud, and discuss NHSCFA quality assessment reports.

~~2.19~~2.22 To ensure that the counter fraud service provides appropriate progress reports and that these are scrutinised and challenged where appropriate.

~~2.20~~2.23 To be responsible for ensuring that the counter fraud service submits an Annual Report and Self-Review Assessment, outlining key work

undertaken during each financial year to meet the NHS Standards for Commissioners; Fraud, Bribery and Corruption.

~~2.21~~2.24 To report concerns of suspected fraud, bribery and corruption to the NHSCFA.

Freedom to Speak Up

~~2.22~~2.25 To review the adequacy and security of NHS Devon's arrangements for its employees, contractors and external parties to raise concerns, in confidence, in relation to financial, clinical management, or other matters. The Committee shall ensure that these arrangements allow proportionate and independent investigation of such matters and appropriate follow up action.

Emergency planning, resilience and recovery

2.26 To undertake a scrutiny and independent assurance oversight role in relation to the effectiveness of the systems and processes in place within the ICB in relation to emergency planning resilience and recovery (EPRR), including risk assessments, action plans and tests, to ensure the ICB fulfils its category 1 responder statutory requirements.

Information Governance (IG)

~~2.23~~2.27 To receive regular updates on IG compliance (including uptake & completion of data security training), data breaches and any related issues and risks.

~~2.24~~2.28 To review the annual Senior Information Risk Owner (SIRO) report, the submission for the Data Security & Protection Toolkit and relevant reports and action plans.

~~2.25~~2.29 To receive reports on audits to assess information and IT security arrangements, including the annual Data Security & Protection Toolkit audit.

~~2.26~~2.30 To provide assurance to the NHS Devon Board that there is an effective framework in place for the management of risks associated with IG.

Financial reporting

~~2.27~~2.31 To monitor the integrity of the financial statements of NHS Devon and any formal announcements relating to its financial performance.

~~2.28~~2.32 To ensure that the systems for financial reporting to the NHS Devon Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

~~2.29~~2.33 To review the annual report and financial statements (including accounting policies) before submission to the NHS Devon Board focusing particularly on:

a) The wording in the Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
b) Changes in accounting policies, practices and estimation techniques;
c) Unadjusted mis-statements in the Financial Statements;
d) Significant judgements and estimates made in preparing of the Financial Statements;
e) Significant adjustments resulting from the audit;
f) Letter of representation; and
g) Qualitative aspects of financial reporting.

Conflicts of Interest

~~2.30~~2.34 The Chair of the Audit Committee will be the nominated Conflicts of Interest Guardian.

~~2.31~~2.35 The Committee shall satisfy itself that NHS Devon's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the ICB policy and procedures relating to conflicts of interest.

Management

~~2.32~~2.36 To request and review reports and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

~~2.33~~2.37 The Committee may also request specific reports from individual functions within NHS Devon as they may be appropriate to the overall arrangements.

~~2.34~~2.38 To receive reports of breaches of policy and normal procedure or proceedings, including such as suspensions of NHS Devon's standing orders, in order provide assurance in relation to the appropriateness of decisions and to derive future learning.

3. Membership

3.1 Members of the Committee shall be appointed by the NHS Devon Board in accordance with the NHS Devon Constitution.

Chair & Vice Chair

3.2 In accordance with the NHS Devon Constitution, the Committee will be chaired by an Independent Non-Executive Member of the NHS Devon Board, appointed on account of their specific knowledge, skills and experience making them suitable to chair the Committee.

3.3 The Chair of the Committee shall be independent and therefore may not chair any other Committees of the NHS Devon Board. In so far as it is possible, they will not be a member of any other NHS Devon Board Assurance Committee.

3.4 Committee members may appoint a Vice Chair from amongst the membership of the Committee, who must be an Independent Non-Executive Member of the NHS Devon Board who has the requisite skills and experience to act in that capacity.

3.5 The Chair of the Committee will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Membership

3.6 The membership of the Committee shall be constituted as follows:

- Independent Non-Executive Member (Chair)
- Independent Non-Executive Member
- Independent Non-Executive Member

3.7 Neither the Chair of the NHS Devon Board, nor employees of NHS Devon will be members of the Committee.

3.8 Members will possess between them knowledge, skills and experience in: accounting, risk management, internal, external audit; and technical or specialist issues pertinent to NHS Devon's business.

3.9 Members of the Committee need not be members of the board, but they may be.

~~3.9~~3.10 When deciding the membership of the committee, active consideration will be made to diversity and equality.

Other Attendees

~~3.10~~3.11 Only members of the Committee have the right to attend and vote at Committee meetings; however, meetings of the Committee will also be attended by the following individuals who are not members:

- ~~Chief Finance Officer~~NHS Cornwall and Isles of Scilly and NHS Devon Cluster Executive with responsibility for finance
- ~~Chief Communications and Corporate Affairs Officer~~NHS Cornwall and Isles of Scilly and NHS Devon Cluster Corporate Governance Lead
- ~~Director of Governance~~
- Representatives of both internal and external audit
- Individuals who lead on counter fraud matters

~~3.11~~3.12 Other attendees may be invited to attend all or part of any meeting as and when the Chair of the Committee considers they have expertise that would be relevant to the responsibilities of the Committee, including representatives from health and wellbeing boards, secondary and community providers.

~~3.12~~3.13 The NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chief Executive Officer should be invited to attend the Committee at least annually.

~~3.13~~3.14 The NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chair ~~of the NHS Devon Board~~ may also be invited to attend one meeting each year in order to gain an understanding of the Committee's operations.

~~3.14~~3.15 The Chair of the Committee may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

Attendance

~~3.15~~3.16 Members of the Committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair of the Committee. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are normally expected to attend at least 75% of meetings during the year.

Access

~~3.16~~3.17 Regardless of attendance, External Audit, Internal Audit, Local Counter Fraud and Security Management providers will have full and unrestricted rights of access to the Committee.

4. Quorum, Decisions and Voting

Quorum

4.1 For a meeting of the Committee to be quorate a minimum of 50% members (i.e., 2 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 another Independent Non-Executive Member of the NHS Devon Board~~.

4.2 If any member of the Committee is unable to participate in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

4.3 If the quorum has not been reached, then the meeting may proceed informally if those attending agree, but no decisions may be taken.

Decision Making and Voting

4.4 In line with NHS Devon's Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each member of the Committee will have one vote, the process for which is set out below:

a) All members of the Committee who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the Committee are set out at paragraph 3.6; attendees and observers do not have voting rights).

b) Absent members may not vote by proxy. Absence is defined as not being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so.

c) A resolution will be passed if more votes are cast for the resolution than against it.

d) If an equal number of votes are cast for and against a resolution, then the Chair of the Committee (or in their absence, the Vice Chair) will have a second and casting vote.

e) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

4.5 For urgent decisions, the Chair of the Committee may call a meeting at a notice of 2 days, setting out the reason for the urgency and the decision to be taken.

4.6 When there is an urgent matter where a decision is required outside of the meeting (which cannot wait for the next scheduled meeting), the Chair of the Committee may make a decision after conferring with at least two other members ("Chair's Action").

4.7 When Chair's Action has been taken then the next quorate meeting of the Committee must ratify it. Urgent decisions will only be taken when there is insufficient time available for the decision to be delayed until the next meeting.

5. Ways of Working

5.1 All members of the Committee will have due regard to and operate within the Constitution of NHS Devon, its Standing Orders, Standing Financial Instructions ~~and other financial procedures~~ and standards of business conduct policy.

5.2 Members of the Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

5.3 Members of the Committee must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

5.4 A Register of Interests will be reviewed at each Committee meeting. Those in attendance will be asked by the Chair of the Committee to declare any interests at the beginning of each meeting. If a member of the Committee feels compromised by any agenda item, they should declare a conflict of interest and agreement reached as the action to be taken as set out in the NHS Devon Conflicts of Interest Policy.

6. Reporting Arrangements

6.1 The Committee is accountable to the NHS Devon Board and shall report to the Board on how it discharges its responsibilities.

~~6.1~~6.2 The Chair of the Committee will be responsible for ensuring that minutes of the meetings are formally recorded by the secretary and submitted to the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Joint Committee/Board on behalf of the NHS Devon Board in accordance with standing orders.

6.3 The Chair of the Committee will provide an assurance report on behalf of the Committee to the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Joint Committee/Board ~~NHS Devon Board at~~ after each meeting on how it has discharged its responsibilities. The report shall be presented to the public meeting of the NHS Devon Board.

~~6.2~~6.4 Where minutes and reports identify confidential matters, they will not be made public and will be presented at a private meeting of the NHS Devon Board.

6.5 The Committee shall undertake an annual self-assessment of its own performance against its annual programme of business, membership and ToR. The outcome of this self-assessment will be included within the Review of Corporate Governance reported to the NHS Devon Board on an annual basis.

~~6.3~~6.6 The Committee will provide the NHS Devon Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report will summarise its conclusions from the work it has done during the year specifically commenting on:

a) The fitness for purpose of the assurance framework;
b) The completeness and ‘embeddedness’ of risk management in the organisation;
c) The integration of governance arrangements;
d) The appropriateness of the evidence that shows the organisation is fulfilling its regulatory requirements; and
e) The robustness of the processes behind the quality accounts.

7. Meetings and Administration

Frequency of Meetings

7.1 The Committee will meet in private at least ~~six~~ four times a year. Additional meetings may take place as required.

7.2 The NHS Devon Board, Chair or Chief Executive Officer may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

7.3 The External Auditor, or Head of Internal Audit, may also request a meeting should they consider one necessary.

~~7.3~~7.4 At least once a year the committee will meet privately with the external and internal auditors.

7.5 Arrangements and notice for calling meetings are set out in the NHS Devon Standing Orders.

~~7.4~~7.6 In line with the standing orders, the committee may meet virtually when necessary and members attending using electronic means will count towards the quorum.

Administration

~~7.5~~7.7 The Committee shall be supported by an administrator from within the NHS Cornwall and Isles of Scilly and NHS Devon Cluster~~NHS Devon~~ Corporate Governance Team. Their duties in this respect will include:

a) Agreement of agendas with the Chair and attendees.
b) Preparation, collation and circulation of papers in good time.
c) Ensuring that those invited to each meeting attend, highlighting any concerns to Chair (including interests of members that may conflict with an agenda item).
d) Taking the minutes and helping the Chair to prepare reports to the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Joint Committee/Board~~NHS Devon Board~~.
e) Keeping a record of matters arising and issues to be carried forward.
f) Maintaining records of members' appointments and renewal dates.
g) Ensuring that action points are taken forward between meetings.
h) Ensuring that members receive the development and training they need.
i) Providing appropriate support to the Chair and members.

~~7.6~~7.8 Following each meeting of the Committee, the administrator will:

a) Maintain an attendance log and follow up as appropriate after each meeting to ensure the Committee adheres to the required frequency of attendance

by members.

b) Maintain a decisions log of reporting arrangements into each formal meeting of the Committee.

c) Maintain a log of summary written reports provided to the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Joint Committee/Board ~~NHS Devon Board~~ from formal meetings of the Committee.

~~8. Review of Terms of Reference~~

~~8.1 These ToR will be reviewed at least annually and earlier if required. Any proposed amendments to the ToR will be submitted to the NHS Devon Board for approval.~~

Document Control

Document Reference	A~~R~~C ToR
Version	V~~1.1~~2
Senior Responsible Officer	Philippa Harding, Director of Governance
Approval by	NHS Devon Board
Date last reviewed/ approved	~~30 May 2024~~28 August 2025
Next review date	Before 31 March 2026

Change Record

Date	Change	Comments
27.03.2025 28.08.2025	Members and Attendees Update Alignment with NHS CIOs Audit Committee ToR	Amendment of Company Secretary to Director of Governance. Removal of Co-opted member. Removal of responsibilities in respect of communication. Minor amendments to align with the Terms of Reference of the NHS Cornwall and Isles of Scilly Audit Committee, to facilitate meetings of the Committee in Common as part of Cluster arrangements.

Remuneration Committee

Terms of Reference

1. Constitutional Obligations

1.1. The Remuneration Committee (the Committee), and it's associated Non-Executive Member (NEM) Remuneration Panel is established by the Integrated Care Board for Devon (known and referred to as NHS Devon) as a Committee of the Board in accordance with its Constitution, Standing Orders and Scheme of Reservation and Delegation.

1.2. These Terms of Reference (ToR), including the Annex, which must be published on the NHS Devon website, set out the membership, remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the NHS Devon Board.

1.3. The Committee is a Non-Executive Committee of the NHS Devon Board and its members, including any who are not members of the NHS Devon Board, are bound by the Constitution, Standing Orders and Scheme of Reservation and Delegation and other policies of NHS Devon.

1.4. The Committee is authorised by the NHS Devon Board to:

a) Investigate any activity within its ToR;
b) Seek any information it requires within its remit, from any employee or member of NHS Devon (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these ToR;
c) Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by NHS Devon for obtaining legal or professional advice;
d) Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and ToR of any such task and finish sub-groups in accordance with NHS Devon's Constitution, Standing Orders and Scheme of Reservation and Delegation, but may /not delegate any decisions to such groups.

1.5. For the avoidance of doubt the Committee will comply with the ~~, in the event of any conflict,~~ NHS Devon~~'s~~ Standing Orders, Standing Financial

Instructions and Scheme of Reservation and Delegation ~~will prevail over these ToR~~, other than the Committee being permitted to meet in private.

2. Purpose and Responsibilities

Purpose

2.1 The Committee will be responsible for approving the remuneration and pay frameworks for all NHS Devon employees and Board Members (excluding the NHS Devon Chair whose remuneration is determined by NHS England).

2.2 It will exercise the functions of NHS Devon relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006, by confirming NHS Devon Pay Policy, including adoption of any pay frameworks for all employees including senior managers/directors (including Executive and ~~Independent~~ Non-Executive Members of the NHS Devon Board, although excluding the NHS Devon Chair), as well as any arrangement relation to the termination of their employment (including redundancy and non-disclosure agreements).

2.3 In respect of the Non-Executive Members of the NHS Devon Board, this shall be carried out through the NEM Remuneration Panel. The remit of the Panel is set out at the Annex to these Terms of Reference.

2.4 The NHS Devon Board has also delegated the following functions to the committee:

- Oversight of the performance of Executive Members of the NHS Devon Board

2.5 The Committee has no executive powers, other than those delegated in the Scheme of Reservation and Delegation and specified in these Terms of Reference.

~~2.3~~2.6 The Committee shall agree an annual programme of business ~~with the NHS Devon Board~~; however, this programme of business will be flexible to new and emerging priorities and risks.

Responsibilities

~~2.4~~2.7 The responsibilities of the Committee are as follows:

Remuneration of the Chief Executive, Directors and other Very Senior Managers (VSMs):

~~Approve on behalf of the NHS Devon Board a framework and policy for the appropriate remuneration of Executive and Independent Non-Executive members of the NHS Devon Board and other NHS Devon VSMs, as well as individuals' remuneration packages, taking account of all factors which it~~

~~deems necessary, including relevant legal and regulatory requirements, national guidance, and other best practice as appropriate.~~

~~2.5 Approve business cases relating to the fees to be applied to other individuals who provide specific services to NHS Devon at VSM level and above (defined as any who are proposed to be paid at a level that, if annualised, would equate to a VSM salary.~~

~~2.5 Approve business cases for the termination of employment and other contractual terms and non-contractual terms (including contractual payments such as redundancy or early retirement provisions as well as other payments) for NHS Devon Executive members and other NHS Devon VSMs.~~

2.8 Determine all aspects of remuneration including but not limited to salary, (including any performance-related elements) bonuses, fees or allowances

2.9 Approve provisions for other benefits, including pensions (and the NHS Pension Scheme), relocation and cars

2.10 Determine arrangements for termination of employment and other contractual terms and non-contractual terms

2.11 Assess proper calculation and scrutiny of termination payments taking account of such national guidance as appropriate, advising on and overseeing appropriate contractual arrangements for such staff

2.12 Assess proper calculation and scrutiny of any special payments

2.13 Functions in relation to performance review/ oversight for directors/senior managers undertaken by the chief executive or their nominated deputy

2.14 Consider and approve the annual review of the performance of the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chief Executive conducted by the Cluster Chair

2.15 Consider and approve the annual review of the performance of the executive directors conducted by the Cluster Chief Executive

2.16 Succession planning for the NHS Devon Board

2.17 Approve changes to the director structure when reliance on the ~~ICB's~~ organisational change policy is required

Remuneration of all NHS Devon staff:

~~2.6~~2.18 Approve the pay policy for NHS Devon staff (including the adoption of pay frameworks such as Agenda for Change).

~~2.7~~2.19 Oversee staff contractual arrangements including those resulting from use of the ~~ICB's~~ organisational change policy.

~~2.8~~2.20 Approve proposals for termination payments and any special payments (including arrangements for dealing with legal cases relating to employment issues) following scrutiny of their proper calculation and taking account of such national guidance as appropriate.

Other Board appointments and performance:

~~Consider and approve the annual review of the performance of the NHS Devon Partner Members conducted by the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chair~~~~Provide assurance that robust succession planning is in place for the NHS Devon Board.~~

~~2.10~~2.21 Review the outcomes of the NHS Devon Board performance evaluation process, including thematic outcomes from appraisals, that relate to the performance and effectiveness of the NHS Devon Board

~~2.11~~2.22 Provide assurance with regard to the policy and process for the appointment of Co-opted Members of NHS Devon Board Committees.

~~2.12~~2.23 Provide assurance in relation to NHS Devon statutory duties relating to people such as compliance with employment legislation including such as Fit and Proper Person Regulation (FPPR) and conflicts of interest requirements.

3. Membership

3.1 Members of the Committee shall be appointed by the NHS Devon Board in accordance with the NHS Devon Constitution.

Chair & Vice Chair

3.2 In accordance with the NHS Devon Constitution, the Committee will be chaired by a~~n Independent~~ Non-Executive Member of the NHs Devon Board, appointed on account of their specific knowledge, skills and experience making them suitable to chair the Committee.

3.3 Committee members may appoint a Vice Chair from amongst the membership of the Committee, who must be a~~n Independent~~ Non-Executive Member of the NHS Devon Board who has the requisite skills and experience to act in that capacity.

3.4 The Chair of the Committee will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Membership

3.5 The membership of the Committee shall be constituted as follows:

- Independent Non-Executive Member (Chair)

- Independent Non-Executive Member (Vice-Chair)
- Independent Non-Executive Member
- Independent Non-Executive Member
- Independent Non-Executive Member
- NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chair
- ~~NHS Devon Chair~~
- ~~Partner Member - Providers of Primary Medical Services~~
- ~~Co-opted Member – Chair of the One Devon Integrated Care Partnership~~

3.6 Members will possess between them the requisite knowledge, skills and experience pertinent to the committee's terms of reference, calling on specialist advice when needed

~~3.10~~3.7 The Chair of the NHS Devon Audit ~~and Risk~~ Committee may not be a member of the Committee.

~~3.11~~3.8 The NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chair ~~Chair of the NHS Devon Board~~ may be a member of the Committee but may not be appointed as the Chair or Vice Chair of the Committee.

~~3.12~~3.9 When determining the membership of the Committee, active consideration will be made to diversity and equality.

Other Attendees

~~3.13~~3.10 Only members of the Committee have the right to attend and vote at Committee meetings; however, meetings of the Committee will also be attended by the following individuals who are not members:

- Chair of NHS Devon Audit and Risk Committee
- NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chief Executive Officer
- NHS Cornwall and Isles of Scilly and NHS Devon Cluster Officer with responsibility for people~~Chief People Officer~~
- NHS Cornwall and Isles of Scilly and NHS Devon Cluster Corporate Governance Lead~~Director of Governance~~

~~3.14~~3.11 Other attendees may be invited to attend all or part of any meeting as and when the Chair of the Committee considers they have expertise that would be relevant to the responsibilities of the Committee.

~~3.15~~3.12 The Chair of the Committee may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

~~3.16~~3.13 No individual should be present during any discussion relating to:

a) Any aspect of their own pay; or

b) Any aspect of the pay of others when it has an impact on them.

Attendance

~~3.17~~3.14 Members of the Committee may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair of the Committee. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are normally expected to attend at least 75% of meetings during the year.

4. Quorum, Decisions and Voting

4.1 The committee will meet in private.

Quorum

~~4.1~~4.2 For a meeting of the Committee to be quorate a minimum of 50% members (i.e., ~~4~~ 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).

~~Where the Committee is considering the remuneration of any of its members, those members shall be disqualified from participating on that item in the agenda, by reason of a declaration of conflicts of interest. In that circumstance, for the Committee to be quorate a minimum of 50% members who have not been disqualified from participating on that agenda item (i.e., 2 members) is required.~~

4.3 If any member of the Committee is unable to participate in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

4.4 If the quorum has not been reached, then the meeting may proceed informally if those attending agree, but no decisions may be taken.

Decision Making and Voting

4.5 Decisions will be guided by national NHS policy and best practice to ensure that staff are fairly motivated and rewarded for their individual contribution to the organisation, whilst ensuring proper regard to wider influences such as national consistency.

4.6 In line with NHS Devon's Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each member of the Committee will have one vote, the process for which is set out below:

a) All members of the Committee who are present at the meeting will be

eligible to cast one vote each. (For the sake of clarity, members of the Committee are set out at paragraphs 3.5-3.8; attendees and observers do not have voting rights).

b) Absent members may not vote by proxy. Absence is defined as not being present at the time of the vote but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so.

c) A resolution will be passed if more votes are cast for the resolution than against it.

d) If an equal number of votes are cast for and against a resolution, then the Chair of the Committee (or in their absence, the Vice Chair) will have a second and casting vote.

e) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.

4.7 For urgent decisions, the Chair of the Committee may call a meeting at a notice of 2 days, setting out the reason for the urgency and the decision to be taken.

4.8 When there is an urgent matter where a decision is required outside of the meeting (which cannot wait for the next scheduled meeting), the Chair of the Committee may make a decision after conferring with at least two other members ("Chair's Action").

4.9 When Chair's Action has been taken then the next quorate meeting of the Committee must ratify it. Urgent decisions will only be taken when there is insufficient time available for the decision to be delayed until the next meeting.

5. Ways of Working

5.1 All members of the Committee will have due regard to and operate within the Constitution of NHS Devon, its Standing Orders, Standing Financial Instructions and ~~other financial procedures~~standards of business conduct policy.

5.2 Members of the Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

5.3 Members of the Committee must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

5.4 The Committee will take proper account of National Agreements and appropriate benchmarking, for example Agenda for Change and guidance

issued by the Government, the Department of Health and Social Care, NHS England and the wider NHS in reaching their determinations.

5.5 A Register of Interests will be reviewed at each Committee meeting. Those in attendance will be asked by the Chair of the Committee to declare any interests at the beginning of each meeting. If a member of the Committee feels compromised by any agenda item, they should declare a conflict of interest and agreement reached as the action to be taken as set out in the NHS Devon Conflicts of Interest Policy.

6. Reporting Arrangements

6.1 The Committee is accountable to the NHS Devon Board and shall report to the Board on how it discharges its responsibilities.

6.2 The Chair of the Committee will be responsible for ensuring that minutes of the meetings are formally recorded by the secretary and submitted to the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Joint Committee/Board on behalf of the NHS Devon Board in accordance with standing orders.

~~6.2~~6.3 The Chair of the Committee will provide an assurance report on behalf of the Committee to the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Joint Committee/Board ~~NHS Devon Board at~~ after each meeting on how it has discharged its responsibilities. The report shall be presented to the public meeting ~~of the NHS Devon Board~~whenever possible. Where minutes and reports identify individuals, they will not be made public and will be presented at a private meeting of the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Joint Committee/Board~~NHS Devon Board~~. Public reports will be made as appropriate to satisfy any requirements in relation to disclosure of public sector executive pay.

~~6.3~~6.4 The Committee shall undertake an annual self-assessment of its own performance against its annual programme of business, membership and ToR. The outcome of this self-assessment will be included within the Review of Corporate Governance reported to the NHS Devon Board on an annual basis.

~~6.4~~6.5 The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

7. Meetings and Administration

Frequency of Meetings

7.1 The Committee will meet in private at least ~~four~~ two times a year. Additional meetings may take place as required.

7.2 The NHS Cornwall and Isles of Scilly and NHS Devon Cluster Joint Committee/Board, the NHS Devon Board, Cluster Chair or Cluster Chief Executive Officer may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.

7.3 Arrangements and notice for calling meetings are set out in the NHS Devon Standing Orders.

Administration

7.4 The Committee shall be supported by an administrator from within the NHS Cornwall and Isles of Scilly and NHS Devon Cluster ~~NHS Devon~~ Corporate Governance Team. Their duties in this respect will include:

a) Agreement of agendas with the Chair and attendees.
b) Preparation, collation and circulation of papers in good time.
c) Ensuring that those invited to each meeting attend, highlighting any concerns to Chair (including interests of members that may conflict with an agenda item).
d) Taking the minutes and helping the Chair to prepare reports to the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Joint Committee/Board~~NHS Devon Board~~.
e) Keeping a record of matters arising and issues to be carried forward.
f) Maintaining records of members' appointments and renewal dates.
g) Ensuring that action points are taken forward between meetings.
h) Ensuring that members receive the development and training they need.
i) Providing appropriate support to the Chair and members.

7.5 Following each meeting of the Committee, the administrator will:

a) Maintain an attendance log and follow up as appropriate after each meeting to ensure the Committee adheres to the required frequency of attendance by members.
b) Maintain a decisions log of reporting arrangements into each formal meeting of the Committee.
c) Maintain a log of summary written reports provided to the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Joint Committee/Board~~NHS Devon Board~~ from formal meetings of the Committee.

~~8. Review of Terms of Reference~~

~~8.1 These ToR will be reviewed at least annually and earlier if required. Any proposed amendments to the ToR will be submitted to the NHS Devon Board for approval.~~

Annex

Non-Executive Member Remuneration Panel

Due to conflicts of interest, Non-Executive Members (NEMs) are unable to consider their own remuneration. To overcome this, the NEM Remuneration Panel (the Panel) which will operate under the principles and ethos contained within the Remuneration Committee's Terms of Reference.

The Panel will act in accordance with the NHS Devon Constitution and Standing Orders, as well as the delegations contained within the Scheme of Reservation and Delegation and Standing Financial Instructions. Despite the Panel's remit being an Annex to the Remuneration Committee's Terms of Reference, it is an independent group of the NHS Devon Integrated Care Board with decision making capabilities.

The Panel shall meet at least annually to consider:

- NEM remuneration
- a summary of the annual performance reviews of NEMs conducted by the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chair

Proposals shall determine all aspects of remuneration, including but not limited to salary and other contractual terms and non-contractual terms, for the NHS Devon NEMs, taking account of relevant national guidance available.

Its membership excludes NEMs, except for the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chair. Instead, the membership shall include:

- the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chair
- 2 Partner Members of the NHS Devon Board
- a co-opted member appointed by the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chair

The following NHS Cornwall and Isles of Scilly and NHS Devon Cluster Officers shall attend the Panel to provide expertise and advice, taking account of any national guidance available:

- Officer responsible for people
- Corporate governance lead

The NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chief Executive may also attend.

Attendees shall not count towards quoracy.

The chair of the review group shall be the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chair. The role of vice chair shall be held by one of the NHS Devon Partner Members.

When presenting the summary of annual NEM appraisals, the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chair shall hand over their chairing role to the vice chair and not count towards quoracy.

Quoracy will require 2 members which must include the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chair or an NHS Devon Partner Member to be present.

Decisions on proposals will be reached by consensus. If this is not possible then members shall vote and the majority view will be carried. Where there is a split vote, with no clear majority, the chair of the committee will hold the casting vote. In exceptional circumstances, where escalation is required following disagreement, this shall be to NHS England.

The Panel does not have responsibility for establishing the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Chair's pay. This remains the responsibility of NHS England.

Decisions made by the Panel shall be reported to the public meeting of the NHS Cornwall and Isles of Scilly and NHS Devon Cluster Joint Committee/Board.

Document Control

Document Reference	RemCo ToR
Version	V~~1.2~~2
Senior Responsible Officer	Philippa Harding, Director of Governance
Approval by	NHS Devon Board
Date last reviewed/ approved	~~27 March 2025~~28 August 2025
Next review date	Before 31 March 2026

Change Record

Date	Change	Comments
28.11.2024	Quoracy requirements	Updated to include quoracy includes the Chair of Vice Chair of the Committee and either the Chair of the NHS Devon Board or another Independent Non-Executive Member.
27.03.2025	Membership and attendance	Updated to add additional Independent Non Executive Member and to add Chair of Audit and Risk Committee to regular attendees. Amendment of quorum.
28.08.2025	Alignment with NHS CIOs Audit Committee ToR	Minor amendments to align with the Terms of Reference of the NHS Cornwall and Isles of Scilly Audit Committee, to facilitate meetings of the Committee in Common as part of Cluster arrangements. Addition of Annex setting out responsibility of NEM Appointments Panel

Terms of Reference: Transition Steering Group NHS Cornwall and Isles of Scilly and NHS Devon ICB Cluster

1. Purpose and Authority

The Transition Steering Group (the TSG) is established to oversee the establishment and implementation of Cluster arrangements between NHS Devon and NHS Cornwall and the Isles of Scilly (CIOS) Integrated Care Boards (the ICBs) in the first instance. Once the organisational changes required to support the Cluster arrangement have been completed, the TSG will oversee the work required to ensure readiness for the formal merger of the ICBs on 01 April 2027.

2. Objectives

The TSG's primary objectives are to:

- **Oversee the clustering transition process** between NHS CIOS and NHS Devon Integrated Care Boards in line with NHS England requirements
- **Ensure safe and effective transition** of functions, governance arrangements, and operational activities
- **Manage risks and interdependencies** arising from the clustering arrangements
- **Facilitate stakeholder engagement** and communication throughout the transition period
- **Monitor progress** against agreed timelines and deliverables
- **Ensure compliance** with regulatory requirements and NHS England guidance
- **Support staff** through the transition process, including change management and workforce planning

3. Scope and Responsibilities

3.1 Strategic Oversight

- Develop and approve the overall transition strategy and implementation plan
- Monitor progress against key milestones and deliverables
- Escalate significant risks or issues to the South West Peninsula Board (the joint committee established by NHS CIOS and NHS Devon Integrated Care Boards to enable the Cluster)
- Ensure alignment with NHS England's Model ICB Blueprint and clustering guidance

3.2 Governance and Legal

- Oversee the development of new governance structures for the Cluster
- Ensure legal and regulatory compliance throughout the transition

- Coordinate with NHS England on approval processes and reporting requirements

3.3 Operational Integration

- Oversee the integration of operational functions and systems
- Monitor the establishment of shared leadership arrangements
- Ensure continuity of services during the transition period
- Approve arrangements for shared back-office functions and support services

3.4 Financial Management

- Oversee the financial aspects of the clustering arrangement
- Monitor achievement of required cost reductions
- Ensure financial controls and reporting mechanisms are maintained
- Approve budget allocations for transition activities

3.5 People and Culture

- Oversee workforce planning and staff consultation processes
- Monitor staff engagement and wellbeing during transition
- Ensure appropriate support for affected staff members
- Approve communications and engagement strategies

3.6 Quality and Safety

- Ensure patient safety and quality of care are maintained throughout the transition
- Monitor impact on service delivery and patient outcomes
- Oversee risk management processes during the transition period

4. Membership

4.1 Core Membership

- **Cluster Chair** (once Cluster arrangement agreed, until that point both current ICB Chairs)
- **Cluster Chief Executive** (once Cluster arrangement agreed, until that point both current ICB Chief Executives)
- **Non-Executive Member** (once Cluster arrangement agreed): Chair of the People and Customer Experience Committee
- **Cluster Chief Officer(s) responsible for finance**
- **Cluster Chief Officer(s) responsible for people**

4.2 Regular Attendees

- Cluster Corporate Governance lead
- When clinical or quality issues are on the agenda, the Cluster Chief Nursing and Medical Officers

4.3 Additional Attendees

The TSG may invite other individuals to attend meetings as required.

5. Meetings and Quorum

5.1 Frequency

- The TSG shall meet **weekly** during the active transition period
- Additional meetings may be convened at the discretion of the Chair or upon request from any three TSG members

5.2 Quorum

The quorum for meetings shall be:

- At least one of either the Cluster Chair or Cluster Chief Executive
- At least one non-executive member (who may be the Cluster Chair)
- At least two Chief Officers

5.3 Decision Making

- Decisions will normally be reached by consensus
- Where consensus cannot be achieved, decisions will be referred to the South West Peninsula Board
- Emergency decisions may be taken by the Cluster Chair in consultation with Cluster Chief Executive, subject to ratification at the next meeting

6. Reporting and Accountability

6.1 Board Reporting

- The TSG shall report to each the South West Peninsula Board whilst it exists
- Written reports shall be provided highlighting:
    - Progress against key milestones
    - Significant risks or issues
    - Decisions taken and recommendations made
    - Financial and operational updates

6.2 External Reporting

- The TSG shall ensure compliance with NHS England reporting requirements
- Regular updates shall be provided to NHS England Regional Team
- Stakeholder communications shall be coordinated through agreed channels

6.3 Public Accountability

- TSG meetings shall be conducted in private due to the commercially sensitive nature of discussions
- Regular public updates shall be provided through ICB websites and public board and South West Peninsula Board meetings

7. Authority

7.1 Financial Delegation

The TSG is authorised to:

- Approve interim operational arrangements during transition
- Authorise temporary staffing arrangements
- Approve communication and engagement plans
- Establish working groups and task forces as required

7.3 Limitations

The TSG **cannot**:

- Make decisions that fundamentally alter the statutory responsibilities of either ICB
- Approve permanent changes to ICB Constitutions (these require Board approval)
- Commit to expenditure exceeding the approved transition budget without South West Peninsula Board and/or individual Board approval
- Make decisions that would compromise patient safety or regulatory compliance

8. Working Groups and Support

8.1 Working Groups

The TSG may establish time-limited working groups to address specific aspects of the transition.

8.2 Programme Management

- A dedicated programme management office shall support the TSG
- Regular programme reporting shall be provided to the TSG
- Risk and issue registers shall be maintained and reviewed at each meeting

9. Review and Dissolution

9.1 Review

These terms of reference shall be reviewed every six months and amended as necessary

9.2 Dissolution

The TSG shall be dissolved upon:

- Successful completion of the clustering transition
- Formal merger of the ICBs
- Decision by both ICB Boards to discontinue the clustering arrangement
- Direction from NHS England to cease clustering activities

10. Effective Date

These terms of reference shall take effect from 21 August 2025 and remain in force until amended or revoked by the TSG.

Next Review Date: by 31 March 2026

NHS Devon Integrated Care Board

Annual Report and Accounts 2024/25 and Annual Assessment by NHS England

Date of meeting	Date report produced
28 August 2025	19 August 2025

Author(s)		Report approved by	
Name and title:	Helen Braid, Governance & Assurance Manager and Board Secretary	**Name and title:**	Philippa Harding, Company Secretary and Interim Chief Communications & Corporate Affairs Officer
Phone:		**Date:**	22 August 2025
Email:	helen.braid@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 report presents Board members with the final Annual Report and Accounts for NHS Devon for the period of 1 April 2024 to 31 March 2025. This report also formally presents the outcome of the 2024/25 Annual Assessment of NHS Devon undertaken by NHS England (NHSE) and the formal notice of NHS Devon's exit from the Recovery Support Programme. .

Committees that have previously discussed/agreed the report, and outcomes of that discussion
Board meeting in private – 19 June 2025 - The Board **approved** the draft NHS Devon Annual Report for submission ahead of the national deadline for final submission of 23 June 2025. Audit and Risk Committee – 19 June 2024 - The Audit and Risk Committee **recommended to the Board** that the draft NHS Devon Annual Report and Accounts should be approved for submission to NHS England ahead of the national deadline of 23 June 2025. Audit and Risk Committee – 06 May 2025 - The Audit and Risk Committee **took assurance** from the process for the production of the 2023/24 Annual Report and accounts including the timeline.

Key recommendations and actions requested
NOTE the final NHS Devon 2024/25 Annual Report and Accounts
NOTE the Annual Assessment for 2024/25 of NHS Devon by NHS England
NOTE the formal notice of NHS Devon's exit from the Recovery Support Programme

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	All
Health inequalities	
Workforce	
Resources and finance	
Legal	
Digital and Data	
Involvement, Engagement and consultation	

Annual Report and Accounts 2024/25 and Annual Assessment by NHS England

Introduction

1. NHS Devon Integrated Care Board (NHS Devon) is required each year to publish an Annual Report which details its governance arrangements and past year's performance. The report also includes the previous year's Annual Accounts. This report presents the final 2024/25 Annual Report for NHS Devon.

2. This report also formally presents the outcome of the 2024/25 Annual Assessment of NHS Devon undertaken by NHS England (NHSE) together with formal notice of NHS Devon's exit from the Recovery Support Programme.

Requirements for the Annual Report set by NHS England

3. The 2024/25 Annual Report, has been written in line with the NHSE Annual Report template intended to help Integrated Care Boards (ICBs) meet relevant requirements, including those set out in legislation.

4. ICB Annual Reports are required to follow the core three-part structure (performance report, accountability report and the financial accounts) and reporting requirements set out within the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM).

5. The DHSC GAM sets out the minimum content required within the Annual Report. Beyond this, additional information should be provided as necessary to reflect NHS Devon's position within the community.

6. The Health and Care Act 2022 additionally requires ICBs to:

    - explain how they have discharged their duties under sections:
        - 14Z34 (improvement in quality of services)
        - 14Z45 (public involvement and consultation)
        - 14Z49 (experience of members)
    - review the extent to which the Board has exercised its functions in accordance with the plans published under sections:
        - 14Z52 (joint forward plans)
        - 14Z56 (capital resource use plan)
    - review the extent to which the board has exercised its functions consistently with NHSE's views set out in the latest statement published under section:
        - 13SA(1) (views about how functions relating to inequalities information should be exercised)
    - review any steps that the Board has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under Local

Government and Public Involvement in Health Act 2007.

Annual Report - content summary

7. The Annual Report follows the guidance as outlined above and is attached as Annex A to this report.

Performance Report

8. The Annual Report provides an overview of performance highlights and key performance metrics. It shows that 2024/25 was a challenging year for the NHS in Devon, with significant pressures on many services, largely due to increased demands of an ageing population as well as service backlogs. This was seen most notably in the urgent care system where key metrics were below national targets including four-hour waits in A&E and ambulance handover delays. We have seen progress in handover delays in the percentage greater than three-hours, having improved from April 2024 (14.45%) to March 2025 (7.91%); however, this has fluctuated throughout the year.

9. Elective care waiting times were also challenged, with some patients waiting for more than two-years (104-weeks) for their treatment; however, this had been reduced to 0 by 31 March 2025.

10. Progress against cancer metrics remained in line or above the national average and improvements were seen in the reduction in the number of inappropriate out-of-area placements for patients with severe mental illness.

11. Devon's service and financial pressures have resulted in the system being placed in the highest tier (Segment 4) of the NHS Oversight Framework (NOF4). Exit criteria had been agreed with NHS England that covered leadership, strategy, urgent and emergency care, elective care, and financial performance; however, due to the move to an updated NOF for 2025/26 together with the significant change and disruption being experienced to deliver major running cost reductions, ICBs will not be allocated segments in 2025/26.

Accountability Report

12. The Accountability Report including the Annual Governance Statement (AGS) is a key section of the annual report that details the system of internal control in place for the organisation and explains how each part contributed towards providing assurance to the Accountable Officer.

13. The AGS provides details of NHS Devon's internal control mechanisms. It includes details of the NHS Devon Board, the scopes of the Committees, and the control systems including risk management, internal audit, and the counter fraud service. The statement also contains the Head of Internal Audit Opinion.

Head of Internal Audit Opinion

14. ASW provided the final Head of Internal Audit Opinion for 2024/25. The Opinion on the internal control, governance and risk management arrangements for the ICB was **satisfactory assurance**.

    "Largely there is a sound system of internal control, designed to meet the ICB's objectives, and controls which are generally being applied consistently. Weaknesses in the design and/or inconsistent application of controls in some key areas put the achievement of particular objectives at risk."

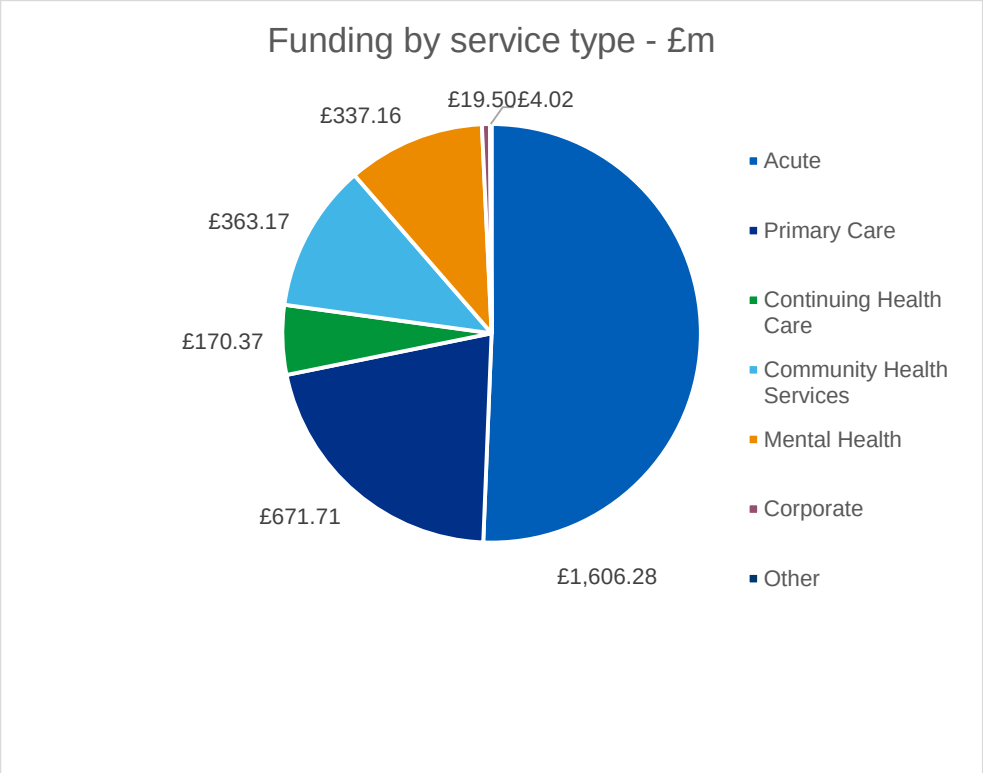
Requirements for the Annual Accounts set by the Department of Health and Social Care

15. ICBs are required to prepare accounts in accordance with International Financial Reporting Standards (IFRS) as adopted in HM Treasury's 'Financial Reporting Manual' (FReM), subject to any agreed divergences for the Department of Health and Social Care (DHSC) group, or through subordination to the Companies Act 2006. The DHSC Group Accounting Manual (GAM) incorporates the requirements of the FReM for ICBs and provides additional guidance and context relevant to the NHS. In compiling its 2024/25 Annual Accounts, NHS Devon has complied with the requirements of the GAM and, in so doing, achieved compliance with the FReM. NHS Devon's 2024/25 Annual Accounts are incorporated into the Annual Report attached at Annex A to this report.

Annual Accounts – content summary

Financial performance

16. NHS Devon received funding totalling £3.172 billion between 1 April 2024 to 31 March 2025. The chart below shows the spend by service type which includes contract and non-contractual expenditure with NHS providers, independent providers, local authorities and the voluntary sector, and shows the running costs for NHS Devon. It largely reflects historical levels of expenditure and trends in current demand.



Financial outlook

17. The Annual Report includes a section on the financial outlook for 2025/26. NHS Devon, in partnership with primary and secondary care providers, continues to collaborate with other One Devon system partners to ensure that expenditures align with available resources. The 2025/26 financial plans focus on improving service performance and productivity, while advancing the key ambitions outlined in the NHS Long Term Plan.

18. In 2025/26, NHS Devon received recurrent base growth funding of 3.85%, equivalent to £94.6m. For the running costs of NHS Devon there is a reduction in base funding from £19.6m to £18.0m, necessitating savings. In addition to the running cost reduction, all ICBs have been asked to produce plans to reduce their overall costs on administration and programme pay costs to £18.96 per head of weighted population. For NHS Devon this is a further reduction in costs of £12.4m. We are awaiting details of how ICBs are expected to achieve this but anticipate that implementation will need to be commenced in the final 6 months of 2025/26.

19. NHS Devon is tasked with achieving a balanced financial position across the One Devon system. While NHS Devon has submitted a surplus plan of £8.0m for 2025/26, the overall One Devon system projects a breakeven position after receiving £53.8m deficit support funding. This underlying financial challenge has led to NHS Devon and the three Devon acute provider organisations staying at Level 4 under the NHS Oversight Framework (NOF4) in 2024/25, the highest level of national oversight for finance and performance.

Annual Assessment of NHS Devon by NHS England

Annual Assessment approach

20. Under the terms of the Health and Social Care Act 2022, NHS England (NHSE) is required to undertake a performance assessment of each ICB in respect of each financial year and publish a report containing a summary of the results of each assessment. The outcome of the assessment is a letter from the relevant NHSE regional director to the ICB chair.

21. The purpose of the assessment is to assess how well the ICB has discharged its statutory functions. In particular, it should:

- objectively consider how effectively each ICB has led the NHS in its system
- provide a clear process of accountability for each ICB to NHS England in the discharge of their functions
- consider the delivery and achievement of objectives to inform future plans
- identify instances of good practice and support the sharing of this with others who could benefit
- reflect on progress towards longer-term strategic priorities
- review the extent to which any supportive interventions have been successful.

22. The assessment is structured across five sections. Each section considers the ICB's overall system leadership and its contribution to each of the four core purposes of an integrated care system (ICS):

- improving population health and healthcare
- tackling unequal outcomes, access and experience
- enhancing productivity and value for money
- helping the NHS support broader social and economic development

23. The assessment draws, wherever possible, on existing processes and information rather than requiring additional effort. All sections of the assessment are underpinned by a consideration of four main questions:

- to what extent has the ICB delivered on the national priorities set by NHS England?
- how far has the ICB achieved the local ambitions articulated in its Joint Forward Plan?
- how has the ICB responded to diagnosed support needs and progressed towards any agreed improvement goals?
- how effectively has the ICB led the NHS in its ICS?

24. In considering these questions, NHSE will reflect on a range of evidence including, but not limited to:

- ICB self-reflection

- The ICB's annual reports and accounts
- Feedback from system partners
- Routine discussions
- Delivery of operating plans
- Progress towards improvement goals

Annual Assessment letter

25. NHS Devon has received its Annual Assessment Letter from the NHSE South West Regional Director, Sue Doheny, dated 22 July 2025. This is at Annex B to this report.

NHS Devon's Exit from the Recovery Support Programme

26. As previously reported, due to the service and financial pressures being experienced during 2024/25 NHS Devon remained in the highest tier (Segment 4) of the NHS Oversight Framework (NOF4).

27. As with all NHS organisations in NOF4, NHS Devon received mandated intensive support from the NHSE Recovery Support Programme (RSP). During 2024/25 the RSP Team reported progress in a number of areas including the introduction of the System Leadership Group and Local Planning and Delivery Groups, establishment of the Transforming Devon Programme together with improvements in elective performance, the majority of Urgent and Emergency Care metrics and joint working through the Acute Provider Collaborative.

28. Throughout 2024/25 the RSP support to NHS Devon moved from delivery support to constructive challenge, advice and oversight in light of the progress that had been made against the NOF4 exit criteria.

29. The NHSE Quality and Performance Committee considered the recommendations of the RSP and on 15 August 2025 agreed that NHS Devon had demonstrated sufficient progress against all exit criteria for leadership, UEC and elective performance to now exit the RSP. The letter confirming this decision is at Annex C to this report.

Conclusion

30. The Board is asked to:

- **NOTE** the final NHS Devon 2024/25 Annual Report and Accounts
- **NOTE** the Annual Assessment for 2024/25 of NHS Devon by NHS England
- **NOTE** the formal notice of NHS Devon's exit from the Recovery Support Programme.

NHS Devon

Annual report and accounts

1 April 2024 – 31 March 2025

One Devon

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

Contents

Foreword from the Chair

Thank you for your interest in this year's annual report, which provides an opportunity to reflect on the work of NHS Devon Integrated Care Board (NHS Devon) over the last 12-months and our plans to address the major challenges that lie ahead.

2024/25 marked our second year, and we continue to respond to our changing responsibilities and the increasing pressures on services, including an unsustainable underlying financial deficit.

Whilst it is encouraging to see progress, there remain areas such as access to urgent and emergency care and reducing waiting times for patients, where we need to keep working together in the One Devon health and care system to significantly improve our performance.

Our organisation, and system, remain in the highest tier of oversight and scrutiny by NHS England (segment four of the NHS Oversight Framework (NOF4)), which sets out a number of priority areas for improvement. While we work hard to address those priorities, we will not lose sight of the importance of prevention of ill-health and reducing health inequalities.

We are indebted to our workforce across the county, who have worked with great skill and determination under ever increasing pressures and have once again shown unwavering commitment to innovation and improvements over the past year.

I would also like to pay tribute to the extraordinary work of our partners in the NHS, local authorities, social care, Healthwatch Devon, Plymouth and Torbay and our voluntary, community and social enterprise (VCSE) sector for their integral support for our people and communities in Devon.

I am delighted to welcome our new board members Phill Mantay (Partner Member for Mental Health and Chief Executive Officer of Devon Partnership NHS Trust), Sam Higginson (Partner Member for NHS Trusts and Foundation Trusts, and Chief Executive Officer of Royal Devon University Healthcare NHS Foundation Trust) and Lincoln Sargeant (Partner Member for Local Authorities and Director of Public Health at Torbay Council), alongside three new Independent Non-Executive Members (INEM), Salma Ali, Kaye Bentley and Lopa Patel who joined the organisation this year, and who all bring with them a wealth of experience across health and care.

I also want to welcome the new members of the executive team this year, namely Libby Ryan-Davies (Chief Strategic Commissioning and Planning Officer and Deputy Chief Executive Officer), Peter Collins (Chief Medical Officer), Piers Tetley (Chief People Officer), Philippa Harding (Interim Chief Communications and Corporate Affairs Officer) and Kirsty Denwood (Interim Chief Financial Officer).

I'd also like to extend our huge thanks to those who have left our organisation this year, Bill Shields (Chief Finance Officer) Nigel Acheson (Chief Medical Officer), Judy Hargadon (INEM), Sheena Asthana (INEM), Martin Sykes (Interim INEM), Ruth Harrell (Partner Member for Local Authorities), each making a significant contribution to health and care services across One Devon.

It is an honour to have been formally appointed as the Chair of NHS Devon in December 2024. This is a pivotal time for the healthcare system, and I look forward to continuing to work collaboratively with our partners, staff, and communities to drive forward improvements in care for all.

There have been several significant programmes of work this year that have shown how working as One Devon can have tangible benefits for the population of Devon.

We took an inclusive and collaborative One Devon approach to engagement on the NHS 10 Year Plan during which we worked across the NHS, the VCSE sector and Healthwatch. This enabled us to reach into some of our most vulnerable communities, so that overall more than 3,400 people engaged with us. This feedback will directly inform our new strategic commissioning plans and will help shape local services.

In March, our NHS Devon Board approved a new People and Communities Framework, which sets the blueprint for how we will work with our population to drive better decision making, develop and improve health and care services, and ensure the voice of local people is at the heart of everything we do. It includes closer working with our partners to share information and the creation of a repository to store the information that we have collected from our engagement of the public in one place. This represents a significant improvement in the way we and our partners conduct our business.

People in Torbay and South Devon will have greater access to a range of scans and treatment following the opening of a new community diagnostic centre (CDC) in Torquay. The expansion of services to the new CDC will help speed up treatment, reduce waiting lists and provide care closer to home for people. More than 40,000 diagnostic tests are expected to be carried out over the next 12 months.

The Healthy Lives Partnership (Livewell Southwest and University Hospitals Plymouth NHS Trust) are working together to implement a new Community Frailty Virtual Ward model across Plymouth and West Devon to help manage more patients with complex needs in the community. The first locality team 'Plymouth North' is now live, with five other teams set to launch in 2025.

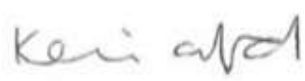
Working together, the NHS and our local authorities have been able to expand supervised toothbrushing to all nursery, pre-school and receptions settings to improve oral health, and schools in all districts in Devon can now access specialised mental health support.

In March, we completed our organisational change process after meeting the significant challenge to reduce our running costs by 30% by 2025/26. The Board remains committed to supporting all our colleagues as we face further changes and national reform.

As part of the NHS Future Operating Model work, we have been working closely with our colleagues in NHS Cornwall and Isles of Scilly to submit our proposed cluster arrangement with the possibility of a full merger in the future, with the aim of setting out how we will deliver services under the new national ICB blueprint, and within the reduced funding targets.

We and our system colleagues remain focused on working for the best interests of the people we serve, continuing work and collaboration with our neighbouring ICBs, and drawing on as much of the local expertise and knowledge as possible as we move towards more neighbourhood heath delivery and becoming a more strategic organisation than ever before.

As well as developing our system operational plan, and refreshing our Joint Forward Plan in 2025, against the backdrop of significant change for the whole NHS, we remain committed to our vision of improving access to all health and care services and giving equal chances for everyone in Devon to lead long, happy and healthy lives.



Kevin Orford

Chair, NHS Devon Integrated Care Board

Performance report

The performance report sets out the activities of NHS Devon Integrated Care Board and demonstrates how effective it has been in meeting both national standards and its local objectives.

As of 1 July 2022, health services have been commissioned by the NHS Devon Integrated Care Board, the organisational form and functions of which are set out below. NHS Devon operates within the Devon Integrated Care System which is known as One Devon.

The report covers the period from 1 April 2024 to 31 March 2025

Steve Moore
Accountable Officer and Chief Executive Officer
NHS Devon Integrated Care Board

19 JUNE 2025

Performance overview

Summary from the Accountable Officer

2024/25 has been a challenging year for the NHS in Devon, with significant pressures on many services, largely due to increased demands of an ageing population as well as service backlogs. This can be seen most notably in the urgent care system where key metrics are below national targets including four-hour waits in A&E and ambulance handover delays. We have seen progress in handover delays in the percentage greater than 3hrs having improved from April 2024 (14.45%) to March 2025 (7.91%); however, this has fluctuated throughout the year.

Elective care waiting times were also challenged, with some patients waiting for more than two-years (104-weeks) for their treatment; however, this had been reduced to 0 by 31 March 2025.

Progress against cancer metrics remains in line or above the national average and improvements have been seen in a reduction in the number of inappropriate out-of-area placements for patients with severe mental illness.

Devon's service and financial pressures are well-documented and have resulted in the system continuing to be in the highest tier (segment four) of the NHS Oversight Framework (NOF4). Exit criteria have been agreed with NHS England that cover leadership, strategy, urgent and emergency care, elective care, and financial performance with the expectation exit from NOF4 is targeted for the end of Q1 in 2025/26. The NHS Performance Assessment Framework will replace the NOF in 2025/26 and NHS Devon awaits confirmation of its assessment under that new framework.

Our purpose

NHS Devon is responsible for the majority of the NHS budget in Devon and develops plans to improve people's health, deliver high quality care and better value for money.

It is led by a diverse board, which includes representatives from local councils, primary medical service providers (GP and other services) acute hospitals, mental health and learning disability and neurodiversity services.

NHS Devon plans and buys hospital and community NHS services in Devon, including:

- Most planned hospital care
- Rehabilitative care
- Urgent and emergency care (including out of hours)
- GP and primary care services
- Dental, optometry and pharmacy services (under powers delegated by NHS England)
- Most community health services such as community nursing and physiotherapy
- Maternity services
- Services for children's and young people's health and wellbeing
- Mental health, learning disability and neurodiversity services
- Continuing healthcare for people with ongoing health needs such as nursing care

In planning and developing these services, NHS Devon involves local patients, carers and the public. It also works closely with organisations such as Healthwatch in Devon, Plymouth and Torbay to better understand local need.

To better meet the needs of local communities, Devon has established five Local Care Partnerships which involve a range of partners across health and care in the following geographical areas:

- Northern Devon
- Eastern Devon
- South Devon
- Western Devon
- Plymouth

Working as One Devon

The Integrated Care System, known as One Devon, is a collaboration of the NHS, local councils and a wide range of other organisations, including the voluntary and community sector, who are working together to improve the lives of people in Devon.

It includes the following health and care organisations:

- Royal Devon University Healthcare NHS Foundation Trust
- University Hospitals Plymouth NHS Trust
- Torbay and South Devon NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- Livewell Southwest
- Devon Partnership NHS Trust
- NHS Devon Integrated Care Board
- All GP practices in Devon, Plymouth and Torbay
- Devon County Council
- Torbay Council
- Plymouth City Council
- Devon, Plymouth and Torbay Health and Wellbeing Boards
- Voluntary, community and social enterprise (VCSE) sector

Through One Devon, NHS Devon aims to effect the changes to health and care set out in the NHS Long Term Plan. This is intended to meet the growing challenges of providing community and hospital care and social care when demand is dramatically increasing. Through the One Devon Integrated Care Strategy and our Five-Year Joint Forward Plan we set out how we will meet the needs of the local population.

The vision for One Devon is: equal chances for everyone in Devon to lead long, happy, and healthy lives.

To deliver its vision, One Devon set out six ambitions that will help transform services and redesign the way care is provided:

1. **Effective and efficient care:** Collaborate across the system to address quality (safety, effectiveness, experience) and productivity.
2. **Integrated Care Model:** Systematic delivery of integrated – or joined up – care across Devon.
3. **The Devon deal:** A citizen-led approach to health and care. We will adopt a new approach to reduce differences in care across the county and will work with communities to identify priorities and tackle the root causes of problems.
4. **Children and young people:** Working together with children, young people and their families. We want all children and young people in Devon to have the best start in life, grow up in loving and supportive families, and be happy, healthy and safe.

5. **Digital Devon:** Invest in a digital Devon: people will only tell their story once, first contact will be digital, and more advice and help will be available online. We want to make the most of advances in digital technology to help people stay well, prevent ill-health, and provide care.
6. **Equally well in Devon:** Work together to tackle the physical health inequalities for people with mental illness, learning disabilities and/or autism.

Integrated Care Strategy and Joint Forward Plan

Every Integrated Care System is required to produce an Integrated Care Strategy, setting out how NHS commissioners, local authorities, providers and other partners will deliver more joined-up, preventive and person-centred care for the whole of their local population across the course of their life.

Devon's Integrated Care Strategy sets out the key challenges for One Devon and a series of strategic goals to tackle them. In May 2023, NHS Devon published its initial response to the strategy; the Joint Forward Plan, a single overarching plan for the county which is aligned to the strategy.

The Joint Forward Plan is delivered through various parts of the system, including Primary Care Networks, Local Care Partnerships and provider collaboratives

The Joint Forward Plan reflects significant input from people and communities throughout Devon, based on an analysis of extensive public feedback about health and care between, as well as views gathered at a joint Health and Wellbeing Boards event and a joint Overview and Scrutiny Committees event. It benefits from substantial input from health and care partners across Devon, drawn from our Local Care Partnerships, Voluntary Care and Social Enterprise Assembly, and system partners. It has also been informed by a partners' survey and a 'Change Leaders Event', attended by more than 50 system leaders.

The Joint Forward Plan is reviewed on an annual basis on consultation with One Devon's Health and Wellbeing Boards. It was most recently updated in March 2025.

The Integrated Care Strategy and Joint Forward Plan are available on the One Devon website – https://onedevon.org.uk/about-us/our-vision-and-ambitions/our-devon-plan/

NHS Oversight Framework

The NHS Oversight Framework describes NHS England's (NHSE) approach to its oversight of NHS organisations, and its monitoring of their performance. It is expected to be revised in 2025.

NHS Devon is currently in Segment 4 of the NHS Oversight Framework (NOF4) and in receipt of mandated support from NHSE as set out in the national Recovery Support Programme. This means the highest level of oversight.

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.

The scope of the NOF covers six domains with NHS Devon's NOF4 categorisation based on three key areas for improvement:

NHS Oversight Framework Domains

1. Quality of care, access and outcomes
2. Preventing ill health and reducing inequalities
3. Finance and use of resources
4. People
5. Leadership and capability
6. Local strategic priorities

Devon Improvement Areas (2024/25)

1. Financial performance, including delivery of an agreed short term financial plan.
2. Joint ownership and delivery of a coherent strategy that secures sustainable clinical services and improved performance
3. Urgent and Emergency Care and Elective Care improvements against targets.

The current segmentation for the NHS organisations within One Devon is as follows:

Organisation	NOF segment
NHS Devon Integrated Care Board	NOF4
University Hospitals Plymouth NHS Trust	NOF4
Royal Devon University Healthcare NHS Foundation Trust	NOF4
Torbay and South Devon NHS Foundation Trust	NOF4
Devon Partnership NHS Trust	NOF2

The NOF includes an oversight process which follows an ongoing cycle of monitoring performance against the six NOF domains. As the Integrated Care Board, NHS Devon has a key role alongside NHSE in assessment of local trusts.

The monitoring process set out in the NOF includes a requirement to hold monthly reviews of progress against key performance indicators and exit criteria which are provided in the form of flash reports. The reviews take place at the System Improvement and Assurance Group (SIAG) on a monthly basis, which is chaired by NHSE.

NHS Devon undertook a self-assessment informed by all NHS system partners with regard to the One Devon ICS position and achievements against the agreed NOF4 exit criteria. The outcomes were presented to NHS Devon Board in May 2025, recognising that there are some significant challenges within its 2025/26 Operational Plan, the One Devon Financial plans, and the impact of the forthcoming, and significant organisational change process in 2025.

The self-assessment reflected that One Devon and NHS Devon has seen a significant amount of change in terms of the individuals leading organisations within it over the past two years and this, in turn, has resulted in a tangible shift in leadership behaviours and culture.

Ways of working have improved significantly, supported by refreshed system oversight and assurance structures, and that One Devon has improved strategic clarity both in the medium and long-term meaning that the system is well placed to ensure that its Integrated Care Strategy and the next iteration of its Joint Forward Plan (JFP) (to be known as the Health and Care Strategy) respond to the NHS 10 Year Plan when it is published in 2025.

Highlights and achievements

Social prescribing pilot in the emergency department

An innovative pilot project in the emergency department (ED) at the Royal Devon and Exeter Hospital (Wonford) is connecting patients with practical, social and emotional needs that affect their health and wellbeing to activities, groups and services in their own community.

Social prescribing is well-established in primary care and there is emerging evidence that connecting people to their community can lead to a range of positive health and wellbeing outcomes, such as improved quality of life and emotional wellbeing.

Despite this, there are only a handful of EDs in England that have integrated a social prescriber link worker into their team.

Partnership pilots revolutionary lung cancer blood test

A ground-breaking blood test for lung cancer, which has been piloted in the Royal Devon since January 2023, is now available across the South West, made possible by advances in genomic medicine.

Thousands of patients in England with suspected lung cancer are being offered the cutting-edge blood test to show if they can get early access to targeted therapies.

Trust and telehealth firm team up on digital 'prehab'

University Hospitals Plymouth NHS Trust (UHP) is working with a telehealth company to deliver digital prehabilitaiton (‘prehab’) services to liver patients across Devon, Cornwall and Somerset.

The year-long trial with the South West Liver Unit at UHP and QuestPrehab will see 50 patients undergoing assessment and listing for liver transplant. If successful, the service may be expanded to patients living with other liver diseases and who currently are not on the list.

Patients who complete a prehab course prior to planned surgery are less likely to be readmitted to hospital, enjoy improved health-related quality of life, return to work earlier and need less involvement with social and primary care providers.

Working with communities to improve general practice

A patients champion from Devon has played a key role in developing a new national training course that highlights how GP practice staff and patient participation groups (PPGs) can work effectively with local people and communities.

The Chair of Healthwatch in Devon, Plymouth and Torbay, Dr Kevin Dixon, was part of the Primary Care Community Engagement Steering Group which designed this new way of looking at primary care and community.

The NHS England (NHSE) course - *Working with people and communities to improve general practice in primary care* – will see participants learn about the reasons for working with people and communities in primary care, the principles involved as well as legal and contractual responsibilities. The course also explores why diversity and inclusion is important and considers the different ways of improving engagement.

STaR partners helping people with complex lives

Partners in Exeter are delivering an innovative alternative treatment approach to people who often find it impossible to access standard treatment for their substance dependency, physical and mental health needs, past trauma and housing.

The Exeter System Treatment and Recovery (STaR) project was set up to work with people who have experienced difficulties engaging with traditional models of care who need specialist interventions for their complex health and social care needs.

CoLab, host for the STaR project, serves as a cross-sector multi-agency wellbeing hub in Exeter and is a unique collaborative community and social laboratory hosting 25+ different organisations, including the Clock Tower Surgery. CoLab actively explores diverse collaborative approaches to support people facing multiple disadvantages, emphasising innovation, system change, and community engagement to create a fairer, more inclusive, and healthier city.

School mental health service rolled out across Devon

Schools in all districts in Devon can now access specialised mental health support after a Children and Family Health Devon (CFHD) service was rolled out across the county.

The Mental Health Support Team in Schools (MHST), which supports children and young people with their mental health and emotional well-being, is now available to nearly 70% of children attending schools within Devon and Torbay.

The MHST's initiative represents a significant investment in the future of children and young people across Devon and Torbay, bringing specialised mental health support to the classroom.

New Community Diagnostic Centre opens in Torbay

People in Torbay and South Devon will have greater access to a range of scans and treatment following the opening of a new community diagnostic centre (CDC) in Torquay.

The centre opened on 9 September to provide ultrasound, echocardiography, cardiac monitoring tapes and phlebotomy. MRI, CT and x-ray services will be available from November and will increase the range of services in addition to those provided at other hospitals and community settings.

The CDC is one of five procured by the NHS in the South West under a partnership deal with InHealth, which will deliver 200,000-plus scans a year at an annual cost of around £30m. Two other CDCs are already operational, at Weston-super-Mare and Bristol, with the final two under construction at Yeovil and Redruth. Mobile units have been used to provide scans during construction of the permanent buildings.

More than 1,400 patients have already been seen at the centre and more than 40,000 diagnostic tests are expected to be carried out during the next 12 months.

New partnership formed for GP homeless service

A new community interest company – Inclusion Health Devon (IncluDe) has been awarded the contract to provide primary medical care GP services to the homeless and vulnerably housed in Exeter and Barnstaple following a competitive procurement process.

Inclusion Health Devon took over the running of the Clock Tower Surgery in Exeter and has now established a permanent service at the Freedom Centre in Barnstaple, following the success of the previous pilot project. They are a newly formed Community Interest Company (CIC) set up by clinicians (GPs and nurses) from both the Clock Tower Surgery in Exeter and Freedom Centre service in Barnstaple, who have many years of experience in delivering care to inclusion health groups.

The aims of the partnership include; increasing the uptake of vaccination and screening offers, and reducing incidence of infectious diseases and Reduce ED attendances and emergency admissions.

Devon staff honoured in Parliamentary Awards

The NHS in the South West is celebrating the remarkable achievements of staff and teams who have won regional categories in the 2024 Parliamentary Awards, after being nominated by their local MPs.

The 2024 Devon winners, selected by NHS leaders in the South West, are:

- **The Excellence in Mental Health Care Award:** Bristol Dementia Wellbeing Service, Devon Partnership NHS Trust
- **The Future NHS Award:** Northern Devon Heart Failure Remote Monitoring Project, led by Angela Tithecott, Royal Devon University Healthcare NHS Foundation Trust – Northern Services (Royal Devon)
- **The Nursing and Midwifery Award:** Louise Barraclough, NHS Devon
- **The Excellence in Primary Care and Community Award:** Belle's Place Primary Care project, Combe Coastal Practice/Royal Devon University Healthcare Trus
- **The Excellence in Education and Training Award:** Dr Yvonne Neubauer, MSI Reproductive Choices UK
- **The Volunteer Award:** Lyndsey Withers, Plymouth

Big Brush Club expands to all Devon primary schools

A scheme to support three- to five-year-olds with cleaning their teeth, known as the Big Brush Club, has now been expanded to all primary schools in Devon.

Funded by NHS Devon, in partnership with Devon County Council, Plymouth City Council and Torbay Council, the project is delivered by dental provider At Home Dental.

Devon is the first area in the south west to expand supervised toothbrushing to all nursery, pre-school and reception settings at primary school.

Plymouth teams complete UK-first procedure

Teams from University Hospitals Plymouth NHS Trust (UHP) performed the first electromagnetic navigational bronchoscopy (ENB) biopsy case in Devon and Cornwall, and the first case in the UK which incorporated digital fluoroscopic navigation.

The thoracic surgery and respiratory medicine teams at UHP came together in July to perform an ENB procedure for first the time in Devon and Cornwall.

UHP was able to undertake this new procedure, thanks to NHS England funding, which provided the necessary equipment last year to help with diagnosing lung cancers more accurately.

Team helping people to turn their lives around

A new health team is supporting frequent attendees of Derriford's Emergency Department to help them address concerns driving them to attend regularly.

The Frequent Users Support and Empowerment (FUSE) service helps people who have gone to the emergency department five or more times in a year.

Practitioners work with them to look holistically at their lives and establish where they can get better help and support in the community. This could be organising treatment for substance abuse, attending a GP appointment with them so that their medication can be better managed or engaging in talking therapies to build their resilience and improve their mental health.

Queen Camilla opens Sexual Assault Referral Centre

Her Majesty The Queen officially opened the new Exeter Sexual Assault Referral Centre (SARC) on Thursday 6 February, with the unveiling of a plaque.

SARCs support people who have been raped, sexually assaulted or abused at any time in their life.

SARCs are available 24 hours, 365 days a year and are open to anyone, regardless of age, sexual orientation or gender identity who may need their services.

The creation of the new Exeter centre was made possible with funding from NHS England with support from the Royal Devon University Healthcare NHS Foundation Trust through which the SARC services are provided. There are also SARCs in Plymouth and Truro, providing support throughout the region.

Performance analysis

Overview

The priorities and objectives set out in NHSE 2024/25 planning guidance identified key targets for ICBs to enable development of plans including targets for urgent and elective care (UEC), elective, cancer, mental health and primary care.

The key requirements were set for systems to maintain the increase in core UEC capacity established in 2023/24, complete the agreed investment plans to increase diagnostic and elective activity, reduce waiting times for patients, and maximise the gain from the investment in primary care in improving access for patients, including the new pharmacy first service.

Systems were required to continue to focus on recovering core service delivery and productivity. NHS Devon will continue to target a reduction in the cost of temporary staffing. It is expected that in 2025/26 a new standard set of metrics will be agreed for all executive teams and boards to use as a minimum to track productivity alongside service delivery.

The below table identifies the key performance requirements set out within the 2024/25 operating guidance, the performance committed to by the NHS Devon Board and an assessment of whether actual performance met the required position in the year to date. Further detail is provided in relation to UEC and elective recovery as these are the focussed areas for NOF4.

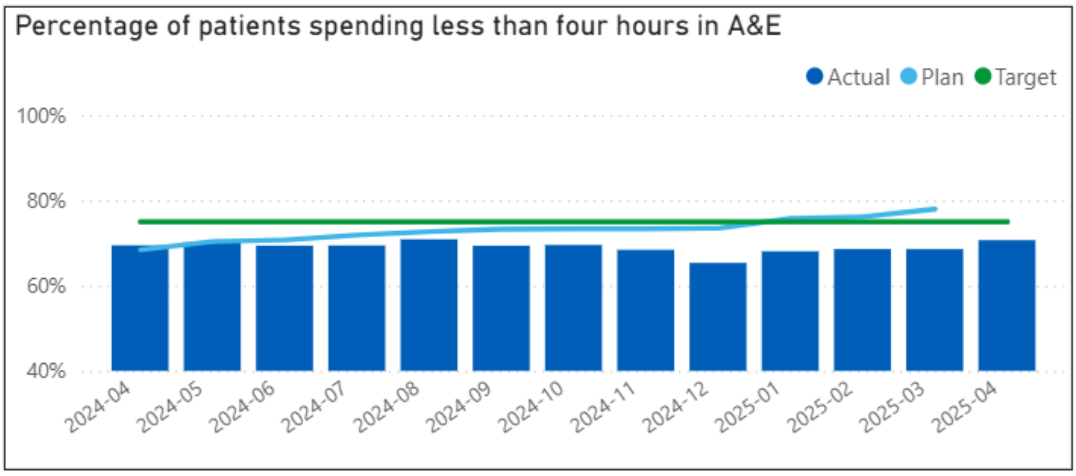
Performance Area	Metric	Submission	Standard Met
Urgent and Emergency Care	Improve A&E waiting times, compared to 2023/24, with a minimum of 78% of patients seen within 4 hours in March 2025	78.00% March 2025	**(green)**
	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25	2024/25 average: 49.17minutes	**(red)**
Primary and Community Services	Continue to improve the experience of access to primary care, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within 2 week and those who contact their practice urgently are assessed the some or next day according to clinical need	82.61% within 2 weeks	**(green)**
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 specialities)	789 by September 2024 (provider position) 0 65 weeks' wait by March 2025	**(red)**

Performance Area	Metric	Submission	Standard Met
	Deliver (or exceed) the system specific activity targets, consistent with the national value weighted activity target of 107%	110.90%	(green)
	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	46.70%	(green)
Cancer	Improve performance against the headline 62-day standard to 70% by March 2025	71.20	(green)
	Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025, toward the 80% ambition by March 2026	78.20%	(green)
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	88.70%	(red)
Mental Health	Improve patient flow and work towards eliminating inappropriate out of area placements (OAP)	2 active inappropriate OAP by the end of the year	(red)
	Increase the number of people accessing transformed models of adult community mental health (to 400,000), perinatal mental health (to 66,000) and children and young people (CYP) services (345,000 additional CYP aged 0-25 compared to 2019)	ACMH 8700 throughout 2024/25 PNMH 1115 CYP 15754 throughout 2024/25	(green)
	Increase the number of adults and older adults completing a course of treatment for anxiety and depression via NHS Talking Therapies to 700,000 with at least 67% achieving reliable improvement and 48% reliable recovery	67% achieving reliable improvement 48% reliable recovery	(green)
	Reduce inequalities by working towards 75% of people with severe mental illness receiving a full annual physical health check, with at least 60% receiving one by March 2025	64.00%	(green)
	Improve quality of life, effectiveness of treatment, and care for people with	65.00%	(red)

Performance Area	Metric	Submission	Standard Met
	dementia by increasing the dementia diagnosis rate to 66.7% by March 2025		
People with a learning disability and autistic people	Ensure 75% of people aged 14 and over on GP learning disability registers receive an annual health check in the year to 31 March 2025	75.10%	(green)
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, to the target of no more than 30 adults or 12-15 under 18s for every 1 million population	Adults: 20.25 Children: 28.08	(green) Adults (red) Children

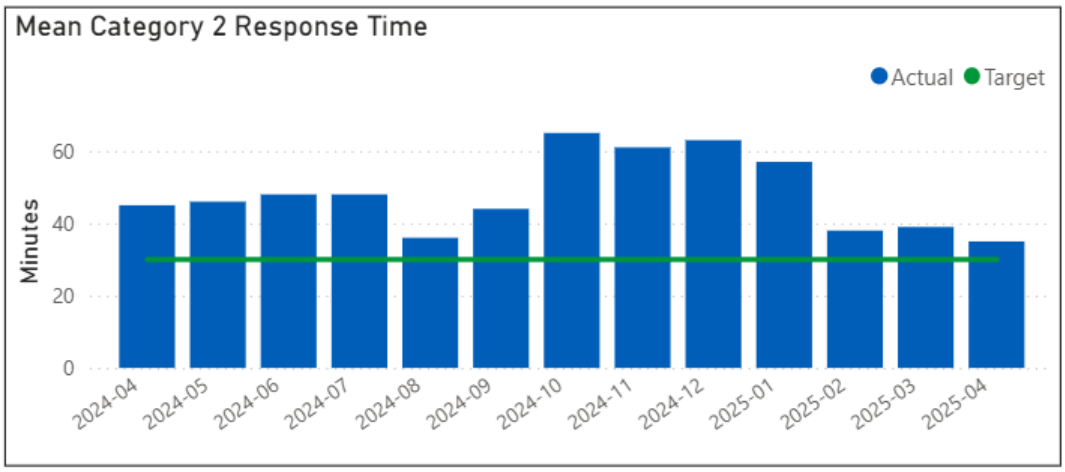
Urgent and emergency care (UEC)

Although not currently meeting the national standard or the improvement trajectories detailed within the operating plan, the One Devon position for urgent care has improved from its 2023/24 position in most performance areas through the year.



Percentage of patients spending less than 4 hours in A&E												
	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual	69.5%	70.1%	69.4%	69.4%	70.9%	69.4%	69.6%	68.4%	65.4%	68.1%	68.7%	68.6%
Plan	68.4%	70.4%	70.2%	71.9%	72.7%	73.3%	73.3%	73.4%	73.5%	75.8%	76.2%	78.0%
Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

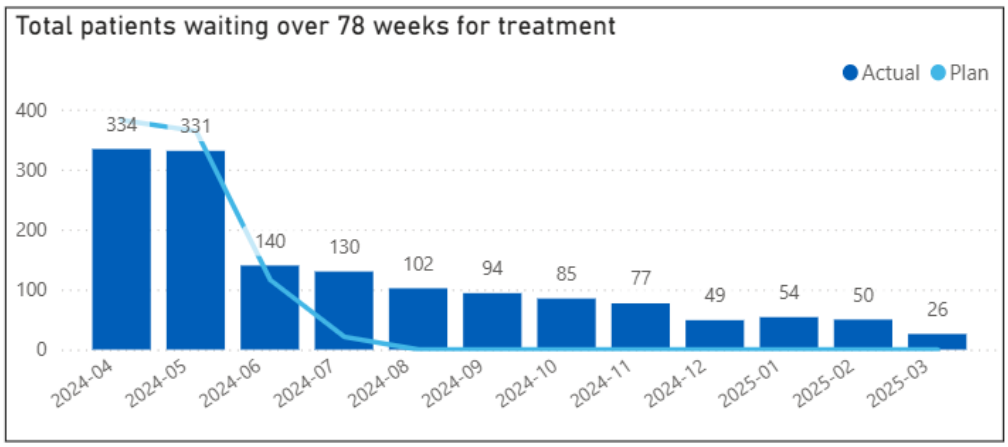
All Devon providers missed trajectory for 4-hour performance; however, performance in January 2025 was an improvement on both the position in January 2024 (62.42%) and the average position across 2023/24 (64.10%). The system all-type year to date position is currently in excess of 69%, maintaining a 5% improvement from the 2023/24 position. As of January 2025, University Hospitals Plymouth NHS Trust had demonstrated a 9.92% improvement from its 2023/24 position, making it the most improved provider nationally at that point.



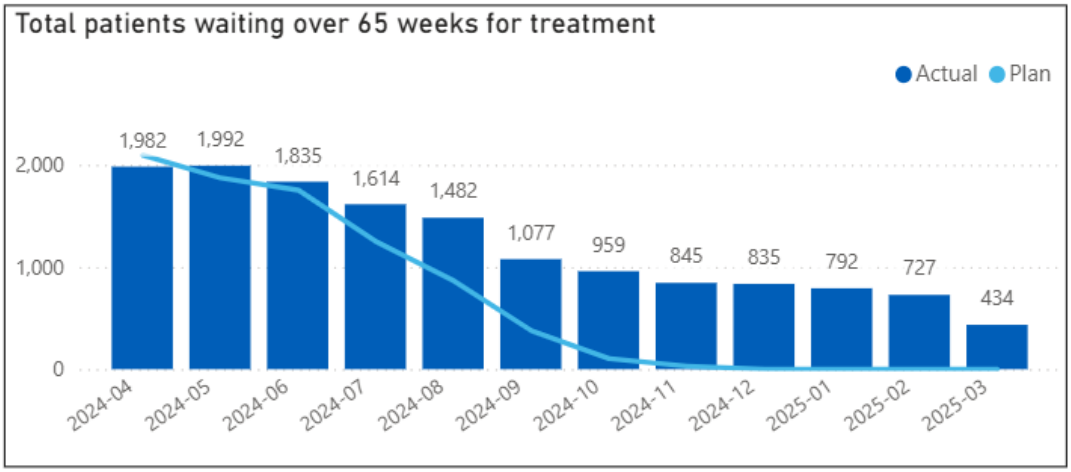
Mean Category 2 Response Time (in minutes)												
	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual	45	46	48	48	36	44	65	61	63	57	38	39
Target	30	30	30	30	30	30	30	30	30	30	30	30

Despite the improvement in ambulance handover performance compared to 2023/24, the category 2 position has worsened through the year and remains approximately 11 minutes worse than the 2023/24 average position. However, One Devon's performance in this area has improved in relation to national performance. In 2023/24 NHS Devon was ranked 40 of 42 Integrated Care Boards nationally against this standard and has improved to 38 out of 42 in 2024/25.

Elective

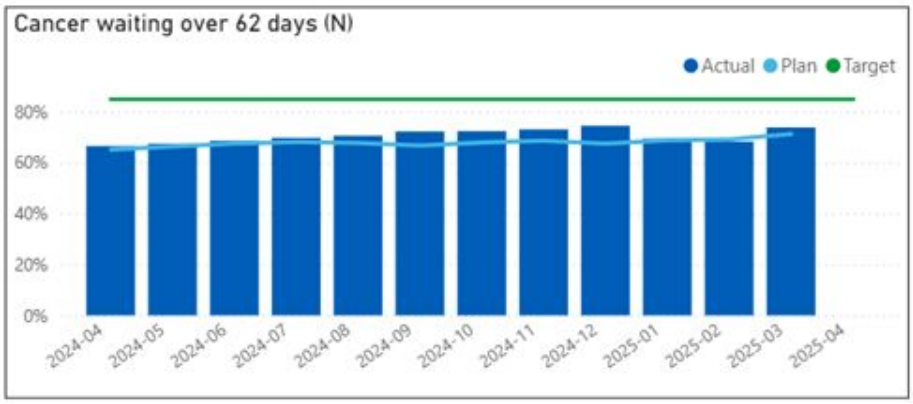


Total patients waiting over 78 weeks for treatment												
	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual	334	331	140	130	102	94	85	77	49	54	50	26
Plan	382	364	116	21	0	0	0	0	0	0	0	0
Target	0	0	0	0	0	0	0	0	0	0	0	0

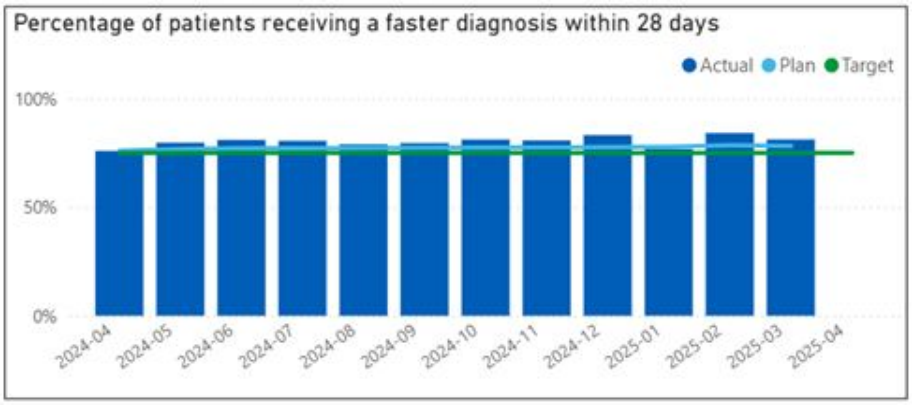


Total patients waiting over 65 weeks for treatment												
	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual	1982	1992	1835	1614	1482	1077	959	845	835	792	727	434
Plan	2093	1874	1753	1251	867	378	104	29	0	0	0	0

The numbers of patients wating beyond 78 weeks and 65 weeks for elective treatment reduced month on month during 2024/25. However, it will not meet the national standards or targets agreed in the One Devon Operational Plan. All providers were given the opportunity to re-forecast trajectories in Q2 and each One Devon provider committed to an elimination of 78 week waiters by the end of December 2024, and 65 week waiters by the end of March 2025. Only Torbay and South Devon NHS Foundation Trust met the target of eliminating 78-week waiters by end of December 2024 and all providers are currently forecasting a risk to meeting the clearance of 65-week waiters by March 2025.



Cancer waiting over 62 days												
	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual	66.5%	67.4%	68.5%	69.7%	70.5%	72.2%	72.4%	73.0%	74.5%	69.4%	68.2%	74.3%
Plan	65.1%	66.3%	67.4%	68.1%	67.7%	66.7%	67.9%	68.6%	67.4%	68.8%	69.1%	71.2%
Target	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



Percentage of patients receiving a faster diagnosis within 28 days												
	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual	76%	80%	81%	81%	79%	80%	81%	81%	83%	77%	84%	79%
Plan	76%	77%	77%	77%	77%	77%	78%	78%	78%	78%	79%	78%
Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

One Devon met its trajectories for both 62-day time to treatment and 28 day faster diagnosis for suspected cancer referrals throughout 2024/25 and this represents an improvement on the 2023/24 position. In the case of faster diagnosis standard, the national standard of 75% has been exceeded in addition to the system trajectory in each month bar month one.

Key issues and risks to future performance

Whilst One Devon has made significant progress in 2024/25, it continues to face many challenges.

As a whole, the 2025/26 Operational Plan, while materially compliant with NHSE requirements, is high risk and challenging to deliver. A new approach to performance management and oversight will be need to be enacted to ensure the plan's delivery. In order to enact this, NHS Devon is creating a "ring fenced" delivery unit, bringing together expertise from across teams to maintain a system focus on delivery.

Operational planning activity took place in the context of NHS Devon receiving an allocation in 2025/26 that is £163.3m (4.81%) above that level which it should receive according to need, also known as its 'fair share' target. This target is based on a national formula that uses population demographics and needs factors, such as age, sex, and deprivation, to identify what a fair share of the NHS resource should be.

In line with our financial plan agreed with NHS England, NHS Devon delivered a financial surplus of £28.4m for the year ending 31 March 2025; however, this surplus forms part of a wider system position, which resulted in an overall deficit of £19.8m. Current modelling suggests that delivery of the 2025/26 plan will reduce the Underlying Position (ULP) of the system by approximately £30.0m going into 2026/27. There will need to be significant further action to close the level of overfunding received by NHS Devon

Given the scale of the challenge over the coming years it is apparent that sustainability can only come from taking a more transformational long term approach, therefore in order to inform planning for 2026/27 (and beyond) NHS Devon has commenced the development of a Health and Care Strategy (Joint Forward Plan) that will describe the strategic change required alongside a refreshed Medium Term Financial Plan (MTFP) that will be presented to the NHS Devon Board by

September 2025. This will also enable both documents to address the NHS 10 Year Plan which is due to be published in 2025.

These significant challenges are compounded by the risk associated with organisational change arising from the recently announced requirement that Integrated Care Boards reduce their running costs by 50% on average. As NHS Devon works through the implication of this and moves to a potential cluster arrangement with NHS Cornwall and Isles of Scilly, there is a very real risk that the focus needed to deliver the required savings will result in a lessening on the focus needed to deliver an already high risk Operational Plan.

Mental Health

The Mental Health Investment Standard (MHIS), set by NHS England (NHSE), requires all ICBs in England to increase their planned spending on Mental Health services by a greater proportion than their overall increase in budget allocation each year.

Based on the above expectations, NHSE sets an annual MHIS uplift target for each Integrated Care Board which is used to calculate the total expenditure to be achieved. This target is calculated using the prior year's spend and applies a percentage uplift. In 2024/25 NHS Devon had a 7.09% MHIS uplift target to achieve.

Per the below table, the 2024/25 annual spend on Mental Health services totalled £300.6m) equating to a MHIS uplift of 7.09% (£20.7m) which is in line with the MHIS target.

Financial Years	2023/24	2024/25 (Unaudited)
Mental Health Spend	£279.9m	£300.6m
NHS Devon Programme Allocation	£2,547.4m	£2,791.3m
Mental Health Spend as a proportion of NHS Devon's Programme Allocation	11.0%	10.08%

The total spend on Mental Health services in 2024/25 equated to an 10.08% proportion of the overall NHS Devon programme allocation. In comparison to the prior year this proportion has remained the same.

The overall NHS Devon programme allocation has increased by 9.6%

The majority of Mental Health Investments in 2024/25 were placed in core Mental Health provider contracts for adults and children and young peoples' services aligning with the priorities of the NHS Long Term Plan. In addition, expenditure was incurred with voluntary sector organisations, Individual Patient Placements and Continuing Healthcare.

Regionally, NHS Devon is a participant in the Southwest Mental Health Programme Board led by NHS England Southwest. In 2024/25, this programme continued to evolve supporting the development of peer leadership groups and developments of regional communities of practice in challenging areas such as S117 aftercare and operational and planning developments.

The Urgent Care system for mental health services remains an area of focus in Devon. High occupancy of mental health beds, in a low-bedded mental health system, is a feature of current provision. Devon providers continue to work closely with NHS Devon to find solutions to one of our most significant challenges. The new financial year will see a continued focus and system

energy on actions to improve flow, understanding the demand for mental health bedded care and reduce the waits for admission.

2024/25 saw the implementation of a Mental Health Vehicle (MHV). The premise of the MHV is to avoid inappropriate attendance at the emergency department by people who are experiencing Mental health crisis, so that they can access the support they need at an earlier point.

A review of the Crisis Café provision was undertaken in 2024/25, which included robust engagement with service users, resulting in a redesign of the offer and a procurement is currently underway for 2025/26.

A core responsibility and accountability of NHS Devon in 2024/25 was continued progress against the Mental Health Long Term Plan (LTP) and the Operating Plan priorities in the NHS. During 2024/25 the LTP targets aligned to Perinatal Access, reliable recovery and improvement in Talking Therapies were achieved. There has been a steady increase in those who experience serious mental illness receiving annual health checks, as well as steady growth in dementia diagnosis rates.

As a system, One Devon continues to achieve national standards aligned to talking therapies and providers have continued to work to improve access so that those who would benefit from Talking Therapies can be directed to the provision. The decision to reduce some counselling provision has enabled the provision to be available to those whose needs cannot be appropriately supported by talking therapies.

Collaborative work continues across Devon with children and young people and their families, communities, providers and local authorities, including partners in social care, public health and education to deliver our vision to improve emotional wellbeing and mental health so that more children and young people can live happier and healthier lives with mental health problems prevented, recovered from and/or better managed.

Children and young people's emotional wellbeing and mental health is a key priority, nationally rates of probable mental disorders doubled between 2017 and 2023, and following COVID, it is widely identified that the average acuity of need had increased. Building access to help which meets emotional wellbeing and mental health needs earlier in their development has been a focus for NHS Devon in 2024/25, over the course of the year:

- three additional Mental Health Support Teams in schools were mobilised expanding our school-based support offer to a further 22,500 children and young people in Devon
- a procurement was undertaken to expand, develop and ensure sustainability of a Children and Young People's Emotional Wellbeing and Mental Health Service which will offer advice, guidance and help to children and young people across Devon both digitally and face to face in communities. This service will be mobilised in 2025/26 by the successful bidder, Young Devon, working in partnership with Kooth and local voluntary, community and social enterprise (VCSE) partners.

The Community Mental Health Framework (CMHF) set out how the vision for a new place-based community mental health model could be realised, and how community mental health services were to be modernised to shift to whole person, whole population health approaches.

The first post implementation review informs the system of the following:

- 2024 data shows 13,725 people in Devon Partnership NHS Trust (DPT) and 3,415 people in Livewell South West (LSW) (115 recorded by Mind/DMHA) totalling 17,125 people have accessed transformed community services against a target of 8,700. Total access figures are reducing slightly from a peak in December 2023, but this is not a significant variation.

- Across NHS Devon there is a target of 5,979 people with serious mental illness (SMI) receiving a full annual physical health check. March 2025 data shows NHS Devon is currently above target with 6,305 checks completed.

- March 2025 data showed that 950 people (100 in LSW and 850 in DPT) have accessed Individual Placement and Support (IPS) services, which is above the Devon target of 881.

Over the past year, recovery practitioners have supported 906 people with 644 new entrants – on average this means supporting 410 people per month.

There has been positive feedback received on the role of recovery practitioners with people feeling that they were “listened to and heard” for the first time and that staff have been “understanding and supportive and able to deal with complexities”.

Mental Health, Learning Disability, and Neurodiversity (MHLDN) Collaborative

In 2024/25, the MHLDN Collaborative (a partnership of mental health care providers across Devon, Plymouth and Torbay) embraced a strategic refocus to better meet population needs and drive impactful transformation.

This new direction reflects the Collaborative's commitment to delivering innovative solutions and improving health outcomes across the region.

This approach represents a move away from a strategic commissioning delivery model towards a more focused effort on transforming how care is delivered. By prioritising these three core programmes, the MHLDN Collaborative has sought to ensure a more integrated and effective system that meets the needs of individuals and families.

The MHLDN Collaborative’s focus will be aimed at the following areas:

1. Dementia care transformation: Creating coordinated care pathways to improve the quality of dementia care and reduce avoidable hospital admissions, ensuring a more supportive and compassionate experience for individuals and their families.
2. 24/7 community mental health support: Expanding round-the-clock mental health services to provide timely support, reduce emergency department visits, and offer continuous care for those in crisis.
3. Closing the treatment gap for complex mental health needs: Addressing unmet needs among individuals with complex mental health conditions, ensuring access to specialised care and better long-term outcomes.

Safeguarding

Children and Young People

NHS Devon has a statutory duty under Section 11 of the Children Act 2004 to ensure that in discharging its functions as a commissioner of services, due regard is given to the need to safeguard and promote the welfare of children and young people.

The NHS Devon safeguarding team further delivers the statutory functions as directed within the Care Act 2014; the Health of Children in Care 2015; the Domestic Abuse Act 2012; the Police, Crime, Sentencing and Courts Act 2022; the Counter Terrorism Act 2015; the Counter Terrorism and Border Security Act 2019 and the Mental Capacity Act 2005.

Consideration is also given to other statutory legislation linked to safeguarding which includes child sexual exploitation, female genital mutilation and modern slavery. NHS Devon works to the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework 2024. Safeguarding is a high priority for the organisation.

NHS Devon is committed to creating the culture, capabilities and partnerships required to enable the improvement needed to deliver the statutory requirements of NHS Devon's Joint Forward Plan:

- Addressing the particular needs of children and young people
- Addressing the particular needs of victims of abuse

This will ensure that safeguarding and promoting the welfare of children and young people remains core business and everyone's responsibility.

The NHSE Safeguarding Accountability and Assurance Framework states that designated professionals "must be consulted and able to influence at all points in the commissioning cycle from procurement to quality assurance". This ensures that all services commissioned meet the statutory requirement to safeguard and promote the welfare of children, looked after children and adults requiring health services in Devon.

NHS Devon has a quarterly Safeguarding Steering Group, which provides scrutiny and challenge in relation to compliance with all aspects of safeguarding duties and responsibilities. Assurance to the NHS Devon Board is provided through regular safeguarding reports to the Quality and Patient Experience Committee. The Safeguarding Steering Group is chaired by the Director of Nursing and Quality.

System safeguarding issues and concerns are raised at the One Devon System Quality Group. This enables One Devon members to be sighted on safeguarding issues, learning from statutory reviews, and initiatives being undertaken by the safeguarding partnerships to improve the safety and wellbeing of children and adults at risk of abuse.

NHS Devon has secured the expertise of designated professionals for safeguarding children, adults and children in care and care leavers, in addition to a Trauma and Serious Violence Lead, and a Mental Capacity Act lead. Furthermore, individual designated professionals assume lead roles around Prevent and Exploitation. There are Designated Doctors for Children in Care and a Designated Doctor for Safeguarding Children in post. There is named GP and safeguarding nurse capacity to support NHS Devon in its role as delegated commissioner for primary care medical services, pharmacy, optometry, and dentistry.

The National Safeguarding Steering Group has recently updated a suite of protocols that outline Integrated Care Board responsibilities in relation to:

- Child Protection – Information System
- Female Genital Mutilation
- Child Death Review Process
- Domestic Abuse and Sexual Violence
- Modern Slavery and Human Trafficking
- Domestic Homicide Reviews

NHS Devon has undertaken a mapping exercise and will develop action plans related to the above protocols.

Safeguarding training compliance of NHS Devon staff is monitored by the Safeguarding Steering Group to ensure that staff maintain the safeguarding skills and competencies required to undertake their roles. Staff also receive updates of learning from local and national statutory

reviews that impact on the commissioning and quality of services. The Designated Nurses deliver bespoke training to NHS Devon staff to enhance their safeguarding skills and notify them of relevant external training opportunities.

The Designated Nurses work collaboratively with commissioning colleagues through attendance at, and contribution to, a range of commissioning meetings including Women and Children, Children and Young People, and Mental Health Commissioning meetings. This ensures the voice of children and young people who experience abuse and neglect is heard and influences commissioning decisions. There is a co-production approach with the local authorities to ensure children's voices are heard and influence service design and delivery with some good examples such as the Plymouth Young Safeguarders. The Patient Experience team are developing a child focussed pathway that will enable children and young people to access the NHS Devon Patient Experience and Complaints process.

NHS Devon, as one of the three statutory safeguarding partners, works with local authority and police partners to safeguard and promote the welfare of children across the three safeguarding children's partnerships within the NHS Devon footprint.

The Chief Executive is the Lead Safeguarding Partner, and the Chief Nursing Officer, the Delegated Safeguarding Partner as outlined in Working Together to Safeguard Children 2023.

Each safeguarding children partnership executive meeting is attended by the Chief Nursing Officer and the Deputy Director of Safeguarding and Patient Safety. Designated Nurses for Safeguarding Children further support the local arrangements through attendance at NHS Devon Board meetings, and attendance at and chairing of relevant subgroups.

They play a key role in the identification of learning through Rapid Reviews and Child Safeguarding Practice Reviews, the oversight of action plans and the dissemination of learning across the health system. Themes from child safeguarding practice reviews, rapid reviews and child death overview panel have included safe sleeping, neglect, adolescent mental health and suicide, and non-accidental injury in babies. Learning briefs following each review are shared widely with staff and can be found on the One Devon Partnership websites.

NHS Devon and NHS Cornwall and the Isles of Scilly Integrated Care Boards have worked together to roll out ICON. ICON is a programme was developed with the purpose of helping prevent abusive head trauma by offering support to parents through a series of interventions, aiming to help them cope with a crying baby. It is hoped that the programme will reduce the number of injuries inflicted on babies. The designated nurses for safeguarding children work collaboratively with NHS Cornwall and the Isles of Scilly, facilitating an ICON Steering Group which monitors the rollout of the ICON programme, training and shares good practice.

Throughout 2024/25 NHS Devon has provided increased levels of leadership at both executive and chief executive level, particularly with regard to local safeguarding partnership arrangements, as stated in *Working Together to Safeguard Children* 2023.

Details of the local safeguarding children partnership arrangements are published on the partnership websites as below:

- Torbay Safeguarding Children Partnership
- Plymouth Safeguarding Children Partnership
- Devon Safeguarding Children Partnership

Each partnership publishes an annual report, which details how the NHS Devon executive safeguarding lead and designated professionals have supported progression of the safeguarding arrangements and identified priorities. They can be found here:

- Torbay – annual report
- Plymouth – annual report
- Devon – annual report

There is regular Designated Nurse contribution to the Child Death Overview Panel (CDOP) meetings, and a process has been embedded that supports sharing of themes and recommendations between CDOP and the safeguarding children's partnerships. The Designated Nurses for Safeguarding Children attend the CDOP Steering Group to enable triangulation of learning, impact upon practice and oversight of the progress against system actions.

Assurance of provider safeguarding practices is gained through Designated Nurse attendance at provider organisations' internal safeguarding committees. This enables robust monitoring of action plans and recommendations for health providers, in addition to the quality assurance of safeguarding processes through contractual arrangements. Any concerns are escalated to the NHS Devon Quality and Patient Experience Committee.

Provider Named Nurses receive regular safeguarding supervision from the designated team, and peer supervision is facilitated through the regular Safeguarding Leads meetings. These meetings also enable the sharing of learning, issues, legislative changes and best practice.

Significant work has previously been undertaken by the designated professionals to support the health and safeguarding arrangements for asylum seekers and refugees across the NHS Devon footprint. Work with commissioners and the local authority will continue where safeguarding concerns are identified.

NHS Devon launched its commissioned primary care Interpersonal Trauma Response Service (ITRS) in 2023. This service is providing training to General Practice to enable them to recognise trauma from domestic abuse and sexual violence and then to refer to a specialist attached to the practice who can work with the individual to increase safety and reduce trauma symptoms. The service is open for children affected by domestic abuse and has received 181 referrals for children since it launched.

The NHS Devon Children in Care and Care Leavers Team (CIC) supports NHS Devon to meet its statutory functions to promote the health of the care experienced population and provide expertise and strategic leadership across the Devon integrated care system. The designated professionals are active members of the local Corporate Parenting Boards and subgroups. The CIC team attend both regional and national meetings, and one of the designated nurses is a member of the Coram BAAF Health Advisory Committee. NHS Devon has a CIC policy and staff complete level one and two CIC training, as per the Intercollegiate document.

The designated professionals work collaboratively with all three local authorities within Devon and report to their respective Corporate Parenting Boards. The designated nurses have established a multidisciplinary Rapid Improvement Task and Finish Group to improve performance and health outcomes for CIC within each of the three local authorities.

The team provide expertise to strategic planning processes including the Children's Transformation Plan, Core20Plus5, the Joint Forward Plan and the SEND agenda to address inequalities and ensure that commissioned services incorporate the voice of our care-experienced population.

NHS Devon works with local providers and NHSE to ensure accurate data is shared for the NHS Safeguarding Integrated Data Dashboard (SIDD). There is work in progress to ensure robust reporting, monitoring and analysis of performance data and health outcomes for our CIC and to develop a local CIC dashboard and contribute to the NHS Devon Children and Young People Dashboard.

There is also joint work to address mental health needs through working with the mental health commissioning team, providers, local authorities and the mental health collaborative.

The NHS Devon designated professionals for CIC and Care Leavers transferred from the Safeguarding team into the Women and Children's team in Autumn 2024, as part of the transformation restructure and their focus on improvement.

Adults

The NHS Devon safeguarding adult team delivers the statutory functions by providing expertise and strategic leadership across the integrated care system and the two Safeguarding Adult Boards in Devon. They take an active strategic leadership role, supporting and engaging others; and implementing local and national learning from Safeguarding Adult Reviews (SAR) and domestic homicide reviews to improve the safety and welfare of adults in Devon.

The safeguarding adult team are continuing to strengthen links across NHS Devon, by working closely with the commissioning and patient safety team to meet recommendations arising from both published and unpublished SARs and in relation to safeguarding enquiries.

The Counter Terrorism Act (2015) places a statutory duty on the NHS to have due regard to the need to prevent people from being drawn into terrorism. The team are active participants in the Devon & Cornwall CONTEST Board and Prevent Partnership across Devon.

The NHS Devon safeguarding team have supported the introduction of the national police led initiative Right Care, Right Person. Closer working between Devon and Cornwall Police, mental health trusts and the local emergency department teams, will reduce inappropriate police involvement in care and support better access to mental health specialists.

Primary care

NHS Devon primary care safeguarding team support the primary care workforce across the One Devon footprint to safeguard adults and children. The team works closely with primary care safeguarding leads in practice to ensure there are robust safeguarding processes in place. A safeguarding assurance tool is provided to all practices for their self-assessment. This provides NHS Devon with assurance and for the NHS Devon team to support areas for practice development.

The team work collaboratively with NHS Devon primary care commissioning colleagues around complex cases including the Special Allocation System (SAS).

The team deliver quarterly safeguarding forums and bitesize sessions to support the training requirements and learning needs of practice safeguarding leads. These meetings provide a speaker on a safeguarding topic, an opportunity for peer supervision, anonymised case discussion and safeguarding updates.

The team work alongside the designate professionals to support the adults, children’s and community safety partnership work across Devon. They support GPs to contribute to statutory reviews and support learning from reviews being embedded into practice.

Environmental matters

NHS Devon discharges its general duties by hosting a centralised sustainability function and by complying with NHS England mandatory requirements to produce and submit Green Plan documents and to undertake frequent sustainability data submissions.

ICB has undertaken NHSE mandatory requirements and produced green plan documents for submission in addition to quarterly submissions to the NHSE regional team. The annual and refresh documents are approved by the ICB board. The Board's oversight at the ICB includes approval of the ICS green plan which encompasses all provider sustainability activity. The ICB manages this through arrangements with UHP to host the system sustainability management group. Any key approvals or activity by the providers which requires ICB sign off is undertaken by the ICB Director of Estates, or where outside of delegation progressed to either its Finance and Performance Committee or Executive Board accordingly.

The Department of Health and Social Care General Accounting Manual has adopted a phased approach to incorporating the recommended Taskforce on Climate-related Financial Disclosures (TCFD), as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally, by NHS England. However, NHS bodies in Devon are voluntary committing to publish their scope 1,2 and 3 emissions within their green plan reports which shall be publicly available.

TCFD recommended disclosures, as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year.

For 2024/25, the phased approach incorporates the disclosure requirements of the following pillars: Governance, Risk management, and Metrics and targets. The ICB's direct carbon footprint activity is minimal, however its wider emissions impact extends to the commissioning of provider services of which amongst this activity, has a significant carbon footprint. It is the management's role to coordinate and manage the ICS green plan work that is due to be submitted and published during 2025. Under the current structure of the ICB, the management has a role in tracking, monitoring and to be aware whilst influencing the providers energy and sustainability agenda's and supporting with initiatives where possible. The ICB's own scope 1 and 2 emissions are however limited to the running of its leased HQ and staff travel, of which both activities are low impact due to the energy efficiency rating of the HQ offices, all salary sacrifice vehicles are either fully electric or hybrid, and staff travel has significantly decreased due to the consolidation of its offices to one single HQ and a hybrid working from home position.

Governance

The ICB informs the board of climate change issues through its sustainability reporting, of which to date has been an annual report and in July 2025 the board will be asked to approve the submission of the ICS Green Plan to NHSE. Performance of the ICS organisations shall be reflected within the green plan document due for submission in July 2025 which articulates its plans, achievements and new activities. In regard to the ICB specifically, the organisation has consolidated its office estate and the profile of staff travel has now significantly reduced, the ICB is using 2024/25 as the new baseline to now monitor its performance. However, its emission reduction from prior to 2024/5 is significant given the ICB used to operate from four substantial offices and staff travel was much greater. The board shall be able to monitor progress through the annual ICB update reports, in addition the NHS SW Greener dashboard is available to access which contains data from the ICB's quarterly submissions.

The ICB has one member of staff who is the designated lead for sustainability as a part of their portfolio, and reports to the ICS Director of Estates who has overall responsibility for system infrastructure. All activity undertaken within this portfolio does consider climate change impact as a part of all their work as a matter of course, and carbon reduction is naturally undertaken within

programmes such as estates consolidation or investment into renewing assets. The ICB in turn relies on an informal sustainability group chaired by UHP to help drive forward plans on behalf of the system. Each respective Trust board has a process in place for climate-related activities to be reported accordingly, with the process via the system sustainability group to report and where necessary seek approval via the ICB. Where out of delegation, matters shall be escalated to the ICB board accordingly.

Risk Management

The ICB has a risk management process where risks such as climate change related activity can be raised as appropriate. Risks are currently managed through the system sustainability group which also extends to wider partner organisations in Cornwall as a part of the collaboration. Where risks need to be managed by the respective provider, they shall add to their risk register and be managed by their board accordingly. Where the matter sites outside of the provider's control, the ICB Director of Estates shall raise it within the ICB risk management process and if necessary, raise it at the ICB board, however no such risk has reached this tier of escalation to date.

Our providers identify their risks through their respective energy and sustainability management team, they decide how to manage and control the risk internally, typically via their EFM departments. Where its outside of its delegated cost and control it shall raise the risk on both the finance and corporate risk registers. Risks outside of 12 / 25 shall be considered by their respective risk management committees and if needed board accordingly. Any high risks, or risks which require system support to manage are discussed and managed as best as possible through the system sustainability group and where required, on to the ICB corporate risk register to be considered by the ICB board accordingly. A standard risk matrix is typically used, however judgements over likelihood, impacts and resolutions are used based on individual staff experience, group knowledge on geographical factors and where required, the NHSE SW team has a designated individual that can discuss the risks and mitigations with the system and this role typically attends the system sustainability group. External risk frameworks are not routinely used, however they have been specifically in Devon due to coastal factors and the providers are aware of what resources are available to them in order to assist in managing such risks.

Metrics and Targets

One Devon has continued to actively support the co-ordination of carbon reduction across the system through the actions to reach net-zero outlined in the Devon Greener NHS plans and the Devon Carbon Plan.

One Devon has a Green Plan which outlines the initiatives, projects and activities that partners will deliver towards the collective focus in the Southwest to reach our target of Net Zero. This plan ensures that all Devon NHS organisations have increased awareness, knowledge of, and understanding of our objectives and responsibilities, sharing our impact in reducing carbon emissions produced by our activity. New statutory green plan guidance has been published (4th February 2025) to support NHS organisations in developing robust plans to improve health outcomes, reduce costs, minimise waste and continuing the journey to achieving net zero in the NHS. The NHS Devon green plan will need to be approved by board and published in an accessible location on the organisation’s website and shared with NHS England by 31 July 2025.

Key system highlights for 2024/25, broken down by each NHS organisation for the year are as follows:

- Carbon emissions associated with the use of volatile anaesthetic gasses decreased by 73% since 2019/20 due to the reduced usage of desflurane and isoflurane, which are less environmentally friendly to comparable alternatives

- 79% of fleet vehicles of acute Trusts are low emission vehicles
- Approximately 59% of the acute hospital estate has had LED lighting installed ensuring the most efficient type of lighting reducing energy consumption

Royal Devon University Healthcare NHS Foundation Trust (Royal Devon)

- NHS Energy Efficiency Fund (NEEF) - £500k funding received to improve lighting, Building Management Systems and metering
- Secured a £6m grant from UKRI for a research hub in collaboration with the Health Economics and Health Policy team at the University of Exeter
- Significantly progressed appraisals for decarbonisation and efficiency studies on several buildings
- Installed 80kW solar PV at Royal Devon Exeter
- Participated in a specialist grant funding bid for solar PV and utility scale battery electricity storage
- Enhanced the ecology programme and developed parcels of wildflower areas
- Trust Urology Team, supported by NHS England GIRFT and University of Exeter researchers, developed a model to assess the carbon footprint of bladder surgery and published strategies for reducing pathway carbon costs
- Facilitating a Greener pilot to encourage/improve Sustainability at work and home as a part of our workforce development and staff benefits:
    - Green Champions Net Zero
    - Carbon Literacy Training
    - Sustainability section in new job descriptions
    - Sustainability objective in appraisals promoted
    - Devon Climate Emergency Tactical Group
- One Northern Devon Active Travel Group
    - An enhancement in clinical transformation sustainability:
    - Progression of virtual wards
    - PSA home finger prick test pilot
    - Diabetes and Urology projects
    - Green Wards, Green Theatres, My Green Lab (Pathology)
    - LEAF (Genomics)
    - NOAH (Neonatal antibiotics).
- Sustainability in medicines:
    - Desflurane removed from Trust
    - Nitrous Oxide manifolds decommissioned apart from maternity
    - Promoting dry powered inhalers instead of metered-dose inhaler (MDI)
    - Ward waste reduction of medication project
- Travel and transport:
    - 6 fleet electric vehicles and infrastructure installed
    - 17 charging points for fleet and 4 for clinicians installed
    - 10 e-bikes for staff to trial, e-bike charging installed
    - Introduced five more foldable electric bikes for staff to ‘try before you buy’ and encourage sustainable travel practices
    - Salary sacrifice promoted on fully electric vehicles.
- Procurement
    - Introduced requirements for suppliers to provide information about their social value impact, including environmental credentials, in public procurement tenders

Devon Partnership NHS Trust (DPT)

- Over £3million has been awarded from Great British Energy for the installation of a ground solar array at Langdon in Dawlish along with roof top arrays at six other sites.

- Salix announced a £2.1 million award to connect Wonford House in the centre of Exeter to the Exeter Energy Network (EEN).
- Salaried sacrifice EV/ULEVS offered to staff of which 80% of cars ordered are fully EV to date
- Green prescribing at Langdon Hospital expanding with trees planted donated by NHS forest and charitable trust donation to install habitat homes crafted at New Leaf in Exminster
- Utilising patients own medication upon admission to reduce waste. Supplying new medication in papers bags
- Improved monitoring of travel and transport to inform annual data collection
- To date 6% reduction in electric consumption trust wide. Energy campaign running trustwide. Energy campaign running from Jan 2024
- Tenders awarded with the 10% sustainability scoring
- Local ingredients procured where possible and prepared on site at Langdon Hospital
- Working with partnership organisations across Devon.

University Hospitals Plymouth NHS Trust (UHP)

- Awarded £1.2million towards energy efficiency projects and renewable energy from the Department for Energy Security and Net Zero
- Awarded £637K for LED lighting and solar projects from the NHS National Energy Efficiency fund and £24K from the Heat Network Efficiency Scheme
- Further roll out of Carbon Literacy Training
- Development of Sustainability QI framework
- Green ED received RCEM Bronze accreditation
- Launch of Green Theatres programme
- Sustainability in medicines:
    - Nitrous oxide project underway to reduce consumption switch to cannisters in some areas
    - Reduced spending on drugs – Pharmacy projects / Green ED
- 91% of Trust Fleet are ZEV and ULEV
- NEEF funding received for LED lighting and Solar PV
- Phase 1 funding awarded for new Emergency Department
- Incinerator modifications now functional and able to begin heating the Trust's water for circulation around the site
- Installation of metering at building level audit complete.
- Single use items reviewed and swapped to reusable such as kidney dishes, jugs, gallipots, bowls and patient belonging bags in theatres
- Food waste working group established
- Catering Transformation Project underway
- Climate change has been embedded in the risk register.

Torbay and South Devon NHS Foundation Trust (TSD)

- The Trust has a programme to reduce reliance on Nitrous Oxide by changing to mobile cylinders with regulators which will enable decommissioning of our piped manifold. Estimate that this change will save around 244 tonnes of CO2 a year and reduce harmful gas releases by up to a factor of 300 times
- Desflurane anaesthetics gas has been fully removed from use at the Trust.
- The Trust continues to promote its biodiversity programme and has driven initiatives to build on its hedgerow and tree planting landscaping.

NHS Devon Integrated Care Board

- NHS Devon has reduced its offices from five to two, and is progressing its final disposal to fully consolidate to one location which has had a significant impact on the reduction of emissions from its estate activities
- The new NHS Devon headquarters are located within a building which has high sustainability credentials, including on-site EV chargers, a PV roof scheme and low carbon outputs
- A staff hybrid working arrangement is agreed to enable staff to utilise some of their working time at home which helps reduce emissions produced from staff travel
- All staff can use a salary sacrifice scheme to benefit from a fully electric vehicle of which can be charged at the NHS Devon headquarters
- To promote a reduction in paper, NHS Devon has reduced its printing hub to one location within the building which has naturally discouraged paper use
- The estates team has driven an initiative with the landlord to promote multiple waste streams to ensure effective segregation and continues to work on further such initiatives

One Devon acknowledges the ongoing necessity to pinpoint and address the principal risks posed by climate change. In response, we are formulating strategies to both adapt to and lessen these risks.

We recognise that tackling the climate and ecological crises presents a chance to build a society that is more equitable, healthier, resilient, and prosperous. Promoting increased physical activity through walking and cycling, enhancing air quality via vehicle electrification, insulating buildings, and advocating for sustainable and balanced diets are all steps that will not only boost public health but also alleviate strain on the NHS and social care systems.

Metrics used within our reports and submissions are in line with NHSE requirements of assessing emission scopes 1-3 against baseline targets, typically using tonnes of carbon emissions and specifics on water reduction (m3) and kg of anaesthetic gases. Each NHS organisation uses different baselines for the purposes of internal reporting and to monitor against specific schemes of investments, however all use the standard 1990 base line with targets of 80% reduction by 2028-2032 and 100% Net Zero by 2040. Each respective Trust green plan report provides significant detail of the methods used for employing the appropriate metrics and how they have been applied. The entities within the system do not employ internal carbon pricing but trade-offs are used in investment projects where fossil fuels are relied upon to use the least impactful fuel, for example districting heating schemes or CHP.

As part of our green plan delivery, we track key metrics including greenhouse gas emissions, energy consumption and waste management and we routinely use ERIC to manage the monitoring process in relation to incidents of wards overheating, weather related fire incidents, flooding and impacts on the patient whilst in hospital care. We continue to improve our ability to measure emissions at system and organisational levels. However, as emissions data is calculated centrally by NHS England, we focus locally on delivering carbon reduction initiatives and improving reporting quality. The areas that we routinely discuss and monitor outside of specific weather-related incidents are as follows:

- Energy consumption, fleet data and waste management returns across our partner organisations.

- Implementation of Heat Decarbonisation Plans across our partner NHS Trusts.

- Monitoring carbon literacy uptake and sustainability training across staff groups.

- Implementation of measurable interventions, such as; inhaler waste reduction and patient education; and reduction in single-use plastics and digitisation of services.

We also benchmark our system's overall performance against NHS England's Greener NHS metrics. We are committed to improving the quality and availability of emissions data, including through the development of a System Carbon Footprint Dashboard currently provided through SW NHSE Green Team, this shall feature in our 2025-30 ICS Green Plan.

Improving quality

NHS Devon functions

In accordance with the "Health and Care Act 2022: Duty as to improvement in quality of services (14Z34)", NHS Devon continues to exercise its functions, including securing continuous improvement in the quality of services and patient outcomes.

NHS Devon is fully aligned to the principles and directions of the National Quality Board in its commitment to quality and NHSE's Quality Functions: Responsibilities of providers, Integrated Care Boards and NHS England.

In doing so, NHS Devon continues to undertake statutory and non-statutory functions. Quality Systems and Assurance processes that enable this include:

- Statutory safeguarding, quality and equality assurance
- Ongoing implementation of Better Births through the Local Maternity and Neonatal System including the recommendations from the Ockenden Report
- Continued provision of continuing healthcare services for those with ongoing needs, ensuring that people can access the care that they need in a timely way
- Monitoring of patient safety serious incidents through the implementation of the 'National Patient Safety Strategy' – patient safety incident response framework and plan
- Learning from deaths
- Medical examiners
- Infection prevention and control (IPC); antimicrobial resistance (AMR), healthcare associated infections (HCAI)
- Independent investigations (including mental health homicides)
- Regulation 28 reports
- Judicial reviews
- Controlled drugs assurance and oversight
- Complaints
- Whistleblowing and Freedom to Speak Up
- Review of provider quality accounts

In line with 14Z37 of the National Health Service Act 2006, NHS Devon continues to make strides to enable patients to make choices with respect to aspects of health services provided to them. Examples include choice of provider at referral stage and also options available during waiting; the Netcall system is now being fully embedded as well as additional validation administrators being employed across providers.

This improves not only the quality of the waiting lists but also provides a touchpoint for patients waiting to discuss if they still need to have their procedure. Another example is Patient Initiated Follow up (PIFU)in Devon, focused work, within the identified priority specialties, is on-going to maximise the numbers of patients discharged to a PIFU pathway.

Patients are now able to choose and access high quality diagnostic services closer to home in Devon. As part of national diagnostics improvement programme, Devon is developing and implementing 3 community diagnostic centres (CDCs). Exeter CDC (opened 2021) is a centre of excellence, Torbay CDC (opened Sept 2024) in partnership with InHealth and Plymouth CDC is set to open in March 2026. By 2026 CDCs in Devon aim to provide over 100,000 additional tests in the community in state of the art centres with new and innovative equipment.

Quality Governance

NHS Devon's Quality and Patient Experience Committee and the One Devon Integrated Care System Quality Group each work to the National Quality Board (NQB) definition of quality. This is a shared single view of quality, that there is "high-quality, personalised and equitable care for all, now and into the future". Systems that support the delivery of care are expected to be:

- Safe – care delivered in a way that minimises things going wrong and maximises things going right; continuously reduces risk, empowers, supports and enables people to make safe choices and protects people from harm, neglect, abuse and breaches of their human rights; and ensures improvements are made when problems occur
- Effective – care informed by consistent and up to date high quality training, guidelines and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing the wider determinants of health; delivered in a way that enables continuous quality improvements based on research, evidence, benchmarking and clinical audit
- A positive experience – care which is responsive and personalised, shaped by what matters to people, their preferences and strengths; empowers people to make informed decisions and design their own care; coordinated; inclusive and equitable
- Caring – care delivered with compassion, dignity and mutual respect
- Well-led – care driven by collective and compassionate leadership, which champions a shared vision, values and learning; delivered by accountable organisations and systems with proportionate governance; driven by continual promotion of a just and inclusive culture, allowing organisations to learn rather than blame
- Sustainably-resourced – care focused on delivering optimum outcomes within financial envelopes, reduces impact on public health and the environment
- Quality care is also equitable – everybody should have equitable access to high-quality care and outcomes, and those working in systems must be committed to understanding and reducing variation and inequalities

The National Quality Board guidance on quality risk response and escalation in Integrated Care Systems, sets out how quality risks should be managed. The guidance is in place to ensure explicit agreement that quality concerns and risks are managed as close to the point of care as possible.

In addition, assurance is provided to the NHS Devon Board around the arrangements for discharging, and implications of, the NHS Devon responsibilities in respect of the themes under NHSE's Quality Functions: Responsibilities of providers, Integrated Care Boards and NHS England.

- **Strategic management of quality -** National Quality Board and NHS England guidance
- **Operational management of quality –** Independent Investigations (including Mental Health Homicides); Regulation 28 reports; Professional Standards; Controlled Drugs Accountable Officer Function; Whistleblowing and Freedom to Speak Up; Quality Accounts; Medicines Optimisation; Infection Prevention and Control and Antimicrobial Resistance

- **Patient safety -** Insight, involvement and improvement (including medical examiners, patient safety improvement priorities, Patient Safety Incident Response Framework (PSIRF), Learning from Patient Safety Events (LFPSE)
- **Experience** – Improving patient, service user and unpaid carer experience of care; insight and feedback
- **Effectiveness** – National Clinical Audits; NICE technologies appraisals and guidance
- **Safeguarding** – Safeguarding Assurance & Accountability Framework (SAAF), including Child Protection information System (CPIS) which includes all children on a protection plan (CPP) and looked after children (LAC); child death overview process (CDOP); Child Safeguarding Practice Reviews (CSPRs); Domestic Homicide Reviews (DHRs); Female Genital Mutilation (FGM); Prevent & Counter Terrorism and Modern Slavery & Human Trafficking; Serious Violence Duty.
- **Mental health, learning disabilities and autism**

NHS Devon's Quality and Patient Experience Committee

The Quality and Patient Experience Committee was established by NHS Devon to provide oversight of the overall delivery of the NHS Devon objectives to create opportunities for the benefit of local residents, to support health and wellbeing, to bring care closer to home and to improve and transform services. It provides the NHS Devon Board with assurance that the organisation is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022.

The Quality and Patient Experience Committee scrutinises the robustness of,gains and provides assurance to the NHS Devon Board that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high-quality care.

It continues to support a single framework of governance that enables NHS Devon and its Local Care Partnerships to collaboratively to drive improvement to quality, delivery, and outcomes against each of the dimensions of quality set out in the 'Shared Commitment to Quality' and enshrined in the Health and Care Act 2022.

In line with the "Health and Care Act 2022 (14Z49) 'duty to keep experience of members under review'", NHS Devon's nursing and quality directorate facilitates quality training, including safeguarding.

One Devon Integrated Care System Quality Group

The System's Quality Group (SQG) is required to meet the 'core' arrangements expected in each system as outlined in the NHS England ICS Design Framework and is aligned to the National Quality Board publications for Integrated Care Systems and NHS England's Quality Functions: Responsibilities of providers, Integrated Care Boards and NHS England.

The SQG provides a single framework of governance that enables and supports Local Care Partnerships collaboratively to drive improvement to quality, delivery and outcomes and provides clear line of sight on performance and risk at system level. To do this, it systematically brings together different parts of the health and care system in Devon to work cohesively as a system. Examples of work that has come through SQG include;

- The System's approach to equality and quality impact assessments (EQIAs) across Devon.

- The Systems response to national cascades, including 'Principles for providing safe and good quality care in temporary escalation spaces (PRN1560)' (NHSE September 24).
- Reducing harm in relation to urgent care, including ambulance delays.
- The plan to implement the guidance 'Principles for assessing and managing risks across integrated care systems' (NHSE December 24).
- An increased focus on Allied Health Professional (AHP) standards.

One Devon Integrated Care System's Morbidity and Mortality Group

The remit of the System Morbidity and Mortality Group is to facilitate the coordination of work of the key organisations to identify, analyse and explain changes and variation in population mortality in Devon and share best practice in improving mortality outcomes. It monitors the effectiveness of mortality review processes across health providers in Devon, by bringing together representations from provider organisations and those with specific area of interest to share best practice, with the ultimate outcome to reduce avoidable deaths.

The System Morbidity and Mortality Group is now increasing its focus on deprivation as described using the Index of Multiple Deprivation (IMD) that can be built up using geographic areas called Lower-layer Super Output Areas (LSOAs). The next step is for the group to include data at Primary Care Network (PCN) level and different causes of death.

Quality Metrics

During 2024/25, NHS Devon built on its role as one of four pilot sites for the testing of the National Quality Board Early Warning Score (QEWS). This work enabled Devon to feedback on the final iteration. QEWS can alert system leaders, NHSE and wider partners (e.g. regulators) when there are early warning signs, signals and insights relating to deteriorating care quality.

The development of a quality dashboard has commenced as a Quality Improvement (QI) project and incorporates QEWS, Model Health, Learning from Patient Safety Events (LfPSE) and other national data sources.

Equality Quality Impact Assessments (EQIAs)

One of the main ways NHS Devon complies with the Public Sector Equality Duty is by undertaking Equality Quality Impact Assessments (EQIAs). EQIAs help to demonstrate that the impact of policies, services and practices on the population and workforce have been considered, particularly those people with protected characteristics or those who experience health inequalities. They also have regard to services being appropriate, equitable and accessible for everyone.

NHS Devon's EQIA process and panel has been operating successfully for over eight years, pausing briefly during the COVID-19 pandemic. When NHS Devon introduces any new policy, service, strategy or makes changes to any existing service, it reviews the impact on patient safety, patient experiences, clinical effectiveness, staff, population, and those with protected characteristics.

Following a self-assessment gap analysis completed by NHS Devon and providers, a new policy, process and tool is in place for EQIA. Authors engage with specialist teams, such as patient safety, patient experience, Equality, Diversity and Inclusion (EDI) and communications to receive feedback and expertise prior to submitting the EQIA.

In line with the self-assessment findings, EQIA training has become mandatory for all NHS Devon staff to ensure that decisions are informed by a clear understanding of potential impacts on quality, equality and health inequalities.

EQIAs are completed for:

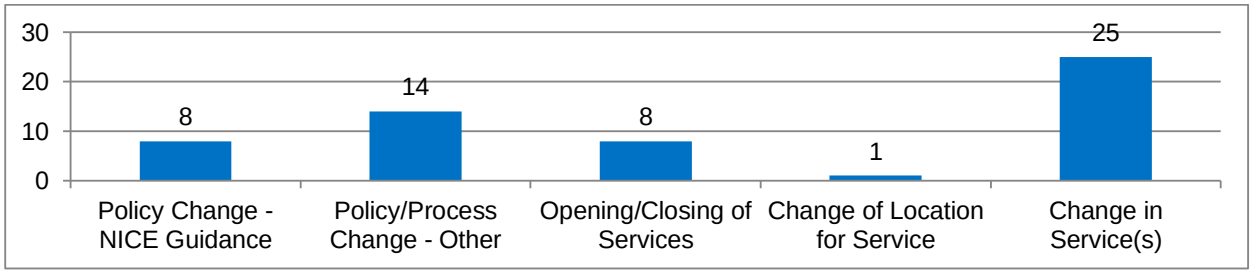
- Changes to services, functions or activities
- Newly commissioned or decommissioned services
- Commissioning reviews
- Financial decisions affecting staff, functions, or services
- Policies (including workplace)
- Strategies.

The EQIA provides a framework for undertaking impact assessments. This enables NHS Devon to show due regard to the Public Sector Equality Duty prior to any decisions being made by the NHS Devon Board or NHS Devon Executive that may impact on equality.

From 01/04/2024-31/03/2025 NHS Devon received 73 EQIAs for review, an increase from 40 in 2023/24.

Chart below illustrates all EQIAs received categorised by type.

Type of EQIA received (as recorded)



The Public Sector Equality Duty (PSED) | EHRC (equalityhumanrights.com)

Public sector equality duty - GOV.UK (www.gov.uk)

Patient Experience

In line with the Health and Care Act 2022 (14Z45), NHS Devon continually finds new, innovative ways to ensure individuals to whom the services are being provided (or may be provided) and that carers and representatives are involved. The focus remains on engagement with patients, family and carers through feedback and aims to place the experience of care at the centre of improvement and transformation programmes, which includes co-production with people with lived experience.

NHS Devon data from 1 April 2023 – 31 March 2024 show an overall increase in patient experience reporting. The number of formal complaints continue to increase year on year to 35 compared to 33 last year. We also managed 178 primary care formal complaints during this period, supported by the Primary Care Hub. The delegation to Integrated Care Boards of commissioning of pharmacy, optometry and dentistry services has led to an increase in the volume of contacts with the patient experience team. An NHSE regional hub for formal complaints of pharmacy, optometry and dentistry is in place to assist.

Every patient experience communication receives an immediate response which, in many cases, can resolve the issue with further information and signposting to services. Complex cases are often multi-agency and take longer to resolve. Matters relating to Continuing Healthcare remain the subject of many of our complaints. Learning from these complaints is used to improve processes in these services.

A patient experience network for professionals across the One Devon Integrated Care System is being developed. The aim is for learning from patient experience issues to be shared across providers.

A local system was replaced by the new national 'Learning from Patient Safety Events' reporting system, which is compulsory for all NHS providers. It enables providers to report directly to each other about concerns, identify risks to patient care and will enable greater scale learning. Direct contact between providers enables faster resolution of issues related to referral and discharges for patients.

Patient Safety

Incidents and the Patient Safety Incident Response Framework

NHS Devon continues to collaborate with its providers to promote shared learning and align with the principles of the Patient Safety Incident Response Framework (PSIRF). Providers are in the process of reviewing their PSIRF plans, which will include their new locally defined priorities for managing adverse patient safety events.

NHS Devon will maintain oversight and approval of all serious incident investigations from providers until the completion of all serious incidents.

NHS Devon has a PSIRF policy, which outlines how it will support providers, including when cross-learning responses from patient safety investigations are needed. The policy also details how NHS Devon will foster shared learning among providers, engage compassionately with those involved in incidents, and offer a proportionate learning response to such incidents.

The plan for involving patient safety partners within NHS Devon is currently under review to ensure that the patient's voice is effectively incorporated into the decision-making process of patient safety commissioning. The aim is to create a more inclusive and transparent approach, where the perspectives and experiences of patients are not only heard but actively influence decisions related to patient safety initiatives.

All our providers have adopted the Learn from Patient Safety Events (LfPSE), which replaces the National Reporting and Learning System. The Strategic Executive Information System (StEIS) remains in use for providers to report patient safety incident investigations (PSII) until their local risk management systems are updated to properly interface with LfPSE, which is likely to be summer 2025.

The Patient Safety Specialist and Patient Safety Team continue to have oversight on national patient safety alerts, ensuring that all relevant alerts are actioned by providers and closed within the required timescales. If alerts become overdue, NHS Devon monitors these in accordance with the providers' local action plans.

Infection, Prevention and Control

NHS Devon's Infection Prevention and Control (IPC) team provides oversight and support for mandated monitoring of healthcare associated infections (HCAIs) to the relevant committees. There has been an increase in certain infections in Devon over the last year (C. difficile, MSSA), which reflects national trends. We review the levels of infection in collaboration with our providers and are a stakeholder in regional monitoring meetings.

The IPC team takes part in the acute trusts' Infection Control Committees to fulfil the requirements of NHS Devon under section 3 (14Z34) of the Health and Care Act 2022.

The IPC team takes part in antimicrobial stewardship and resistance reduction through participation in an enhanced Peninsula Antimicrobial Management Group. This involves liaising closely with the medicines optimisation lead in connection with the Commissioning for Quality and Innovation (CQUIN) requirements.

The team participates at regional and national level in NHS England collaboratives around HCAI management as well as quality improvement projects such as urinary tract reduction initiatives.

The team lead acts as the influenza lead for NHS Devon, providing compliance with both 14Z34 and 14Z35 of the Health and Care Act 2022 (Health Inequalities). Areas of focus and development include improving services for tuberculosis, avian influenza, and community infection management.

Continuing Healthcare

Continuing Healthcare (CHC) is a key NHS Devon statutory function that contributes to safety, experience and effectiveness of care. CHC provides healthcare funding for ongoing packages of care, required because of disability, accident or illness. Eligibility is determined following an assessment that considers the nature, intensity, complexity and unpredictability of the individual's presentation.

This is a statutory function of NHS Devon and decision making cannot be delegated to system partners. The key performance details and targets are as below. Detail is also included against the overall activity of the team.

Key achievements include:

1. In quarter 3, impacted by capacity challenges, the Key Performance Indicator of 80% of assessments to be completed within 28-days was not met (achieved 64% against a national achievement of 73%) however the team have put in place an improvement programme and have made steady progress in improving this position in 24/25.

2. CHC assessment to conversion to full CHC funding remains at 15%. This is consistent with performance over the last five years

3. Positively, 0% of continuing healthcare assessments take place in an acute setting

4. NHS Devon has worked on improving patient experience in CHC. The majority of concerns and complaints relate to communication as the main concern. Letter templates to individuals and families have been revised, with clear outcomes and contact details for the CHC teams

5. The public facing website has been revised to make contact details and explanations clearer

6. Team training has been revised, to ensure that assessments are jargon free, and terms and processes clearly explained

7. All CHC policies have been rewritten, so detail is more clearly explained. These revised polices are uploaded onto the CHC functions website

8. The CHC team has supported development of, and is participating in, a national apprenticeship programme for CHC assessors, to enable the workforce to be remodelled and make better use of the clinical team's time

9. The CHC team have undertaken an assessment of workforce, using a national modelling tool. The team are working to implement this re-modelled service

10. A business case has been agreed for CHC digital transformation procurement approved, which will lead to improved efficiencies and productivity. The CHC team are working through the implementation of this procurement, which will be mobilised in 2025/26.

Metric	2024/25
Total CHC Eligible	970
Standard CHC Eligible (average over the 12m)	829
Fast Tracks (total over 12m)	141
Referral Conversion Standard	14%
*% of referrals completed in an acute hospital setting. (Standard 0%)	0%
*% of referrals concluded within 28 days (Standard is 80%)	64%

Effectiveness

Clinical effectiveness

NHS Devon has continued to ensure effectiveness through processes that include the monitoring of national clinical audits, providers' compliance with NICE health and care guidance, quality standards, technology appraisals and Getting it Right First Time (GIRFT) reports.

Transformation and Quality Improvement

Local transformation and improvement priorities have continued across the Integrated Care System, including maternity, vaccination, end of Life, mental health.

The NHS Devon Quality Improvement (QI) Hub formally launched in January 2025. With a renewed focus on QI, the team are progressing the workplan that includes:

- QI training & development through the Quality Service Improvement & Redesign (QSIR) training
- A QI intranet page
- QI resources
- A QI Community of Practice (CoP)

Further data on quality can be found at the following links:

- Data on specialty treatments
- Data on services
- Data on health & wellbeing

Engaging people and communities

NHS Devon has worked hard over the last year to implement a consistent approach to inclusive system-wide engagement, that enables effective, equitable and accessible opportunities for the whole population to have their voices heard.

By working in partnership across Devon, we have widened opportunities for engagement, so that those who experience health inequalities, or those who live in rural, coastal or remote locations have an equal chance of being heard and influencing decision-making.

This approach clearly demonstrates that NHS Devon has discharged its general duties per sections 14Z45 of the National health Service Act 2006 (as amended), through programmes like the Devon 10 Year Plan engagement.

Key milestones in 2024/25

- A new framework and reporting approach for holding NHS Devon to account to the voices of our people and communities
- Integrating Healthwatch and the VCSE Assembly into NHS Devon governance to enhance public accountability and consumer insight
- Establishing the One Devon Involvement Platform to enhance engagement and participation across the healthcare system
- Devon Engagement Partnership launched and helped create the approach to the Devon 10-year plan engagement programme.

People and Communities Framework

The NHS Devon People and Communities Framework is now published on the One Devon website. This details the approach NHS Devon will take in involving the People and Communities in Devon in our work and how we will meet our statutory duties under 14Z45 of the Health and Social Care Act 2022. The Framework was recently approved by NHS Devon Board and was described as “leading the rest of the country”.

The Devon 10 Year Plan engagement programme case study (Appendix 1 – Pages 10-11 of the Framework document) evidences the success of this approach that we will use as a blueprint for future system wide engagement programmes.

The NHS Devon People and Communities Framework was developed in collaboration with Healthwatch Devon, Plymouth and Torbay and the NHS Devon VCSE Assembly. This approach builds on guidance from NHS England. The framework sets out the intention that:

- Partners will work together to ensure whole system involvement through the established Devon Engagement Partnership
- Insights will be coordinated to ensure visibility of the population voice – and these will be made available by a single engagement platform hosted by NHS Devon
- The views and experiences of the population will influence decision-making through regular reporting to NHS Devon Board assurance structures
- NHS Devon Board will hold itself and the system to account on the involvement of people and communities.

The framework sets out an intent to share ambitions, to champion best practice, to build the voice of people into the governance of NHS Devon, putting the voice of the people and communities in Devon on the decision-making table.

In addition to supporting the delivery of the four key aims of an integrated care system, the framework will provide:

- support for compliance with statutory duties to involve people and communities
- an agreed approach for system partners to use in engagement, ensuring consistency from neighbourhoods to system level
- a focus on listening to our people and communities, and understanding what really matters to them, their experiences and ideas for improvement
- opportunities to develop solutions with people that shape a sustainable future for the NHS that meets people's needs and aspirations.

Devon Engagement Partnership

The Devon Engagement Partnership (DEP) brings together engagement partners from across the health and care system, with the intention of working to a shared set of ambitions and aligning the work engagement work to system and partner priorities.

To date, the DEP has discussed a series of shared ambitions for working together to involve people and communities in Devon. These are:

1. Engagement should be inclusive
2. Relationships should be co-ordinated to widen involvement opportunities to as many people as possible.
3. Provide support, advice and guidance to align engagement to the core aims of the integrated care system
4. Demonstrate how the voices of people and communities are being used
5. Enable continuous and meaningful engagement, with a focus on what really matters to all people and communities in Devon.

The DEP will report to the NHS Devon Population Health Improvement Committee (PHIC).

Online platform

NHS Devon has developed a new 'Get Involved' section on the One Devon website, to provide a single place for all health and care public engagement from across Devon. It provides a consistent and accessible place for NHS commissioners and/or system partners to access public engagement insights and also conduct their own engagement.

The aim is to provide a single point of access for all public engagement opportunities across the One Devon integrated care system, acting as a signpost for people and communities. This platform links to health and care local and national communication campaigns.

The platform is fully accessible as an online offer (noting that not all people are digitally enabled, and additional support will be put in place), supporting the delivery of inclusive engagement (including translation and screen readers) and reaching as far into our Core20PLUS5 communities as possible.

The platform hosts the new online insight library, which is accessible to all system partners as a starting point for involvement, but is also the place where outcomes of engagement are published, providing the public assurances that their voice has been heard.

VCSE and Healthwatch

As part of the new ways of working, as set out in People and Communities Framework, the work of our VCSE Assembly and Healthwatch Devon, Plymouth and Torbay will form a key part of our reporting into the revised governance and reporting approach. This moves more towards bringing insights and involvement into a single place, to where it can be heard by the leaders in the health and care system and have the most impact.

Reducing health inequalities

One of the four core aims of every Integrated Care Board is to tackle inequalities in outcomes, experience and access. NHS Devon continues to make good progress on this aim by using the Core20PLUS5 frameworks for adults and children to focus efforts and co-ordinate activities.

This section sets out key achievements in 2024/25, actions, ambitions and framework for future work in this area.

Delivery and governance structures

In November 2024 the formally established Population Health Improvement Committee (PHIC) met for the first time. The purpose of this Committee is to provide assurance that NHS Devon is fulfilling its role as a partner in the One Devon Integrated Care System to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Help the NHS support broader social and economic development

The Committee will work with partners across One Devon to identify opportunities to improve the health of the population and hold to account those with responsibility for making change. It will also regularly monitor relevant information to ensure progress is being made.

To support the work of the Population Health Improvement Committee the underpinning governance structure is being revised to ensure sufficient detailed oversight of the work being carried out across the system. The groups overseeing this work will be:

Population Health Strategy Group will focus on developing an enabling environment to support an increased emphasis on Population Health. This will include developing and strengthening our Population Health Management approach (using data to identify people who are most in need and the appropriate interventions to support them) and developing innovative new approaches to measuring and monitoring progress which are based on what is most important to people not services.

Prevention Steering Group will have oversight of the delivery of priority prevention plans for CVD, diabetes, respiratory and falls and frailty as well as providing support for prevention in other areas:

- Core20PLUS5 Steering Group will have oversight of the delivery of interventions specifically focused on reducing inequalities for people living in the 20% most deprived areas in the county as well as the groups that are particularly disadvantaged in Devon:
- Individuals, families and communities experiencing rural and coastal deprivation
- Individuals and families adversely affected by differential exposure to the wider determinants of health – for example, those with unstable housing or homeless people, vulnerable migrants and/or those experiencing domestic abuse
- People with severe mental illness and/or learning disability, and neurodiverse people

- Children in need

The group will also ensure that we have robust monitoring mechanisms in place for the 5 clinical areas identified in the frameworks for both adults and children (as well as smoking cessation).

Anchor Organisations Steering Group will oversee delivery of the Anchor Strategy. This strategy sets out how the stakeholders in the One Devon Integrated Care System will use their assets to support social and economic development in local communities. The strategy is based around 5 key themes

1. Widen access to Quality work
2. Broaden apprenticeships and enhance partner capabilities
3. Purchase locally
4. Leverage social value for community benefit
5. Strengthen ties with community and local organisations

The three individual One Devon Directors of Public Health (DPH), will each chair one of the governance groups, with membership drawn from a diverse range of stakeholders. This ensures NHS Devon receives well-rounded, expert advice to effectively discharge its functions. Members will collectively bring a wide spectrum of professional expertise, including the prevention, diagnosis, and treatment of illness, as well as the protection and improvement of public health.

Supporting work at locality level

Aligned with the principle of subsidiarity, a significant portion of the population health funding has been delegated to the Local Care Partnerships (LCPs) to target areas where they can have the greatest impact on reducing health inequalities. This funding is supporting a range of projects, including those delivered in collaboration with the voluntary, community, and social enterprise (VCSE) sector. Alongside driving health improvements, these projects are strengthening relationships and building infrastructure that will be vital for sustainable progress in the future.

Examples include:

Normal Magic – West Devon

Mental health challenges often arise early in life, with one in five children aged 5–15 experiencing a mental disorder. Half of all mental health conditions are established by the age of 14, and three-quarters by the age of 24. Early access to the right support is vital in helping children and young people manage difficulties and thrive, promoting their long-term health and well-being.

Increasing demand for hospital admissions due to self-harm among children aged 10–14, along with a rising number of secondary school pupils with social, emotional, and mental health needs, highlights the urgency of addressing these issues.

In response, West Devon LCP commissioned Normal Magic, a VCSE organisation composed of mental health professionals, to provide an Early Intervention and Prevention Mental Health Service for children and young people.

Normal Magic work closely with primary care, providing accessible mental health care and family support directly in GP surgeries. There is no threshold to access the service and families, families can self-refer into the service and there is no open or closed care. Parents, carers, and young people can access a wide range of evidence-based advice and support, from Single Session Approaches to longer-term interventions, delivered in their local GP surgery.

Community Health & Well Being Workers (CHWW) – Plymouth

The team in Plymouth join a growing army of dedicated community health and wellbeing workers across the country, supporting some of the most deprived and under-served communities access vital health and care support.

Recruited locally to the Stonehouse neighbourhood in Plymouth and integrated with Adelaide Street surgery, the CHWW's provide day to day health and social care support to residents in small, defined geographies of around 100-150 households. In its simplest sense CHWW workers act as the eyes and ears for primary care in the community. CHWWs visit every one of their households in their patch every month, regardless of need and at these visits they deal with any pressing issues within the households across their physical, mental and social health. They form a team around the resident and work with the wider system including primary care, social prescribing, VCSEs and the local authority to support residents' health and crucially help address the wider determinants of health.

Community Flow – North Devon

The key aims of Community Flow are to enable faster, safer and sustainable discharge from hospital, avoid readmission and reduce reliance on health and social care services.

Many people are successfully discharged home from hospital without any formal care or support, or the support of a family member or friend.

Often, a patient is medically fit for discharge but unable to go home for which results in an extended length of stay. The reasons are all socio-economic and range from substandard accommodation, landlord issues, the patient not having a means to shop for food, or to collect prescriptions.

These fall outside the remit of reablement/social care. Community Flow has demonstrated that it can address these issues so that discharges are successful because people leaving hospital are better supported in their own homes and communities.

Community Flow caseworkers work with patients, focussing on the things that are important to that person, and building a team around that person rather than professionals undertaking multiple isolated interventions. It ensures a comprehensive approach is taken to how the individual manages their life including physical and emotional health, housing/accommodation, finance, selfcare, diet and nutrition.

Using information

We are continuing to develop the One Devon Dataset to provide the integrated information needed to support our work on population health. In addition to using data for specific geographic areas and population groups, we are now exploring how to enhance our information systems to better inform and strengthen our strategic commissioning decisions.

We have developed reports to equip the Population Health Improvement Committee with the information needed to monitor progress. These reports are aligned with the reporting arrangements set out in NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the NHS Act 2006) and are detailed in Appendix 2. Following feedback from our Boards and localities, this reporting will be further refined to maintain a strong focus on priority areas. Additionally, we will use this information to identify and share examples of good practice across the system.

Inclusion Health

A Complex Lives Lead has been appointed to work with the system-wide Inclusion Health Steering Group to deliver our Inclusion Health Framework action plan which will ensure that we

- Commit to action on Inclusion Health
- Understand the characteristics and needs of people in Inclusion Health Groups
- Develop the workforce for Inclusion Health
- Deliver Integrated and Accessible Services for Inclusion Health
- Demonstrate impact and improvement through action on Inclusion Health

This action plan will be developed with representatives in the Health Inclusion Partnership, building on services already in place and, most importantly, on the feedback received from service users on their experiences of existing services.

Efforts continue to engage with and better understand the physical, mental, and social health needs of individuals with the highest levels of emergency department attendances. While our approach aligns with NHSE's expectations, we are strengthening it by building networks across the entire system. This collaborative approach will enable us to support people in accessing the most appropriate services for their needs before they reach a point of high service demand.

A monitoring framework is being developed which is based on peoples' feedback of their lived experiences not just on service activity. The Ilfracombe Poverty Truth Commission started to meet this year. This exciting initiative gives Civic Commissioners (from ICS organisations) the opportunity to work in detail with Community Commissioners (people with lived experience of poverty) to understand the issues that really impact on peoples' health and wellbeing and develop innovative solutions to address them. As well as developing new ways of delivering services it is anticipated that the work will lead to cultural change and a "humanising" of the way we deliver services

The Joy App

The Joy App currently provides a service for 26 Primary Care Networks (PCN) in Devon to deliver Social Prescription related services in their practice area. It is a web-based app that does 4 distinct things – and its free for all to use:

- It talks to GP systems (both EMIS and Systm1) enabling PCN's to refer patients to community offers and to receive outcome data
- It has a case management system for the Social Prescriber to manage patients from inbound referral to community offer
- It creates the marketplace of community offers – a living directory for anyone across Devon to use
- It creates a data dashboard for all ranging from system wide data to individual PCN and practice data.

The app enables live referrals to and from community assets that support Social Prescription, it collects outcomes from the referral, it talks to EMIS and SystmOne which makes data collection much more robust and easier for the Social Prescriber and its organic in that it grows as it goes. The more people use it, the more relevant it becomes. It also has the ability for people to make self-referrals to community organisations.

Over the past year:

- 16,830 referrals have been made by primary care using JOY
- 1,018 VCSE/community organisations are receiving referrals through JOY

- 80% of patients have said that their wellbeing has improved because of the referral. This equates to 13,464 patients
- 16.1% referrals are addressing mental health (2,710 patients), 12.8% referrals are addressing social isolation/loneliness (2,154 patients) and 7.6% referrals are addressing long term conditions (1,279 patients)
- There has been a 28% reduction in GP surgery re-attendance in Plymouth PCN's for patients referred via JOY. This equates to a saving of £38,680.
- 7.4% referrals are for people struggling with finances that has a direct impact on their health and wellbeing (1,245 patients)

The Joy App also assists us in reducing the number of GP appointments and attendance at Accident and Emergency departments. In a sample size of 814 patients, we observed a 40% reduction in people re-attending Primary Care and/or Secondary Care within a 6-month period.

Health Inequalities Fellows Programme

This programme gives the opportunity for professionals working in primary care to develop their understanding of and skills in reducing inequalities through a variety of training and development events.

The Fellows complete a project working with their local communities on an issue leading to inequalities. These projects have included substance misuse, access to screening, menopause in ethnic communities and support for families. These projects are leading to real changes in local communities.

The feedback from the programme itself has been fantastic with several examples of GPs saying that they were on the verge of leaving their jobs before the programme and one GP even moving to a role in a more deprived area.

Due the success of the programme it will continue for a further two years. This will increase the number of clinicians (including GPs, pharmacists and nurses) embedded across the Devon system with a focus on reducing health inequalities.

Oral Health

The Oral Health Steering Group was established to promote collaborative working across the One Devon footprint, enabling the three local authorities (Devon County Council, Plymouth City Council and Torbay Council) to fulfil their statutory duties with regards to oral health improvement and addressing oral health inequalities. The responsibilities of the group are:

- To discuss and share best practise for oral health improvement
- Use local demographic and deprivation profiles to identify groups that may be at high risk of poor oral health
- Develop an Oral Health Strategy for Devon. This needs to address the oral health needs of the local population (universal approaches), the needs of groups at high risk of poor oral health (targeted approaches) and any oral health inequalities
- Identify where strategies and initiatives are needed to improve oral health across the life course but with an inequality focus
- Agree on the use of the Dental Budget and underspend for oral health improvement
- Support the planning, coordination, implementation and evaluation of oral health improvement programmes across organisations, partnerships and communities in Devon
- Endorse/contribute to local/regional and national campaigns.

NHS Devon has recently approved the Oral Health Steering Group's proposal to expand and extend the reach of existing oral health improvement programmes in schools across Devon, ensuring that every child has the best possible start in life. This proposal seeks to reduce ongoing oral health inequalities, mitigate the effects of limited NHS dental access and increased waiting times for children and families, raise awareness of oral health and dental disease risk factors within schools and communities, encourage dental visits for children not receiving regular care, and achieve long-term cost savings by prioritising prevention at an early age.

The oral health improvement programmes outlined in the proposal include expanding the existing supervised toothbrushing scheme to cover all primary schools and nurseries, regardless of Index of Multiple Deprivation (IMD) category or whether the nursery is independent.

The proposal also aims to establish (or expand, depending on the local authority) fluoride varnish schemes in all primary schools within IMD 1-6, and to establish (or expand, depending on the local authority) the Open Wide and Step Inside programme in all primary schools within IMD 1-6. Open Wide Step Inside is a fully evaluated, educational resource for Year 2 primary school children, designed to raise awareness of better oral health.

Smokefree NHS Group

The Devon Smokefree NHS Group brings together partners ensuring that local NHS organisations do as much as possible to reduce the prevalence of smoking in Devon.

The group initially supported the roll-out of the Treating Tobacco Dependency programme but is now focusing on a range of other initiatives including the development of a single staff support policy across all organisations, training for staff at all levels, increasing leadership awareness and accountability and improving the co-ordination of communications.

All this work is underpinned by a good understanding of the inequalities that exist across the county which impact on smoking behaviours.

Falls and Frailty

As a county with a population aging faster than the rest of the country, Devon has a wide range of programmes, some at locality level and some encompassing the whole county including:

- Frailty Multi-Disciplinary Teams (MDT) are well embedded into primary care
- Identification of frailty within primary care
- FaME – Falls and Management Exercise (Devon-wide)
- Links between NHS strength and balance groups to external support agencies
- Physical activities outdoors
- Live Longer Better programmes
- Digital enablement for older people
- Falls prevention training in primary care, care homes and hospitals
- STAR framework partnership working between Devon carers and Secondary and Primary Care

New programme structures are being developed to ensure engagement across all sectors working with Local Care Partnerships and Locality Healthy Ageing Boards.

Cardiovascular disease (CVD)

The CVD Prevention Group includes key partners from across the One Devon system with an interest in improving CVD rates. By using the One Devon dataset and CVD Prevent data, the

group are now able to identify those parts of the population who are most likely to have hypertension and where both good practice, and gaps in provision, are within our population.

The group has focused on how to tackle both case finding and treating to target at the scale required to effect change. By working as a multiagency group, Devon has secured CLEAR project funding to action key aims of the Prevention Group. Key practice-level data had been embedded within our Medicines Optimisation team to enable teams to look at where improvements can be made in patient care

Children's Core20PLUS5

Children's Core20PLUS5 includes the following 5 key priority areas: Asthma, Diabetes, Epilepsy, Oral Health and Mental Health. In each of these areas there is work focused on reducing health inequalities for those living in areas of deprivation as well as targeted work for vulnerable groups of children including children in care and care leavers.

Asthma

The National Bundle of Care is being delivered by the NHS Devon Asthma team including Women and Children's Commissioning, Clinical Lead and Asthma Practitioner. Asthma training has been delivered both online and in person including training on air pollution (both indoor and outdoor) and the impact of housing on respiratory health. Currently there are 3016 education staff trained in children's asthma in Devon. This training has also been offered to foster carers.

As part of the pilot, work is underway to help schools achieve Asthma Friendly status. There are 5 accredited schools in Devon, 30 in the process and 130 who have joined an initial webinar. There is a capacity risk to this work with the funding for the Asthma Practitioner Pilot due to end on 31st March 2025.

A Fuel Poverty Pilot was run in 2 PCNs in Torbay. This used risk stratification searches to identify the children at highest risk of asthma exacerbation cross referenced with IMD to give access to fuel poverty funding.

Stakeholders are working together to ensure that housing quality is not impacting on health. There is NHS Devon representation at the Torbay council housing and health group where training has been developed for landlords around the risks of damp and mould, leaflets, and videos created for healthcare settings to signpost support available.

A reduction has been seen in unplanned admissions for Children and Younger People's (CYP) asthma in Devon when compared to pre-pandemic levels. Devon and Cornwall are the only ICBs in the South West to prevent asthma admissions rising back above pre-pandemic levels.

	Devon ICB	BSW* ICB	BNSSG** ICB	Cornwall ICB	Dorset ICB	Gloucester ICB	Somerset ICB
2019/20	405	199	285	158	199	180	125
2020/21	207	126	131	68	85	108	70
2021/22	270	173	156	101	180	128	90
2022/23	319	188	206	103	176	159	134
2023/24	365	249	363	134	201	191	128

Diabetes

A ‘Getting It Right First-Time’ report for diabetes has been completed and actions for reducing health inequalities are being addressed by the diabetes delivery group.

The primary focus for Type 1 diabetes has been the roll out of Hybrid Closed Loop (HCL) technology, all children under 19 are eligible for this technology and are the current priority group along with pregnant women and vulnerable groups of adults. At the end of Q2 2024 51% children with Type 1 diabetes in Devon were on HCL technology and access to this technology is relatively equitable between children living in the most and least deprived areas of the county.

There is work underway to focus on reducing Type 2 diabetes risk factors. Links have been made with Public Health work focused on healthy weight and improving school food. There was a Devon wide event focused on Type 2 diabetes prevention in November 2024.

Epilepsy

There is an Epilepsy Operational Delivery Network (ODN)report for each provider in Devon and actions on equity of access to Epilepsy Specialist Nurses, transitions to adult services, improving mental health support and considering cost of travel to tertiary services are being progressed.

Oral Health

As outlined above, improving the oral health of children and young people has been a focus of the Oral Health Steering Group. There have been three oral health improvement programmes commissioned for CYP with supervised toothbrushing and the Open Wide Step inside programme already up and running. There is a dental service commissioned for children in care and care leavers, currently based in Ilfracombe and Plymouth with plans to look to extend this offer for 2025/26.

The Community Dental Service provides care to children with complex dental problems and those who cannot access mainstream primary care dental services due to additional needs. This service is currently under review and will be considering best options for CYP with learning disabilities and neurodiversity in plans for the service.

The waiting lists for tooth extractions under general anaesthetic have reduced for all age groups (0-17) compared to 2023/24.

Mental Health

The Children’s Mental Health Team has now integrated with the Women and Children’s Team. Initial meetings have been held to explore the project scope for CORE20PLUS5 actions in mental health. A prioritisation matrix is currently being used to guide the placement of Mental Health Support Teams in schools within areas of deprivation.

There is also a focus on embedding the reduction of health inequalities into the mental health strategy, with particular emphasis on "plus" groups, including children in care, those with Special Educational Needs and Disabilities (SEND), and neurodiverse children.

Research and Innovation

NHS Devon is a key partner in the Peninsula Research and Innovation Programme (PRIP) with partners across the Peninsula to foster collaborative improvements and innovation in healthcare. These partners include Health Innovation South West, Plymouth and Exeter universities, the Peninsula Applied Research Collaborative and the Peninsula Research Delivery Network. This partnership is focused on creating a flourishing research and innovation ecosystem that supports

academic research and translation into clinical practice. While NHS Devon does not directly engage in research, it uses research evidence in the development of clinical policies and guidelines that influence clinical practice across the system. For example, during the reporting support was made available to the pilot for Neonatal Oral Antibiotics at Home (NOAH) which allows eligible newborns with suspected early-onset infection to transition from intravenous antibiotics in the hospital to oral antibiotics at home after 36 hours. This reduces hospital stays, improves family experiences, minimises potential risk from gentamicin exposure, lowers costs, and optimises workforce capacity. This innovative approach was piloted in Royal Devon University Healthcare NHS Foundation Trust following a research study in the Netherlands. The pilot project was supported by the South West Peninsula Applied Research Collaboration and Health Innovation South West – who are key partners with the ICB in the Peninsula Research and Innovation Partnership. Following that pilot, the approach has been evaluated and is now part of routine practice in RDUH and can be rolled-out to other providers."

NHS Devon also works closely Cornwall and Somerset to implement key deliverables in the Peninsula Research and Innovation Strategy (PRIS), enhancing regional healthcare research and development.

NHS Devon continues 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.

NHS Devon has created a geographic mapping tool powered by dynamic, up to date information about research activity in terms of patient engagement and staff activity. This tool will be used to further identify gaps in activity and address inequalities in participation.

Health and wellbeing strategy

NHS Devon has fulfilled its general duties under Section 14Z52 of the National Health Service Act 2006 through the publication and delivery of its 5-Year Joint Forward Plan (2024-2029).

By publishing the plan and evidencing the implementation of the activities outlined in the Joint Forward Plan (JFP), described in the table below, NHS Devon demonstrates how it has responded to relevant Joint Strategic Needs Assessments (JSNAs), local Joint Health and Wellbeing Strategies (JHWSs), and delivered on the strategic goals set out in One Devon's Integrated Care Strategy.

Strategic Alignment

Developed in 2023, One Devon's Integrated Care Strategy sets the strategic direction for a five-year period. The strategy was co-produced through extensive engagement with stakeholders, including Overview and Scrutiny Committees, Health and Wellbeing Boards, and the public. It builds on previous system-wide efforts to address the priorities that matter most to our communities and improve health outcomes across Devon.

At the time of its development in 2023, the strategy was informed by the most up-to-date Joint Strategic Needs Assessments (JSNA) from the three Health and Wellbeing Boards (HWBB) in Devon, Plymouth, and Torbay, ensuring alignment with local Joint Health and Wellbeing Strategies (JHWS).

Since its initial publication, there has been ongoing engagement with the three Devon Health and Wellbeing Boards, with the JFP being refreshed annually. As part of this update process, Health

and Wellbeing Boards are asked to confirm alignment between the JFP and their latest JSNAs and local Health and Wellbeing Strategies.

The table below presents the statements provided by the Health and Wellbeing Boards during the last review of the Joint Forward Plan (2024-2029) undertaken in July/August 2024. These statements are included in the JFP to evidence strategic alignment.

Health and Wellbeing Board statements confirming strategic alignment

Torbay Council
Torbay Health and Wellbeing Board endorse the refreshed Devon Joint Forward Plan (2024-29), being satisfied that the Plan continues to take account of the current Health and Wellbeing Strategy for Torbay and continues to support its ongoing development.
Plymouth City Council
Plymouth's HWBB have reviewed the updated JFP (2024-29), which builds on the previous version which was developed with engagement and consultation with the HWB. The Plymouth HWBB endorses the Plan and is assured that it takes account of the current health and wellbeing strategy for Plymouth. The focus on inequalities in access and in outcomes is welcomed, and we look forward to seeing the shift in resources required to deliver on this aim.
Devon County Council
The Devon Health and Wellbeing Board has been engaged throughout the process of development of the JFP and has been consulted on each formal draft, raising questions and highlighting potential omissions. The DCC HWBB is happy to endorse the refreshed Plan (2024-29) and is assured that it takes account of the current health and wellbeing strategy for Devon.

How NHS Devon is Discharging Its Duties

The following table, taken from Appendix A of the published Joint Forward Plan (2024-2029), outlines how specifically the Integrated Care Board intended to discharge its statutory duties under Sections 14Z34 to 14Z45 and Sections 223GB to 223N (financial duties) for the financial year 2024/25.

NHS statutory duties	How we meet our duties	ICB Duty Sections
Describe health services the ICB proposes to arrange to meet needs	This Joint Forward Plan broadly describes the health services we have in place, and will arrange, to meet the needs of our population as set out in the Integrated Care Strategy. Each year we also produce an Operating Plan that provides more detail about the planned performance of services.	14Z52, 14Z53, 14Z54
Duty to promote integration	The Joint Forward Plan is an integrated system-wide plan that encompasses a wide range of programmes that will contribute to improving the health and wellbeing of people living and working in Devon. Each section describes how system partners are working together to deliver joined up services. NHS Devon is discharging its statutory duty to promote the integration of health services with health-related and social care services through strengthened collaboration across One Devon. Our approach focuses on aligning clinical leadership, quality oversight, and service transformation to ensure that individuals	14Z42

NHS statutory duties	How we meet our duties	ICB Duty Sections
	experiences coordinated and joined-up care, particularly those with complex or long-term needs. The integration agenda is further supported using EQIA-informed training and governance, helping staff consider system-wide impacts as part of business-as-usual. Ongoing development of collaborative working arrangements through forums such as the Clinical Cabinet and SQG will continue to strengthen NHS Devon's delivery against this duty.	
Duty to have regard to wider effect of decisions	The Joint Forward Plan is a system-wide plan to meet the aims and strategic goals set out in the Integrated Care Strategy. The strategy is overseen by the One Devon Partnership which will have the remit to ensure the full consequences of any decisions made are understood	14Z43
Implementing any JLHWS	There are three Health and Wellbeing Boards in Devon and we have worked closely with all three to ensure that their priorities are reflected in this plan.	14Z52, 14Z53, 14Z54
Financial duties	Refresh of system-wide Medium Term Financial plan that will set out how Devon will achieve financial balance over the JFP 5 year period. Year on year delivery of agreed annual financial plan.	223M
Duty to improve quality of services	Everybody has the right to feel safe and have confidence in the services provided across Devon. We are committed to securing continuous improvement and will ensure that our services are of appropriate quality. In accordance with the National Quality Board (NQB) guidance have robust mechanisms in place to enable proactive improvement and risk management where quality and safety standards are not being met or are at risk. We have developed ways to effectively share intelligence and triangulate insights. and have a performance and quality reporting function in place. Our Chief Nursing Officer provides executive leadership for oversight of quality across our system recognising responsibility sits in different teams across provider, NHS Devon and others.	14Z34
Duty to reduce inequalities	One of our system aims is 'tackling inequalities in outcomes, experience and access' and two of our strategic goals focus on the top five risk factors and causes of death and disability. A third strategic goals explicitly states that we want 'everyone to have an equal opportunity to be healthy and well'. To achieve this each section of our plan outlines how relevant workstreams will contribute to reducing inequalities, particularly in relation to Core20PLUS5 (including Children) and, in line with the 2022 Armed Forces Bill, with regard to serving military personnel, reservists, veterans and their families. NHS Devon's newly established Population Health function will be a key enabler and will co-ordinate our cross system work in this area	14Z35
Duty to promote involvement of each patient	We are committed to promoting personalised care across all the services we deliver across our organisations. Our approach outlined in the strategic goal 'People in Devon will be support to stay well at home, through preventative, proactive and personalised care'. Specifically, the Primary and Community Care workstream describes how it will use the comprehensive model of personalised care to deliver this ambition.	14Z37

NHS statutory duties	How we meet our duties	ICB Duty Sections
Duty to involve the public	Our Working with People and Communities Framework sets out our principles for involving local people. The communications and involvement enabling programme outlines how we will support delivery leads to ensure people and communities are involved in a meaningful way.	14Z45
Duty to enable patient choice	We support patient choice in our commissioning plans in a number of ways. These include expanding the use of personal budgets through our personalised care commissioning and the use of the Devon Referral Support Service (DRSS), which supports patient choice at the point of referral into secondary care.	14Z37
Duty to obtain appropriate advice	We ensure that we obtain appropriate advice throughout the development of plans. This includes from clinicians (both local and through regional networks), NHSE (regional and national), the South West Clinical Senate and legal advice. Obtaining advice is particularly important to us in our delivery of transformation. Our system approach to delivering the JFP means that relevant partners are included on our Programme Boards and are able to influence and give advice as appropriate, this includes police, housing, education and public health.	14Z38
Duty to promote innovation	We work closely with Health Innovation South West and Peninsula Research and Innovation Partnership to ensure we are cognisant of innovation and best practice. The Research and Innovation enabling programme has been developed to ensure all delivery programmes are supported in the delivery of this duty.	14Z39
Duty in respect of research	NHS Devon is a key partner in the Peninsula Research and Innovation Programme (PRIP) with partners across the Peninsula to foster collaborative improvements and innovation in healthcare. These partners include Health Innovation South West, Plymouth and Exeter universities, the Peninsula Applied Research Collaborative and the Peninsula Research Delivery Network. This partnership is focused on creating a flourishing research and innovation ecosystem that supports academic research and translation into clinical practice. While the NHS Devon does not directly engage in research, it uses research evidence in the development of clinical policies and guidelines that influence clinical practice across the system. We work closely Cornwall and the Isles of Scilly and Somerset to implement key deliverables in the Peninsula Research and Innovation Strategy (PRIS), enhancing regional healthcare research and development. NHS Devon continues 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. NHS Devon has created a geographic mapping tool powered by dynamic, up to date information about research activity in terms of patient engagement and staff activity. This tool will be used to further identify gaps in activity and address inequalities in participation.	14Z40

NHS statutory duties	How we meet our duties	ICB Duty Sections
Duty to promote education and training	NHS Devon works collaboratively with academic institutions including Petroc, City College Plymouth, Exeter and South Devon colleges, Marjon, Plymouth, Exeter and Bristol Universities, NHS partners, and social care providers to promote health and care as a career option. This includes supporting the development of education programmes and learners within practice settings. Our strategic workforce plans are aligned with service transformation priorities to ensure a sustainable supply of skilled staff, delivering care at the right time, in the right place, supported by clear reporting frameworks and robust metrics. In discharging our statutory duty to promote education and training, NHS Devon has embedded equality and quality awareness across the organisation. A comprehensive training programme delivery for all staff is ongoing, with strong uptake across directorates. The EQIA policy has been updated in line with legislation and best practice, equipping staff to assess and address inequality and quality risks in service design and delivery. Training content is continuously improved based on participant feedback, ensuring relevance and effectiveness. The Datix system has also been enhanced to track compliance with EQIA processes, strengthening governance and assurance around the delivery of safe, equitable care.	14Z41
Duty as to regard to climate change etc	Our Green Plan enabling programme outlines our clear commitment to successfully deliver targets for all local authorities to be carbon neutral by 2030 and the NHS by 2040.	14Z44
Addressing the particular needs of children and young people	Our plan includes specific strategic goals on children and young people and the children and young people delivery programme outlines the wide programme of work. Specific work programmes ensure that the NHS Devon's duties are met for; • Special Education Needs and Disabilities (SEND) • Safeguarding • Children in Care	
Addressing the particular needs of victims of abuse	We are active members of the three Safety Partnerships, two Safeguarding Adult Boards and three Safeguarding Children Partnerships in Devon. We work together to improve recognition of and protection of victims of abuse, to understand the needs of victims and survivors so they feel safe and can recover, and to work with communities to prevent and tackle community safety issues. We undertake individual case reviews to identify good practice and areas for improvement, and we work with partners to embed learning into practice to improve care, safety, and patient experience. We work with our health providers to improve the recognition of and response to those affected by violence and abuse, whether they be patients or staff members, and to meet the health needs of those impacted by trauma.	

Delivering the Joint Forward Plan through NHS Devon's Annual Plan

In 2024/25, NHS Devon's Annual Plan has been the primary delivery mechanism for progressing the strategic objectives set out in the Joint Forward Plan.

Progress on delivery has been closely monitored through the organisation's Programme Management Office (PMO), with the Board receiving regular assurance via a monthly Board report.

The table below highlights some of the key objectives led by NHS Devon that demonstrate the progress that has been made in 2024/25 towards delivering the JFP and One Devon Integrated Care Strategy in response to Joint Strategic Needs Assessments (JSNAs),

Theme	Focus	What have we delivered in 2024/25
Healthy People	Primary Care and Dental Services	Achieved the lowest level of Did Not Attend (DNA) rates for General Practice appointments of any ICB area (most recent data – December 2024). Ranked second highest in the raw offer of General Practice-provided clinical contacts of any ICB area (most recent data – December 2024). Reduced the number of GP practices with high/very high resilience challenges by approximately 40%, with national interest in our resilience programme. Launched four different pilot models of General Practice at the PCN level. Initiated multiple dental programmes and service changes to deliver an increase in dental activity in 2025/26. Delivered the 'Know Your Numbers' campaign to raise awareness of high blood pressure, its risks, and local services where people can check their blood pressure and get clinical advice or treatment.
	Community Care	Completed the Anchor Organisation Strategy. Secured a successful National Lottery bid for the One Northern Devon Local Care Partnership, in collaboration with the VCFSE, to fund six Community Developer roles and two Connector roles across Northern Devon (Youth/Rural). Continued the use of Prevention and Health Inequalities funding at LCP level to support the Community Development workforce. Established the Devon Engagement Partnership (DEP) to bring together health and care engagement professionals, including partners from Healthwatch and the VCSE Assembly.
	Elective Care	Clearance of all 104ww patients.

		Significant reduction in all long waiting patients across the system. System achievement of the 28-day faster cancer diagnosis and the 62 day performance. Community Diagnostic Centre (CDC) opened in Torbay with an additional expansion opened in Exeter. System achievement of the Patient Initiated Follow Up (PIFU) 5% deliverable. System achievement of Advice and Guidance utilisation deliverable.
	Urgent Care	Delivered progress across six core workstreams: SDEC, Virtual Wards, Frailty, End of Life, UCR, and Community Urgent Care. Achieved a significant reduction in ambulance handover delays. Improved performance in Emergency Departments and Category 2 response times. Successfully transitioned Care Coordination into the IUCS service. Took a system-wide approach to winter communications for the eighth consecutive year, building on award-winning work to provide clear, practical advice to vulnerable groups on staying healthy during colder months.
	Children and Young People	Enhanced executive/ director leadership in the ICB, across multiagency partnerships and with health providers to ensure the needs of children are understood and prioritised. Focused use of improvement tools and levers drive necessary change. Multi Agency Safeguarding Hub (MASH) capacity increased to enable the Devon to meet its statutory duties under Working Together to Safeguard Children responsibilities. Improved reporting and increased access for children and young people with needs relating to emotional wellbeing and mental health both in 2024/25 and in future years through investment in Mental Health Support Teams and the procurement of the system wide Emotional Wellbeing & Mental Health Service. Autism recovery programme implemented across the Devon system to establish a more streamlined pathway of support, assessment and delivery models.

		Neurodiversity Hub established on MyHealth Devon providing support, information and resources for children, young people and families. Children and Young People provider services represented on the System escalation dashboard to enable reporting on operational pressures. Launched Council for Disabled Children SEND level 1 training and developed Standard Operating Processes across the health system for SEND statutory processes.
	Maternity, Neonatal and Women's Health	Executive leadership to drive the effectiveness of the Board for the Local Neonatal Maternity System. Focus on the diagnostics arising from the national maternity safety support programme to oversee and enable necessary improvement and transformation. Perinatal Pelvic Health Services (PPHS) have been implemented in all Trusts All Trusts have provided sufficient evidence to be compliant with Saving Babies Lives. Development of definition and criteria of complex social factors (CSF) to support the work for vulnerable pregnant women and development of a system wide infant feeding strategy. Implementation of Real Birth Company antenatal education in all Trusts. Implementation of the Devon Menopause Service (DMS).
	Adult Mental Health	Met the NHS Long-Term Plan target, ensuring 1,115 women and birthing people could access perinatal mental health support. Developed a GP information and resource pack to support engagement with individuals with Severe Mental Illness, improving uptake of annual health checks. Implemented the 111 Press 2 option, creating a single point of contact for those experiencing a mental health crisis Drafted a dementia strategy through the Mental Health Collaborative. Completed the first year of implementing the Mental Health Inpatient Strategy, providing a clearer understanding of capacity requirements and gender specific needs for inpatient beds. Conducted a review of the Psychiatric Liaison Service across the NHS Devon footprint.

	Learning Disability, Autism and Neurodiversity	As of December 2024, performance is up 1% on the previous year, with an increase in Learning Disability register size to 8,053, continuing the expected upward trajectory, with the majority of uptake recorded in Q4. Relocated LD/MH inpatient beds to the South West following £40 million in capital investment. Established a partnership with Bath, North East Somerset ,Swindon and Wiltshire ICB to offer a regional bed provision and introduced the South West Regional Front Door protocol for bed admissions. Gained a greater understanding of the LDA community's needs through bed occupancy analysis, leading to quantifiable data that informs future commissioning—particularly a shift from single LD diagnoses to more complex cases involving ASC and other mental health comorbidities. Established a governance structure and accreditation process for Right to Choose, supporting the delivery of Autism and ADHD diagnoses. This has led to increased provision and strengthened quality and safety assurance. Continued the rollout of Oliver McGowan Mandatory Training across the health system, improving awareness and access to support for people with learning disabilities and autism. Developed workforce plans to support the end-to-end pathway in the community, helping to drive progress in reducing health inequalities. This includes work on screening, digital Red Flag alerts, learning from LeDeR, and ongoing AHC audits.
Healthy Safe Communities	Housing	We have continued to identify and support low-income households living in poor-quality homes, providing advice on improving housing conditions, reducing fuel costs, and maximising income. Efforts have been targeted at high-risk groups, such as older people not receiving Pension Credit and those with frequent hospital admissions. Data sharing across the ICS is improving, helping to better target interventions through tools like the One Devon Dataset and Low-Income Family Tracker. The Devon Housing Commission has reported its findings, with recommendations being taken forward by the Combined Authority and local agencies. Plymouth's Housing Taskforce has developed an action plan to address local housing challenges. Homelessness remains a pressing issue. While Exeter has the highest recorded rates, rural homelessness is harder to measure. Plymouth faces significant challenges but prevents hundreds of families from becoming homeless each quarter. Work continues across Devon to support those at risk or already homeless.

	Suicide Prevention	In 2024, Pete's Dragons suicide bereavement service have supported 686 (387 new and 299 existing) people affected by suicide. Delivered Community Suicide Awareness and Emotional Resilience training to 801 participants across Devon in 2024. Delivered Primary Care Suicide Prevention Training to 89 clinicians across Devon ICS in 2024. Put on a Domestic abuse and Suicide Conference - November 2024, attended by over 120 delegates. Development and distribution of thousands of 'It's OK to talk about suicide leaflets' - co-designed with people with lived experience. Provided small-grants suicide prevention funding of between £1,000 and £10,000 to 26 community and grass roots organisations across One Devon.
	Health Protection	Increased access to winter vaccinations through wider provision from Community Pharmacies and outreach teams. Increased activity to data cleanse 0-5s vaccination records to support accurate reporting and identification of future priorities. Delivered a range of vaccination campaigns targeting different groups, contributing to some of the highest vaccination uptake rates in the country.
Healthy Sustainability System	Clinical Effectiveness, research, Innovation and Improvement	Agreement of £50k funding for PRIP for 2024/25 PRIP Mission groups established and supported by One Devon colleagues Letter of support for PenARC bid Involvement in design of national R&I metrics as a member of ICB R&I metrics pilot project. Collaboration with neighbouring ICBs to share approaches to improving connections between R&I work and commercial research activity
	Estates and Infrastructure	Delivery of an ICS system infrastructure strategy NHS estate in Devon mapped out in considerable detail PCN estates strategy completed Achieved full system of collaboration of Estates and Facilities Directors
	Workforce	Robust system wide workforce controls implemented securing associated financial savings and improvements including

		reduction in agency usage to 2.1% of pay bill (lowest agency usage in Southwest) Implementation and delivery of workforce financial recovery programs supporting workforce transformation, reduced reliance on temporary workforce, improved medical & non-medical productivity. Commencement of programs to support workforce transformation (i.e. standardised job evaluation, development of workforce transformation product).
	Digital and Data	Devon and Cornwall Care Record – eTEP implemented on the DCCR now with over 19,500 eTEPs, 20,000 users, RDUH connected with 6,000 users, supported the development of the National Record Locator within the Orion Health platform. Roadmap developed for a Digital Collaborative Corporate Service TSDFT and UHP achieved sign-off of FBC for a new Electronic Patient Record Digitising Social Care programme performed higher than the national average and is currently exceeding the national target of 80% with 92% of care home and domiciliary care providers with a digital social care record. Rationalisation of data centres from 15 to 8 HSJ Winner (Gold) for the Virtual Care Project of the Year 2024 for ICS Devon developed 'GP in the Cloud' remote working solution for GP locums

Financial review

This financial review covers the year ended 31 March 2025.

The NHS financial framework enables NHS Devon to take the appropriate spending decisions to provide health services to our population. We receive additional specific resource allocations for primary medical care services, elective recovery and discharge funding, as well as funding for service development.

In line with our financial plan agreed with NHS England, NHS Devon delivered a financial surplus of £28.4m for the year ending 31 March 2025.

NHS Devon's reported position against its revenue resource limit is set out below:

Financial Summary	Year ended 31 March 2025 £ million	Year ended 31 March 2024 £ million

Revenue resource limit	3,200.63	2,981.67
Total net operating cost for the financial period	3,172.21	2,945.25
(Overspend) / Underspend	28.42	36.42

NHS Devon has purchased capital items totalling £0.1m, meeting its capital resource limit.

NHS Devon also managed to meet the following further financial duties:

- Running costs contained within the agreed allocation: for NHS Devon this was achieved with reported expenditure of £19.50m.
- Managing cash resources received from NHS England against a mandated threshold, the annual cash drawdown requirement.
- Compliance with the Better Payment Practice Code

How NHS Devon funds were spent in the year ended 31 March 2025

NHS Devon is accountable to the public for how it allocates and spends taxpayers' money in each financial year.

The table below shows the spend by service type which includes contract and non-contractual expenditure with NHS providers, independent providers, local authorities and the voluntary sector, and shows the running costs for NHS Devon. It largely reflects historical levels of expenditure and trends in current demand:

	31-Mar-25		31-Mar-24	
Service type	**£m**	**%**	**£m**	**%**
Acute	1,606.28	50.6%	1,479.21	50.2%
Primary care	671.71	21.2%	620.31	21.1%
Continuing care	170.37	5.4%	161.29	5.5%
Community health services	363.17	11.4%	339.49	11.5%
Mental health	337.16	10.6%	308.11	10.5%
Other	4.02	0.1%	13.66	0.5%
Corporate	19.5	0.6%	23.18	0.8%
Total	3,172.21	100.0%	2,945.25	100.0%

Going concern

The NHS Devon Board has prepared these financial statements on a going concern basis, in other words the organisation will continue to operate for the foreseeable future. Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Name of external auditor, plus costs

NHS Devon appointed KPMG LLP as its external auditor and paid £252,886 (£210,738 excluding VAT) for year ended 31 March 2025, £247,200 (£206,000 excluding VAT) for the year ended 31st March 2024.

Included in the accounts is £18,414 (£15,345 excluding VAT) for an independent review of the 2024-25 Mental Health Investment Standard.

Basis of accounting

The financial statements contained within this report have been prepared in accordance with the direction given by NHS England under the National Health Service Act 2006 (as amended) and in a format instructed by the Department of Health with the approval of HM Treasury.

The accounts present our results for, and financial position to, the period ended 31 March 2025. They have been prepared under International Financial Reporting Standards (IFRS) using the accounting policies shown in the notes to the accounts, in accordance with the 2024/25 Group Accounting Manual (GAM) issued by the Department of Health and Social Care. They comprise a Statement of Financial Position, Statement of Comprehensive Net Expenditure, a Statement of Cash Flows, and a Statement of Changes in Taxpayers' Equity, all with related notes.

Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments, and special notation in the accounts to draw them to the attention of Parliament. They are divided into different categories including cash losses, bad debts, extra contractual payments to contractors and compensation payments.

During 2024/25 there have been three compensation payments totalling £23,616.76.

2025/26 Financial Outlook

NHS Devon, in partnership with primary and secondary care providers, continues to collaborate with other One Devon system partners to ensure that expenditures align with available resources. The 2025/26 financial plans focus on improving service performance and productivity, while advancing the key ambitions outlined in the NHS Long Term Plan.

Funding
In 2025/26, NHS Devon received recurrent base growth funding of 3.85%, equivalent to £94.6m. For the running costs of NHS Devon there is a reduction in base funding from £19.6m to £18.0m, necessitating savings. In addition to the running cost reduction all ICB's have been asked to produce plans to reduce their overall costs on administration and programme pay costs to £18.96 per head of weighted population. For NHS Devon this is a further reduction in costs of £12.4m. We are awaiting details of how ICB's are expected to achieve this but anticipate that implementation will need to be commenced in the final 6 months of 25/26.

Key Challenges
Despite additional funding, the efficiency requirements will make 2025/26 a particularly challenging year.

The national priorities to improve patient outcomes in 2025/26 are:

- **Elective Care:** Reduce waiting times, ensuring 65% of patients receive elective treatment within 18 weeks by March 2026.

- **Cancer Diagnosis:** Improve performance against the 62-day treatment target and increase compliance with the Faster Diagnosis Standard.
- **Emergency Care:** Improve A&E and ambulance response times, with at least 78% of A&E patients seen within 4 hours and Category 2: for emergency calls, such as stroke patients, ambulance response times averaging no more than 30 minutes.
- **Primary & Urgent Care:** Enhance GP access, patient experience, and provide additional urgent dental appointments.
- **Mental Health:** Improve patient flow in crisis and acute pathways, reduce length of stay in adult acute beds, and expand access to children and young people's (CYP) mental health services.

In delivering on these priorities for patients and service users, NHS Devon and providers will work together, with support from NHS England, to:

- **Reducing Demand & Improving Access:** Develop models to prevent avoidable hospital admissions and enhance access to urgent and emergency care.
- **Digital Transformation:** Making full use of digital tools to drive the shift from analogue to digital.
- **Health Inequalities & Prevention:** Focus on secondary prevention, systematically detecting the early stages to disease before full symptoms develop, to reduce health inequalities and improve long-term outcomes.
- **Financial Sustainability:** Operate within allocated budgets by reducing waste, improving productivity, and prioritising resources to achieve a balanced system financial position across system partners.
- **Quality & Safety:** Maintain high standards, particularly in maternity and neonatal care and addressing variation in access, experience, and outcomes.

Financial and System Performance

NHS Devon is tasked with achieving a balanced financial position across the One Devon system. While the NHS Devon has submitted a surplus plan of £8.0m for 2025/26, the overall One Devon system projects a breakeven position after receiving £53.8m deficit support funding. This underlying financial challenge has led to NHS Devon and the three Devon acute provider organisations being kept at Level 4 under the NHS Oversight Framework (NOF4) in 2024/25, the highest level of national oversight for finance and performance.

Recovery Support Programme

As part of NOF4, NHS Devon and its partners receive intensive, mandated support from NHS England through the nationally coordinated Recovery Support Programme. This programme includes targeted interventions designed to address systemic issues within a defined timeframe.

NHS Devon has implemented a Transforming Devon Programme to lead the delivery of medium term, system wide programmes that will contribute to the delivery of clinical, workforce and financial sustainability across the system. Initially delivering across four key pillars – Clinical Service Change, System Productivity and Efficiency, Integrated Clinical Support Services and Shared Non-Clinical Support Services, the Transforming Devon Programme will ultimately become the vehicle for the delivery of NHS Devon's Health and Care Strategy that will be developed in the first half of 2025/26

Financial Recovery and Risk Management

The Devon system remains committed to financial recovery, developing and implementing plans to improve both financial and service performance. The 2025/26 plan carries inherent risks, requiring

continuous evaluation and mitigation in collaboration with partner organisations. Key financial risks include:

1. **Core Services and Productivity:** Maintaining core services while ensuring adequate resources to support Government commitments, such as meeting the Mental Health Investment Standard.

2. **Funding Provider Contracts:** Meeting contractual obligations and managing in year financial risks amidst substantial system savings targets.

3. **NHS Devon Running Costs:** Adapting to the reduced running costs allowance, which may exacerbate staffing pressures and workforce challenges.

NHS Devon's success depends on effective collaboration with local authorities, primary care services, and hospitals, as well as engaging service users and the public to better understand the health needs of the local population.

Risk Management Framework

Not all risks can be fully mitigated. NHS Devon manages risks using a structured risk register, which evaluates risks based on likelihood, impact, and the strength of existing controls. Each risk is assigned to an accountable individual and reviewed regularly by the Audit and Risk Committee, the Executive Committee, and the Board to ensure robust oversight.

Through collective action and risk management, NHS Devon strives to balance financial challenges while enhancing patient outcomes and experience.

Accountability report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

1. The Corporate Governance Report sets out how we have governed the organisation during the period 1 April 2024 to 31 March 2025 including membership and organisation of our governance structures and how they supported the achievement of our objectives.
2. The Remuneration and Staff Report describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.
3. The Parliamentary Accountability and Audit Report brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Steve Moore
Accountable Officer and Chief Executive Officer
NHS Devon Integrated Care Board

24 April 2025

Corporate Governance Report

Members Report

The NHS Devon Integrated Care Board (NHS Devon) was established on 1 July 2022 with the following core purposes:

- To agree the strategic priorities and resource allocation for all NHS organisations in Devon; and
- To lead the improvement and integration of high-quality health and care services for all communities across Devon

The NHS Devon Board takes responsibility for determining the governing arrangements for NHS Devon, including arrangements for clinical leadership which are set out in the NHS Devon Constitution.

The NHS Devon Board comprises executive, independent non-executive and partner members together with a mental health member.

- Executive members, who are appointed through an open and competitive recruitment process in line with national guidelines, propose the strategic direction of the organisation and are responsible for its decision-making and performance to ensure the delivery of high quality, safe and efficient services
- Independent non-executive members, who are also appointed through an open and competitive recruitment process in line with national guidelines, bring independent judgment, external perspectives and advice in respect of strategy, vision and performance and constructively challenge, influence and support the executive members
- Partner members and the mental health member, who are appointed by an appointments panel which sets out a role specification and requests nominations from the membership of each professional group, bring knowledge and a perspective from their sector, but do not act as a delegate from that sector

At the end of 2024/25 the NHS Devon Board agreed to propose a number of amendments to the NHS Devon Constitution (which were approved by NHSE England in May 2025 and are effective as of 01 June 2025). Amongst these amendments was the addition of a Voluntary, Community and Social Enterprise (VCSE) member to the NHS Devon Board.

Composition of NHS Devon's Board

The members of the NHS Devon Board as of 31 March 2025 are as shown below, with all members commencing their tenure on 1 July 2022, unless indicated. Kevin Orford became Acting Chair as of 10 June 2024. Following a full recruitment process to appoint a new Chair for the organisation, he was subsequently appointed as Chair on 17 December 2024.

In accordance with the NHS Devon Constitution (as approved in May 2025), the Board has 17 members. However, to enable a handover of responsibilities there was an additional Independent Non-Executive Member whose term of office end on 31 March 2025. As at 31 March 2025 eight Board members were female and nine were male.

Biographies for our Board members are available on our website: https://devon.icb.nhs.uk/nhs-devon-board/board-members/

Kevin Orford

Independent Chair (from 17.12.2024)

Acting Chair (from 10.06.2024 until 17.12.2024)

Independent Non-Executive Member, Finance and Remuneration (until 10.06.24)

Steve Moore

Chief Executive Officer (CEO)

(from 12/2/24)

Kirsty Denwood

Interim Chief Finance Officer (from 01.01.2025)

Peter Collins

Chief Medical Officer (from 14.10.2024

Penny Smith

Chief Nursing Officer (from 1/12/2023)

Piers Tetley

Chief People officer

Philippa Harding

Interim chief communications and corporate affairs officer

Thandiwe Hara

Independent Non-Executive Member

Graham Clarke

Independent Non-Executive Member

Lopa Patel MBE

Independent Non-Executive Member

Salma Ali

Independent Non-Executive Member

Kaye Bentley

Independent Non-Executive Member

Sam Higginson

Partner member for NHS and Foundations trusts, (Chief Executive, Royal Devon University Healthcare NHS Foundation Trust

Dr Frank O'Kelly

Primary Care for Partner Member (GP Partner, Amicus Health)

Donna Manson

Partner member for local authorities (Chief Executive, Devon County Council)

Lincoln Sargeant

Partner Member for local authorities (Director of Public Health at Torbay Council)

Phill Mantay

Partner member for Mental Health (Chief Executive, Devon Partnership Trust)

Vacant

Partner member, Voluntary, Community and Social Enterprise (VCSE)

Membership of the Audit and Risk Committee and the Remuneration Committee (previously known as the Remuneration and ICB Internal Workforce Committee) can be seen in Appendix 1.

In addition to the membership set out above, other Board Members between 1 April 2024 and 31 March 2025 were:

Name	Role	Term of Office
Sarah Wollaston	Independent Chair	1 July 2022 – 10 June 2024
Nigel Acheson	Chief Medical Officer	1 July 2022 - 30 June 2024
Ruth Harrell	Partner Member for Local Authorities	23 August 2023 – 31 July 2024
Liz Davenport	Partner Member for NHS Trusts and NHS Foundation Trusts	1 July 2022 – 31 December 2024
Bill Shields	Chief Finance Officer and Deputy Chief Executive	7 November 2022 - 01 January 2025
Sheena Asthana	Independent Non-Executive Member for Health Inequalities and Population Health	1 July 2022 – 7 January 2025
Judy Hargadon	Independent Non-Executive Member for Primary Care	17 March 2023 - 31 March 2025
Martin Sykes	Interim Independent Non-Executive Member	12 November 2024 – 31 March 2025

During the reporting period, the NHS Devon Board regularly invited the following individuals to attend any or all of its meetings:

- Chief executive of Cornwall and the Isles of Scilly Integrated Care Board
- Chair of the Integrated Care Partnership
- Chief communications and corporate affairs officer
- Chief operating officer
- Chief people officer

Register of Interests

NHS Devon maintains an electronic register of interests and a register of gifts and hospitality declarations via the platform Civica Declare. The process for managing and maintaining the register of interest is overseen by the Corporate Governance Team and regular assurance reports are shared with the Audit and Risk Committee. The organisation's policy for managing conflicts of interest can be found on its website.

The registers for NHS Devon Board Members and managers classified as 'decision-makers' (Agenda for Change Band 8d and above) can be found on the NHS Devon website: https://nhsdevonicb.mydeclarations.co.uk/home

Personal data related incidents

Personal data breaches are reported on Datix via the 'Internal Incidents' icon available to every member of staff on their desktop. All incidents are reviewed, graded and investigated further by NHS South Central and West Information Governance Services and the Data Protection Officer (DPO).

During the period of 1 April 2024 – 24 February 2025, NHS Devon reported 139 internal incidents. The majority of incidents were graded as 'green' and therefore considered as minor incidents with no/low risk. In the reporting period, one of the incidents was reported to the Information Commissioner's Office (ICO) but no further action was taken by the ICO.

Modern Slavery Act

NHS Devon fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2025 is published on our website at https://onedevon.org.uk/nhs-devon/safeguarding/

Statement of Accountable Officer's responsibilities

Under the National Health Service Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS Devon and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts and
- Prepare the accounts on a going concern basis and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The National Health Service Act 2006 (as amended) states that each ICB shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive Officer to be the Accountable Officer of NHS Devon. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the NHS Devon assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the National Health Service Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Devon's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Steve Moore

Accountable Officer, Chief Executive Officer

NHS Devon Integrated Care Board

19 June 2025

Governance Statement

Introduction and context

NHS Devon Integrated Care Board (NHS Devon) is a body corporate established by NHS England on 1 July 2022 under the National Health Service Act 2006 (as amended) (known as the 2006 Act).

NHS Devon's statutory functions are set out under the 2006 Act.

NHS Devon's general function is arranging the provision of services for persons for the purposes of the health service in England. NHS Devon is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

Between 1 April 2023 and 31 March 2025, NHS Devon was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006 (as amended).

Since 13 July 2022 NHS Devon has been identified as being within Segment 4 of the NHS Oversight Framework (NOF4). This means NHS Devon has been under the

national Recovery Support Programme (RSP), which has provided it with intensive support. At the same time as helping to address the specific issues that have triggered mandated intensive support, NHS England has considered long-term solutions and any structural issues affecting NHS Devon's ability to ensure high quality, sustainable services for the public.

During 2024/25 NHS Devon and NHS England agreed that the following criteria must be met before NHS Devon moves out of NOF4:

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

- 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

Urgent and Emergency Care

- 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

Finance

- Develop and deliver a short-term financial plan (2024/25) that is signed off regionally and nationally.
- Delivery reductions in the run rate for each consecutive quarter.
- Agree financial recovery trajectory with NHS England, 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.

In addition to NHS Devon being in NOF4, the three acute trusts within the One Devon System are also in this segmentation. Whilst each organisation has accountability for approving and delivering its own improvement plan, the NHS Devon Board also has a role in the system-wide recovery process by providing strategic leadership for whole-system approaches to service and financial sustainability. Accordingly, there is now a System Recovery Programme in place which provides clear roles and responsibilities

for NHS Devon and the three acute trusts and how progress is reported to NHS England.

A key element of the NOF4 monitoring process are the monthly reviews of progress against key performance indicators and exit criteria undertaken by the NHS England System Improvement and Assurance Group (SIAG), which is chaired by the NHS England South West Director. These meetings are used to hold to account the Chief Executive Officers of NHS Devon and the three acute Trusts for delivering their improvement plan.

The SIAG requires a report to each of its meetings in relation to each of the acute providers as well as NHS Devon, containing details on performance against agreed trajectories, progress within the last month, actions for the next month, risks and mitigations, and any areas of escalation for support.

To meet the SIAG and all other reporting requirements, NHS Devon reports performance aligned to the NOF4 domains on a monthly basis. This report is then used as a framework to report to the Locality Delivery and Planning Groups, the One Devon System Leadership Group, the NHS Devon Executive and the NHS Devon Board.

This reporting is supplemented with a narrative to provide any further clarification, detail, or escalation, by exception, where performance or improvements has not met or has exceeded agreed standards. This narrative report, supported by the SIAG report, is presented to the NHS Devon Finance and Performance Committee and Quality and Patient Experience Committee for detailed review to enable it to provide assurance to the Board when the report is received at each meeting in public of the NHS Devon Board.

NHS Devon and the other provider organisations with this the One Devon Integrated Care System who have been allocated to NOF4 undertook a self-assessment of their position in relation to the published exit criteria. This has been submitted to NHSE for consideration in light of the proposed move to a new oversight framework.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of NHS Devon's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my NHS Devon Accountable Officer Appointment Letter.

I am responsible for ensuring that NHS Devon is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within NHS Devon as set out in this governance statement.

Governance arrangements and effectiveness

NHS Devon is an Integrated Care Board, which is a statutory body with the general function of arranging for the provision of services for the purposes of the health service in England. It is an NHS body for the purposes of the 2006 Act.

The membership and attendance record for the Board and its committees, together with highlights of their work are at Appendix 1. The Terms of Reference of these committee are contained within the Governance Handbook

The Board has seven committees reporting to it. This includes two statutory committees (the Audit and Risk Committee and the Remuneration Committee), the NHS Devon Executive and an additional four Board Assurance Committees (the Quality and Patient Experience Committee, the Finance and Performance Committee, the Population Health Improvement Committee and the People and Organisational Development Committee). NHS Devon undertook a light touch review of the effectiveness of its Board Assurance Committees at the beginning of 2025 and agreed revised terms of reference and membership of these at its meeting in public on 29 March 2025.

I confirm that NHS Devon has maintained a strong focus on effective governance with this being under constant review to ensure that it meets the needs of the organisation. In addition, a comprehensive review of the effectiveness of the Corporate Governance Framework 2024/25 was also undertaken. Changes made to the Board and its committees during 2024/25 include:

- Establishment of a Population Health Improvement Committee and People and Organisational Development Committee
- Dis-establishment of the Primary Care Commissioning Transition Committee, in light of the establishment of an Executive Commissioning Group.
- Updates to Terms of Reference to ensure that responsibilities around workforce and patient engagement were appropriately allocated.

Other governance updates have included the establishment of an Executive Commissioning Group, One Devon System Leadership Group and the implementation of Locality Planning and Development Meetings to support the system recovery programme and Transforming Devon programme.

To comply with section 14Z49 of the Health & Social Care Act 2022 (general duties of ICBs) NHS Devon keeps under review the skills, knowledge and experience that it considers necessary for members of the board to possess (when taken together) in order for the board effectively to carry out its functions. In line with the fit and proper person's test criteria all board members are required to undertake a range of local and NHS Mandatory Training including modules in respect of safeguarding; patient safety; conflict resolution; equality, diversity and human rights; information governance and conflicts of interest.

In addition, an annual development plan is delivered to address any identified gaps in skills, knowledge or experience gaps and provide updates on areas of focus for NHS Devon and the NHS in general. The 2024/25 Board Development Plan is set out below:

Date	Subject / Area
April 2024	• Children & Young People – understanding our statutory and regulatory accountabilities and responsibilities • 2024-25 Annual Plan – Delivery and Assurance Structures
June 2024	• Estates Infrastructure Strategy • Developing the Governance Improvement Plan
August 2024	• CEO Perspectives on NHS Devon – six months in • Developing the Vision for NHS Devon – next steps
October 2024	• Feedback from Recovery Support Programme meeting with NHS England • Proposed Transformation Programme for NHS Devon • The Board's role in the development and approval of the 2025/26 Annual Plan • Organisational Purpose • Specialised Commissioning • Provider Collaboratives
December 2024	• Collaborative Working with Primary Care • Planning and Transformation • NHS Devon Purpose, Role and Capabilities – next steps
February 2025	• Devolution White Paper • Strategic Connection – Integrated Care Strategy and Joint Forward Plan • 2025/26 NHS Devon Annual Plan • 2025/26 Operational Plan
March 2025	• 2025/26 Operational Plan • 2025/26 Board Assurance Framework

UK Corporate Governance Code

NHS Devon is not required to comply with the UK Code of Corporate Governance.

NHS Devon establishes and reviews its corporate governance arrangements by drawing on best practice, including those aspects of the UK Corporate Governance Code it considers to be relevant. This governance statement is therefore intended to demonstrate NHS Devon's compliance with the principles set out in the Code.

Discharge of Statutory Functions

On 1 July 2022, NHS Devon was established and took on the statutory powers and duties and powers conferred on it by the 2006 Act and other associated legislature and

regulations. As a result, I can confirm that NHS Devon is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead executive director. Responsibility for each duty and power is clearly outlined in NHS Devon's Scheme of Reservation and Delegation, within the financial limits policy delegations are allocated to a lead director.

Like all ICBs in the country, NHS Devon was required to significantly reduce its running costs during 2023/24 and 2024/25. In order to meet this reduction, and to evolve the organisation into its new system role, a complete re-design of its organisational structures was undertaken. Phase One of this work was completed during 2023/24 and involved reviewing the executive and senior team structures to align portfolios with the delivery of strategic objectives and statutory requirements. Phase 2 of the re-design of the organisation continued throughout 2024/25 and is now substantially complete. Further work on Phase 2 has been paused in light of recent announcements about further running cost reductions.

On 10 March 2025 it was announced that ICBs would be required to reduce their running costs by an average of 50%. Work has been begun on a proposed "clustering" of NHS Devon and NHS Cornwall and the Isles of Scilly ICBs in order to enable the achievement of the required savings.

Risk management arrangements and effectiveness

NHS Devon recognises that risk management is an integral part of good management practice and to be most effective, it must be embedded within the organisation's culture. A significant amount of work has been undertaken during 2024/25 to further improve the risk management arrangements.

NHS Devon's Risk Management Policy sets out the principles that the organisation will apply in respect of risk management. It provides the tools to assist staff to ensure, as far as is reasonably practicable, that all risks are identified and controlled appropriately and also sets out the process for risk management including how each risk is identified, assessed, recorded, and managed.

Within NHS Devon, risks are derived from two directions (internal sources):

Bottom Up: Individuals, teams, directorates, Chief Officers, the NHS Devon Executive and Board Assurance Committees can identify operational risks, with those scoring 12 or above collectively forming NHS Devon's Corporate Risk Register.

Top Down: The NHS Devon Board discusses and agrees those strategic risks that it considers the organisation faces in pursuit of its strategic aims, and in fulfilment of its statutory purposes as an Integrated Care Board. These form the strategic risks of NHS Devon and are recorded in its Board Assurance Framework (BAF).

Risks are also identified from external sources such as patients, visitors, contactors, and from other stakeholders. NHS Devon works with its partners to both inform risk

identification and also to assist in management of risks that impact its partners. NHS Devon engages the services of a Counter Fraud Service to support with the identification of possible fraud risks and the associated work to prevent such occurrences.

The amount and type of risk that NHS Devon is prepared to pursue, retain or take in pursuit of its strategic aims and objectives, its risk appetite, was approved by the NHS Devon Board at its meeting in March 2024 along with its strategic risks resulting in the Board Assurance Framework in operation from the start 2024/25.

Capacity to Handle Risk

The NHS Devon Board is ultimately responsible for the organisation's systems of internal control and risk management arrangements, and for demonstrating leadership, active involvement, and support for risk management across NHS Devon. The role and responsibilities of the Chief Executive Officer, Senior Information Risk Owner, Chief Nursing Officer, Chief Medical Officer and Director of Governance are set out within the Risk Management Policy.

The Risk Management Policy, supporting Standard Operating Procedures together with delivery of a risk management training programme ensures that all staff are equipped to assess, manage, escalate and report risks affecting the organisation and will facilitate decision making about those risks that need immediate treatment and those that the organisation can tolerate for a specified amount of time.

During 2024/25 informal risk management training was provided to Risk Owners who have operational responsibility for the management of risks, and to administrative staff, such as 'Risk Co-ordinators', who record and update the risk related documentation following periodic reviews of risks with Risk Owners. A formal risk management training programme is in development and will be delivered from April 2025 to all NHS Devon staff.

The Corporate Governance team supports Chief Officers, Risk Owners and Risk Co-ordinators with reviews, where necessary, of operational and strategic risks. Identifying learning and best practice enables NHS Devon to share this learning throughout the organisation and helps inform risk management training requirements.

Risk Assessment

Operational Risks (Corporate Risk Register)

On 31 March 2025, the Corporate Risk Register contained 30 risks with a current score of 15 or above (15 or above being deemed an 'Extreme Risk').

Each risk on the Corporate Risk Register has an assigned Chief Officer who is ultimately responsible for the risk and the area of work to which the risk relates, and a Risk Owner who has operational responsibility for management of the risk.

During the 2024/25 financial year and as a result of risk discussions within the organisation, a number of new operational risks were added to the Corporate Risk Register covering topics such as in-year delivery of NHS Devon's 2024/25 financial

plan, delivery of the One Devon Integrated Care System financial plan for 2024/25, One Devon Integrated Care System Capital Resources 2024/25, Tuberculosis service provision, potential GP collective action, workforce risks, contracting and commissioning risks, quality and safety risks.

Strategic Risks – Board Assurance Framework (BAF)

For 2024/25, the NHS Devon Board agreed a new approach to the BAF, closely aligning it to the six themes as set out in the NHS Oversight Framework (NOF): 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.

The new approach has simplified the BAF from that which was in place for the 2023/24 financial year, enabling a better focus on the agreed BAF risks associated with these themes.

The NHS Devon Executive reviews the content of the BAF and recommends it to the NHS Devon Board for approval. Board Assurance Committees also have regular oversight of relevant BAF risks, with the Chair of each committee providing assurance via their report to each meeting of the NHS Devon Board. In addition, the Audit and Risk Committee regularly reviews the operation of the organisation's risk management system and provides assurance to the NHS Devon Board of its effectiveness.

On 31 March 2025, the BAF contained the following risks:

NOF Theme: 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.
NOF Theme: 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.
NOF Theme: 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.
NOF Theme: 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.
NOF Theme: 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.

NB: No BAF risk was identified in relation to the Local Strategic Priorities theme during 2024/25.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place at NHS Devon to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The external auditors provide independent assurance that NHS Devon is spending and accounting for public money properly, whilst NHS Devon's internal auditors include this within their Head of Internal Audit Opinion (included at the end of this section of the report).

The systems of internal control related to risk management are monitored by the Corporate Governance team to ensure regular reviews of risk are carried out and any breaches are reported, should they occur. The risk reports for the NHS Devon Board, NHS Devon Executive and Board Assurance Committees are produced by the Corporate Governance team.

NHS Devon contracts for clinical services using the NHS Standard Contract which sets out the requirement for the Provider and Commissioner to meet regularly to discuss performance under the contract. The frequency of meetings of is determined by the financial value and/or the complexity of the service. As a minimum small value contract reviews will take place on an annual basis but generally meetings are held more frequently. The frequency can be amended as the need arises. Contract review meetings (CRM) cover activity and finance and achievement of key performance indicators and quality requirements detailed in the contract. Concerns arising from

CRMs are escalated to Deputy Director Contracting and the appropriate NHS Devon lead for the concern e.g Commissioning, Quality, Safeguarding.

System level contracts are monitored through the Director or Performance and Assurance. The contract team are not involved in this monitoring.

Performance of Primary Care Contracts (GMS/PMS & APMS) is monitored by the Primary Care Team and reported through the Chief Operating Officer Senior Leadership Team who in turn would escalate any performance concerns through the Executive Committee.

Non-clinical contracts are managed through South Central and West Commissioning Support Unit.

Data Quality

The data supplied to the NHS Devon Board and its Committees is obtained from various sources, the majority of which are national systems and official NHS data sets. Provider data is quality assured through a number of mechanisms including contract and performance monitoring. NHS Devon maintains good close working relationships with local providers and addresses any data quality issues in a timely and productive way.

Members are satisfied that the information it is presented with has been through appropriate review and scrutiny, and that it continues to develop with organisational needs.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to NHS Devon, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively. The Data Security and Protection Toolkit (DSPT) submission date for 2023/24 was 30 June 2024 which covered the period 1 July 2023 to 30 June 2024. NHS Devon successfully published a ‘standards met’ toolkit on 27 June 2024. The 2024/25 DSPT will be published before the deadline of 30 June 2025 and NHS Devon is on track to submit a ‘standards met’ DSPT for 2024/25. NHS Devon published a baseline submission for the 24/25 DSPT on the 20 December 2024. Due to the new DSPT coming into effect in September 2024, SCW IG services have worked closely with the ICB to ensure all objectives are compliant.

NHS Devon records all risks relating to data security on a risk register and has taken steps to ensure that all data is held securely, as mandated by Data Protection legislation and NHS requirements.

NHS Devon continues to use the NHS England Data Security Awareness training modules via the Electronic Staff Record portal and this continues to form part of the annual mandatory training for all staff. NHS Devon regularly reviews its processes in

relation to fair processing, subject access requests, incident reporting and investigation, and updates its privacy notice regularly.

The internal incidents portal available via the icon on every staff member's desktop permits direct and quick access to Datix for the reporting of incidents, breaches and near misses. It provides a consistent approach for all staff for reporting whether that be data protection or for example, health and safety. The ongoing reviews and staff engagement ensures awareness surrounding information risk culture throughout the organisation.

High importance is placed on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established a data protection framework and have data protection processes and procedures in line with the DSPT.

NHS Devon routinely reports any untoward incidents involving personal data to its Data Protection Steering Group which meets every quarter and reports are produced for the Audit and Risk Committee

Business Critical Models

In line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, confirm that an appropriate framework and environment is in place to provide quality assurance of business-critical models.

Third party assurances

The following International Standard on Assurance Engagements (ISAE) third party assurance reports have been received:

- ISAE 3000 Third Party Assurance Report in respect of NHS Business Service Authority – Electronic Staff Record (ESR) System
- ISAE Third Party Assurance Report in respect of NHS Business Services Authority – Dental Payments Process System
- ISAE Third Party Assurance Report in respect of NHS Business Services Authority – Prescription Payments Process System
- Internal Controls (Type II) Calculating Quality Reporting Service (CQRS) National SAE Third Party Assurance Report in respect of NHS Shared Business Services – Finance & Accounting Services
- Type II ISAE 3000 Controls Report on the Extraction and Processing of General Practitioner Data Services
- Primary Care Support England ISAE 3402 Type II Report

These are Service Auditor Reports which typically set out the following:

- Respective responsibilities in the Service end-to-end process
- A high-level description of the governance and assurance arrangements in place at the Service Organisation including arrangements for effective risk management and assurance
- A high-level description of the Service control environment

- An assertion by the Service Organisation management regarding the design of internal controls over the process and,
- A low-level description of the Service's control objectives and supporting key controls. Service Auditor Reports are an internationally recognised method for Service Organisations to provide details of controls and their operation in a specified period to their clients and are prepared to internationally recognised standards (typically ISAE 3000 and 3402)

Control Issues

During 2024/25 NHS Devon remained in Segment 4 of the NHS Oversight Framework (NOF4) and has subsequently highlighted a number of control issues connected with quality and performance throughout this period including:

- Accident and Emergency performance – 4 hours see, treat and discharge; pre-midday discharges; no criteria to reside; and ambulance handover delays
- Ambulance Services – Category 2 response times
- Return to Treatment – 65, 78 and 104 week waits
- Finance – developing and delivering national approved financial plan for 2024/25.

A system-wide oversight and assurance framework has been established with progress against NOF4 exit criteria being monitored on a locality basis via Locality Planning and Delivery Meetings and on a system-wide basis via the One Devon System Leadership Group. The NHS Devon Executive, NHS Devon Board and its assurance Committees seek additional assurance in respect of the delivery of the NOF4 exit criteria. A monthly System Integrated Assurance Group (SIAG) meeting takes place, chaired by the NHSE Regional Director to address key issues.

Review of economy, efficiency & effectiveness of the use of resources

The Board has responsibility for ensuring that NHS Devon has appropriate arrangements in place to manage its functions economically, efficiently and effectively. The Board makes sure that NHS Devon operates within the corporate governance framework (i.e. its standing orders, scheme of delegations and standing financial instructions) and has established an Audit and Risk Committee to assist the Board in delivering its responsibilities for the conduct of public business, and the stewardship of funds under its control.

The Audit and Risk Committee provides assurance to the Board that an appropriate system of internal control is in place to ensure that:

- Business is conducted in accordance with the law and proper standards
- Public money is safeguarded and properly accounted for
- Affairs are managed to secure economic, efficient and effective use of resources
- Reasonable steps are taken to prevent and detect fraud and other irregularities

The Finance and Performance Committee provides oversight and assurance on the delivery of a viable and sustainable financial plan, performance in relation to operational

plan delivery, NHS System Oversight Framework requirements and local standards, targets and priorities.

NHS Devon has a procurement policy that seeks to be an effective way to help ensure quality and value for money requirements are achieved; helping NHS Devon commission the right services to improve the lives of those who live in Devon.

Adherence to procurement regulations helps ensure the most advantageous balance of quality and value and enables an assessment of the best possible provider. The Provider Selection regime (for healthcare services) continues to ensure that quality and value are key elements for procurement processes. It includes compliant processes for direct awarding contracts in specific situations; thereby moving away from the requirement to undertake competitive processes as a default. This allows NHS Devon to take a proportionate approach to procurement and to identify the optimum approach to balancing staffing resource with quality and value benefits.

NHS Devon uses internal audit functions to confirm controls are operating effectively, to provide independent assurance and advise on areas of improvement. Audit report findings are discussed in detail at Audit and Risk Committee and summarised in the Head of Internal Audit Opinion Statement.

Delegation of NHS Devon functions

Along with the other six ICBs across the Southwest, NHS Devon jointly exercises its commissioning functions in relation to emergency ambulance services via the Ambulance Partnership Board (APB) which functions as a corporate decision-making body for the management and exercise of these commissioning functions. The APB reports to NHS Dorset ICB, as lead commissioning organisation, twice yearly. The first report presents the annual workplan with the second being a year-end performance report. Regular reporting with regard to ambulance performance is included within the Annual Plan – Delivery Assurance Report which is presented to the NHS Devon Executive, the Finance and Performance Committee, the Quality and Patient Experience Committee and the NHS Devon Board.

NHS Devon has delegated responsibility for commissioning local primary care services including, since 1 April 2023, pharmacy, ophthalmic and dental services.

During 2024/25 assurance on the discharge of these functions was provided to the Board through the Primary Care Commissioning Transitional Committee (PCCTC) and regular reports from that committee's chair. Following the dis-establishment of the PCCTC assurance will be obtained through the Executive Commissioning Group.

Delegated functions are set out in the articles of the constitution, scheme of reservation and delegation or the standing orders.

Compliance with NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR)

NHS Devon reported its compliance against the NHS England Core Standards for EPRR to the Audit and Risk Committee on 6 January 2025 and the NHS Devon Board on 3 January 2025. NHS Devon was assessed as Substantially Compliant.

Counter fraud arrangements

Audit South West Assurance and their accredited Counter Fraud Specialists provide an independent counter-fraud service to NHS Devon.

NHS Devon has a Counter Fraud, Bribery and Corruption Policy which deals with the specific issues in the title. NHS Devon's policies relating to Standards of Business Conduct, Conflicts of Interest, Gifts and Hospitality, and its Disciplinary Policy link to Counter Fraud. Additionally, appropriate policies are reviewed throughout the year for fraud resilience and, where applicable, are updated to protect NHS Devon from economic crime and wrongdoing.

The Audit and Risk Committee receives regular reports from the Counter Fraud team and provides assurance to the Board that an appropriate system of internal control is in place to ensure reasonable steps are taken to prevent and detect fraud and other irregularities.

In 2024-25 local proactive exercises were undertaken in respect of fraud alerts, due diligence and contract management within the procurement process, Association of the British Pharmaceutical Industry (ABPI) checks and participating in the 2024/25 National Fraud initiative.

During this reporting period, training and awareness raising has included:

- Developing of an ELearning fraud induction module with case studies and contact details for the LCFS and NHS Counter Fraud Authority.
- An online fraud awareness survey to raise and test staff awareness of fraud and the evaluate the services provided by LCFS.
- Publishing "Fraud Counts" newsletters which focussed on a range of issues including recent fraud cases, Artificial Intelligence, potential social media scams,
- Promoting relevant material in support of International Fraud Awareness Week (17-23 November 2024).

The NHS Devon Audit and Risk Committee receives regular reports in respect of progress against the annual counter fraud workplan together with annual report in respect of compliance with the 13 components of the Government Function Standards 013: Counter Fraud. This report includes the Trust's submission of its "Counter Fraud Functional Standard Review" to the NHS Counter Fraud Authority. The 2024/25 CFFSR assessed NHS Devon with an overall rating of Green.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2024 – 31 March 2025 for NHS Devon, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of NHS Devon's system of risk management, governance and internal control. The final Head of Internal Audit provided "**Satisfactory Assurance**" and concluded that: "Largely there is a sound system of internal control, designed to meet the ICB's objectives, and controls which are generally being applied consistently. Weaknesses in the design and/or inconsistent application of controls in some key areas put the achievement of particular objectives at risk."

During the reporting period, Internal Audit issued the following audit reports as part of their 2023/24 and 2024/25 Internal Audit Plans:

2023/24 Internal Audit Plan

Area of Audit	Issued	Level of Assurance Given
Financial Management (including productivity and delivery of financial plan)	17.05.2024	Limited
Payroll	05.06.2025	Satisfactory
DSPT (Information Governance)	26.04.2024 30.05.2024	Part 1 – Moderate Part 2 – Substantial
Pharmaceutical, Optometry and Dental Commissioning and Delivery Arrangements	22.05.2024	Satisfactory / Limited
Sustainability of General Practice: Management of Risk	04.07.2024	Satisfactory
Workforce Policy Compliance – Absence Management	17.05.2024	Significant

The Financial Management review found that there were differences in the reporting of performance against system-wide saving plans when comparing updates to some Provider Boards, to figures included within system wide reports.

This was with specific reference to forecast year end positions as reported by NHS Devon. It was also found that the system-wide year end forecast position includes a high-level of uncertainty as at Month 9 the system cost improvement plan savings target was still in development, and a further 7% of savings required further scoping. As such, limited assurance was provided that the system is able to identify and develop

sustainable, robust cost saving plans, to drive out costs, in order to achieve its significant savings target.

The internal audit undertaken to evaluate NHS Devon's arrangements for commissioning Pharmaceutical, Ophthalmic and Dental (POD) services rated as satisfactory for overall arrangements with it being noted that progress has been made in working with the Collaborative Commissioning Hub to develop a service that meets the specific needs of the ICB and its priority areas, especially in respect of the commissioning of Dental services. Based on feedback from the Primary Care Commissioning Team, the Collaborative Commissioning Hub is providing a good service to NHS Devon, in accordance with the Memorandum of Understanding. There was one area identified for urgent attention which related to compliance with NHSE's Primary Care Commissioning Assurance Framework which has now been addressed.

For both of the above internal review findings an action plan has been agreed to address these challenges with progress being reported to the Audit and Risk Committee.

2024/25 Internal Audit Plan

Area of Audit	Level of Assurance Given
Assurance Framework and Risk Management	Satisfactory
Conflicts of Interest	Satisfactory
Business Continuity / Emergency Planning	Limited
Financial Management, including productivity and delivery of Financial Plan	Satisfactory
High Level Financial Controls	Significant
Payroll	Satisfactory
Data Security and Protection Toolkit – Part 1	Overall Risk Assurance: Very High Risk; and Confidence in Veracity of Self-Assessment: Medium
Data Security and Protection Toolkit – Part 2	Overall Risk Assurance: Low Risk; and Confidence in Veracity of Self-Assessment: High
Data Protection / GDPR	Satisfactory
Primary Care Commissioning	Satisfactory
Clinical Governance – Section 117/IPP Review	Limited
Clinical Governance – Patient Safety Incident Response Framework	Satisfactory
HR Policy Compliance Absence, Mandatory Training etc	Satisfactory
Review of Organisation Design Phase 2 implementation	Satisfactory

The Section 117 / IPP review found that whilst the ICB's main delegated service providers, Devon Partnership Trust (DPT) and Livewell Southwest (LWSW), continue to commission, procure and monitor services which generally meet NHS Devon's requirements, limited capacity within the ICB's IPP/Section 117 team, and reduced senior oversight/support of the team has impacted the team's ability to maintain robust controls in respect of the commissioning and management of services, including the effective and timely reporting of emerging risks.

The Business Continuity / Emergency Planning review found that overall, NHS Devon has in place an appropriate system for Business Continuity Management (BCM), with EPRR policies, templates for directorate business continuity plans, and the training needs analysis template, which align with external guidance and are appropriate for the organisation. NHS Devon's high level BCP is appropriate, and the organisation had been involved in three multi agency exercises/tests during the last 12 months. However, at a directorate level there is a need for improvement; two thirds of the expected plans are either out of date or not available, although those in-date plans reviewed were of good quality.

For both of the above internal review findings an action plan has been agreed to address these challenges with progress being reported to the Audit and Risk Committee.

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and executive managers within NHS Devon who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to NHS Devon achieving its principal objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The Board
- The Audit and Risk Committee
- The Finance and Performance Committee
- The Quality and Patient Experience Committee
- Internal audit
- External audit

Conclusion

In line with the HIAO I can confirm that there is satisfactory assurance on the internal control, governance and risk management arrangements for NHS Devon. Whilst NHS Devon has undertaken a significant programme of work to improve and strengthen its core governance, internal control and risk management arrangements, with these revised practices now becoming fully embedded within day-to-day business activities.

Steve Moore

Accountable Officer, Chief Executive Officer

NHS Devon Integrated Care Board

19 June 2025

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The Remuneration Committee fulfils the remuneration committee functions required by statute, principally to determine remuneration, fees and allowances payable to NHS Devon staff, and make recommendations to the board. As well as this, the committee deals with remuneration and terms of service in relation to the board and the executive team.

The committee consists of members of the board who are not executive, as well as the chair of the One Devon Integrated Care Partnership. The quorum is a minimum of three of the non-executive members, including the Chair or Vice Chair.

Percentage change in remuneration of highest paid director

	Salary and allowances	
	2024/25	2023/24
The percentage change from the previous financial year in respect of the highest paid director	4%	18%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	7%	5%

The 2023/24 increase in respect of the highest paid director is due to the appointment of the new chief executive in which their pay was based on the NHS very senior managers pay framework rates of similar sized Integrated care boards.

The average 7% increase in employee costs reflects the 5.5% consolidated pay award for 2024/25, alongside a workforce reorganisation that resulted in a reduction of 56 FTEs — 63% of whom were earning below the average salary.

Performance-related pay or bonus schemes do not apply within the ICB.

Pay ratio information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's

workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded annual remuneration of the highest paid director / member in NHS Devon ICB in the reporting year end 31 March 2025 was £242,500, (£240,000 - £245,000) , (year 1 April 2023 – 31 March 2024 was £ 232,500 (£230,000-£235,000)). This salary is in line with the executive salary scale for Integrated Care Boards.

The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

2024/25 / (2023/24)	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	36,483 /30,639	52,809 / 50,056	72,293 / 68,525
Salary component of total remuneration (£)	36,483 /30,639	52,809 / 50,056	72,293 / 68,525
Pay ratio information	6.65 /7.59	4.59 /4.64	3.35 /3.39

This was 6.65 (7.59) times the 25th percentile of remuneration of the workforce, which was £36,483 (£30,639), 4.59 (4.64) times the median remuneration of the workforce, which was £52,809 (£50,056) and 3.35 (3.39) times the 75th percentile of remuneration of the workforce, which was £72,293 (£68,525).

Movements have been impacted by the reorganisation of NHS Devon. The workforce has shrunk by 56 FTE's, 63% of which were on salaries less than the average.

During the reporting period 2024/25, no employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £16,530 (£15,668) to £225,000 (£210,000).

Total remuneration includes salary, benefits-in-kind, and severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Policy on the remuneration of senior managers

All employed senior managers are engaged under NHS Agenda for Change terms and conditions of employment, however for those remunerated as very senior managers, remuneration is determined through a VSM pay framework. This pay framework is internally reviewed annually, with consideration given to NHS guidance on appropriate remuneration for ICB very senior managers.

Employed board members hold contracts of employment with the ICB, with appropriate notice periods built into each contract. Redundancy clauses in each contract matched the provisions in the Agenda for Change contract of employment.

Some Board members are not employed but engaged through office holder contracts for a period of tenure. Remuneration for these roles is determined internally, with consideration given to NHS guidance on the appropriate fee for such roles.

Senior manager performance related pay

NHS Devon does not have performance related pay.

Remuneration of very senior managers

Senior manager remuneration (including salary and pension entitlements) April-March 2024/25 (subject to audit).

Name and Title	Note	April-March 2024/25					
		(a)	(b)	(c)	(d)	(e)	(f)
		Salary	Expense payments	Performance pay and bonuses	Long term performance pay and bonuses	All pension-related benefits	TOTAL
		(bands of £5,000)	(taxable) to nearest	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(a to e)
			£100**				(bands of £5,000)
		£000	£	£000	£000	£000	£000
Nigel Acheson Chief Medical Officer	1	40-45	0	0	0	95-97.5	135-140
Salma Ali Non-Executive Member	2	0-5	0	0	0	0	0-5
Sheena Asthana Non-Executive Member	3	10-15	0	0	0	0	10-15
Kaye Bentley Non-Executive Member	4	0-5	0	0	0	0	0-5
Graham Clarke Non-Executive Member		15-20	0	0	0	0	15-20
Peter Collins Chief Medical Officer	5	90-95	11900	0	0	25-27.5	130-135
Kirsty Denwood Interim Chief Finance Officer	6	35-40	0	0	0	0-2.5	35-40
John Finn Acting Chief Operating Officer	7	35-40	0	0	0	7.5-10	40-45
Anthony Fitzgerald Chief Delivery Officer	8	165-170	100	0	0	22.5-25	190-195
Thandiwe Hara Non-Executive Member		15-20	100	0	0	0	15-20
Philippa Harding Chief Communications and Corporate Affairs Officer	9	125-130	0	0	0	32.5-35	160-165
Judy Hargadon Non-Executive Member	10	15-20	0	0	0	0	15-20
Andrew Millward Chief Communication and Corporate Affairs Officer	11	80-85	100	0	0	0	85-90

Steve Moore Chief Executive Officer and Accountable Officer		240-245	300	0	0	0	240-245
Frank O'Kelly Primary Care Representative		35-40	0	0	0	0	35-40
Kevin Orford Independent Chair	12	55-60	1200	0	0	0	60-65
Lopa Patel Non-Executive Member	13	0-5	0	0	0	0	0-5
Bill Shields Chief Finance Officer	14	165-170	400	0	0	0	165-170
Penny Smith Chief Nursing Officer	15	140-145	100	0	0	105-107.5	245-250
Martin Sykes Non-Executive Member	16	5-10	0	0	0	0	5-10
Piers Tetley Chief People Officer		140-145	0	0	0	35-37.5	180-185
Dr Sarah Wollaston Independent Chair	17	10-15	0	0	0	0	10-15

1. Nigel Acheson finished role 30 June 2024. Full year equivalent salary of £162,844.
2. Salma Ali began role on 1 February 2025. Full year equivalent salary £17,000.
3. Sheena Asthana finished role on 7 January 2025. Full year equivalent salary £17,000.
4. Kaye Bentley began role on 1 February 2025. Full year equivalent salary £17,000.
5. Peter Collins began role on 14 October 2024. Full year equivalent salary £201,600.
6. Kirsty Denwood began role on 1 January 2025. Full year equivalent salary £145,067.
7. John Finn began role on 1 January 2025. Full year equivalent salary £144,619.
8. Anthony Fitzgerald finished role on 31 December 2024. Full year equivalent salary £148,838. The value in the table includes a severance payment made in accordance with contractual terms and HM Treasury guidance.
9. Philippa Harding began role on 1 May 2024. Full year equivalent salary £139,650.
10. Judy Hargadon finished role on 31 March 2025.
11. Andrew Millward retired in year. Full year equivalent salary £145,920.
12. Kevin Orford finished role as a Non-Executive Member on 10 June 2024, and thereafter took up the role of Acting Chair and then Chair. Full year equivalent salary for the latest role £70,000.

13. Lopa Patel began role on 1 February 2025. Full year equivalent salary of £17,000.

14. Bill Shields finished role on 31 December 2024. Full year equivalent salary £219,994.

15. Penny Smith was Interim Chief Nursing officer until November 2024 and now holds the role of Chief Nursing Officer. Full year equivalent salary £150,000.

16. Martyn Sykes started as an Interim Non-Executive Director between 12 November 2024 and 31 March 2025. Full year equivalent salary £17,000.

17. Dr Sarah Wollaston finished role on 10 June 2024. Full year equivalent salary £65,000.

Additional Board members and attendees not receiving remuneration from Devon ICB in 2024/25

- Liz Davenport is Chief Executive Officer, Torbay and South Devon NHS Trust., finished role 31 December 2024. No payments are made for attendance.
- Dr Ruth Harrell, Partner Member LA, Plymouth City Council, finished role 31 July 2024. No payments are made for attendance.
- Mary Aspinall is an elected member of Plymouth City Council. Mary serves as Chair of Plymouth City Council's Health and Wellbeing Board as well as the Integrated Care Partnership Chair. Role started 9 January 2025 and no payments are made for attendance.
- Sam Higginson, CEO of Royal Devon University Healthcare NHS Foundation Trust , started role 1 January 2025. No payments made for attendance.
- Donna Manson, Partner Member LA - Devon County Council. No payments are made for attendance.
- Phill Mantay is the Mental health, learning disability and neurodiversity member, CEO of Devon Partnership NHS Trust. No payments are made for attendance.
- Cllr James McInnes is Co-Chair Devon Integrated Care Partnership and finished role in May 2024. No payments were made for attendance.
- Lincoln Sargeant, population health and prevention member, Director of Public Health Torbay Council, started role 18 September 2024. No payments made for attendance.
- Kate Shields is Chief Executive Officer, Cornwall and Isles of Scilly ICB. No payments are made for attendance.

Senior manager remuneration (including salary and pension entitlements) April-March 2023/24 (audited)

Name and Title	Note	April-March 2023/24					
		(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100**	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
Nigel Acheson Chief Medical Officer		160-165	-			-	160-165
Darryn Allcorn Chief Nursing Officer	1	10-15	100			-	10-15
Sheena Asthana Non-Executive Member		15-20	-			-	15-20
Naomi Chapman Interim Chief Nursing Officer	2	55-60	-			-	55-60
Graham Clarke Non-Executive Member		15-20	-			-	15-20
Anthony Fitzgerald Chief Delivery Officer		140-145	-			112.5-115	255-260
Sarah-Lou Glover Mental Health Representative	3	10-15	100			-	10-15
Natasha Goswell Interim Chief Nursing Officer	4	15-20	-			-	15-20
Thandiwe Hara Non-Executive Member		15-20	-			-	15-20
Judy Hargadon Non-Executive Member		15-20	-			-	15-20
Hisham Khalil Non-Executive Member	5	10-15	-			-	10-15
Susan Masters Interim Chief Nursing Officer	6	5-10	-			-	5-10
Jane Milligan Chief Executive Officer and Accountable Officer	7	120-125	100			-	120-125
Andrew Millward Chief Communication and Corporate Affairs Officer		140-145	200			-	145-150
Steve Moore Chief Executive Officer and Accountable Officer	8	30-35	-			-	30-35
Frank O'Kelly Primary Care Representative		35-40	-			-	35-40
Kevin Orford Non-Executive Member			300			-	

		15-20					15-20
Paul Renshaw Director of Strategic Workforce	9	120-125	200			57.5-60	180-185
Bill Shields Chief Finance Officer		205-210	300			-	205-210
Penny Smith Interim Chief Nursing Officer	10	45-50	-			-	45-50
Simon Tapley Chief Transformation & Strategic Planning Officer	11	15-20	100			-	15-20
Sarah Wollaston Independent Chair		65-70	-			-	65-70

***Note: Taxable expenses and benefits in kind are expressed to the nearest £100.*

1. Darryn Allcorn finished role on 30 April 2023. Full year equivalent salary £152,250.
2. Naomi Chapman held role from 15t May 23-30 September 2023. Full year equivalent salary £145,000.
3. Sarah-Lou Glover finished role on 8 December 2023. Full year equivalent salary £21,333.
4. Natasha Goswell held role from 1 October 2023 -1 December 2023. Full year equivalent salary £114,949.
5. Hisham Khalil finished role on 8 December 2023. Full year equivalent salary £17,000.
6. Susan Masters held role from 11 September 2023 - 1 October 2023. Full year equivalent salary £114,949
7. Jane Milligan finished role on 31 October 2023. Full year equivalent salary £206,484.
8. Steve Moore began role 12 February 2024. Full year equivalent salary £230,000.
9. Paul Renshaw finished role 31 January 2024. Full year equivalent salary £145,688.
10. Penny Smith began role 1 December 2023. Full year equivalent salary £135,000.
11. Simon Tapley finished role 14 May 2023. Full year equivalent salary £154,609.

Additional Board members and attendees not receiving remuneration from NHS Devon in 2023/24

- Donna Manson, Partner Member LA - Devon County Council, started role 1 August 2023. No payments are made for attendance.
- Dr Ruth Harrell, Partner Member LA, Plymouth City Council, started role 22 August 2023. No payments are made for attendance.
- Liz Davenport is Chief Executive Officer, Torbay and South Devon NHS Trust. No payments are made for attendance.
- Kate Shields is Chief Executive Officer, Cornwall and Isles of Scilly ICB. No payments are made for attendance.
- Cllr James McInnes is Co-Chair Devon Integrated Care Partnership. No payments are made for attendance.

- Steve Brown, Director of Public Health, Devon County Council, finished role on 21 July 2023. No payments are made for attendance.
- Tracey Lee, Partner Member, LA - Plymouth City Council, finished role on 20 June 2023. No payments are made for attendance.

Pension benefits April–March 2024/25 (subject to audit)

NHS Pension information is provided by NHS Business Services Authority.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual.

The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.

This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Factors determining the variation in the values recorded between individuals include but is not limited to:

- A change in role with a resulting change in pay and impact on pension benefits
- A change in the pension scheme itself
- Changes in the contribution rates
- Changes in the wider remuneration package of an individual

Pension benefits relate to the total employment with NHS Devon even if the member has a split role but are pro rata to time spent in senior management position.

Pension benefits April–March 2024/25 (subject to audit)

Name and Title	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2025	Lump sum at pension age related to accrued pension at 31 March 2025	Cash Equivalent Transfer Value at 1 April 2024	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025	Employer's contribution to stakeholder pension
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
	£000	£000	£000	£000	£000	£000	£000	£000
Nigel Acheson Chief Medical Officer	2.5-5	10-12.5	80-85	220-225	1799	0	0	0
Peter Collins Chief Medical Officer	0-2.5	0	75-80	190-195	1564	30	1745	0
Kirsty Denwood Interim Chief Finance Officer	0-2.5	0	60-65	160-165	1322	3	1438	0
John Finn Chief Operating Officer	0-2.5	0-2.5	40-45	0-5	619	8	709	0
Anthony Fitzgerald Chief Delivery Officer	0-2.5	0	55-60	145-150	1216	0	1181	0
Philippa Harding Chief Communications and Corporate Affairs Officer	2.5-5	0	15-20	5-10	223	20	276	0
Andrew Millward Chief Communication and Corporate Affairs Officer	0	0	55-60	155-160	92	0	0	0
Steve Moore Chief Executive Officer and Accountable Officer	0	0	70-75	170-175	1597	0	1590	0
Penny Smith Chief Nursing Officer	5-7.5	12.5-15	55-60	160-165	1265	135	1503	0
Piers Tetley Chief People Officer	2.5-5	0	15-20	0	189	21	239	0

Negative values are not disclosed in this table but are substituted with a zero as directed by the 2024/25 Department of Health and Social Care group accounting manual.

Where members took pension during the year, no cash equivalent transfer value (CETV) is applicable.

Where members are over the national retirement age in the existing scheme, a CETV calculation is not applicable.

Where Senior Managers chose not to be covered by the pension arrangements during the reporting year; they will be excluded from the above.

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2025. HM Treasury published.

As the Chair and independent non-executive members do not receive pensionable remuneration, there are no pension-related entries reported for them.
Accrued pension benefits included in this table for any individual affected by the Public Service Pensions Remedy have been calculated based on their inclusion in the legacy scheme for the period between 1 April 2015 and 31 March 2022, following the McCloud judgment. The Public Service Pensions Remedy applies to individuals that were members, or eligible to be members, of a public service pension scheme on 31 March 2012 and were members of a public service pension scheme between 1 April 2015 and 31 March 2022. The basis for the calculation reflects the legal position that impacted members have been rolled back into the relevant legacy scheme for the remedy period and that this will apply unless the member actively exercises their entitlement on retirement to decide instead to receive benefits calculated under the terms of the Alpha scheme for the period from 1 April 2015 to 31 March 2022.

Pension benefits April–March 2023/24 (audited)

Name and Title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2024 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2023	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2024	(h) Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Nigel Acheson Chief Medical Officer	0	32.5-35	70-75	195-200	1568	52	1799	0
Darryn Allcorn Chief Nursing Officer	0	2.5-5	50-55	140-145	882	23	1151	0
Anthony Fitzgerald Chief Delivery Officer	5-7.5	15-17.5	50-55	140-145	880	229	1216	0
Susan Masters Interim Chief Nursing Officer	0-2.5	0	5-10	0	31	3	85	0
Jane Milligan Chief Executive Officer and Accountable Officer	0	100-102.5	50-55	265-270	1436	0	0	0
Andrew Millward Chief Communication and Corporate Affairs Officer	0	15-17.5	55-60	155-160	1265	0	92	0
Steve Moore Chief Executive Officer and Accountable Officer	0	30-32.5	70-75	185-190	1251	216	1597	0
Paul Renshaw Director of Strategic Workforce	2.5-5	0	20-25	0	240	82	360	0
Simon Tapley Chief Transformation & Strategic Planning Officer	0	0	45-50	125-130	1072	0	1066	0

Members are affected by the public service pensions remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995 to 2008 Scheme on 1 October 2023.

Taxable expenses

No expenses, other than reimbursement of those actually incurred and in support of training and development of senior managers, have been paid.

Expenses, all of which relate to mileage claims and relocation costs, give rise to a tax liability and have been disclosed separately as benefits in kind. The tax liability arises as either the rate per mile reimbursed by NHS Devon exceeds that allowed as a tax-free amount by HMRC, or the total annual amount paid by NHS Devon exceeds that allowed as a tax-free amount by HMRC respectively.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement of for loss of office

There was one early retirement through ill health during the year ending 31 March 2025 amounting to £389,969, which is funded through NHS Pensions.

Payments to past directors

There were no awards made to past senior managers in-year.

Staff Costs

The table below sets out the breakdown of employee benefits for the year ending 31 March 2025

Year ended 31 March 2025		Total			Admin			Programme	
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Salaries and wages	24,359	22,359	2,000	9,327	8,352	975	15,032	14,007	1,025
Social security costs	2,610	2,610	-	1,135	1,135	-	1,475	1,475	-
Employer Contributions to NHS Pension scheme	4,799	4,799	-	3,041	3,041	-	1,758	1,758	-
Other pension costs	10	10	-	10	10	-	-	-	-
Apprenticeship Levy	89	89	-	89	89	-	-	-	-
Termination benefits	(1,615)	(1,615)	-	(336)	(336)	-	(1,279)	(1,279)	-
Gross employee benefits expenditure	30,252	28,252	2,000	13,266	12,291	975	16,986	15,961	1,025
Less recoveries in respect of employee benefits	(1,173)	(1,173)	-	(384)	(384)	-	(789)	(789)	-
Net admin employee benefits	29,079	27,079	2,000	12,882	11,907	975	16,197	15,172	1,025

The termination benefits in 2024/25 are shown as a negative figure because an estimate for the potential redundancies was included in the 2023/24 accounts following the reorganisation. However, the associated costs did not fully materialise in 2024/25, as the individuals either secured alternative roles within the ICB or chose to leave voluntarily.

The table below sets out the breakdown of employee benefits for the period ending 31 March 2024.

Period ended 31 March 2024	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Salaries and wages	27,242	25,059	2,183	10,890	9,920	970	16,352	15,139	1,213
Social security costs	2,720	2,720	-	1,146	1,146	-	1,574	1,574	-
Employer Contributions to NHS Pension scheme	4,795	4,795	-	2,781	2,781	-	2,014	2,014	-
Other pension costs	11	11	-	4	4	-	7	7	-
Apprenticeship Levy	112	112	-	112	112	-	-	-	-
Termination benefits	3,827	3,827	-	2,496	2,496		1,331	1,331	
Gross employee benefits expenditure	38,707	36,524	2,183	17,429	16,459	970	21,278	20,065	1,213
Less recoveries in respect of employee benefits	(1,371)	(1,371)	-	(590)	(590)	-	(781)	(781)	-
Net admin employee benefits	37,336	35,153	2,183	16,839	15,869	970	20,497	19,284	1,213

Exit packages, including special (non-contractual) payments

Table 1: Exit Packages

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	2	16,583	0	0	2	16,583	0	0
£10,000 - £25,000	3	53,502	2	36,980	5	90,482	0	0
£25,001 - £50,000	1	33,324	0	0	1	33,324	0	0
£50,001 - £100,000	1	50,543	4	287,268	5	337,811	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 – £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	7	153,952	6	324,248	13	478,200	0	0

Redundancy and other departure cost have been paid in accordance with the provisions of the NHS terms and conditions handbook, NHS pension scheme and NHS standard contract where applicable. Exit costs in this note are accounted for in full in the year of departure. Where NHS Devon ICB has agreed early retirements, the additional costs are met by NHS Devon ICB and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 2: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	**5**	**251,789**
Mutually agreed resignations (MARS) contractual costs	**0**	**0**
Early retirements in the efficiency of the service contractual costs	**0**	**0**
Contractual payments in lieu of notice*	**1**	**72,459**
Exit payments following Employment Tribunals or court orders	**0**	**0**
Non-contractual payments requiring HMT approval**	**0**	**0**
TOTAL	**6**	**324,248**

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in table 1 above which will be the number of individuals.

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Independent auditor's report

Report on the audit of the financial statements

Opinion

We have audited the financial statements of NHS Devon Integrated Care Board ("the ICB") for the year ended 31 March 2025 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2025 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 23 April 2025 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the ICB in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis, as they have not been informed by the relevant national body of the intention to either cease the ICB's services or dissolve the ICB without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the ICB over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the ICB will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit and Risk Committee and internal audit and inspection of policy documentation as to the ICB's high-level policies and procedures to prevent and detect fraud, as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the ICB by NHS England.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reading the ICB's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated statutory resource limits, we performed procedures to address the risk of management override of controls, in particular the risk that ICB management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the ICB, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. We therefore assessed that there was limited opportunity for the ICB to manipulate the income that was reported.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to the completeness of expenditure. We consider this would be most likely to occur through understating purchase of goods and services, specifically services from foundation trusts and purchase of healthcare from non-NHS bodies.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual postings to cash, unusual postings to expenditure, and journals that move expenditure between programme and administrative expenditure
- For a selection of cash payments and purchase invoices in the period post 31 March 2024, we assessed whether the expenditure had been recognised in the appropriate accounting period to which the expenditure related.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Board and other management (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The ICB is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the ICB is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2024/25.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 80, the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the ICB or dissolve the ICB without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are

considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

Report on other legal and regulatory matters

Opinion on regularity

The Accountable Officer is responsible for ensuring the regularity of expenditure and income.

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Basis for opinion on regularity

We conducted our work on regularity in accordance with Statement of Recommended Practice - Practice Note 10: *Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022)* issued by the FRC. We planned and performed procedures to obtain sufficient appropriate evidence to give an opinion over whether the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. The procedures selected depend on our judgement, including the assessment of the risks of material irregular transactions. We are required to obtain sufficient appropriate evidence on which to base our opinion.

Report on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the ICB to secure economy, efficiency and effectiveness in its use of resources.

Except for the matters detailed below, we have nothing else to report in this respect.

Significant weakness – Financial sustainability

We identified a significant weakness in the ICB's arrangements in relation to financial sustainability in our audit for the periods ended 31 March 2023 and 31 March 2024, due to the Devon Integrated Care System's ("ICS") significant cumulative deficit position and its reliance on a significant savings plan which it was at risk of not delivering.

Whilst the 2024/25 efficiency plan was achieved, this was only met through additional non-recurrent funding being received from NHS England. In addition, the final financial plan for the ICS for 2025/26 describes an in-year delivery of breakeven for the system as a whole, being an £8.0 million surplus in the ICB, offset by an £8.0 million deficit in the providers. However, this position is only achievable if £53.8 million deficit support funding is received, which is dependent upon the system as a whole meeting efficiency plans. Financial sustainability should not be reliant upon non-recurrent efficiency savings and deficit support funding.

We have therefore concluded that there remains a significant weakness over the arrangements that the ICB has in place to deliver financial sustainability.

Recommendation

We recommend that the ICB ensures that there is a robust process for ensuring Cost Improvement Plans are deliverable without dependency on non-recurrent funding, and monitored so that any required mitigations can be identified and actioned.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 80, the Accountable Officer is responsible for ensuring that the ICB exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the ICB has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the ICB had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we make written recommendations to the ICB under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Members of the Board of NHS Devon Integrated Care Board, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Board of the ICB, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

Delay in certification of competition of the audit

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the ICB's accounts consolidation template for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of NHS Devon Integrated Care Board for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the NAO Code of Audit Practice.

Jonathan Brown

for and on behalf of KPMG LLP

Chartered Accountants

66 Queen Square

Bristol

BS1 4BE

[date]

Annual accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2025

	Note	Year ending 31 March 2025 £'000	Year ending 31 March 2024 £'000
Income from sale of goods and services	2	(29,492)	(30,892)
Other operating income	2	(19,705)	(63,161)
Total operating income		**(49,197)**	**(94,053)**
Staff costs	4	30,252	38,707
Purchase of goods and services	5	3,193,983	2,994,425
Depreciation and impairment charges	5	973	848
Other Operating Expenditure	5	(4,480)	5,138
Total operating expenditure		**3,220,728**	**3,039,118**
Net Operating Expenditure		**3,171,531**	**2,945,065**
Finance income	8	-	-
Finance expense	9	170	82
Other gains and losses	10	505	100
Net expenditure for the Period		**3,172,206**	**2,945,247**
Comprehensive Expenditure for the Period		**3,172,206**	**2,945,247**

The notes on the following pages form part of this statement

Statement of Financial Position as at 31 March 2025

	Note	Year ending 31 March 2025 £'000	Year ending 31 March 2024 £'000
Non-current assets:			
Property, plant and equipment	11	940	1,162
Right-of-use Assets	12	3,653	4,842
Intangible assets	13	0	0
Other financial assets	16	0	0
Total non-current assets		**4,593**	6,004
Current assets:			
Inventories	14	2,239	1,903
Trade and other receivables	15	27,240	38,800
Cash and cash equivalents	17	0	0
Total current assets		**29,479**	40,703
Total assets		**34,072**	46,707
Current Liabilities			
Trade and other payables	18	(150,472)	(219,063)
Lease liabilities	12	(464)	(689)
Borrowings	19	(1,422)	(1,767)
Provisions	20	(137)	(1,952)
Total current liabilities		**(152,495)**	(223,471)
Total Assets less Current Liabilities		**(118,423)**	(176,764)
Non-current liabilities			
Other financial liabilities		-	-
Lease liabilities	12	(3,174)	(4,127)
Borrowings	19	-	-
Provisions	20	(260)	(251)
Total non-current liabilities		**(3,434)**	(4,378)
Assets less Liabilities		**(121,857)**	(181,142)
Financed by Taxpayers' Equity			
General fund		(121,857)	(181,142)
Total taxpayers' equity:		**(121,857)**	(181,142)

The notes on the following pages form part of this statement

The financial statements on the following pages were approved by the Governing Body on 19 June 2025 and signed on its behalf by:

Steve Moore
Chief Executive

Statement of Changes In Taxpayers Equity for the year ended 31 March 2025

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for Year ending 31 March 2025		
Balance at 01 April 2024	(181,142)	**(181,142)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	**-**
Adjusted ICB balance	**(181,142)**	**(181,142)**
Changes in NHS ICB taxpayers' equity for Year ending 31 March 2025		
Net expenditure for the financial period	(3,172,206)	**(3,172,206)**
Net Recognised NHS ICB Expenditure for the Financial Year	**(3,172,206)**	**(3,172,206)**
Net funding	3,231,491	**3,231,491**
Balance at 31 March 2025	**(121,857)**	**(121,857)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for Period ending 31 March 2024		
Balance at 01 April 2023	(140,777)	(140,777)
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	**-**
Adjusted ICB balance	**(140,777)**	**(140,777)**
Changes in NHS ICB taxpayers' equity for year ending 31 March 2024		
Net expenditure for the financial period	(2,945,247)	(2,945,247)
Net Recognised NHS ICB Expenditure for the Financial Year	**(2,945,247)**	**(2,945,247)**
Net funding	2,904,882	2,904,882
Balance at 31 March 2024	**(181,142)**	**(181,142)**

The notes on the following pages from part of this statement

Statement of Cash Flows for the year ended 31 March 2025

	Note	Year ending 31 March 2025 £'000	Year ending 31 March 2024 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(3,172,756)	(2,945,407)
Depreciation and amortisation	5	973	848
Movement due to transfer by Modified Absorption		-	-
Interest paid	9	148	80
Other Gains & Losses	10	505	100
Unwinding of Discounts	9	22	2
(Increase)/decrease in inventories	14	(336)	(691)
(Increase)/decrease in trade & other receivables	15	11,561	(33,224)
(Increase)/decrease in other current assets		-	-
Increase/(decrease) in trade & other payables	18	(68,373)	72,256
Increase/(decrease) in other current liabilities		-	-
Provisions utilised	20	(213)	-
Increase/(decrease) in provisions	20	(1,615)	2,201
Net Cash Inflow (Outflow) from Operating Activities		**(3,230,084)**	(2,903,835)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment	11	(332)	(531)
(Payments) for intangible assets	13	-	-
(Payments) for leases right-of-use assets	12	-	(249)
Proceeds from disposal of assets: property, plant and equipment	13	-	150
Net Cash Inflow (Outflow) from Investing Activities		**(332)**	(630)
Net Cash Inflow (Outflow) before Financing		**(3,230,416)**	(2,904,465)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		3,231,491	2,904,882
Repayment of lease liabilities	12	(730)	(700)
Net Cash Inflow (Outflow) from Financing Activities		**3,230,761**	2,904,182
Net Increase/(Decrease) in Cash & Cash Equivalents	17	**345**	(283)
Cash & Cash Equivalents at the Beginning of the Financial Year		(1,767)	(1,484)
Transfer from other public bodies under absorption (including bank overdrafts)		-	-
Cash & Cash Equivalents at the End of the Financial Year		**(1,422)**	(1,767)

The notes on the following pages form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual (GAM) issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2024-25 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards (IFRS) to the extent that they are meaningful and appropriate to ICBs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

Management is required to assess, at the time of preparing the financial statements, the entity's ability to continue as a going concern. The accounting concept of a going concern refers to the basis on which an organisation's assets and liabilities are recorded and included in the accounts. If an organisation is a going concern it is expected to operate for the foreseeable future, usually 12 months from the date the final accounts have been approved by the Board. An organisation that was not a going concern would prepare its accounts on a different basis, reflecting their value on the winding up of the entity. Consequently, assets are more likely to be recorded at a much lower break-up value and medium and long-term liabilities would become short-term liabilities.

The Department of Health and Social Care Group Accounting Manual 2024-25 states that for non-trading entities in the public sector, the anticipated continuation of the provision of service in the future, as evidenced by inclusion of financial provision of that service in published documents, is normally sufficient evidence of going concern. The 2024-25 Annual Report for the year ended 31 March 2025 discusses and reviews the ICBs future service plans and aims for their local populations.

With the above in mind the accounts have been prepared on a going-concern basis. This is effectively in relation to the ICBs intention to continue its operations for the foreseeable future and the awareness of any circumstances affecting this in its preparation of these financial statements.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Joint arrangements

Arrangements over which the ICB has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control and have rights to the assets and obligations for the liabilities relating to the arrangement. Where the ICB is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

The ICB has entered into five arrangements, four of which has been assessed as joint operations.

The first of which is a joint operation under a Section 75 agreement with Plymouth City Council (PCC) to form the Plymouth Integrated Fund to manage Health and Social Care spending for the population of Plymouth. There are two elements to the integrated fund being 1) pooled funds (including the Plymouth Better Care Fund (BCF)) and 2) aligned funds where they cannot be managed within the pool but can be aligned for inclusion in the risk share arrangements. Under the section 75 agreement the ICB is the host to the pooled element of the fund however PCC remain lead commissioner for their element of spend within the pool. Under a joint operation each entity accounts for its share of the arrangement.

The second of which is a joint operation under a Section 75 agreement with Devon County Council (DCC) to form the Devon BCF. DCC are host to the fund and the ICB is lead commissioner to some of the funds elements. The net cost of the Devon BCF is reported within purchase of goods and services. Under a joint operation each entity accounts for its share of the arrangement.

The third arrangement is with Torbay Council for the Joint Community Equipment Store and the fourth concerns the Better Care Fund with Torbay Council.

The arrangement for Torbay is hosted by the ICB. The ICB accounts for its share of the income and expenditure arising from the activities of the arrangements, identified in accordance with the pooled budget agreements.

If the ICB is involved in a joint venture, the parties that have joint control have rights to the net assets of the arrangement. This must involve a separate vehicle and will need to account for their interest as an investment. Joint ventures are accounted for using the equity method.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.
The ICB has entered into a joint venture with Plymouth City Council for the provision of IT services through the company DELT Shared Services Ltd (DELT). DELT commenced providing services on 1 September 2014. No IT assets transferred from the ICB to DELT. Existing IT assets remain on the ICB's fixed asset register with the exception of GPIT assets which remain on NHS England's fixed asset register.
The ICB holds a shareholding interest in DELT in respect of 1 A ordinary Share with a nominal total value of £1 being 50% of the total shareholding and 30 B ordinary shares with a total nominal value of £30 being 30% of the total shareholding.

The ICB has considered the materiality of DELT as an entity and has concluded that the value falls below a materiality threshold and therefore group accounts have not been prepared.

1.4 **Revenue**

The ICB receives its main funding through a resource allocation from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• As per paragraph 121 of the Standard the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

From 1 April 2023 the ICB was delegated responsibility from NHS England for the commissioning of primary care pharmacy, ophthalmic and dental services and as a consequence is in receipt of patient fees and charges. Other income the ICB receives is pass-through funds from organisations, for example from NHS England, as well as refunds for drugs that the ICB purchased during the year.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.5 **Employee Benefits**

1.5.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.5.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/nhs-pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment. The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Some employees have joined the National Employment Savings Trust (NEST) pension scheme which is a defined contribution scheme and was set up by the government. The contributions the employee makes, along with the level of growth from the investments, will determine the size of the pension available on retirement.

1.6 **Other Expenses**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and are measured at the fair value of the consideration payable. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the ICB recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.8 **Property, Plant & Equipment**

1.8.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the ICB;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.8.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.8.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 **Intangible Assets**

1.9.1 **Recognition**

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the ICB's business or which arise from contractual or other legal rights. They are recognised only:

· When it is probable that future economic benefits will flow to, or service potential be provided to, the ICB;

· Where the cost of the asset can be measured reliably; and,

· Where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised but is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

· The technical feasibility of completing the intangible asset so that it will be available for use;

· The intention to complete the intangible asset and use it;

· The ability to sell or use the intangible asset;

· How the intangible asset will generate probable future economic benefits or service potential;

· The availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and,

· The ability to measure reliably the expenditure attributable to the intangible asset during its development.

1.9.2 **Measurement**

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost or the value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.9.3 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the ICB expects to obtain economic benefits or service potential from the asset. This is specific to the ICB and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the ICB checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.10 **Leases**

A lease is a contract, or part of a contract, that conveys the right to use an asset for a period of time in exchange for consideration. The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.10.1 **The ICB as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 4.72% (3.51%) is applied for leases commencing, transitioning or being remeasured in the 2024 (2023) calendar year; and 4.81% to new leases commencing in 2025 under IFRS 16.

Lease payments included in the measurement of the lease liability comprise

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the ‘Depreciation, amortisation and impairments’ policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.11 **Inventories**

Inventories are valued at the lower of cost and net realisable value. The ICB's share of the inventory in the Better Care Fund with Devon County Council is disclosed in note 14.

1.12 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the ICB's cash management.

1.13 **Provisions**

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 4.03% (2023-24: 4.26%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 4.07% (2023-24: 4.03%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 4.81% (2023-24: 4.72%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 4.55% (2023-24: 4.40%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

The ICBs financial statements include a provision for dilapidation costs associated with the lease for Aperture House, its headquarters, along with a redundancy provision because of the restructure of the ICB due to the requirement to reduce its costs related to the running of the organisation. Refer to note 20 for further information.

1.14 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the ICB is disclosed in Note 20.

1.15 **Non-clinical Risk Pooling**

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due. The value of these scheme provisions carried by NHS Resolution on behalf of the ICB is disclosed in Note 20.

1.16 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.17 **Financial Assets**

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.
Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.17.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.17.2 **Financial assets at fair value through other comprehensive income**

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the ICB elected to measure an equity instrument in this category on initial recognition.

1.17.3 **Financial assets at fair value through profit and loss**

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.
The ICB has no embedded derivatives that are required to be accounted for separately.
The ICB's only financial assets are trade receivables and cash and cash equivalents which are disclosed in note 22.2. Trade receivables are recognised at the consideration agreed at the date of the transaction and the cash and cash equivalents are recognised at face value.

1.17.4 **Impairment of financial assets**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets or assets measured at fair value through other comprehensive income, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.
The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally, Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.
For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.18 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.18.1 **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

· The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,

· The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.18.2 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the ICB's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability. The ICB has no embedded derivatives that are required to be accounted for separately.

1.18.3 **Other Financial Liabilities**

The ICB's other financial liabilities are trade payables and loans with external bodies. These are disclosed in note 22.3. Trade payables are recognised at the consideration agreed at the date of the transactions. Loans with external bodies is a technical overdraft with the bank due to the ICB meeting its obligation to pay general practitioners, at the start of the month, while ensuring the bank account balance is within 1.25% of the ICB's February's funding. Loans with external bodies is recognised as the amount in the bank less the BACs run processed.
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.19 **Value Added Tax**

Most of the activities of the ICB are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 **Foreign Currencies**

The ICB's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. No significant foreign currency transactions occurred during the year.

1.21 **Third Party Assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the ICB has no beneficial interest in them.

1.22 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the ICB's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects

only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.22.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the ICB's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Apart from the accounting treatment of the better care fund budgets mentioned in 1.3 above and those involving estimations (see below), management has made no other critical accounting judgements in the process of applying the ICB's accounting policies that have would have a significant effect on the amounts recognised in the financial statements:

1.22.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial period.

Estimation techniques are used to ensure that the correct levels of income and expenditure relating to current year are included through the inclusion of accruals. These are based on known commitments and local knowledge. Historically the difference between the estimated accruals and actual cost have not been material and it is expected to follow suit this period. The accruals will be carried forward into the period 1 April 2025 to 31 March 2026 and matched against the actual costs incurred within the ICB.

For the main acute contracts these are estimated at year end based on full year affect which is agreed and discussed with the providers.

Regarding prescribing costs, the ICB relies on the Business Services Authority's (BSA) forecasting methodology applied to primary care prescribing as well as local factors that fall outside of the national model. Due to the timing of published data the year end position includes an estimate for both February and March's prescribing costs.

A provision has been included in the accounts to reflect an estimate of the redundancy costs due to the decisions made. The provision has been calculated by looking at the agreements agreed and in place.

Other estimates and judgements made in applying the ICB's accounting policies relate to the valuation of Property, Plant and Equipment, Leases Right-of-use assets and Intangibles. The nature of the assumptions and carrying value of the assets and liabilities are detailed in note 11, 12 and 13 respectively.

1.23 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The Department of Health and Social Care GAM does not require the following IFRS Accounting Standards and Interpretation to be applied for the year ended 31 March 2025.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2023. IFRS 17 will be adopted by the FReM 1 April 2025. Early adoption is not permitted. IFRS 17 standardises the recognition, measurement, presentation, and disclosure of insurance contracts, enhancing transparency and comparability across the industry. It requires insurers to measure liabilities using current assumptions, recognise profits over the contract's duration, and provide detailed disclosures on risks and financial performance. The ICB assessed existing contracts for insurance components to determine IFRS 17's applicability. The review concluded that none of the current contracts met the criteria for classification under the standard. To ensure compliance going forward, business processes will be implemented to review new contracts for insurance components, with IFRS 17 applied where relevant.

● IFRS 18 Presentation and Disclosure in Financial Statements – The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The objective of the Standard is to set out requirements for the presentation and disclosure of information in general financial statements to help ensure they provide relevant information that faithfully represents an entity's assets, liabilities, equity, income and expenses. Implementation of IFRS 18 will have no impact on the ICB's financial position.

● IFRS 19 Subsidiaries without Public Accountability: Disclosures – The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK-endorsed and not yet adopted by the FReM. Early adoption is not permitted. IFRS 19 specifies reduced disclosure requirements that an eligible entity is permitted to apply instead of the disclosure requirements in other

IFRS Accounting Standards. Implementation of IFRS 19 will have no impact on the ICB's financial position.

2 Other Operating Revenue

	Year ending 31 March 2025 Total	Year ending 31 March 2024 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	**-**	-
Non-patient care services to other bodies	**-**	-
Patient transport services	**-**	-
Prescription fees and charges	**15,842**	15,350
Dental fees and charges	**12,477**	14,171
Income generation	**-**	-
Other Contract income	**-**	-
Recoveries in respect of employee benefits	**1,173**	1,371
Total Income from sale of goods and services	**29,492**	30,892
Other operating income		
Non cash apprenticeship training grants revenue	**20**	39
Other non contract revenue	**19,685**	63,122
Total Other operating income	**19,705**	63,161
Total Operating Income	**49,197**	94,053

The main ICB funding is not included in this note. Revenue received from NHS England is drawn down directly into the bank account of the ICB and credited to the General Fund.

From 1 April 2023 the ICB was delegated responsibility from NHS England for the commissioning of primary care pharmacy, ophthalmic and dental contracts and as a consequence is in receipt of patient fees and charges.

3 Disaggregation of Income - Income from sale of good and services (contracts)

The ICB receives income as part of the joint arrangements with its partner organisations. Income also includes reimbursments for cost of drugs that the ICB purchased during the year and patient fees and charges from primary care pharmacy and dental contracts.

4 Employee benefits and staff numbers

	Total		Year ending 31 March 2025
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**22,359**	**2,000**	**24,359**
Social security costs	**2,610**	**-**	**2,610**
Employer Contributions to NHS Pension scheme	**4,799**	**-**	**4,799**
Other pension costs	**10**	**-**	**10**
Apprenticeship Levy	**89**	**-**	**89**
Termination benefits	**(1,615)**	**-**	**(1,615)**
Gross employee benefits expenditure	**28,252**	**2,000**	**30,252**
Less recoveries in respect of employee benefits (note 4.1.2)	**(1,173)**	**-**	**(1,173)**
Total - Net admin employee benefits including capitalised costs	**27,079**	**2,000**	**29,079**
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	**27,079**	**2,000**	**29,079**

4.1.1 Employee benefits	Total		Year ending 31 March 2024
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	25,059	2,183	27,242
Social security costs	2,720	-	2,720
Employer Contributions to NHS Pension scheme	4,795	-	4,795
Other pension costs	11	-	11
Apprenticeship Levy	112	-	112
Termination benefits	3,827	-	3,827
Gross employee benefits expenditure	36,524	2,183	38,707
Less recoveries in respect of employee benefits (note 4.1.2)	(1,371)	-	(1,371)
Total - Net admin employee benefits including capitalised costs	35,153	2,183	37,336
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	35,153	2,183	37,336

4.1.2 Recoveries in respect of employee benefits **Year ending 31 March 2025**

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits - Revenue			
Salaries and wages	**(969)**	**-**	**(969)**
Social security costs	**(100)**	**-**	**(100)**
Employer contributions to the NHS Pension Scheme	**(104)**	**-**	**(104)**
Other pension costs	**-**	**-**	**-**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**
Total recoveries in respect of employee benefits	(1,173)	-	(1,173)

4.2 Average number of people employed

	Year ending 31 March 2025			Year ending 31 March 2024		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**380.37**	**16.82**	**397.19**	474.93	25.39	500.32
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**			

4.3 Staff Annual Leave Accrual Balances

	Year ending 31 March 2025			Year ending 31 March 2024		
	Total	**Permanent Staff**	**Temp/Agency**	Total	Permanent Staff	Temp/Agency
	£000s	**£000s**	**£000s**	£000s	£000s	£000s
	(408)	**(408)**	**-**	(299)	(299)	-

4.4 Exit packages agreed in the financial year

	Year ending 31 March 2025 Compulsory redundancies		Year ending 31 March 2025 Other agreed departures		Year ending 31 March 2025 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	2	16,583	-	-	2	16,583
£10,001 to £25,000	3	53,502	2	36,980	5	90,482
£25,001 to £50,000	1	33,324	-	-	1	33,324
£50,001 to £100,000	1	50,543	4	287,268	5	337,811
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**7**	**153,952**	**6**	**324,248**	**13**	**478,200**

	Year ending 31 March 2024 Compulsory redundancies		Year ending 31 March 2024 Other Agreed Departures		Year ending 31 March 2024 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	1	8,000	1	8,000
£10,001 to £25,000	1	14,581	1	11,836	2	26,417
£25,001 to £50,000	1	33,333	3	108,050	4	141,383
£50,001 to £100,000	1	60,000	3	207,955	4	267,955
£100,001 to £150,000	-	-	6	828,390	6	828,390
£150,001 to £200,000	-	-	3	480,000	3	480,000
Over £200,001	-	-	-	-	-	-
Total	**3**	**107,914**	**17**	**1,644,231**	**20**	**1,752,145**

	Year ending 31 March 2025		Year ending 31 March 2024	
	Departures where special payments have been made		Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

4.5 Analysis of Other Agreed Departures

	Year ending 31 March 2025		Year ending 31 March 2024	
	Other agreed departures		Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	5	251,789	15	1,587,631
Mutually agreed resignations (MARS) contractual costs	-	-	-	-

Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	72,459	1	48,600
Exit payments following Employment Tribunals or court orders	-	-	1	8,000
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**6**	**324,248**	**17**	**1,644,231**

- As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.
- These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.
- Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.
- No non-contractual payments were made to individuals where the payment value was more than 12 months' of their annual salary.
- The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.6 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

4.6.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.6.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

4.6.3 National Employment Savings Trust Pension Scheme

Some employees have joined the National Employment Savings Trust (NEST) pension scheme which is a defined contribution scheme and was set up by the government. The contributions the employee makes, along with the level of growth from the investments, will determine the size of the pension available on retirement.

5 Operating expenses

	Year ending 31 March 2025 Total £'000	Year ending 31 March 2024 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	1,161	2,422
Services from foundation trusts	1,391,159	1,289,941
Services from other NHS trusts	756,355	695,899
Services from Other WGA bodies	8	-
Purchase of healthcare from non-NHS bodies	350,531	330,382
Purchase of social care	55,841	44,762
General dental services and personal dental services	52,737	50,081
Prescribing costs	239,623	243,227
Pharmaceutical services	46,562	44,575
General Ophthalmic services	12,356	11,795
GPMS/APMS and PCTMS	270,370	258,569
Supplies and services – clinical	81	733
Supplies and services – general	2,892	2,186
Consultancy services	481	4,330
Establishment	7,373	9,777
Transport	110	192
Premises	2,790	3,051
Audit fees	253	247
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	18	18
Other professional fees	1,955	1,018
Legal fees	503	582
Education, training and conferences	804	599
Non cash apprenticeship training grants	20	39
Total Purchase of goods and services	**3,193,983**	**2,994,425**
Depreciation and impairment charges		
Depreciation	973	771
Amortisation	-	77
Total Depreciation and impairment charges	**973**	**848**
Other Operating Expenditure		
Chair and Non Executive Members	170	188
Grants to Other bodies	-	-
Clinical negligence	1	1
Research and development (excluding staff costs)	-	50
Expected credit loss on receivables	(4,675)	4,899
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories relate to the ICB's share of inventories held within the Devon Better Care Fund managed by Devon County Council as host of the pooled fund.	-	-
Inventories consumed	-	-
Other expenditure	24	(0)
Total Other Operating Expenditure	**(4,480)**	**5,138**
Total operating expenditure	**3,190,476**	**3,000,411**

- In accordance with SI 2008 no.489, The Companies Regulations 2008, the contract the ICB has with the external auditors, KPMG UK LLP, has a limitation on their liability set at £5m.
- The external audit fee, payable to KPMG UK LLP, is £210,738 plus VAT totalling £252,886 for the year ended 31 March 2025 (2023-24 £247,200 including VAT).
- Other services obtain from KPMG UK LLP is £15,345 plus VAT, totalling £18,414 (2023-24 £18,000 including VAT), for the Mental Health Investment Standard assurance work.
- Spend for dental, pharmacy and ophthalmic services commenced 1 April 2023 as the ICB was delegated responsibility for these services by NHS England.

6.1 Better Payment Practice Code

	Year ending 31 March 2025 Number	**Year ending 31 March 2025 £'000**	Year ending 31 March 2024 **Number**	Year ending 31 March 2024 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	91,487	774,826	76,486	664,694
Total Non-NHS Trade Invoices paid within target	91,310	772,291	76,267	658,409
Percentage of Non-NHS Trade invoices paid within target	**99.81%**	**99.67%**	**99.71%**	**99.05%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,274	2,179,814	1,244	1,961,927
Total NHS Trade Invoices Paid within target	1,269	2,179,789	1,235	1,960,571
Percentage of NHS Trade Invoices paid within target	**99.61%**	**100.00%**	**99.28%**	**99.93%**

The better payment practice code requires the ICB to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**Year ending 31 March 2025 £'000**	Year ending 31 March 2024 £'000
Amounts included in finance costs from claims made under this legislation		
Compensation paid to cover debt recovery costs under this legislation		
Total	**-**	**-**

7 Income Generation Activities

The ICB undertakes income generation activities with an aim of achieving profit, which is then used in commissioning healthcare services. None of these activities had a full cost which exceeded £1m or was otherwise material.

8 Finance income

	Year ending 31 March 2025 £'000	Year ending 31 March 2024 £'000
Investment income		
Investment income (cash)	-	-
Investment income (non-cash)	-	-
		-
Interest Other	-	-
Total interest	**-**	**-**
Unwinding of discount on receivables	-	-
Total finance income	**-**	**-**

9 Finance expense

	Year ending 31 March 2025 £'000	Year ending 31 March 2024 £'000
Interest		
Interest on lease liabilities	148	80
Other interest expense	-	-
Total interest	**148**	**80**
Other finance costs	-	-
Provisions: unwinding of discount	22	2
Total finance costs	**170**	**82**

10 Other Gains & Losses

	Year ending 31 March 2025 £'000	Year ending 31 March 2024 £'000
(Gain) / Loss on disposal of right-of-use assets other than by sale	505	160
(Gain) / Loss on disposal of intangible assets other than by sale	-	(60)
(Gain) / Loss on disposal of financial assets other than held for sale	-	-
Total	505	100

There was a loss of £505k as a result of surrendering the leases associated with Pomona House.

11 Property, plant and equipment

Year ending 31 March 2025	Buildings £'000	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2024	-	4	1,779	74	1,857
Additions purchased	-	-	113	-	113
Additions donated	-	-	-	-	-
Additions government granted	-	-	-	-	-
Additions leased	-	-	-	-	-
Reclassifications	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-
Disposals other than by sale	-	-	(113)	-	(113)
Impairments charged	-	-	-	-	-
Reversal of impairments	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-
Cumulative depreciation adjustment following revaluation					
Cost/Valuation at 31 March 2025	**-**	**4**	**1,779**	**74**	**1,857**
Depreciation 01 April 2024	0	4	617	73	694
Disposals other than by sale	-	-	(113)	-	(113)
Charged during the year	-	-	335	1	336
Transfer (to)/from other public sector body	-	-	-	-	-
Cumulative depreciation adjustment following revaluation					
Depreciation at 31 March 2025	**0**	**4**	**839**	**74**	**917**
Net Book Value at 31 March 2025	**(0)**	**(0)**	**940**	**(0)**	**940**
Purchased	(0)	(0)	940	(0)	940
Total at 31 March 2025	**(0)**	**(0)**	**940**	**(0)**	**940**

Revaluation Reserve Balance for Property, Plant & Equipment

	Buildings £'000	Plant & machinery £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2024	-	-	-	-	-
Revaluation gains	-	-	-	-	-
Impairments	-	-	-	-	-
Release to general fund	-	-	-	-	-
Other movements	-	-	-	-	-
Balance at 31 March 2025	**-**	**-**	**-**	**-**	**-**

11 Property, plant and equipment cont'd

11.1 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	Year ending 31 March 2025 £'000	Year ending 31 March 2024 £'000
Buildings	-	-
Plant & machinery	4	4
Transport equipment	-	-
Information technology	294	113
Furniture & fittings	74	60
Total	**372**	**177**

11.2 Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Information technology	-	5
Furniture & fittings	-	-

12 Leases Right-of-use assets

Year ending 31 March 2025	Land £'000	Buildings £'000	Total £'000	Of which: leased from DHSC group bodies £'000
Cost or valuation at 01 April 2024	-	5,772	5,772	1,174
Additions	-	-	-	-
Reclassifications	-	-	-	-
Upward revaluation gains	-	-	-	-
Lease remeasurement	-	-	-	-
Modifications	-	-	-	-
Disposals on expiry of lease term	-	-	-	-
Derecognition for early terminations	-	(1,557)	(1,557)	(1,174)
Transfer (to) from other public sector body	-	-	-	-
Cost/Valuation at 31 March 2025	**-**	**4,215**	**4,215**	**-**
Depreciation 01 April 2024	-	931	931	420
Charged during the year	-	637	637	205
Impairments charged	-	-	-	-
Reversal of impairments	-	-	-	-
Disposals on expiry of lease term	-	-	-	-
Derecognition for early terminations	-	(1,006)	(1,006)	(625)
Transfer (to) from other public sector body	-	-	-	-
Depreciation at 31 March 2025	**-**	**562**	**562**	**-**
Net Book Value at 31 March 2025	**-**	**3,653**	**3,653**	**-**
NBV by counterparty				
Leased from DHSC				-
Leased from the NHS England Group				-
Leased from NHS Providers				-
Leased from Executive Agencies				-
Leased from Non-Departmental Public Bodies				-
Leased from other group bodies				-
Net Book Value at 31 March 2025				**0**

Revaluation Reserve Balance for Right-of-use-assets

	Land £'000	Buildings £'000	Total £'000
Balance at 01 April 2024	-	-	-
Revaluation gains	-	-	-
Impairments	-	-	-
Release to general fund	-	-	-
Other movements	-	-	-
Balance at 31 March 2025	**-**	**-**	**-**

12 Leases Right-of-use assets cont'd

12.1 Lease liabilities

	Year ending 31 March 2025 £'000	Year ending 31 March 2024 £'000
Lease liabilities at 1 April 2024	(4,816)	(2,524)
Additions	-	(3,965)
Interest expense relating to lease liabilities	(148)	(80)
Repayment of lease liabilities (capital and interest)	730	700
Lease remeasurement	-	-
Modifications	-	973
Derecognition for early terminations	596	80
Transfer (to) from other public sector body	-	-
Lease liabilities at 31 March 2025	**(3,638)**	(4,816)

12.2 Lease liabilities - Maturity analysis of undiscounted future lease payments

	Year ending 31 March 2025 £'000	**Of which: leased from DHSC group bodies £'000**	Year ending 31 March 2024 £'000	**Of which: leased from DHSC group bodies** £'000
Within one year	(580)	-	(780)	(259)
Between one and five years	(1,842)	-	(2,514)	(612)
After five years	(1,771)	-	(2,313)	-
	(4,193)	-	(5,607)	(871)
Effect of discounting	555	-	791	37
Included in:				
Current lease liabilities	(464)	-	(689)	(240)
Non-current lease liabilities	(3,174)	-	(4,127)	(594)
Total	**(3,638)**	**-**	(4,816)	(834)
Balance by counterparty		-		-
Leased from DHSC		-		-
Leased from the NHS England Group		-		-
Leased from NHS Providers		-		-
Leased from Executive Agencies		-		-
Leased from Non-Departmental Public Bodies		-		-
Leased from other group bodies		-		(834)
Balance as at 31 March 2025		**-**		(834)

12.3 Amounts recognised in Statement of Comprehensive Net Expenditure

	Year ending 31 March 2025 £'000	Year ending 31 March 2024 £'000

Depreciation expense on right-of-use assets	**637**	564
Interest expense on lease liabilities	**148**	80

12.4 Amounts recognised in Statement of Cash Flows

	Year ending 31 March 2025 £'000	Year ending 31 March 2024 £'000
Total cash outflow on leases under IFRS 16	**730**	700
Total cash outflow for lease payments not included within the measurement of lease liabilities	**82**	37

- The ICB's leases relate to its various office locations, including Aperture House (Exeter), County Hall (Exeter) and Pomona House (Torquay). As part of the ICB's strategy to consolidate its property portfolio, it moved into a new headquarters in 2023/24, Aperture House (Exeter), relinquishing its leases at County Hall and Pomona House in 2024/25."
- Irrecoverable VAT is not included in the measurement of leases and so the ICB has an estimated £842k of future VAT payments related to the leases disclosed above.

13 Intangible non-current assets

Year ending 31 March 2025	Computer Software: Purchased £'000	Total £'000
Cost or valuation at 01 April 2024	94	**94**
Additions purchased	-	**-**
Disposals other than by sale	(94)	**(94)**
Upward revaluation gains	-	**-**
Impairments charged	-	**-**
Cost / Valuation At 31 March 2025	**-**	**-**
Amortisation 01 April 2024	94	**94**
Reclassifications	-	**-**
Reclassified as held for sale and reversals	-	**-**
Disposals other than by sale	(94)	**(94)**
Charged during the year	-	**-**
Amortisation At 31 March 2025	**(0)**	**(0)**
Net Book Value at 31 March 2025	**0**	**0**

Revaluation Reserve Balance for intangible assets

	Computer Software: Purchased £'000	Total £'000
Balance at 01 April 2024	-	**-**
Revaluation gains	-	**-**
Impairments	-	**-**
Release to general fund	-	**-**
Other movements	-	**-**
Balance at 31 March 2025	**-**	**-**

The intangible asset has been derecognised from the financial statements as it is fully amortised and no longer in use.

13 Intangible non-current assets cont'd

13.1 Cost or valuation of fully amortised assets

The cost or valuation of fully depreciated assets still in use was as follows:

	Year ending 31 March 2025 £'000	Year ending 31 March 2024 £'000
Computer software: purchased	-	94
Computer software: internally generated	-	-
Licences & trademarks	-	-
Development expenditure (internally generated)	-	-
Total	**-**	**94**

13.2 Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Computer software: purchased	-	-
Computer software: internally generated	-	-
Licences & trademarks	-	-
Patents	-	-
Development expenditure (internally generated)	-	-

14 Inventories

	Drugs	**Consumables**
	£'000	**£'000**
Balance at 01 April 2024	-	1,831
Additions	-	336
Inventories recognised as an expense in the period	-	-
Balance at 31 March 2025	**-**	**2,167**

Inventories relate to the ICB's share of inventories held within the Devon Better Care Fund managed by Devon County Council as host of the pooled fund.

15.1 Trade and other receivables	Current Year ending 31 March 2025 £'000	Non-current Year ending 31 March 2025 £'000	Current Year ending 31 March 2024 £'000	Non-current Year ending 31 March 2024 £'000
NHS receivables: Revenue	1,312	-	1,944	-
NHS accrued income	303	-	43	-
NHS Contract Receivable not yet invoiced/non-invoice	2,892	-	-	-
Non-NHS and Other WGA receivables: Revenue	2,181	-	17,866	-
Non-NHS and Other WGA prepayments	824	-	724	-
Non-NHS and Other WGA accrued income	565	-	4,902	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	18,941	-	17,788	-
Expected credit loss allowance-receivables	(805)	-	(5,480)	-
VAT	1,026	-	1,013	-
Other receivables and accruals	1	-	0	-
Total Trade & other receivables	**27,240**	**-**	**38,800**	**-**
Total current and non current	**27,240**		**38,800**	

As at 31 March 2025 there were no non-current trade and other receivables (none as at 31 March 2024).
There are no prepaid pensions contributions as at 31 March 2025 (none as at 31 March 2024).
The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to ICB's to cor services, no credit scoring of them is considered necessary.

15.2 Receivables past their due date but not impaired

	Year ending 31 March 2025 DHSC Group Bodies £'000	Year ending 31 March 2025 Non DHSC Group Bodies £'000	Year ending 31 March 2024 DHSC Group Bodies £'000	Year ending 31 March 2024 Non DHSC Group Bodies £'000
By up to three months	4	1,142	117	8,159
By three to six months	-	216	17	7,849
By more than six months	0	205	5	1,455
Total	**4**	**1,563**	139	17,463

£5k of the amount above has subsequently been recovered post period end as at 17 April 2025.
The ICB did not hold any collateral against receivables outstanding at 31 March 2025.
Receivables past their due date are stated at the consideration agreed at the date of the transaction and the carrying amount

15.3 Loss allowance on asset classes	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 01 April 2024	(5,480)	-	**(5,480)**

Transfer by Absorption from other entity			**-**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	4,675	-	**4,675**
Lifetime expected credit losses on trade and other receivables-Stage 3	-	-	**-**
Other changes	-	-	**-**
Total	**(805)**	**-**	**(805)**

16 Other financial assets

16.1 Non-Current: capital analysis

The ICB holds a shareholding interest in DELT comprising one A Ordinary Share with a nominal value of £1, representing 50% of the A Ordinary Shareholding, and 30 B Ordinary Shares with a nominal value of £30, representing 30% of the B Ordinary Shareholding. Due to the immaterial value of this investment, it is not reflected in the annual accounts.

17 Cash and cash equivalents

	Year ending 31 March 2025	Year ending 31 March 2024
	£'000	£'000
Balance at 01 April 2024	(1,767)	(1,484)
Net change in year	345	(283)
Balance at 31 March 2025	**(1,422)**	**(1,767)**
Made up of:		
Cash with the Government Banking Service (GBS)	-	(0)
Cash in hand	0	0
Cash and cash equivalents as in statement of financial position	**0**	**0**
Bank overdraft: Government Banking Service	(1,422)	(1,767)
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**(1,422)**	**(1,767)**
Balance at 31 March 2025	**(1,422)**	**(1,767)**

On a monthly basis the ICB draws down cash based on need, aiming to maintain minimal month-end balances. However, due to the requirement to pay general practices at the start of the month, this puts the ICB in a technical overdraft, reported as borrowings. The bank is in credit by £643,102 while the BACS payment £2,065,355 is in progress. NHS England funds are deposited into the ICB account on the day the general practices payments leave the account.

18 Trade and other payables	Current Year ending 31 March 2025 £'000	Non-current Year ending 31 March 2025 £'000	Current Year ending 31 March 2024 £'000	Non-current Year ending 31 March 2024 £'000
NHS payables: Revenue	2,679	-	4,336	-
NHS payables: Capital	-	-	-	-
NHS accruals	23,795	-	45,641	-
NHS deferred income	-	-	-	-
Non-NHS and Other WGA payables: Revenue	13,449	-	43,172	-
Non-NHS and Other WGA payables: Capital	-	-	218	-
Non-NHS and Other WGA accruals	93,303	-	98,262	-
Non-NHS and Other WGA deferred income	2,063	-	795	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	286	-	327	-
VAT	-	-	-	-
Tax	340	-	336	-
Payments received on account	-	-	-	-
Other payables and accruals	14,557	-	25,976	-
Total Trade & Other Payables	**150,472**	**-**	**219,063**	**-**
Total current and non-current	**150,472**		**219,063**	

Other payables and accruals include those for Primary Care, Placements, Acute Care and Community Services that are not part of Whole Government Accounts (WGA), as well as outstanding pension contributions.

19 Borrowings	Current Year ending 31 March 2025 £'000	Non-current Year ending 31 March 2025 £'000	Current Year ending 31 March 2024 £'000	Non-current Year ending 31 March 2024 £'000
Bank overdrafts:				
· Government banking service (GBS)	1,422	-	1,767	-
· Commercial banks	-	-	-	-
Total overdrafts	**1,422**	**-**	1,767	-
Total	**1,422**	**-**	1,767	-
Total current and non-current	**1,422**		1,767	

The ICB is in a technical overdraft which is partly due to the requirement for the ICB to pay general practices and other commitments at the start of the month. The bank is in credit while the BACS payment is in progress. NHS England funds are deposited into the ICB account on the day the general practices payments leave the account.

19.1 Repayment of principal falling due

	Department of Health Year ending 31 March 2025 £'000	Other Year ending 31 March 2025 £'000	Total Year ending 31 March 2025 £'000
Within one year	-	1,422	1,422
Between one and two years	-	-	-
Between two and five years	-	-	-
Between one and five years	**-**	**-**	-
After five years	-	-	-
Total	**-**	**1,422**	**1,422**

	Department of Health Year ending 31 March 2024 £'000	Other Year ending 31 March 2024 £'000	Total Year ending 31 March 2024 £'000
Within one year	-	1,767	1,767
Between one and two years	-	-	-
Between two and five years	-	-	-
Between one and five years	-	-	-
After five years	-	-	-
Total	-	1,767	1,767

20 Provisions

	Current Year ending 31 March 2025 £'000	**Non-current Year ending 31 March 2025 £'000**	Current Period ending 31 March 2024 £'000	Non-current Period ending 31 March 2024 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	137	-	1,952	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	-	-	-	-
Clinician Tax Charge	-	-	-	-
Continuing care	-	-	-	-
Other	-	260	-	251
Total	**137**	**260**	**1,952**	**251**
Total current and non-current	**397**		**2,203**	

	Pensions Relating to Former Directors £'000	**Pensions Relating to Other Staff £'000**	**Restructuring £'000**	**Redundancy £'000**	**Agenda for Change £'000**	**Equal Pay £'000**	**Legal Claims £'000**	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2024	**-**	**-**	**-**	**1,952**	**-**	**-**	**-**	**-**	**251**	**2,203**
Arising during the year	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Utilised during the year	**-**	**-**	**-**	**(213)**	**-**	**-**	**-**	**-**	**-**	**(213)**
Reversed unused	**-**	**-**	**-**	**(1,615)**	**-**	**-**	**-**	**-**	**-**	**(1,615)**
Unwinding of discount	**-**	**-**	**-**	**13**	**-**	**-**	**-**	**-**	**9**	**22**
Change in discount rate	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	-
Transfer (to) from other public sector body under absorption	-	-	-	-	-	-	-	-	-	-
Balance at 31 March 2025	**-**	**-**	**-**	**137**	**-**	**-**	**-**	**-**	**260**	**397**
Expected timing of cash flows:										
Within one year	-	-	-	**137**	-	-	-	-	-	**137**
Between one and five years	-	-	-	-	-	-	-	-	-	-
After five years	-	-	-	-	-	-	-	-	**260**	**260**
Balance at 31 March 2025	**-**	**-**	**-**	**137**	**-**	**-**	**-**	**-**	**260**	**397**

Redundancy

In 2023/24, ICBs were required to deliver a 30% real-terms reduction in Running Cost Allowances by 2025/26, with a minimum of 20% to be achieved in 2024/25. In response, Devon ICB undertook a review of its organisational structure to align with these requirements and its new statutory responsibilities. A provision was included in the 2023/24 accounts to reflect estimated redundancy costs arising from these changes. This provision was calculated by multiplying the anticipated reduction in staff numbers by the average redundancy cost. The full provision was not utilised, as a number of individuals either left the organisation voluntarily or secured roles within the restructured organisation. The remaining redundancy provision relates to individuals for whom redundancy has been agreed but payment is yet to be made.

Other

During 2023/24 the ICB relocated its headquarters to Aperture House and under International Financial Reporting Standards a long-term lease must be capitalised and disclosed as a Right of Use asset. In determining the value of the asset, dilapidation costs are factored in and provided for as a provision to be utilised in due course. The dilapidation provision has been estimated based on the latest averages and cost per square metres.

£nil is included in the provisions of NHS Resolution as at 31 March 2025 in respect of the Liabilities to Third Parties Scheme of the ICB (£10k 31 March 2024).

In addition, £91k is included in provisions of NHS Resolution on behalf of the ICB in respect of the Clinical Negligence Scheme for Trusts as at 31 March 2025 (£nil 31 March 2024).

Legal claims are calculated from the number of claims currently lodged with NHS Resolution and the probabilities provided by them.

21 Contingencies

The ICB had no contingent assets or liabilities for the period ended 31 March 2025.

22 Financial instruments

Financial instruments are disclosed at fair value. Due to the short term nature of the transactions, fair value for cash is recognised at its sterling value; trade receivables, trade payables, other financial assets and liabilities are stated at the consideration agreed at the date of the transaction, hence the carrying value is considered to be a reasonable approximation to fair value.

22.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the ICB is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The ICB has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the ICB in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the ICB standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the ICB and internal auditors.

22.1.1 Currency risk

The ICB is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The ICB has no overseas operations and therefore the ICB has low exposure to currency rate fluctuations.

22.1.2 Interest rate risk

The ICB borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The ICB therefore has low exposure to interest rate fluctuations.

22.1.3 Credit risk

Because the majority of the ICB revenue comes parliamentary funding, the ICB has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

22.1.4 Liquidity risk

The ICB is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The ICB draws down cash to cover expenditure, as the need arises. The ICB is not, therefore, exposed to significant liquidity risks.

22.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

22 Financial instruments cont'd

22.2 Financial assets

	Financial Assets measured at amortised cost	**Equity Instruments designated at FVOCI**	**Total**	Financial Assets measured at amortised cost	Equity Instruments designated at FVOCI	Total
	Year ending 31 March 2025 £'000	**Year ending 31 March 2025 £'000**	**Year ending 31 March 2025 £'000**	Year ending 31 March 2024 £'000	Period ending 31 March 2024 £'000	Period ending 31 March 2024 £'000
Trade and other receivables with NHSE bodies	1,493	-	**1,493**	1,851	-	1,851
Trade and other receivables with other DHSC group bodies	3,018	-	**3,018**	233	-	233
Trade and other receivables with external bodies	21,684	-	**21,684**	40,459	-	40,459
Other financial assets	-	-	**-**	-	-	-
Cash and cash equivalents	-	-	**-**	-	-	
Total	**26,195**	**-**	**26,195**	42,543	-	42,543

22.3 Financial liabilities

	Financial Liabilities measured at amortised cost	**Other**	**Total**	Financial Liabilities measured at amortised cost	Other Year ending 31 March 2024	Total Year ending 31 March 2024
	Year ending 31 March 2025 £'000	**Year ending 31 March 2025 £'000**	**Year ending 31 March 2025 £'000**	Year ending 31 March 2024 £'000	£'000	£'000
Loans with external bodies	1,422		**1,422**	1,767		1,767
Trade and other payables with NHSE bodies	469	-	**469**	1,175	-	1,175
Trade and other payables with other DHSC group bodies	28,054	-	**28,054**	50,305	-	50,305

Trade and other payables with external bodies	119,261	-	**119,261**	166,125	-	166,125
Other financial liabilities	-	-	**-**	-	-	-
Finance leases - right-of-use lease obligations	3,638	-	**3,638**	4,816		4,816
Total	**152,844**	**-**	**152,844**	224,188	-	224,188

Loans with external bodies are the outstanding payments yet to leave the bank account and has resulted in a technical overdraft.

Financial liabilities relating to right-of-use leases have been separately disclosed for the current year, with prior year comparatives restated accordingly.

22.4 Maturity of financial liabilities

	Payable to DHSC	**Payable to Other bodies**	**Total**	Payable to DHSC	Payable to Other bodies Period ending 31 March 2024	Total Period ending 31 March 2024
	Year ending 31 March 2025 £'000	**Year ending 31 March 2025 £'000**	**Year ending 31 March 2025 £'000**	Year ending 31 March 2024 £'000	£'000	£'000
In one year or less	28,523	121,147	**149,670**	51,720	168,341	220,061
In more than one year but not more than two years	-	403	**403**	247	359	606
In more than two years but not more than five years	-	1,105	**1,105**	347	1,068	1,415
In more than five years	-	1,666	**1,666**	-	2,106	2,106
Total	28,523	124,321	**152,844**	52,314	171,874	224,188

23 Operating segments

	Gross expenditure	Income	Net expenditure	Total assets	Total liabilities	Net assets
	£'000	£'000	£'000	£'000	£'000	£'000
Commissioning of Healthcare Services	3,221,403	(49,197)	**3,172,206**	34,072	(155,929)	**(121,857)**

Wherever possible the ICB manages resources and commissioning on a locality basis. Whilst this covers gross expenditure, which is reported using segmental analysis, this is not sufficient to necessitate a full reanalysis of the ICB's spend within these accounts.

24 Joint arrangements - interests in joint operations

24.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY Year ending 31 March 2025				Amounts recognised in Entities books ONLY Year ending 31 March 2024			
			Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Devon Better Care Fund	Devon County Council	Provision of integrated care	2,239	-	37,723	81,506	1,903	-	32,863	74,683
Plymouth Integrated Fund	Plymouth City Council	Provision of integrated care	-	-	12,657	218,128	-	-	12,657	175,570
Joint Community Equipment Store	Torbay Council	Provision of community equipment	-	-	-	884	-	-	-	884
Better Care Fund Torbay	Torbay Council	Provision of integrated care services	-	-	-	14,647	-	-	-	13,862

24.2 Interests in entities not accounted for under IFRS 10 or IFRS 11

Name of entity	Description of principal activities	Basis for treatment eg materiality
DELT Shared Services Ltd	IT Services	Materiality

25 Related party transactions

During the year, apart from the following transactions none of the Department of Health Ministers, leadership or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Devon ICB.

Details of related party transactions are as follows:

	Year ending 31 March 2025			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
DELT Shared Services Ltd	9,051	-	258	-
Devon County Council	137,062	(3,464)	3,759	(222)
Plymouth City Council	109,557	(48,695)	662	(1,198)
Torbay Council	7,570	(814)	345	(188)

The Department of Health and Social Care is regarded as a related party. During the year, the ICB has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. The most significant transactions for the ICB were with the following:

Devon Partnership NHS Trust
Leeds Teaching Hospitals NHS Trust
NHS England
NHS Property Services Ltd
North Bristol NHS Trust
Royal Brompton & Harefield NHS Foundation Trust
Royal Cornwall Hospitals NHS Trust
Royal Devon University Healthcare NHS Foundation Trust
South Western Ambulance NHS Foundation Trust
Taunton & Somerset NHS Foundation Trust
Torbay and South Devon NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
University Hospitals Bristol and Weston NHS Foundation Trust
University Hospitals Plymouth NHS Trust

In addition, the ICB has had a number of material transactions with other Government Departments and other central and local Government bodies. The most significant of these transactions have been with Torbay Council, Devon County Council and Plymouth County Council, details of which are included above.

25 Related party transactions

During the year, apart from the following transactions none of the Department of Health Ministers, leadership or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Devon ICB.

Details of related party transactions are as follows:

	Year ending 31 March 2024			
	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
DELT Shared Services Ltd	8,026	-	1,060	-
Devon County Council	117,280	(27,469)	8,097	(458)
Plymouth City Council	33,222	(15,570)	27,560	(19,508)
Torbay Council	3,752	(104)	1,223	(603)

During the year the ICB paid £15k to Parental Minds CIC, a community interest company, the director of which was also a mental health representative who attended the Board during the year.

The Department of Health and Social Care is regarded as a related party. During the year, the ICB has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. The most significant transactions for the ICB were with the following:

Devon Partnership NHS Trust
Leeds Teaching Hospitals NHS Trust
NHS England
NHS Property Services Ltd
North Bristol NHS Trust
Royal Brompton & Harefield NHS Foundation Trust
Royal Cornwall Hospitals NHS Trust
Royal Devon University Healthcare NHS Foundation Trust

South Western Ambulance NHS Foundation Trust
Taunton & Somerset NHS Foundation Trust
Torbay and South Devon NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
University Hospitals Bristol and Weston NHS Foundation Trust
University Hospitals Plymouth NHS Trust

In addition, the ICB has had a number of material transactions with other Government Departments and other central and local Government bodies. The most significant of these transactions have been with Torbay Council, Devon County Council and Plymouth County Council, details of which are included above.

The ICB has made a provision of £5.1m for doubtful debts in relation to the above related parties.

26 Events after the end of the reporting period

26.1 ICB administration and programme pay cost reduction

ICBs are required to reduce their administration and programme pay costs by 50% in 2025/26, with detailed plans to be developed and implemented by the end of the financial year. Achieving such a significant reduction will present considerable challenges for the ICB and careful planning, prioritisation, and collaboration across the system will be essential to mitigate the risks associated with these reductions.

26.2 Financial Statements

The financial statements were approved by the Board and authorised for issue on 19 June 2025.

The above mentioned post balance sheet events have no material effect on the accounts for the year ended 31 March 2025.

27 Financial performance targets

NHS Integrated Care Board have a number of financial duties under the NHS Act 2006 (as amended).

The ICBs performance against those targets was as follows:

	Year ending 31 March 2025	**Year ending 31 March 2025**	Year ending 31 March 2024	Year ending 31 March 2024	**Year ending 31 March 2025**	Year ending 31 March 2024
	Target	**Performance**	Target	Performance	**Duty**	Duty
	£'000	**£'000**	£'000	£'000	**Achieved?**	Achieved?
Expenditure not to exceed income	**3,249,935**	**3,221,516**	3,079,637	3,043,122	**Y**	Y
Capital resource use does not exceed the amount specified in Directions	**113**	**113**	3,911	3,821	**Y**	Y
Revenue resource use does not exceed the amount specified in Directions	**3,200,625**	**3,172,206**	2,981,672	2,945,247	**Y**	Y
Revenue administration resource use does not exceed the amount specified in Directions	**21,521**	**19,503**	24,682	23,177	**Y**	Y

The ICB met the requirement for spend not to exceed the capital and overall revenue resources received during the year. The ICB's overall expenditure was less than the income and revenue resource received during the year resulting in a surplus of £28.419m.

Summary of Programme and Administration, Income and Expenditure	**Year ending 31 March 2025 £000**	Year ending 31 March 2024 £000
Programme Expenditure	3,201,393	3,015,371
Administration Expenditure	20,010	23,929
Total Expenditure	**3,221,403**	3,039,300
Programme Income	(48,690)	(93,301)
Administration Income	(507)	(752)
Total Income	**(49,197)**	(94,053)
Total Net Expenditure for the financial period	**3,172,206**	2,945,247
Revenue Resource Limit (RRL)	**3,200,625**	2,981,672
Surplus/(Deficit)	**28,419**	36,425
Surplus/(Deficit) % of Revenue Resource Limit	**0.89%**	1.22%

Appendices

Appendix 1 – Highlights of work and attendance by Members at NHS Devon Board and Committee Meetings

These records show attendance by Board and Committee members at formal meetings. Eligibility to attend varies between individuals, impacted by factors including start/end dates in role.

NHS Devon Board

During 2024/25 the NHS Devon Board has covered a wide range of issues, with the main focus being around system recovery and strengthening collaborative working across the One Devon Integrated Care System.

The Board continued to actively monitor performance against the agreed NOF4 exit criteria agreed the oversight and assurance mechanisms for exiting NOF4 and received regular updates of the current performance against the agreed exit criteria which included progress made, risks and mitigations and any areas of escalation for support. Regular updates were also received in respect of quality assurance, financial performance and the mitigation of risks set out in the Board Assurance Framework (BAF). Additional assurance on the performance of NHS Devon was received through the reports to the Board from the Chairs of the Board's Assurance Committees.

During the reporting period the Board approved the One Devon Infrastructure Strategy, the 5 Year Joint Forward Plan, the NHS Devon response to the NHS 10 Year Health Plan, the NHS Devon 2024/25 Annual Plan and an Organisational Development Plan and Governance Improvement Plan for NHS Devon.

The establishment of a Population Health Improvement Committee and a People and Organisational Development Committee was approved, with the de-establishment of the Primary Care Commissioning Transition Committee also being approved in light of the establishment of an Executive Commissioning Group. All governance requirements associated with these changes were also approved by the Board including Terms of Reference and the Scheme of Reservation and Delegation updates. A review of the Corporate Governance Framework was also undertaken with the Board approving updates to the Constitution, Governance Handbook and key policies.

Partnership working remained a priority with regular updates being received from the One Devon Integrated Care Partnership and NHS Cornwall and the Isles of Scilly Integrated Care Board.

Name	Job Title / Organisation	Meeting Role	Attended/ Eligible
Nigel Acheson	Chief Medical Officer, NHS Devon	Chief Medical Officer	5 / 5
Salma Ali	Independent Non-Executive Member, NHS Devon	Independent Non-Executive Member	3 / 3
Sheena Asthana	Independent Non-Executive Member, Health Inequalities and Population Health, NHS Devon	Independent Non-Executive Member	5 / 11
Kaye Bentley	Independent Non-Executive Member, NHS Devon	Independent Non-Executive Member	3 / 3
Graham Clarke	Independent Non-Executive Member, Audit and Risk, NHS Devon	Independent Non-Executive Member	12 / 16
Peter Collins	Chief Medical Officer, NHS Devon	Chief Medical Officer	7 / 7
Liz Davenport	Chief Executive Officer, Torbay and South Devon NHS Foundation Trust	Partner Member for NHS Trusts and Foundation Trusts	9 / 11
Kirsty Denwood	Interim Chief Finance Officer, NHS Devon	Chief Finance Officer	5 / 5
Judy Hargadon	Independent Non-Executive Member, Primary Care, NHS Devon	Independent Non-Executive Member	15 / 16
Thandiwe Hara	Independent Non-Executive Member, Citizen and Community Involvement, NHS Devon	Independent Non-Executive Member	16 / 16
Ruth Harrell	Director of Public Health Plymouth City Council	Partner Member for Local Authorities	5 / 7
Sam Higginson	Chief Executive Officer, Royal Devon University Healthcare NHS Foundation Trust	Partner Member for NHS Trusts and Foundation Trusts	5 / 5
Donna Manson	Chief Executive, Devon County Council	Partner Member for Local Authorities	8 / 16
Phill Mantay	Chief Executive Officer, Devon Partnership NHS Trust	Partner Member for Mental Health	5 / 7
Steven Moore	Chief Executive Officer, NHS Devon	Chief Executive Officer	16 / 16
Frank O'Kelly	General Practitioner, Amicus Health	Partner Member for Providers of Primary Care Services	16 / 16
Kevin Orford	Non-Executive Member, Finance and Remuneration, NHS Devon / Acting Chair / Chair*	Independent Non-Executive Member / Chair	16 / 16
Lopa Patel	Independent Non-Executive Member, NHS Devon	Independent Non-Executive Member	3 / 3
Lincoln Sargeant	Director of Public Health, Torbay Council	Partner Member for Local Authorities	8 / 9
Bill Shields	Chief Finance Officer, NHS Devon	Chief Finance Officer	9 / 11
Penny Smith	Chief Nursing Officer, NHS Devon	Chief Nursing Officer	13 / 16
Martin Sykes	Interim Independent Non-Executive Member, NHS Devon	Independent Non-Executive Member	7 / 7
Sarah Wollaston	Chair, NHS Devon	Independent Chair	3 / 3

Table Notes:

Start dates for NHS Devon Board membership are below:

- Kirsty Denwood – 01 January 2025 (interim)
- Peter Collins – 14 October 2024
- Salma Ali – 01 February 2025
- Kaye Bentley – 01 February 2025
- Lopa Patel – 01 February 2025
- Martin Sykes – 12 November 2024
- Lincoln Sargeant – 18 September 2024
- Sam Higginson – 1 January 2025
- Phill Mantay – 7 November 2024

End dates for NHS Devon Board membership are below:

- Sarah Wollaston – 10 June 2024
- Bill Shields – 31 December 2024 (commenced secondment)
- Nigel Acheson – 30 June 2024
- Sheena Asthana – 07 January 2025
- Ruth Harrell – 31 July 2024
- Liz Davenport – 31 December 2024

*Kevin Orford was the Independent Non-Executive Member for Finance and Remuneration until 10 June 2024 when he was appointed as Acting Chair. On 17 December 2024 Kevin was appointed as Chair of NHS Devon.

Audit and Risk Committee

The Audit and Risk Committee has covered a wide range of issues during the reporting period, with its work being guided by its Terms of Reference, together with the Healthcare Financial Management Association (HFMA) NHS Audit Committee framework.

A particular focus for the Committee has in respect of the corporate governance framework. In addition to receiving assurance reports in respect of the policy framework, management of declarations of interest and risk management, the Committee agreed the approach to the annual review of the corporate governance framework which was undertaken during Q4 of 2024/25.

The Committee approved the 2024/25 Internal Audit Programme and has received regular progress updates, considering the recommendations arising from reviews and the subsequent progress of work to deliver agreed actions.

Financial compliance has been a fixture for agendas with the Committee receiving regular updates in respect of contracting and procurement, losses and special payments and also seeking additional assurance in respect of financial management, following the outcome of the internal audit being limited assurance.

Regular updates have also been received from the Local Counter Fraud Service Manager and the organisation's external auditors, whilst the Data Protection Officer has provided assurance as to compliance and progress against the Data Protection Security Toolkit.

The Audit Chairs' Forum for the One Devon Integrated Care System NHS partners has continued to meet on a regular basis. It has identified items for system audits and also begun to develop principles with regard to risk, governance and assurance that can be adopted across the One Devon system.

Name	Job Title / Organisation	Meeting Role	Attended/ Eligible
Sheena Asthana	Independent Non-Executive Member, Health Inequalities and Population Health, NHS Devon	Independent Non-Executive Member	1 / 4
Kaye Bentley	Independent Non-Executive Member, NHS Devon	Independent Non-Executive Member	1 / 1
Graham Clarke	Independent Non-Executive Member, Audit and Risk, NHS Devon	Non-Executive Member, Committee Chair	6 / 6
Thandiwe Hara	Independent Non-Executive Member, Citizen and Community Involvement, NHS Devon	Independent Non-Executive Member	3 / 3
Hisham Khalil		Co-Opted Member	3 / 4
Kevin Orford	Non-Executive Member, Finance and Remuneration, NHS Devon	Independent Non-Executive Member	2 / 2
Martin Sykes	Interim Independent Non-Executive Member, NHS Devon	Independent Non-Executive Member	2 / 2

Table notes

Start dates for Audit and Risk Committee membership are below:

- Thandiwe Hara – 25 July 2024
- Martin Sykes – 28 November 2024
- Kaye Bentley – 26 February 2025

End dates for Audit and Risk Committee membership are below:

- Kevin Orford – 29 May 2024
- Sheena Asthana – 28 November 2024
- Hisham Khalil – 31 December 2024

Remuneration and Internal ICB Workforce Committee

During the 2024/25 the main focus of the Committee has continued to be the implementation of the Organisational Change Programme required to deliver the running cost reductions required of all ICBs. The Committee received updates in respect of Phase 2 of the programme and was also involved in the Voluntary Redundancy Panel which was established as part of the re-organisation.

Throughout this year of change the Committee made recommendations in respect of Very Senior Management (VSM) appointments, resignations and secondments into and out of the organisation.

The Committee gave consideration to the Gender Pay Gap review together with the associated improvement action plan and also considered by the remuneration of the Partner Member for Providers of Primary Medical Services as this is not covered by a national pay framework.

Name	Job Title / Organisation	Meeting Role	Attended/ Eligible
Councillor Mary Aspinall	Chair, One Devon Integrated Care Partnership	Co-Opted Member	1 / 1
Sheena Asthana	Independent Non-Executive Member, Health Inequalities and Population Health, NHS Devon	Independent Non-Executive Member	1 / 1
Thandiwe Hara	Independent Non-Executive Member, Citizen and Community Involvement, NHS Devon	Independent Non-Executive Member	1 / 1
Judy Hargadon	Independent Non-Executive Member, Primary Care, NHS Devon	Independent Non-Executive Member and Chair	7 / 7
Frank O'Kelly	General Practitioner, Amicus Health	Partner Member - Provider of Primary Medical Services	6 / 6
Kevin Orford	Independent Non-Executive Member, Finance and Performance, NHS Devon, Acting Chair and Chair, NHS Devon	Independent Non-Executive Member	4 / 7
Lopa Patel	Independent Non-Executive Member, NHS Devon	Independent Non-Executive Member	0 / 1
Martin Sykes	Independent Non-Executive Member, NHS Devon	Independent Non-Executive Member	4 / 4
Sarah Wollaston	NHS Devon Chair	Member	0 / 1

Table notes

Start dates for Remuneration and Internal ICB Workforce Committee membership are below:

- Councillor Mary Aspinall – 03 February 2025
- Frank O'Kelly – 30 May 2024
- Lopa Patel – 26 February 2025
- Martin Sykes – 28 November 2024
- Sarah Wollaston – 30 May 2024

End dates for Remuneration and Internal ICB Workforce Committee membership are below:

- Sheena Asthana – 25 July 2024
- Thandiwe Hara – 25 July 2024
- Sarah Wollaston – 10 June 2024

Finance and Performance Committee

The financial position of NHS Devon and the One Devon Integrated Care System together with its National Oversight Framework segmentation rating (NOF4), has driven the work of the Finance and Performance Committee during 2024/25 period, with monthly consideration being given financial reporting, progress against the NOF4 exit criteria and progress against delivery of the 2024/25 Annual Plan which incorporates NHS England targets from the 2024/25 Operational Plan.

During the year the Committee has recommended approval of the Medium Term Finance Plan, the Winter Plan and the business case for the One Devon Finance Shared Service.

Other areas of focus have included performance reviews in the areas of mental health, elective care, urgent care and the processes in place in respect of Equality Quality Impact Assessments. The Estates Infrastructure Strategy and the prioritisation approach to estates have also been subject to the consideration of the Committee.

Name	Job Title / Organisation	Meeting Role	Attended/ Eligible
Nigel Acheson	Chief Medical Officer, NHS Devon	Member	1 / 2
Sheena Asthana	Independent Non-Executive Member for	Independent Non-Executive Member	5 / 8
Kaye Bentley	Independent Non-Executive Member	Independent Non-Executive Member	1 / 1
Mat Chetwynd	Director of Estates, NHS Devon	Member	2 / 2
Kirsty Denwood	Interim Chief Finance Officer, NHS Devon	Member and Executive Lead	3 / 3
John Finn	Acting Chief Operating Officer, NHS Devon	Member	2 / 3
Anthony Fitzgerald	Chief Operating Officer, NHS Devon	Member	8 / 9
Judy Hargadon	Independent Non-Executive Member for Primary Care, NHS Devon	Independent Non-Executive Member	8 / 8
Kevin Orford	Non-Executive Member, Finance and Remuneration / Acting Chair / Chair, NHS Devon	Independent Non-Executive Member	9 / 12
Mark Sowden	Associate Director, Workforce Strategy, Planning and Capacity, NHS Devon	Member	0 / 2
Bill Shields	Chief Finance Officer, NHS Devon	Member and Executive Lead	8 / 9
Penny Smith	Chief Nursing Officer, NHS Devon	Member	8 / 10
Martin Sykes	Interim Independent Non-Executive Member	Independent Non-Executive Member and Chair	4 / 4

Table notes

Start dates for the Finance and Performance Committee membership are below:

- Martin Sykes – 28 November 2024
- Judy Hargadon – 27 July 2024
- Kirsty Denwood – 1 January 2025
- Penny Smith – 30 May 2024
- Kaye Bentley – 26 February 2025
- John Finn – 1 January 2025

End dates for the Finance and Performance Committee membership are below:

- Sheena Asthana – 28 November 2024
- Bill Shields – 31 December 2024
- Nigel Acheson – 29 May 2024
- Mat Chetwynd – 29 May 2024
- Mark Sowden – 29 May 2024
- Anthony Fitzgerald – 31 December 2024

Quality and Patient Experience Committee

The Committee has covered a wide range of issues during 2024/25 with risk management, an overarching Quality Report, One Devon System Quality Group updates and delivery assurance in respect of the 2024/25 NHS Devon Annual Plan featuring on each agenda.

Deep dives were undertaken in respect of mental health, maternity and neo-natal services, planned care and transfers of care.

Regulatory issues have been an area of focus for the Committee with it maintaining oversight of the progress made in response to CQC notices and also the Joint Targeted Area Inspection in Torbay.

An area of development has been the development and re-launch of the approach to Quality and Equality Impact Assessments with these assessments now becoming embedded across the work of NHS Devon.

Name	Job Title / Organisation	Meeting Role	Attended/ Eligible
Nigel Acheson	Chief Medical Officer, NHS Devon	Member	1 / 2
Salma Ali	Independent Non-Executive Member, NHS Devon	Independent Non-Executive Member	1 / 1
Sheena Asthana	Independent Non-Executive Member, Health Inequalities and Population Health NHS Devon	Independent Non-Executive Member	0 / 3
Kaye Bentley	Independent Non-Executive Member, NHS Devon	Independent Non-Executive Member	1 / 1
Peter Collins	Chief Medical Officer, NHS Devon	Member	2 / 2
Thandiwe Hara	Independent Non-Executive Member, Citizen and Community Involvement, NHS Devon	Independent Non-Executive Member, Committee Chair	8 / 8
Philippa Harding	Interim Chief Communications and Corporate Affairs Officer	Member	2 / 4
Nicola McMinn	Chief Nursing Officer, Torbay & South Devon NHS Foundation Trust	Acute Provider Representative	0 / 2
Frank O'Kelly	Partner Member for Providers of Primary Care Services, NHS Devon	Partner Member	8 / 8

Kevin Orford	Independent Non-Executive Member / Acting Chair, NHS Devon	Independent Non-Executive Member	6 / 7
Lorna Sinfield	Research and Intelligence Officer, Healthwatch	Healthwatch Representative	2 / 2

Table notes

Start dates for the Quality and Patient Experience Committee membership are below:

- Sheena Asthana – 5 July 2024
- Philippa Harding – 30 May 2024
- Peter Collins – 28 November 2024
- Salma Ali – 26 February 2025
- Kaye Bentley – 26 February 2025

End dates for the Quality and Patient Experience Committee membership are below:

- Sheena Asthana – 7 January 2025
- Philippa Harding – 28 November 2024
- Nigel Acheson – 29 May 2024
- Nicola McMinn – 29 May 2024
- Lorna Sinfield – 29 May 2024

Primary Care Commissioning Transition Committee

During 2024/25 a new approach to the governance supporting commissioning decisions in NHS Devon was agreed which included the establishment of a sub-group of the NHS Devon Executive known as the Commissioning Group. In light of this new approach a decision was taken to dis-establish the Primary Care Commissioning Transition Committee.

Throughout 2024/25 the Committee maintained its focus on ensuring a comprehensive primary medical service was planned, commissioned and delivered and also provided assurance and oversight for the successful transition for the commissioning of primary dental, community pharmacy and optical services from NHS England.

The Committee received regular updates in respect of primary care budgetary issues; estates issues impacting primary care; performance against national targets; and support for GP practices, contractual and resilience matters and resolving challenges being faced by individual providers within the system.

During the year the Committee received updates in respect of Community Pharmacy, GP Collaborative Action and the reconfiguration of Primary Care Networks.

Name	Job Title / Organisation	Meeting Role	Attended/ Eligible
Justin Wiggin	Senior Manager, South Local Care Partnership	Member	3 / 3
Karen Barry	Director, South and West Locality	Member	1 / 3
Judy Hargadon	Independent Non-Executive Member, Primary Care, NHS Devon	Independent Non-Executive Member, Committee Chair	6 / 6
Thandiwe Hara	Non-Executive Member, Citizen and Community Involvement, NHS Devon	Independent Non-Executive Member	3 / 6
Steve Harris	Strategic clinical lead for primary care	Member	3 / 6
Penny Smith	Chief Nursing Officer, NHS Devon	Member	0 / 6
Frank O'Kelly	Partner Member, Providers of Primary Medical Services	Partner Member	5 / 6
Anthony Fitzgerald	Chief Operating Officer, NHS Devon	Member	3 / 6
Bill Shields	Chief Finance Officer, NHS Devon	Chief Finance Officer	0 / 6
Su Smart	Deputy Director of Out of Hospital Commissioning, NHS Devon	Member	3 / 6

Tina Henry	Deputy Director of Public Health, Devon County Council	Member	4 / 6

Table notes

Start dates for the Primary Care Commissioning Transition Committee membership are below:

- Karen Barry – 1 September 2024

End dates for the Primary Care Commissioning Transition Committee membership are below:

- Justin Wiggins – 31 August 2024

People and Organisational Development Committee

This Committee was established on 30 May 2024 and is still in its infancy, having met on three occasions.

The Committee has agreed how will operate and the information it will receive to enable it to carry out its responsibilities effectively with this including receiving regular updates on the delivery of the Workforce Strategy and a dashboard showing how the One Devon System is performing against key indicators.

Overviews of key areas such as organisational development, learning and education and equality, diversity and inclusion (EDI) have been considered, with an EDI working group having been established to progress this area of work.

As part of the organisation's response to its National Oversight Framework segmentation (NOF4) the Committee is receiving regular reports in respect of the various workstreams of the Financial Recovery Programme to maintain oversight of the workforce challenges being faced across the system.

At the request of the Board, the Committee reviewed the findings of the Gender Pay Gap report for 2023/24 and made its recommendations accordingly.

Name	Job Title / Organisation	Meeting Role	Attended/ Eligible
Salma Ali	Independent Non-Executive Member	Independent Non-Executive Member	1 / 1
Liz Davenport	Partner Member, NHS Trusts and Foundation Trusts	Partner Member	0 / 1
Kirsty Denwood	Interim Chief Finance Officer, NHS Devon	Member	2 / 2
Thandiwe Hara	Non-Executive Member, Citizen and Community Involvement, NHS Devon	Independent Non-Executive Member, Committee Chair	3 / 3
Judy Hargadon	Non-Executive Member, Primary Care, NHS Devon	Independent Non-Executive Member	3 / 3
Sam Higginson	Partner Member, NHS Trusts and Foundation Trusts	Partner Member	1 / 2
Frank O'Kelly	Partner Member, Providers of Primary Medical Services	Partner Member	2 / 2
Kevin Orford	Independent Non-Executive Member / Acting Chair, NHS Devon	Independent Non-Executive Member	1 / 1
Liz Perry	Chief People Officer, Devon Partnership NHS Trust	System Chief People Officer	1 / 2

Bill Shields	Chief Finance Officer, NHS Devon	Member	0 / 1
Piers Tetley	Chief People Officer, NHS Devon	Member and Lead Executive	3 / 3

Table notes

Start dates for the People and Organisational Development Committee membership are below:

- Frank O'Kelly – 28 November 2024
- Sam Higginson – 1 January 2025
- Liz Perry – 28 November 2024
- Kirsty Denwood – 1 January 2025
- Salma Ali – 26 February 2025

End dates for the People and Organisational Development Committee membership are below:

- Kevin Orford – 28 November 2024
- Liz Davenport – 31 December 2024
- Bill Shields – 31 December 2024

Population Health Improvement Committee

This Committee was established on 30 May 2024 and is still in its infancy, having met on two occasions.

The Committee has agreed how will operate and the information it will receive to enable it to carry out its responsibilities effectively with this including benchmarking data and key indicator datasets.

The Committee's initial review of patient and public engagement has resulted in the Committee now receiving regular updates in respect of the Devon Engagement Group and the Healthwatch Patient Experience and Engagement Report. Its recommendation to amend its own Terms of Reference and that of the Quality and Patient Experience Committee to align responsibilities around engagement has been approved by the Board.

At the request of the Audit and Risk Committee, the Committee reviewed the findings of the internal audit review into the governance arrangements in respect of addressing health inequalities. This review resulted in the committee adopting the NHS England Board Assurance Tool to conduct self-assessments.

Name	Job Title / Organisation	Meeting Role	Attended/ Eligible
Sheena Asthana	Independent Non-Executive Member, Health Inequalities and Population Health NHS Devon	Independent Non-Executive Member, Committee Chair	0 / 0

Lopa Patel	Independent Non-Executive Member, NHS Devon	Independent Non-Executive Member	0 / 1
Thandiwe Hara	Non-Executive Member, Citizen and Community Involvement, NHS Devon	Independent Non-Executive Member	2 / 2
Judy Hargadon	Non-Executive Member, Primary Care, NHS Devon	Independent Non-Executive Member	2 / 2
Lincoln Sargeant	Director of Public Health, Torbay Council	Partner Member, Director of Public Health	1 / 2
Frank O'Kelly	Partner Member for Providers of Primary Care Services, NHS Devon	Partner Member, Primary Care	2 / 2
Peter Collins	Chief Medical Officer, NHS Devon	Member and Executive Lead	2 / 2
Anthony Fitzgerald	Chief Operating Officer, NHS Devon	Member	0 / 1
John Finn	Acting Chief Operating Officer, NHS Devon	Member	2 / 2

Table notes

Start dates for the People and Organisational Development Committee membership are below:

- Lopa Patel – 26 February 2025
- Lincoln Sargeant – 18 September 2024
- Frank O'Kelly – 25 July 2024
- Peter Collins – 14 October 2024
- John Finn – 1 January 2025

End dates for the People and Organisational Development Committee membership are below:

- Sheena Asthana – 28 November 2024
- Anthony Fitzgerald – 31 December 2024

One Devon Integrated Care Partnership (ICP)

During 2024/25 there were a number of leadership changes across the One Devon System, including the joint Chairs of the ICP standing down, which impacted on the ICP. This provided an opportunity for the ICP to review its role and purpose and ensure that its membership was fit for purpose.

The ICP is continuing to identify and articulate its longer-term ambition, through its considerations of the forward planning work being undertaken across the system, together with the newly developed People and Communities Framework which will support its engagement with stakeholders across Devon.

Having endorsed the 2024/25 Devon Joint Forward Plan and confirmed its alignment with the priorities set out in the One Devon Integrated Care Strategy, the first area of focus for the ICP will be the development of its operational plan to deliver its responsibilities in the Joint Forward Plan.

Name	Job Title / Organisation	Meeting Role	Attended/ Eligible
Sarah Wollaston	NHS Devon Chair	NHS Devon Chair	1 / 1
Kevin Orford	NHS Devon Chair	NHS Devon Chair	2 / 2
Steve Moore	NHS Devon CEO	NHS Devon CEO	1 / 3
Councillor David Thomas	Chair, Torbay Health and Wellbeing Board	Health and Wellbeing Board Chair	2 / 2
Councillor Hayley Tranter	Chair, Torbay Health and Wellbeing Board	Health and Wellbeing Board Chair	0 / 1
Councillor James McInnes	Chair, Devon Health and Wellbeing Board	Health and Wellbeing Board Chair	1 / 1
Councillor Phil Bullivant	Chair, Devon Health and Wellbeing Board	Health and Wellbeing Board Chair	1 / 2
Councillor Mary Aspinall	Chair, Plymouth Health and Wellbeing Board	Chair and Health and Wellbeing Board Chair	3 / 3
Arshiya Khan	Managing Director, Peninsula Acute Provider Collaborative	Director, NHS Acute Provider Collaborative	1 / 1
Phill Mantay	CEO, Devon Partnership NHS Trust	Chair, Mental Health Learning Difficulties and Neurodiversity Collaborative	0 / 1
Nigel Acheson	Chief Medical Officer	Chair, Clinical and Professional Cabinet / Clinical Senate	1 / 1
Peter Collins	Chief Medical Officer	Chair, Clinical and Professional Cabinet / Clinical Senate	2 / 2
Pat Harris	CEO, Healthwatch Torbay	Healthwatch Devon, Plymouth and Torbay Representative	3 / 3
Lincoln Sargeant	Director of Public Health, Torbay	Health Inequalities System Senior Responsible Officer	3 / 3

Katherin Allen	Director of Strategy, Royal Devon University Healthcare NHS Foundation Trust	Local Care Partnership Representative – North	2 / 2
Andrea Beacham	Programme Manager, One Northern Devon	Local Care Partnership Representative - North	1 / 1
Jeff Chinnock	Head of Stakeholder Communications & Engagement, , Royal Devon University Healthcare NHS Foundation Trust	Local Care Partnership Representative – East	2 / 3
Michelle Thomas	CEO Livewell Southwest	Local Care Partnership Representative - West	2 / 3
Adel Jones	Chief Operating Officer and Deputy Chief Executive, Torbay & South Devon NHS Foundation Trust	Local Care Partnership Representative - South	0 / 3
Thandiwe Hara	NHS Devon Independent Non-Executive Member	NHS Devon Independent Non Executive Member	2 / 3
Ian Smith	Director, Plymouth Food Bank	Voluntary Sector Representative (VCSE)	3 / 3
Jasmine Allen	Citizens Advice	Voluntary Sector Representative (VCSE)	0 / 1
Sue Julyan	CEO, Citizens Advice Exeter and Torbay	Voluntary Sector Representative (VCSE)	2 / 2
Julia Boas	Chief Operating Officer, Safe Foundation	Voluntary Sector Representative (VCSE)	1 / 1
Gary Walbridge	Strategic Director for Adults, Health and Communities, Plymouth City Council	Local Authority Director of Adult Services	1 / 2
Joanna Williams	Director of Adult Community Services, Torbay Council	Local Authority Director of Adult Services	0 / 1
Julian Wooster	Director of Children and Young People's Futures, Devon County Council	Local Authority Director of Childrens Services	0 / 3

Rachael Lankshear	Practice Manager, Brunel Medical Practice	Primary Care representative	3 / 3
Stephen Walford	CEO, Mid Devon District Council	District Council representative	2 / 3

Start dates for the One Devon Integrated Care Partnership membership are below:

- Kevin Orford – 10 June 2024
- Councillor David Thomas – 1 May 2024
- Councillor Phil Bullivant – 18 July 2024
- Arshiya Khan – 26 February 2025
- Peter Collins – 14 October 2024
- Sue Julyan – 21 November 2024

End dates for the One Devon Integrated Care Partnership membership are below:

- Sarah Wollaston – 10 June 2024
- Councillor Hayley Tranter – 30 April 2024
- Councillor James McInnes – 30 April 2024
- Phill Mantay – 30 April 2024
- Nigel Acheson – 30 June 2024
- Jasmine Allen – 21 November 2024

Appendix 2 – Health Inequalities Statement

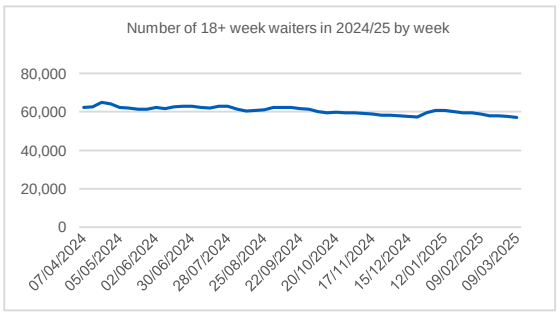
Under duty s.13SA of the National Health Service (NHS) Act 2006 NHS England is required to publish a Statement on Information on Health Inequalities setting out:

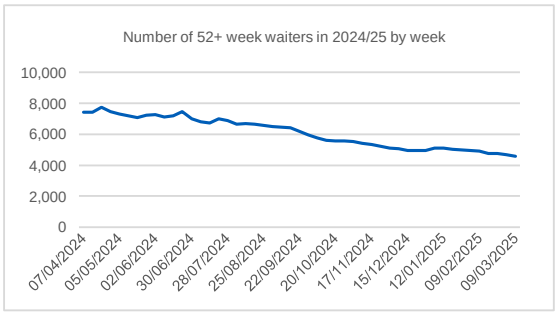
- a description of the powers available to relevant NHS bodies to collect, analyse and publish information; and
- the views of NHS England about how those powers should be exercised in connection with such information.

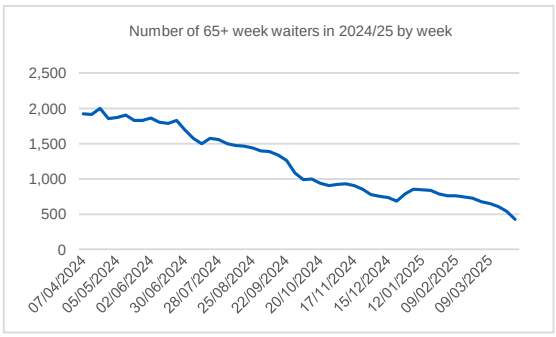
The current Statement provides information on how powers should be exercised in connection with health inequalities information for the period 1 April 2023 to 31 March 2025, and includes a requirement for all NHS organisations to report on inequalities for specified indicators in their annual reports. This section of the report covers those indicators.

Elective recovery

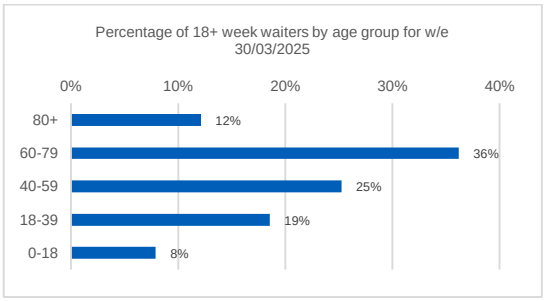
The number of long waits for elective treatment continued to reduce in Devon during 2024/25, with positive progress being made at all providers. The charts below show a falling number of over 18, 52 and 65 week waits for treatment, with particular progress being made in reducing the longest wait patients (those waiting above 65 weeks):

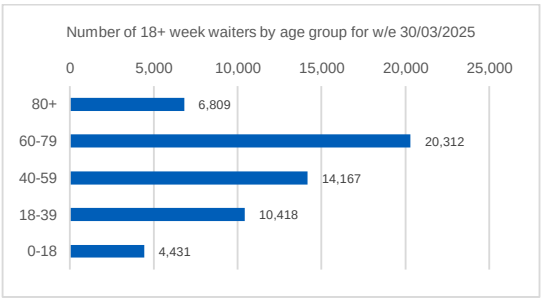




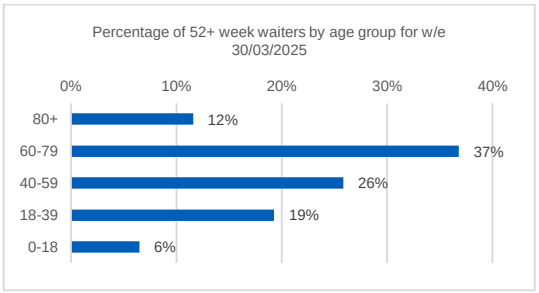


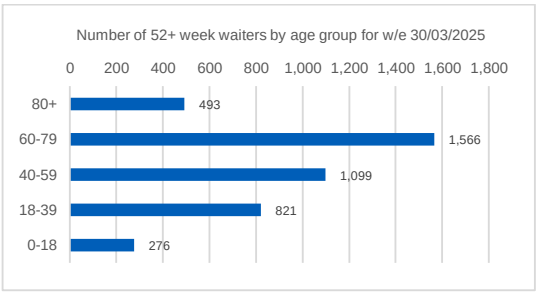
The number of long waits in Devon during 2024/25 continue to fall compared to 2023/24 with waiters over 65 weeks showing a steady decrease.



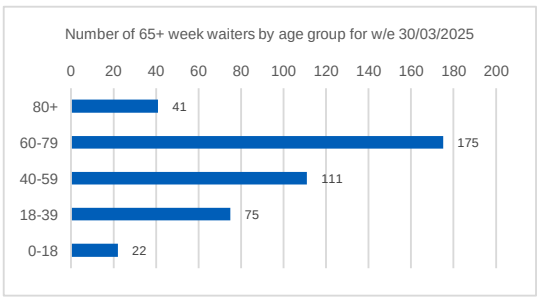


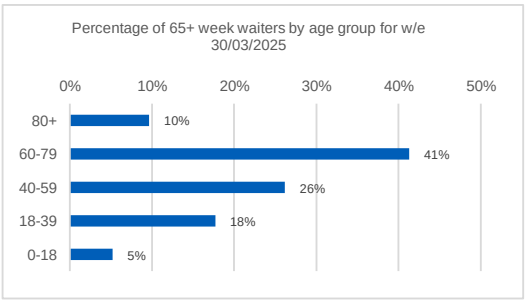
When looking at the number of over 18 week waits by age band, we can see the waiting list is representative of Devon's comparably older population, with almost half the patients aged over 60. This picture is almost exactly the same for over 52 week waits, with very similar proportions of patients split between the different age groups. This consistency suggests patients waiting a long time are not skewed towards any single age group.





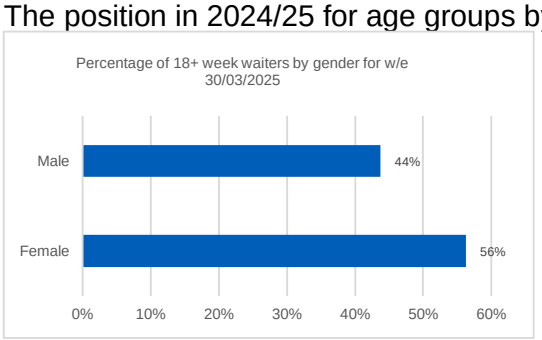
For over 65 week waits the position is again similar, although over 60s are slightly more likely to wait over 65 weeks and children are slightly less likely when compared to over 18 week waits.

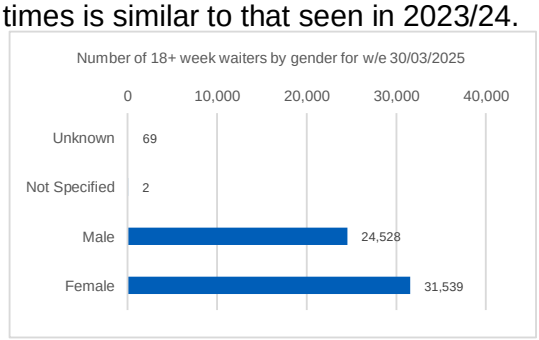




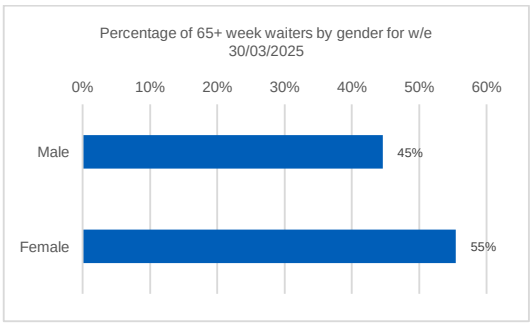
Looking at the elective waiting list by gender, the majority of patients waiting over 18 week are female, but again this is fairly representative of the population, particularly as the proportion of females in the population rises as age increases.

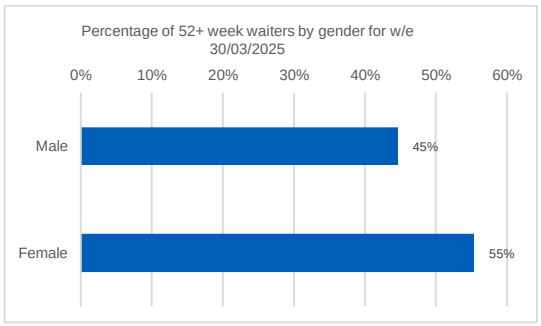
The position in 2024/25 for age groups by wait times is similar to that seen in 2023/24.



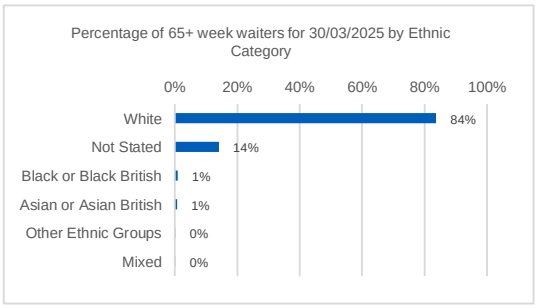


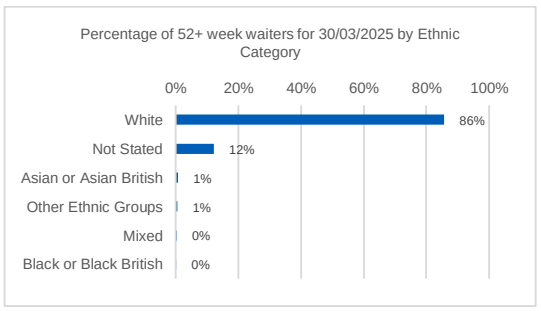
This proportion remains very consistent when looking at long waits, with the position essentially unchanged for both over 52 week and over 65 week waits, suggesting there is no inequality between sexes for elective waits.



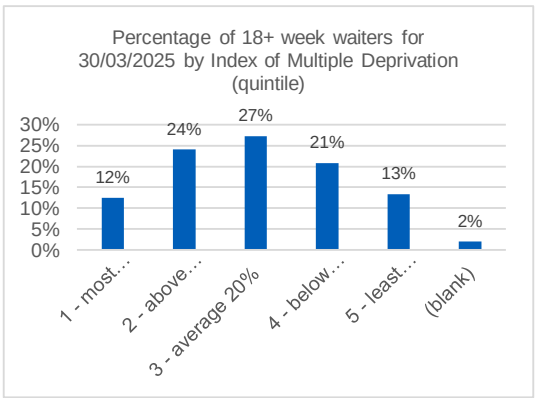


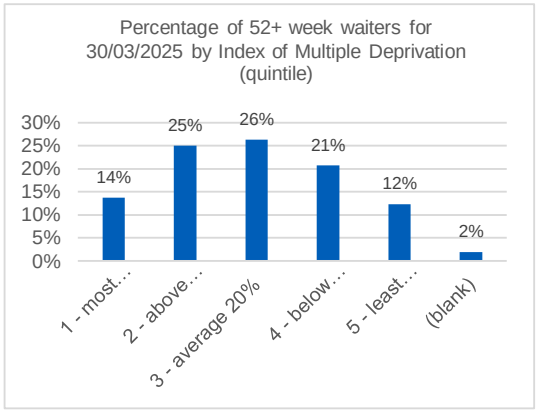
When looking at elective waits by ethnicity it is difficult to draw conclusions around any inequalities due to the very low number of patients recorded in any category other than white. 98% of over 52 week waits are recorded as either white, unknown or as not stated, with the remaining 2% spread across the other categories. There is a similar position for over 65 week waits.

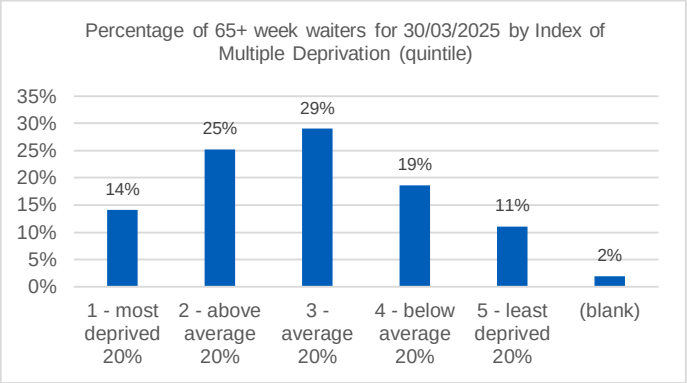




Reviewing the waiting list by the indices of deprivation (the level of deprivation associated with where patients live), the pattern is consistent through the waiting time bands, with the highest proportion of waiters being of average deprivation and a balance between the most and least deprived. This remains broadly the same for over 18, 52 and 65 week waits, suggesting deprivation does not strongly correlate with longer waiting times.







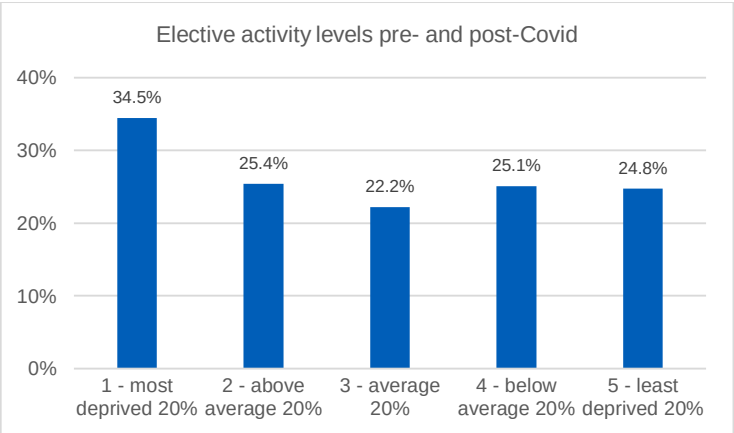
The position in 2024/25 for gender, ethnicity and deprivation quintiles by wait times is similar to that seen in 2023/24.

Activity Rates Compared To Pre-Pandemic

When comparing 2024/25 (ytd – Apr-Feb) elective activity against pre-pandemic (2019/20 ytd - Apr-Feb) levels for under 18s and over 18s we see the following patterns:

- Overall elective activity in 2024/25 was 27% higher than pre-Covid
- Overall elective activity was 33% higher for men and 20% higher for women than pre-Covid
- Overall elective activity increased more for older people, with activity for over 80s rising by almost 62% and 60-79 year olds growing by over 32%. However, younger age ranges have continued to see almost static levels of activity compared with pre-Covid, with 18-39 year olds 0.5% lower and under 18s 0.5% higher.

Comparing pre-pandemic elective activity by deprivation we see that activity levels for people from all deprivation quintiles have recovered with the greatest increase being in the most deprived category.



When viewed by ethnicity, changes in the number of “not stated” ethnicity affects the ability to assess comparable difference between ethnic groups, but overall those in the white ethnicity category have seen less of a rise in activity compared to pre-Covid (20%) against the combined group of other ethnic categories who have seen a rise of 70%. However, caution should be taken with these figures due to the recording gaps.

This is a difference picture to that in 2023/24 when the two most deprived categories were showing a fall in activity compared to pre-Covid.

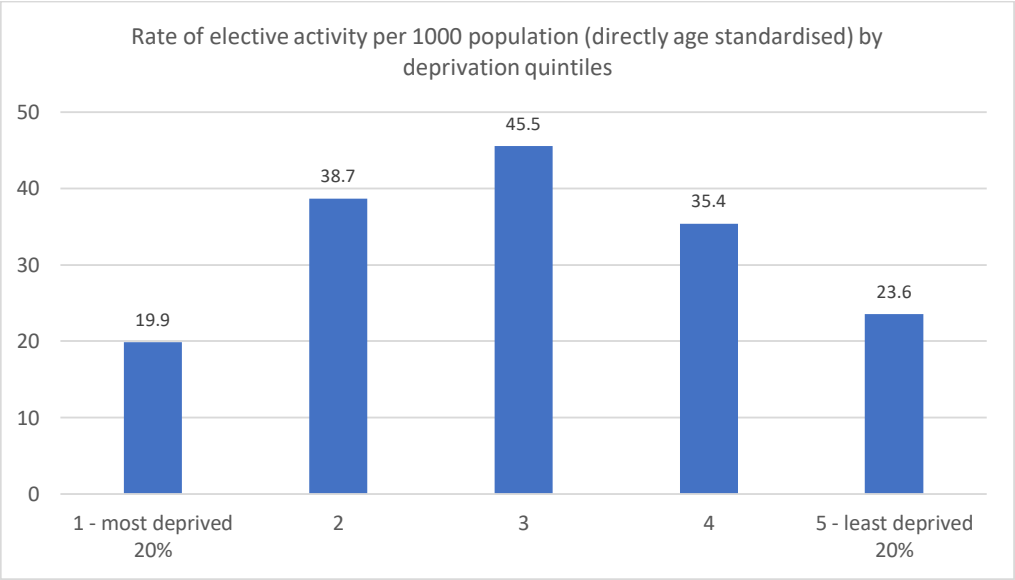
Activity Rates Per Population

This section explores potential variation in age standardised activity rates for elective and emergency admissions and outpatient, virtual outpatient and emergency attendances.

Overall standardised activity rates for total elective activity are 64.7 procedures per 1000 population for women and 58.1 for men. This is generally representative of the age split of the population, taking into account that for older people who are more likely to receive treatment the female to male ratio is higher than for the population as a whole.

When looking at activity rates by deprivation quintiles, those at either end of the deprivation curve see generally lower rates of activity.

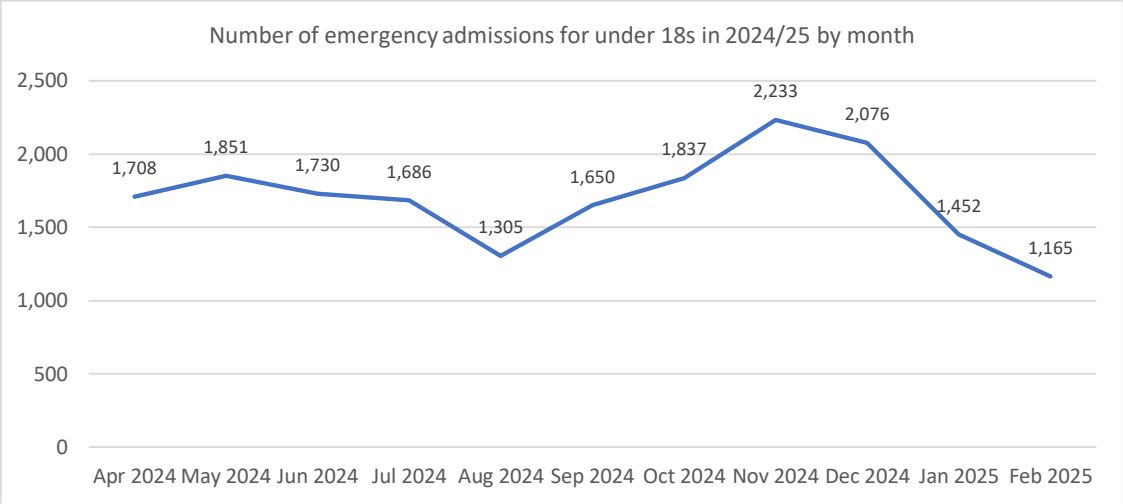
This is a similar position to that seen in 2023/24.



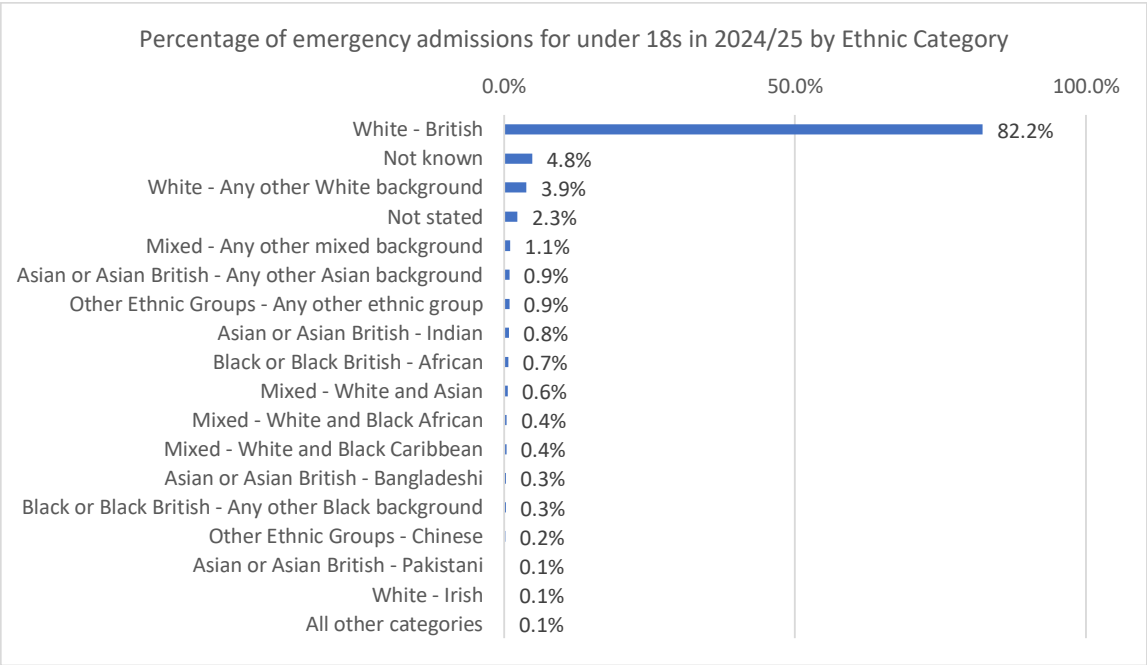
When viewed by ethnicity numbers are not sufficient to draw conclusions around rates of activity per population (many ethnic groups are lower than 1,000 which is generally the population used to calculate rates).

Urgent and emergency care Emergency admissions for under 18s

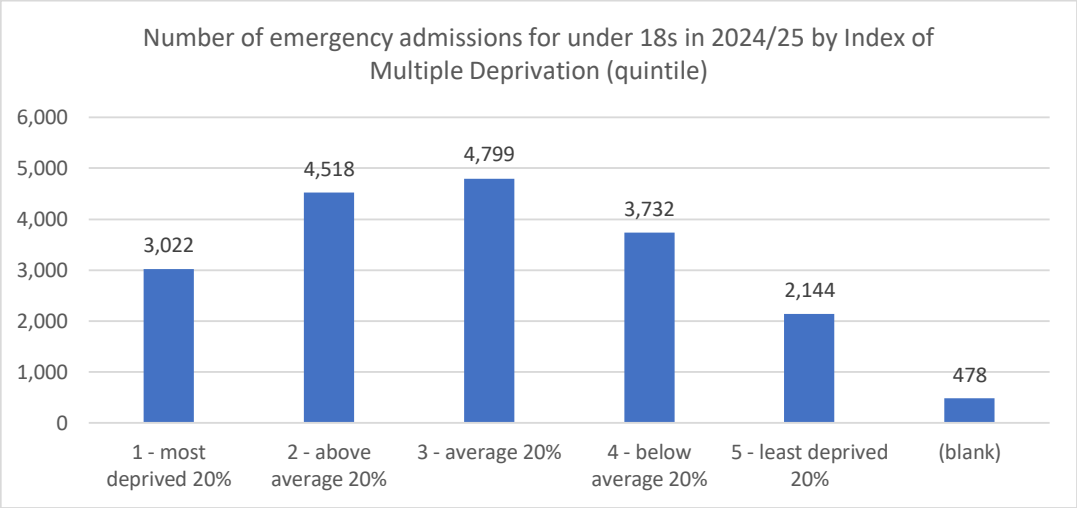
Emergency admissions for children and young people (CYP) have followed a fairly typical pattern in 2024/25, with relatively stable levels for much of the year but with an increase in winter months linked to increasing respiratory admissions for generally very young children and babies (cases of Respiratory Syncytial Virus – or RSV - generally peak in November/December).

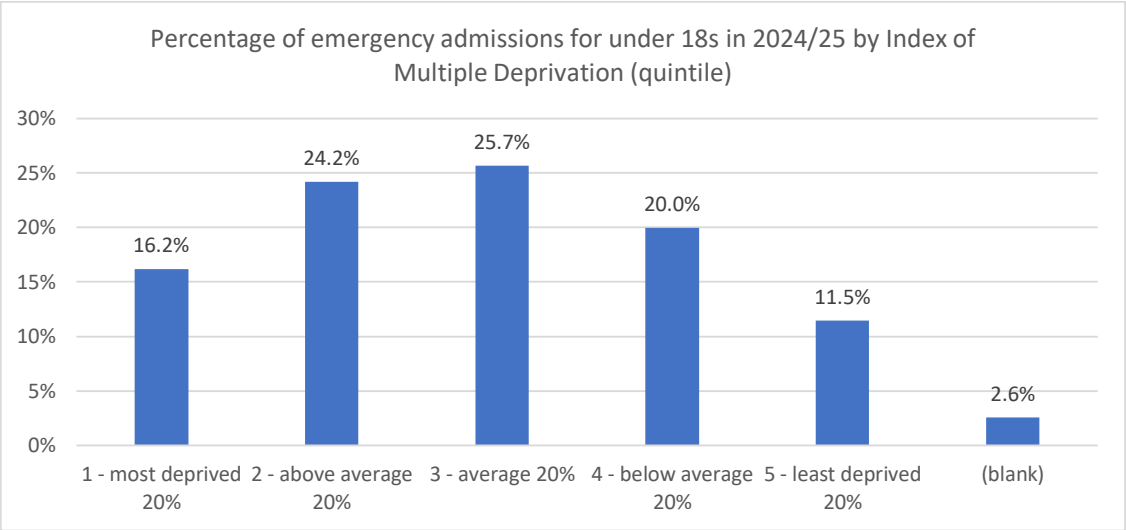


Looking at these emergency admissions by ethnic category we broadly see a reflection of the ethnic position of the general population in Devon.



Looking at the deprivation quintile of these patients, the majority were from areas of average deprivation, although the proportion from areas of highest deprivation were above those in lowest deprivation areas (16% vs 12%).





The position for emergency admissions for under 18s in 2024/25 for ethnicity and deprivation quintiles is similar to that seen in 2023/24.

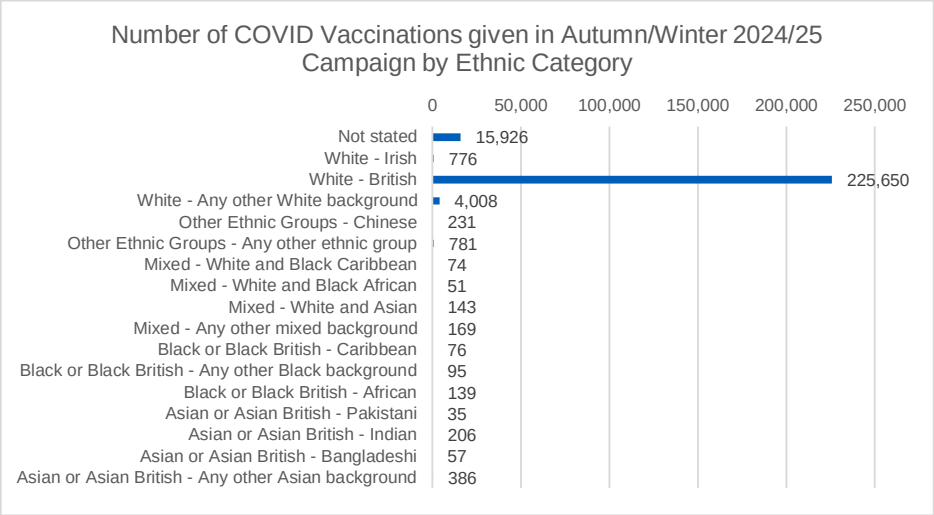
Respiratory

This section looks at the uptake of COVID and flu vaccinations by sociodemographic group.

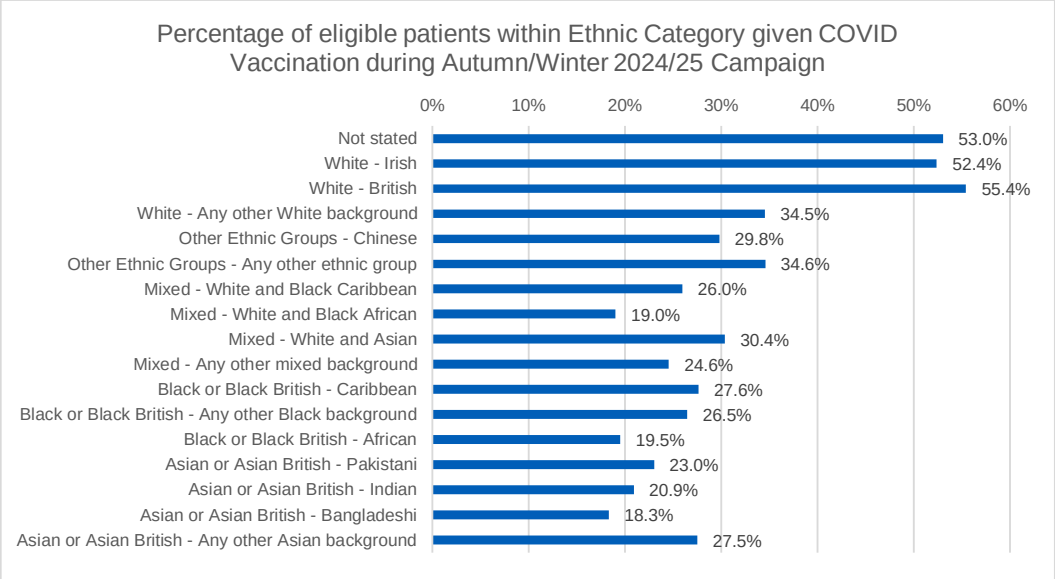
For COVID this is the number and percentage of eligible patients (patients aged 65+ or patients aged below 65 who are in an at-risk group) who received a COVID vaccination during the Autumn/Winter 2024/25 booster campaign.

For flu this is the number and percentage of eligible patients (patients aged 65+ by 31.03.2025, or patients aged 18-64 and in an at-risk group) who received an adult flu vaccination during the 2024/25 flu season.

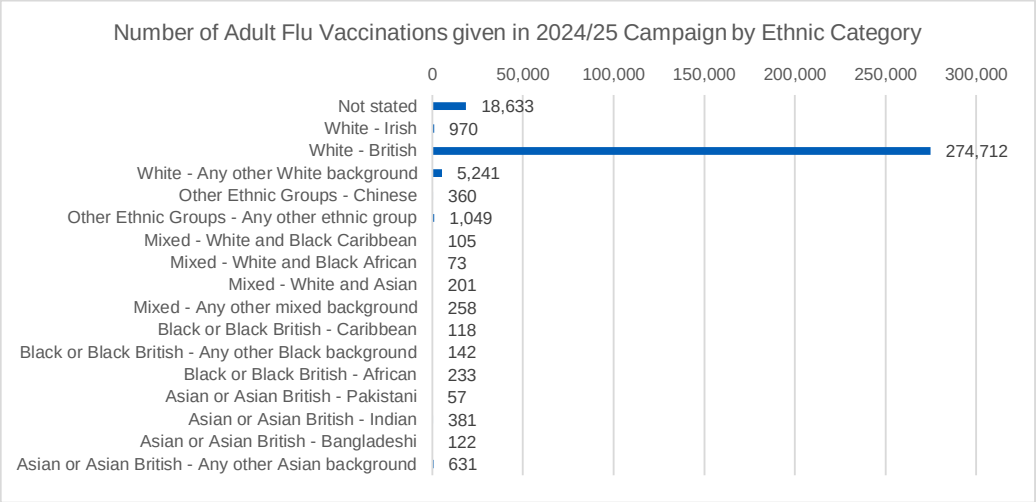
The charts below show the number of people receiving a Covid vaccination by their ethnicity.

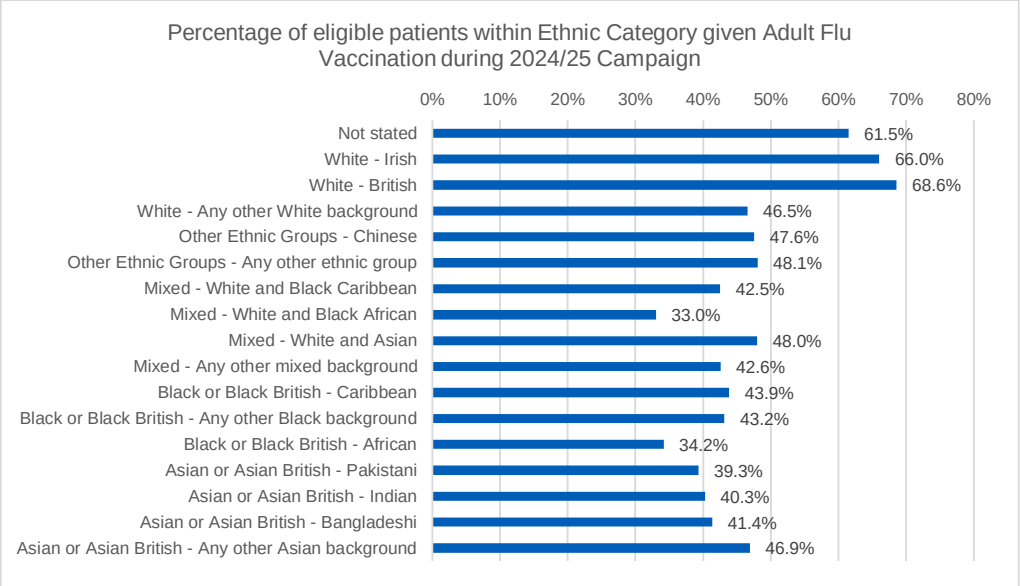


Percentages shown below are the percentage of patients given the relevant vaccine out of all eligible patients within that ethnic category.

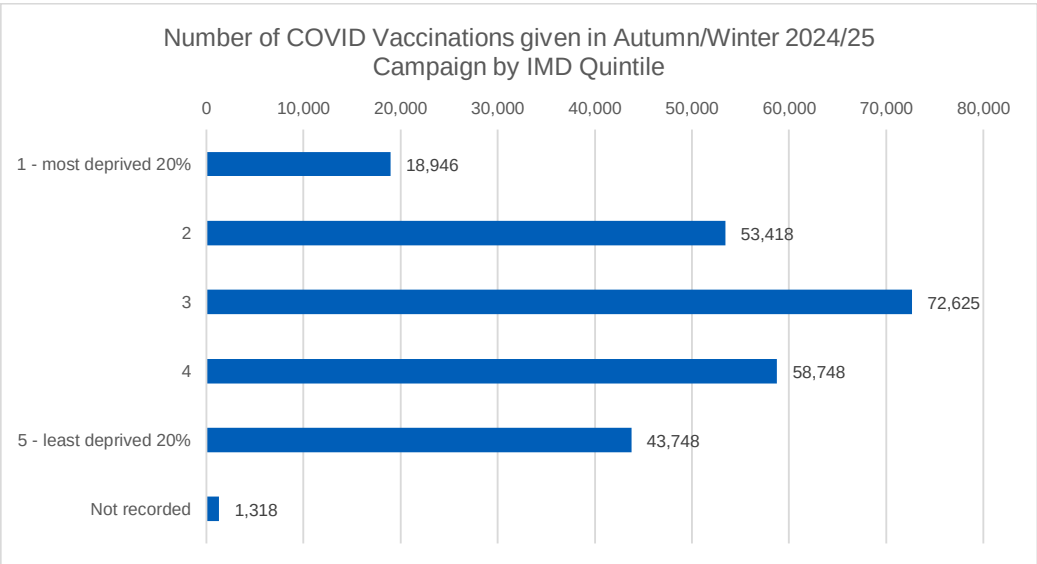


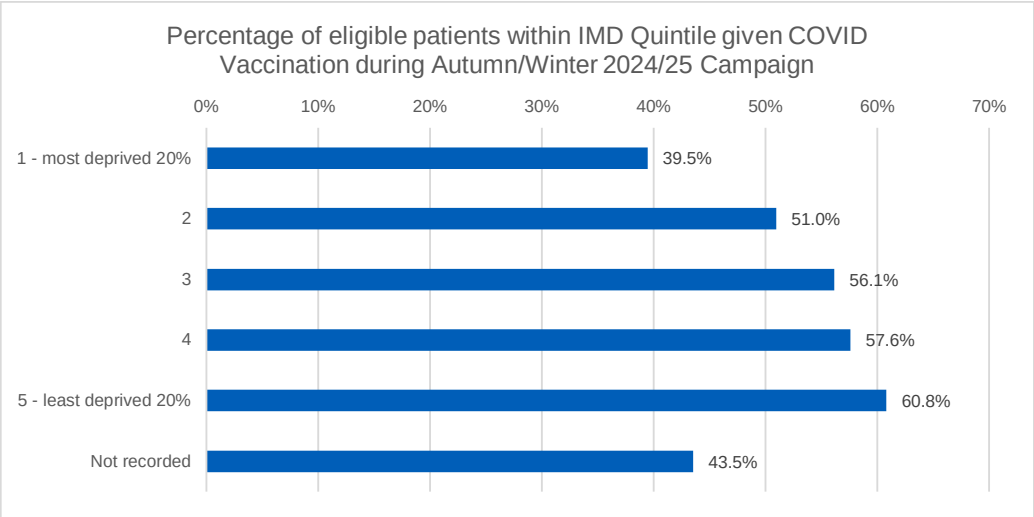
The uptake of Covid vaccinations clearly varies between ethnic groups, with white groups seeing around double the uptake in this time period. A similar position is true of flu vaccinations, with slightly lower variation.



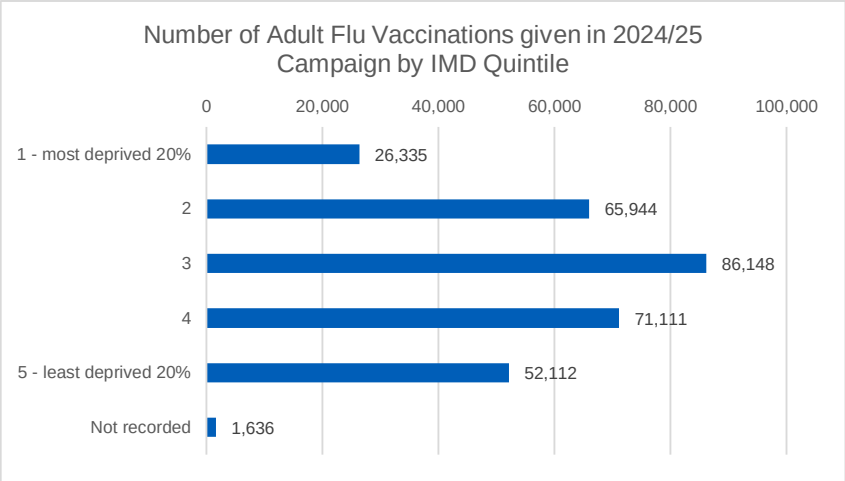


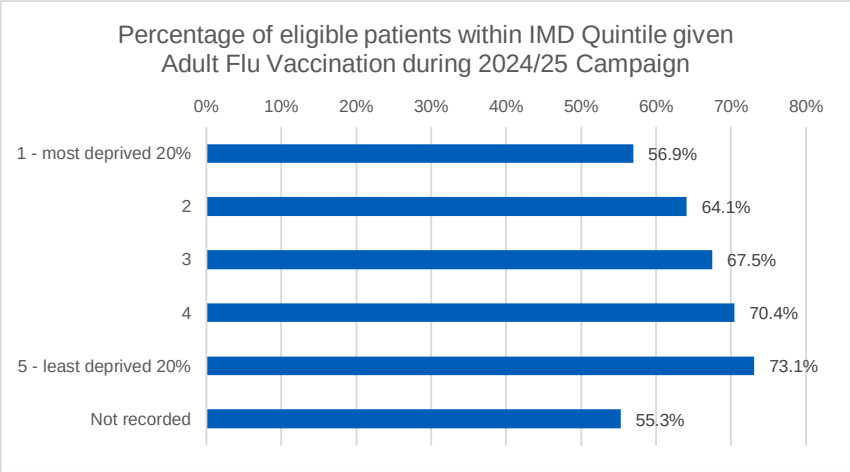
Uptake of the Covid vaccinations by IMD Quintile also shows a clear picture, this time of reducing uptake as deprivation rises. There is a 21% difference in uptake between the least deprived and most deprived areas.



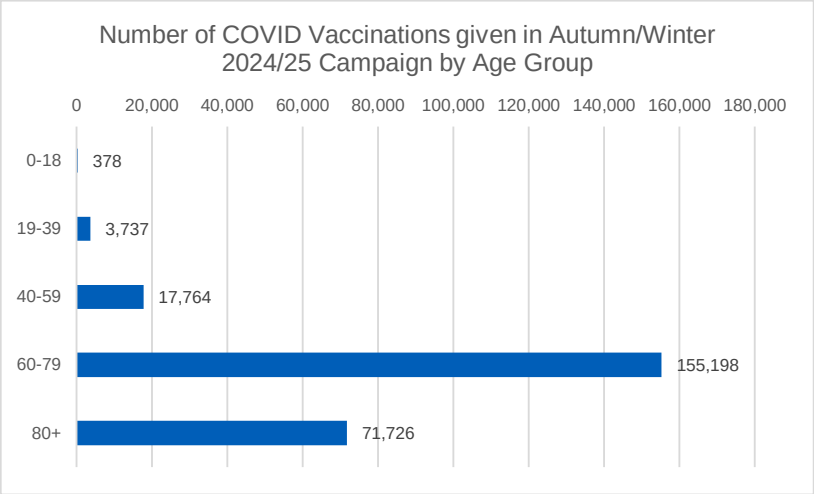


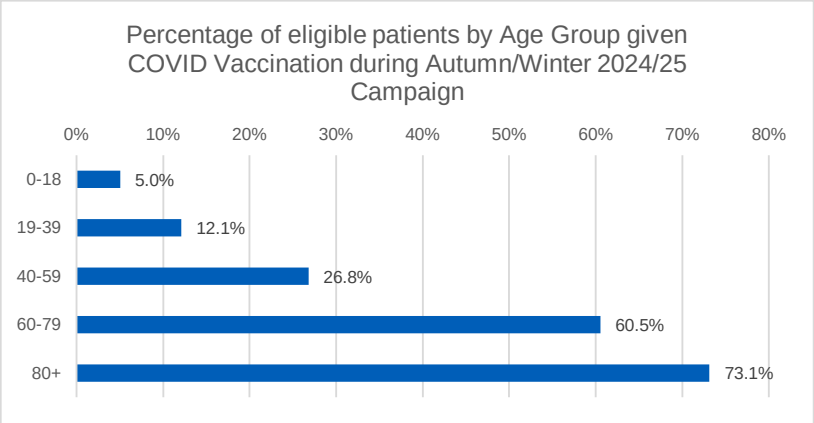
Perhaps unsurprisingly this pattern holds true for flu vaccinations too, as can be seen in the charts below.



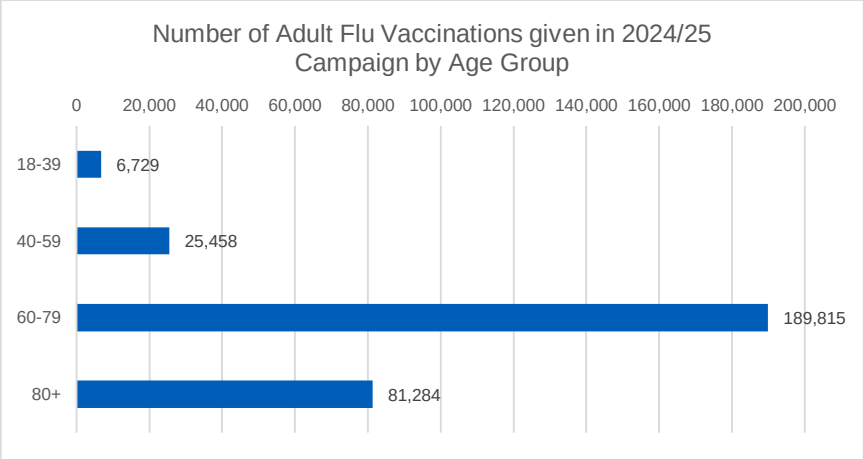


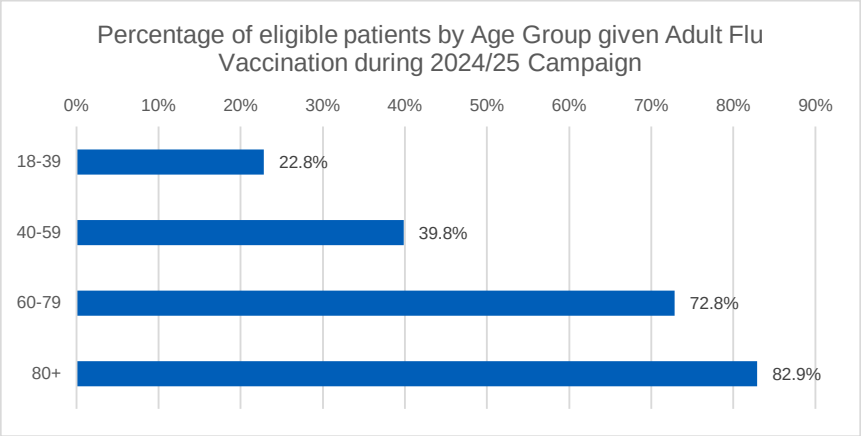
When looking at uptake of Covid vaccinations by age group we see a huge disparity in uptake, with older people significantly more likely to choose to be vaccinated than younger age groups, albeit in the context of significantly higher numbers of vaccinations being offered to older people.



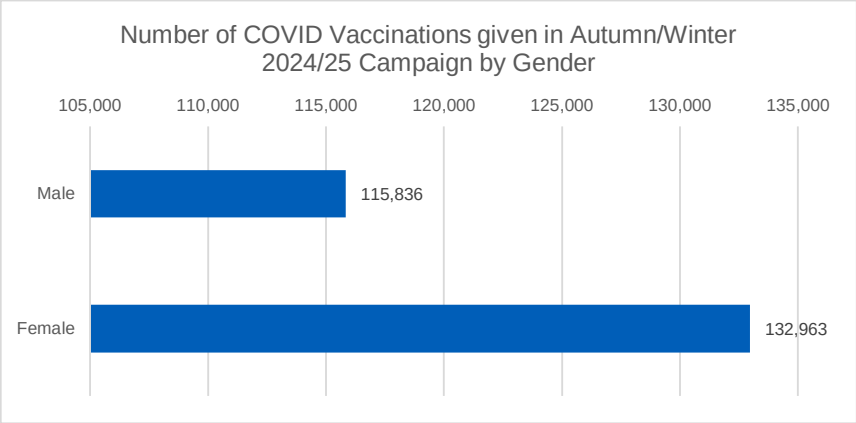


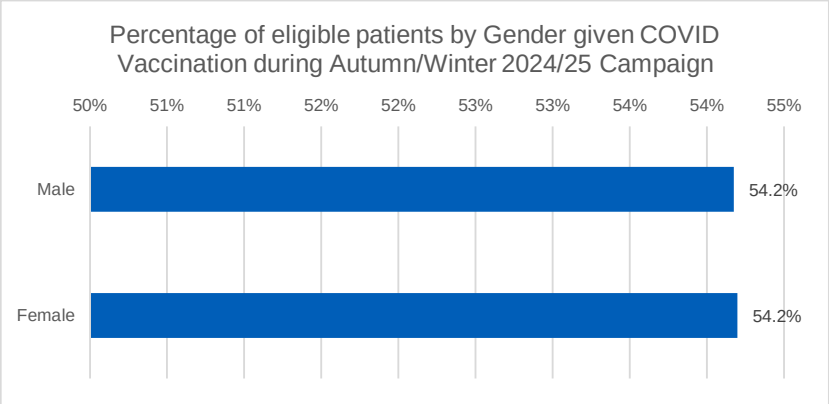
Again, the same pattern can be seen for flu vaccinations, although less marked.

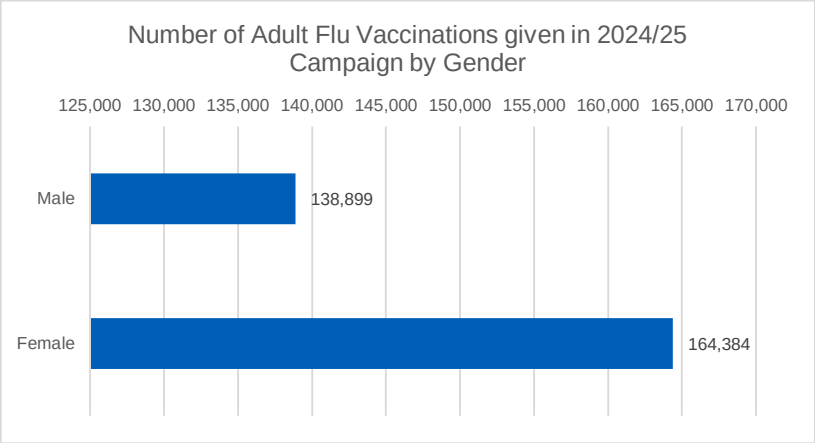


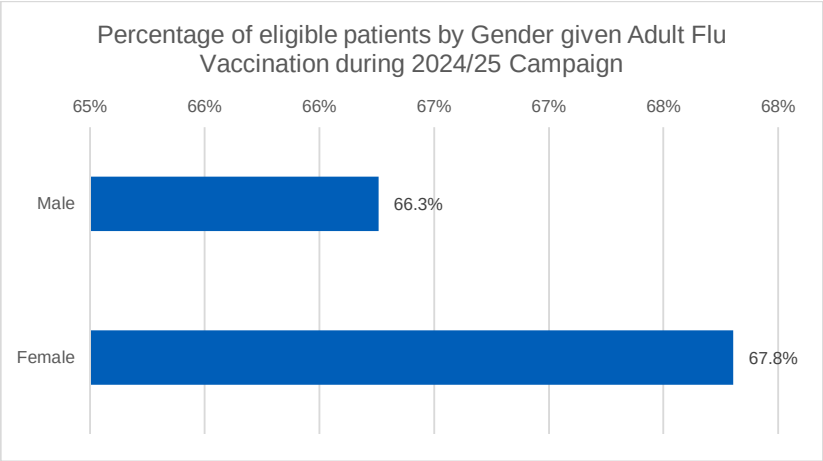


The variation by gender is much less obvious, although females are slightly more likely to choose to be vaccinated than men for Flu.









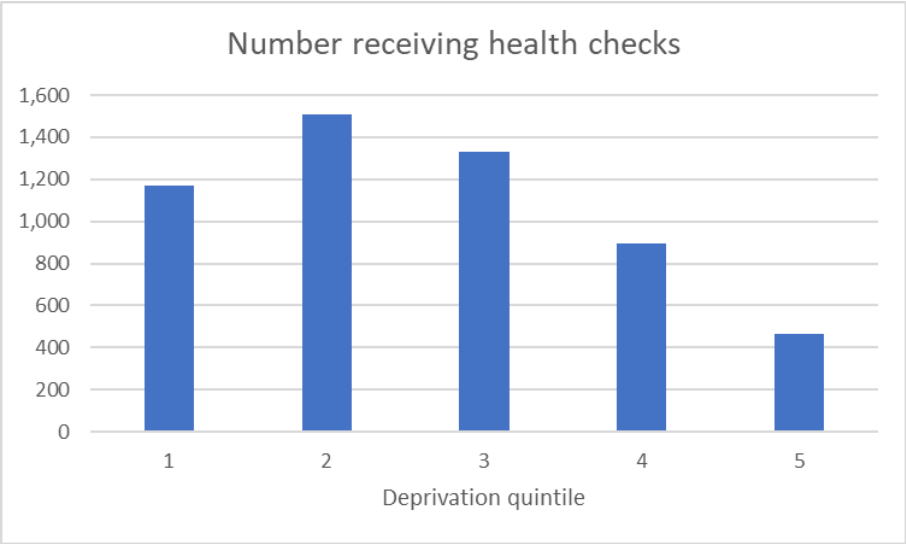
The Covid and flu vaccination position in 2024/25 for gender, age, ethnicity and deprivation quintiles is similar when compared to that seen in 2023/24.

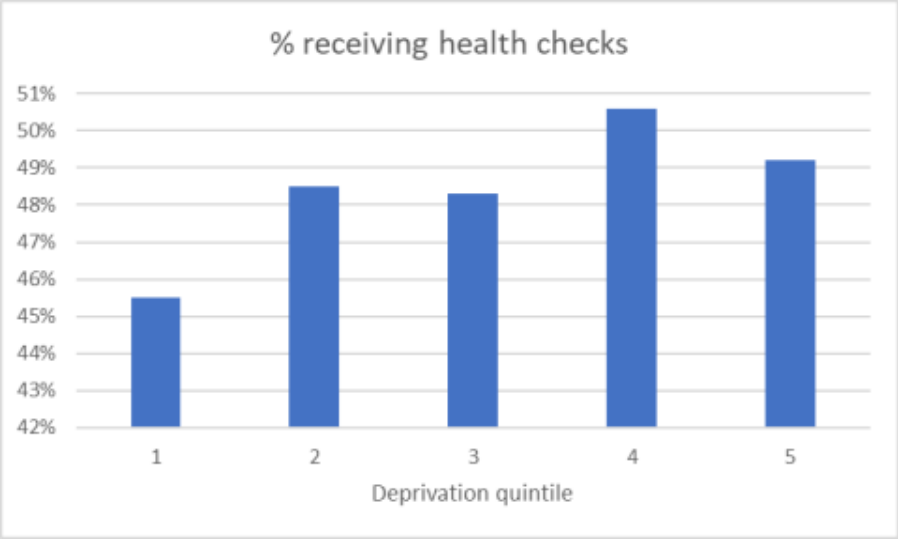
Mental health

Severe mental illness (SMI) physical health checks

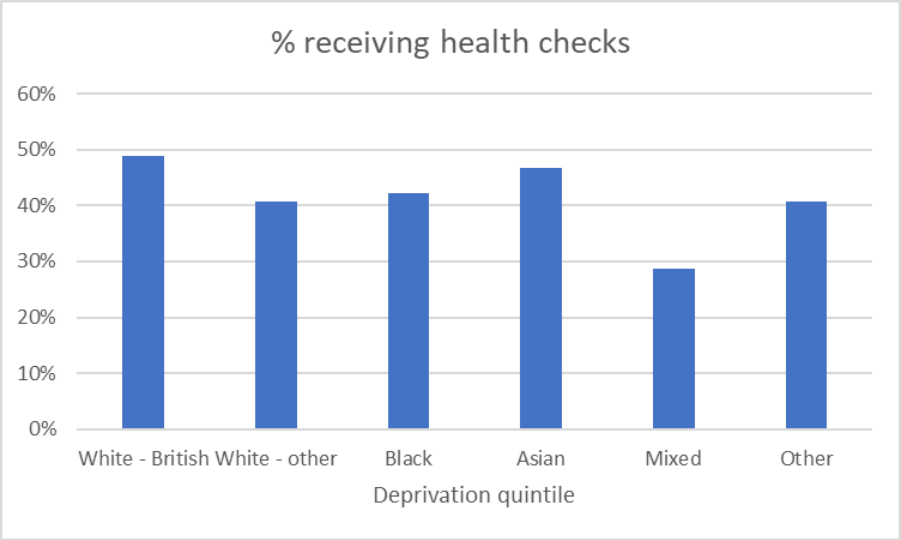
This section looks at the number of SMI physical health checks and the percentage performance comparing those people who have had checks against the total number of patients who should be offered a check.

Looking by deprivation quintiles the volume of people receiving health checks is higher in more deprived and averagely deprived areas when compared to least deprived areas. However, the proportion of those receiving checks is lower for the most deprived areas.

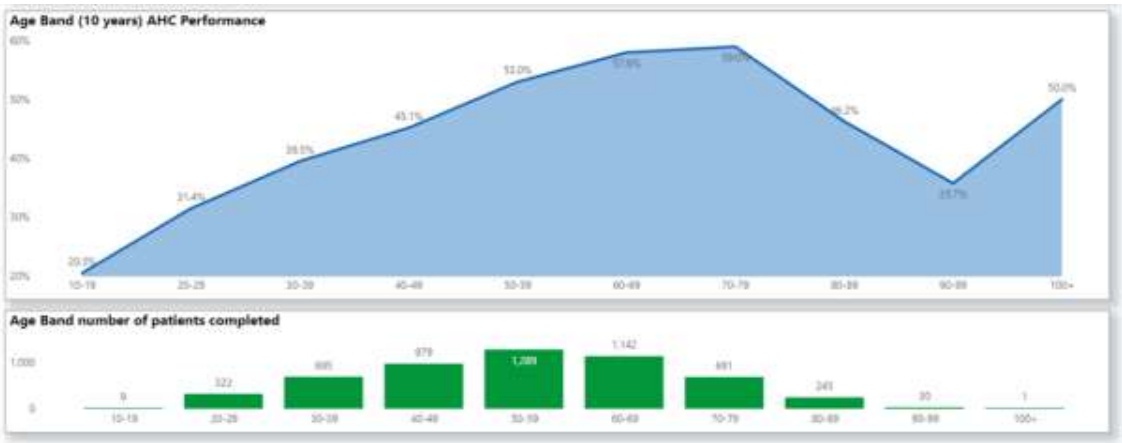




Looking at ethnicity, people from the White British ethnic group are more likely to receive health checks than other ethnic groups, with mixed ethnicity seeing the lowest level of checks.



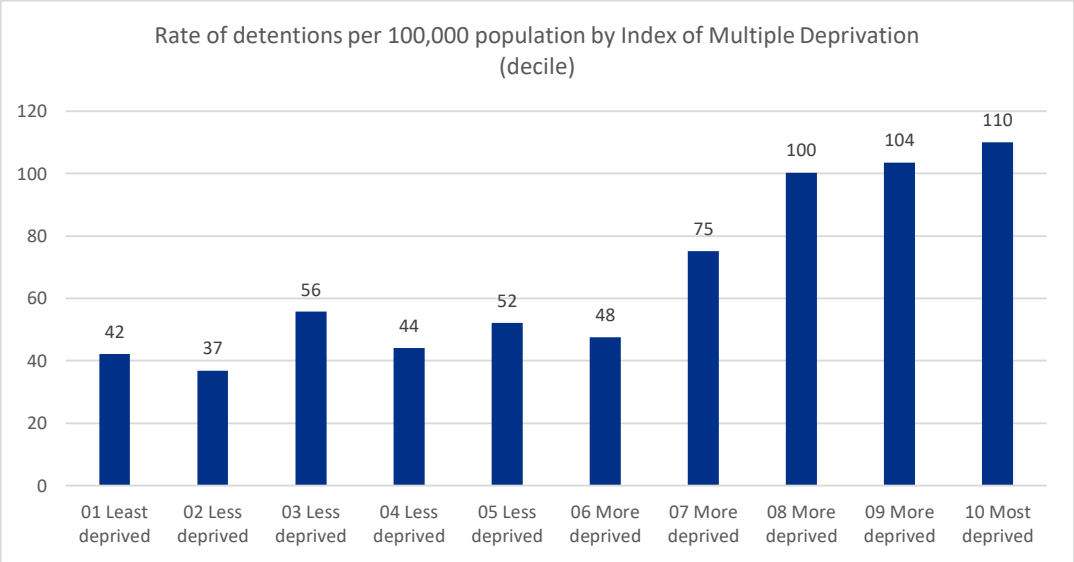
By gender females (49.6%) are more likely to receive a health check than men (46.9%), despite there being very similar numbers of eligible people. By age there is a correlation with younger age groups receiving comparatively less health checks then older people (up to 80 years old).



Rates of total Mental Health Act detentions

This section looks at the number of Mental Health Act detentions. Overall standardised detention rates are 65 detentions per 100,000 population for men and 60 for women.

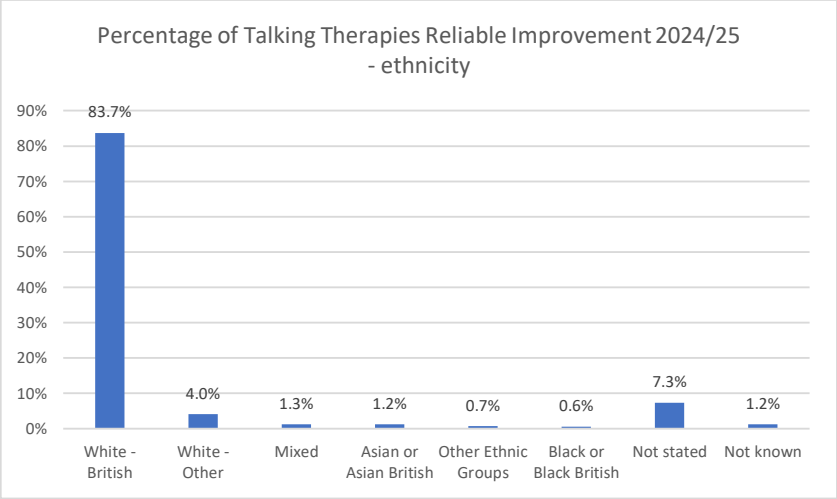
When looking at detention rates by Index of deprivation, the rate increases as deprivation rises.



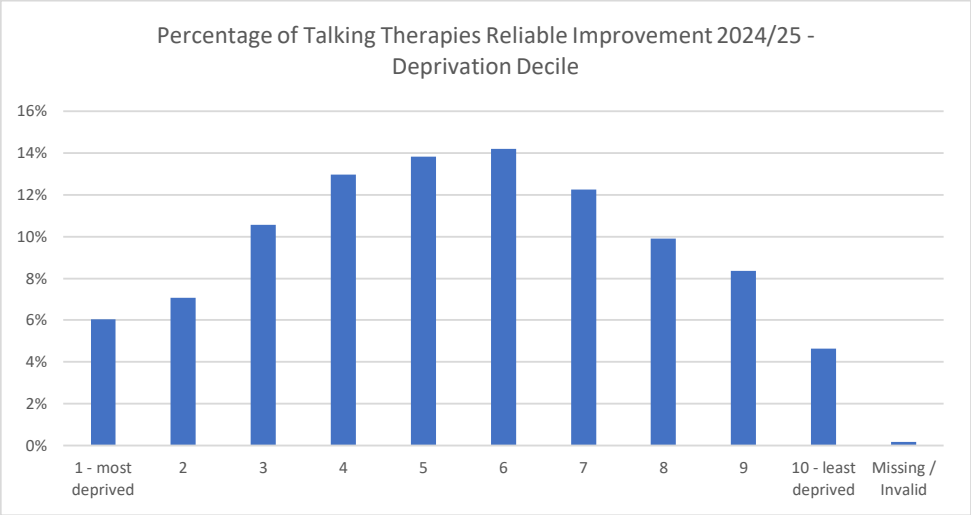
NHS Talking Therapies (formerly IAPT) recovery

69% of Talking Therapies are received by women and 72% by patients aged between 26 and 65, with 19% between ages 18 and 25 and 8% for over 65s.

Looking at ethnicity, the majority of uptake is from White British, although 8.5% of patients have an unknown/unstated ethnicity.



By deprivation, the majority of uptake is from patients living in medium deprived areas, reflecting the general population split.

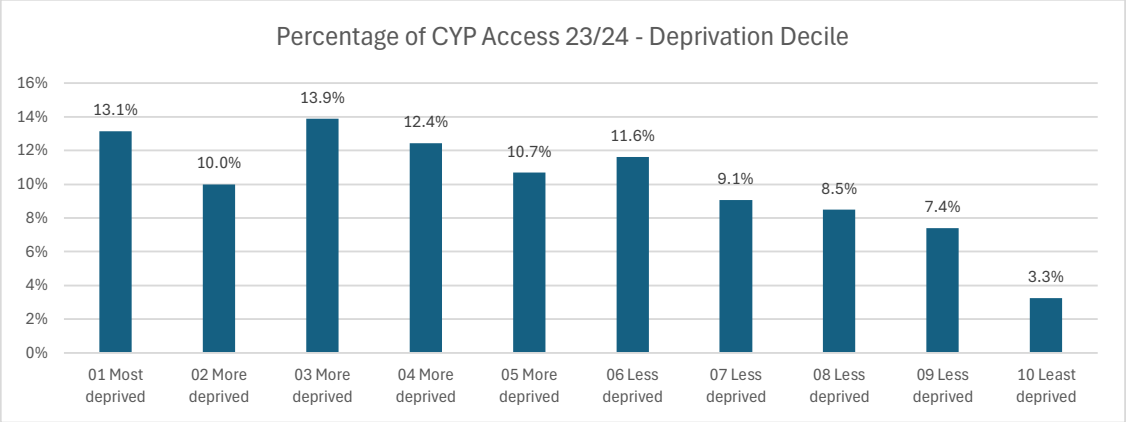


The position for Talking Therapies in 2024/25 for ethnicity and deprivation quintiles is similar to that seen in 2023/24.

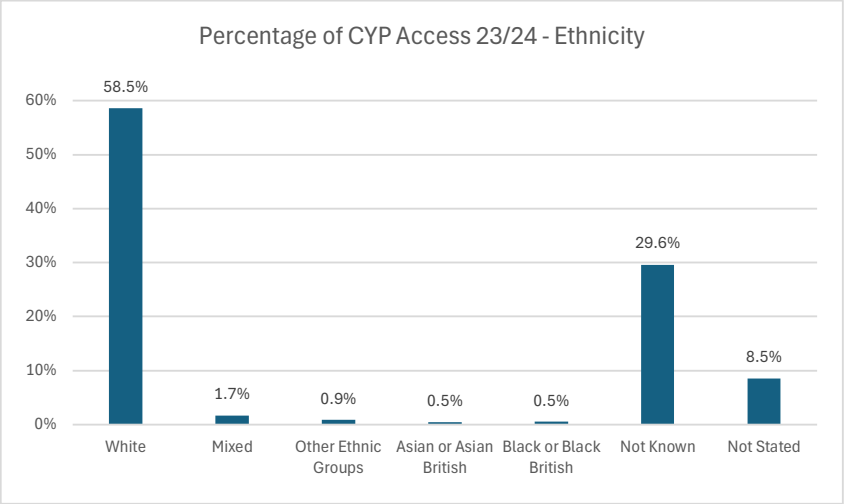
Children and young people's mental health access

Period covered in this report is Apr 23 – Mar 24 reflecting the latest available data.

61% of children accessing CYP mental health services are female, with 37% male and 1% non-binary. 56% of children are aged 11 to 15, a quarter are over 16 and 18% are ten or under. By deprivation decile the largest proportion of children accessing services are from the most deprived areas and whilst this is not significantly higher than other areas it is disproportionate to the population split.



By ethnicity over 38% of ethnicity is not stated or unknown, with 59% of children receiving CYP mental health services being White British.

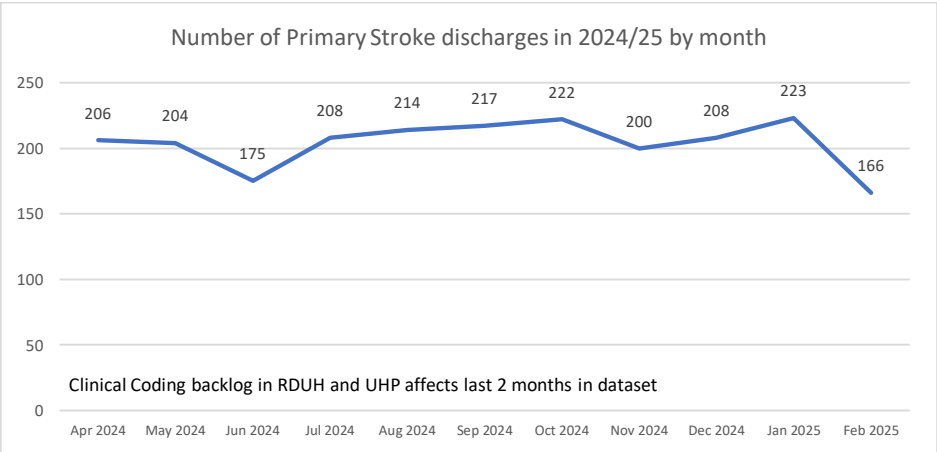


The position for children receiving CYP mental health services in 2024/25 for deprivation decile is similar to that seen in 2023/24. The proportion where ethnicity is not stated or unknown has increased considerably since 2023/24.

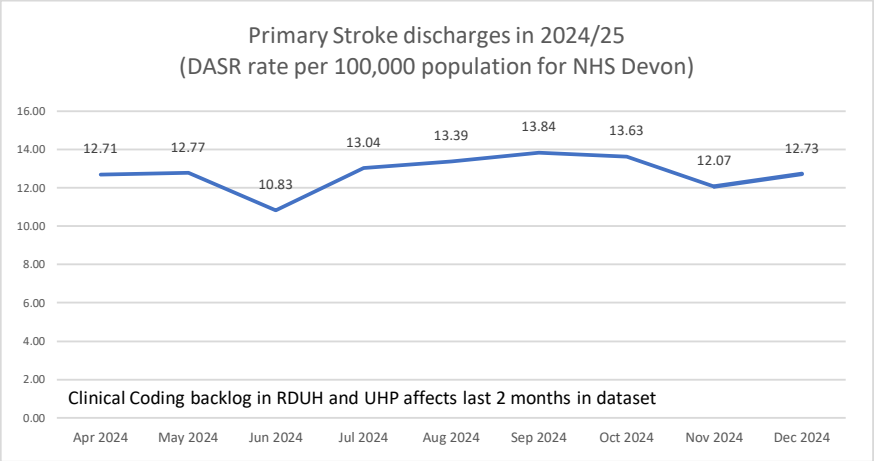
Cardiovascular disease

Stroke

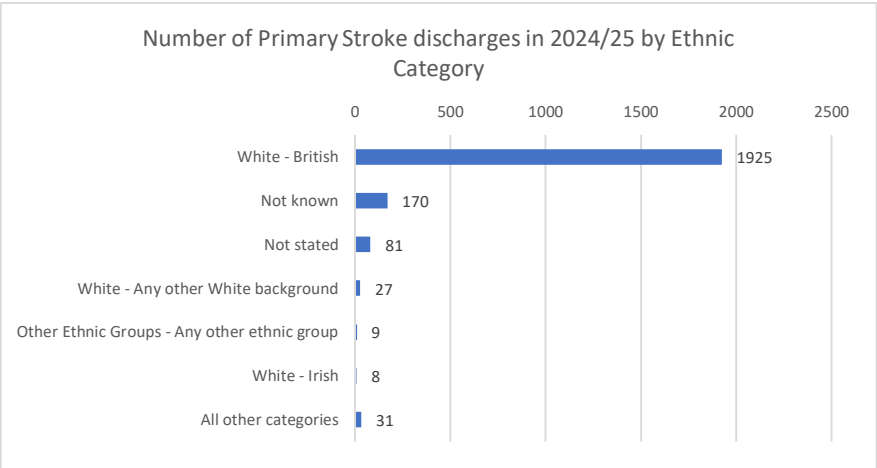
This section looks at the rate of non-elective admissions for stroke (per 100,000, age-sex standardised). The number of patients admitted and then discharged from hospitals in Devon is shown in the chart below and shows a generally consistent picture, although please note that coding backlogs affect later months.

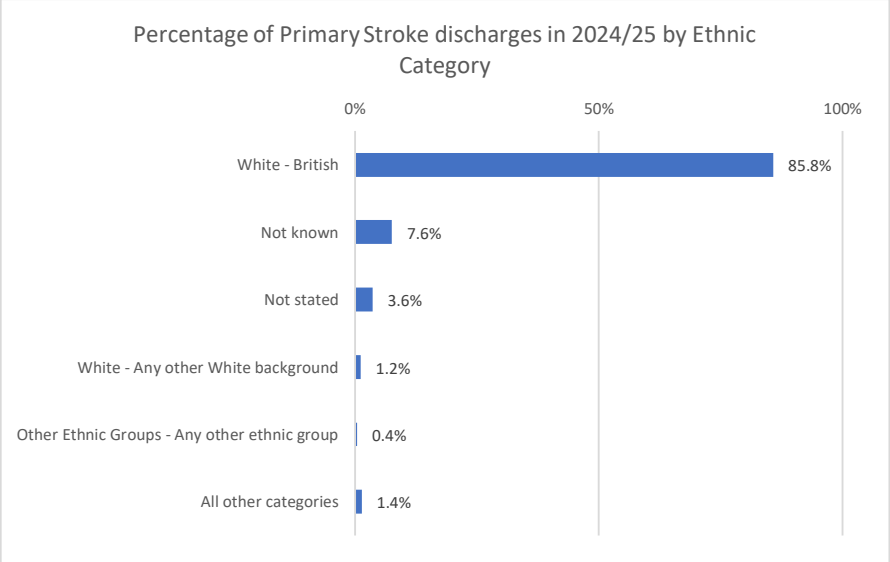


The rate of stroke discharges remains relatively steady.

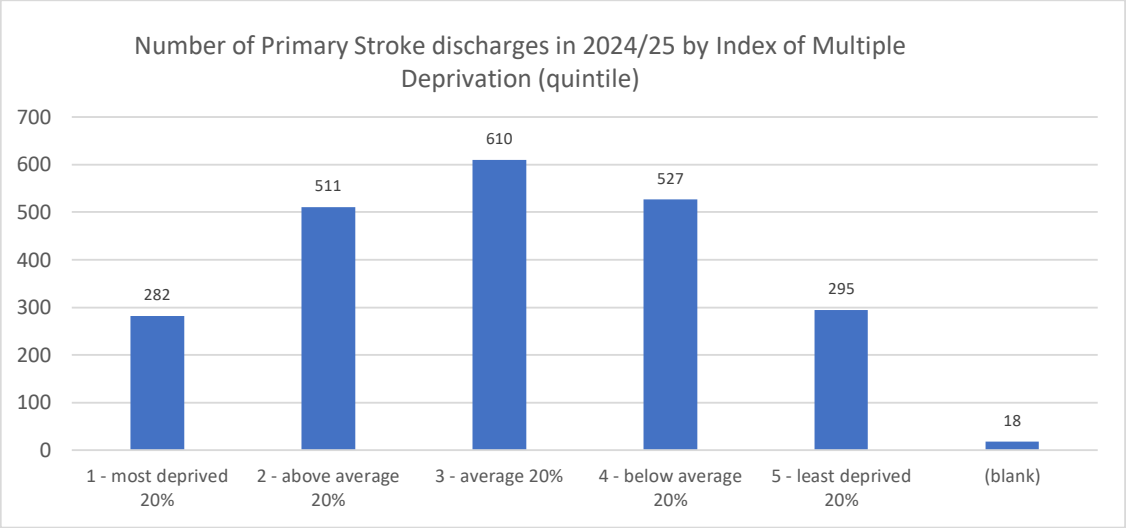


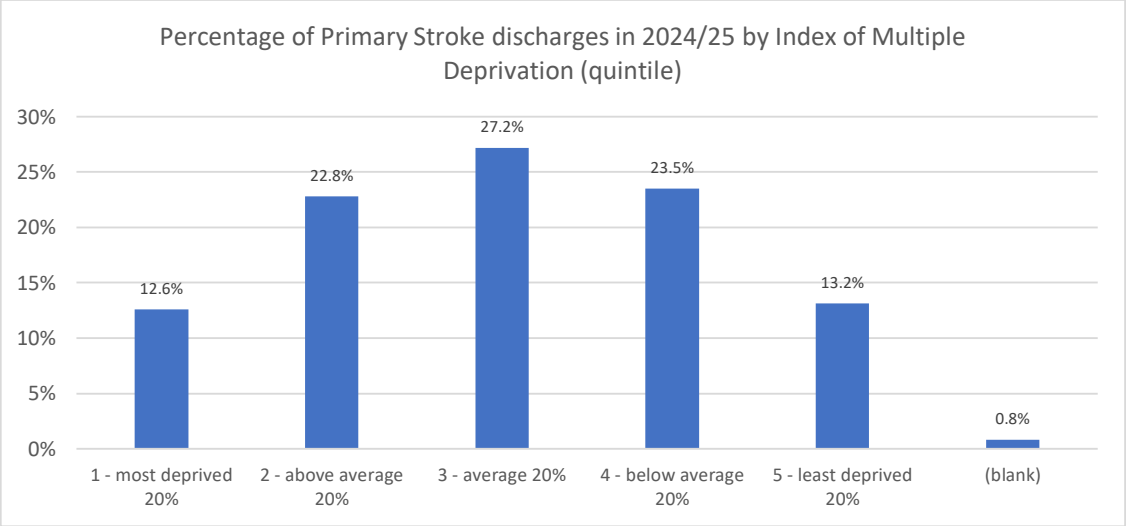
Stroke discharges by ethnic category shows a very similar position to the Devon demographics, with the vast majority recorded as white and only small numbers being recorded in other ethnic categories.





Looking at stroke discharges by deprivation quintile, the balance matches the deprivation make-up of Devon.

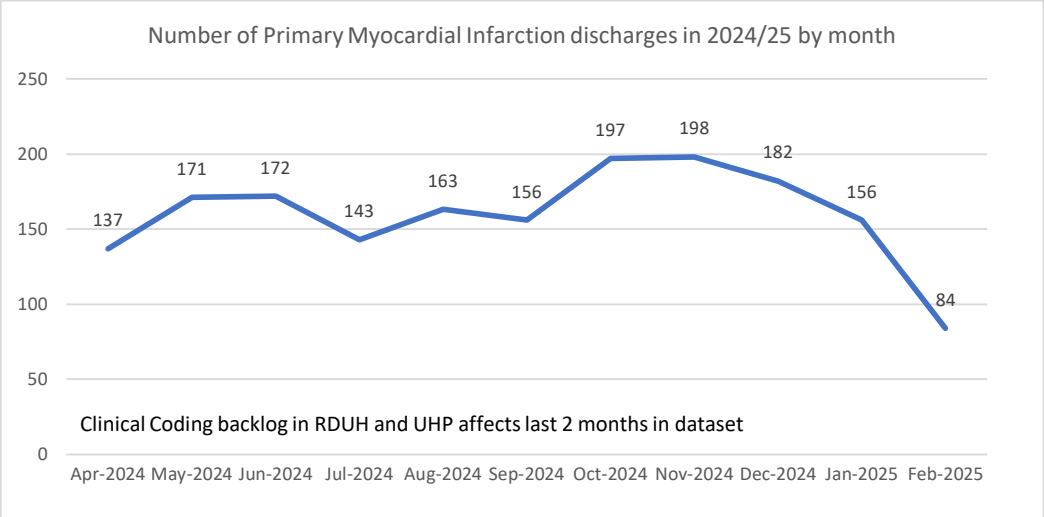


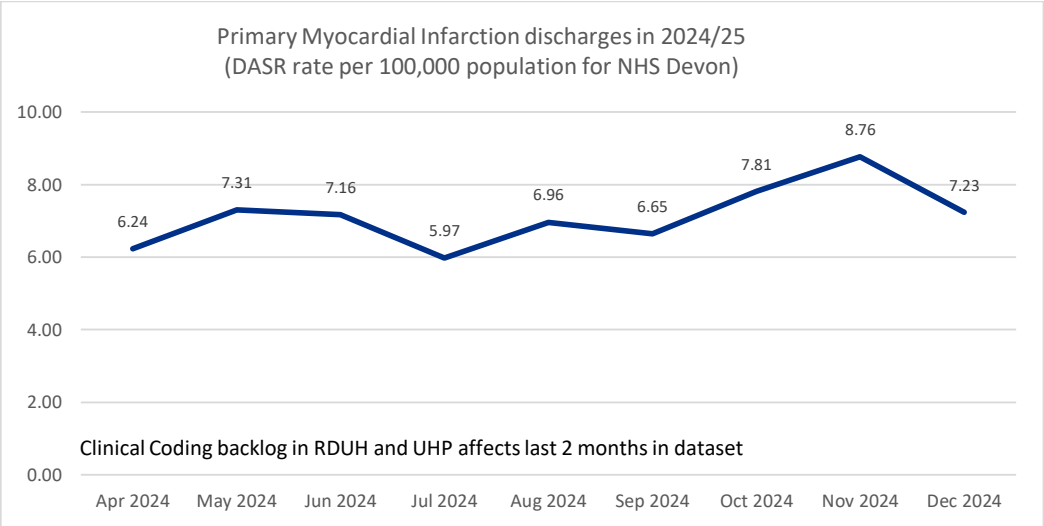


The position for primary stroke discharges in 2024/25 for ethnicity and deprivation quintiles is similar to that seen in 2023/24.

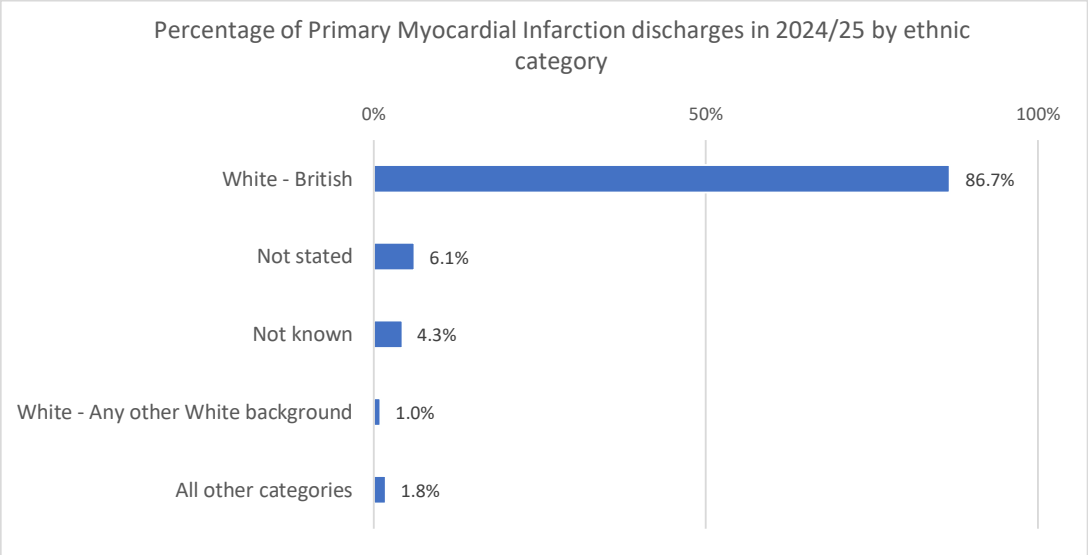
Myocardial Infarction (Heart Attack)

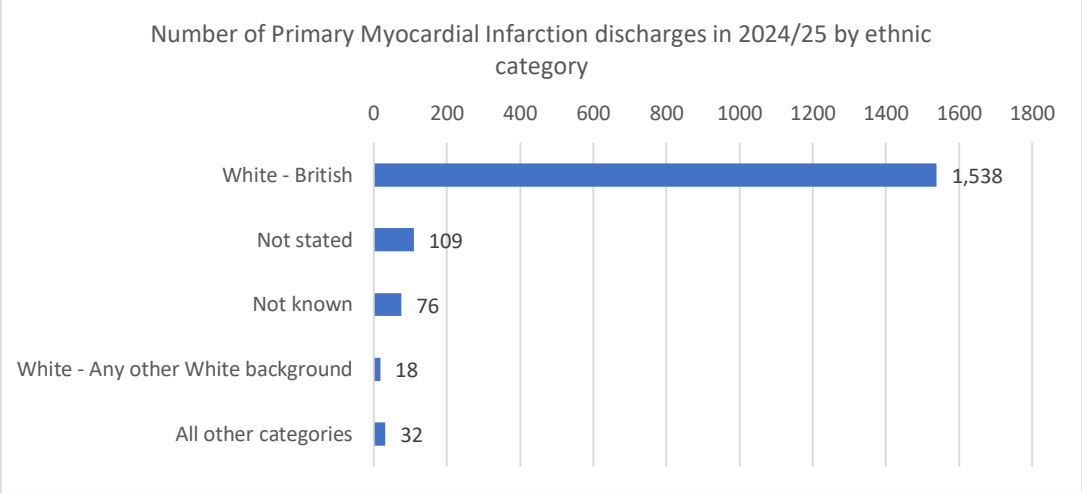
The number and rate of non-elective admissions for heart attacks in Devon (per 100,000 age-sex standardised) rose towards the end of 2024 before returning to levels similar to those earlier in the year (please note, later months are affected by delays in coding).



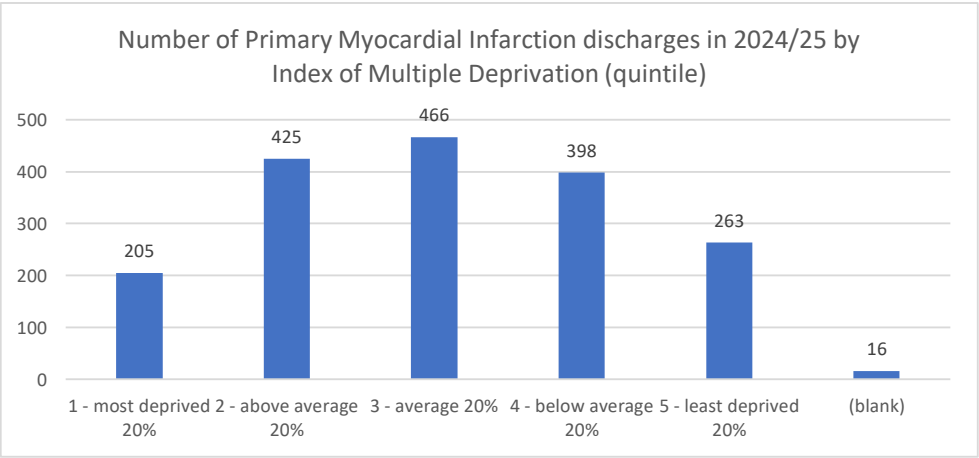


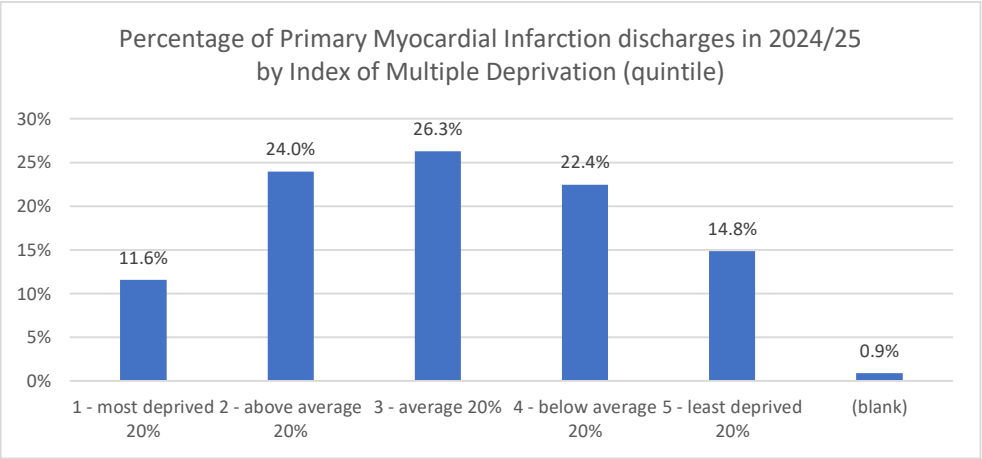
The ethnic category of heart attacks shows a consistent position with the population demographics.





Looking at heart attacks by deprivation quintile, a slightly lower number of below-average deprivation patients are seen than might be expected, with a slightly higher number of above-average deprivation patients, which may be linked to the spread of risk factors between the deprivation groups.



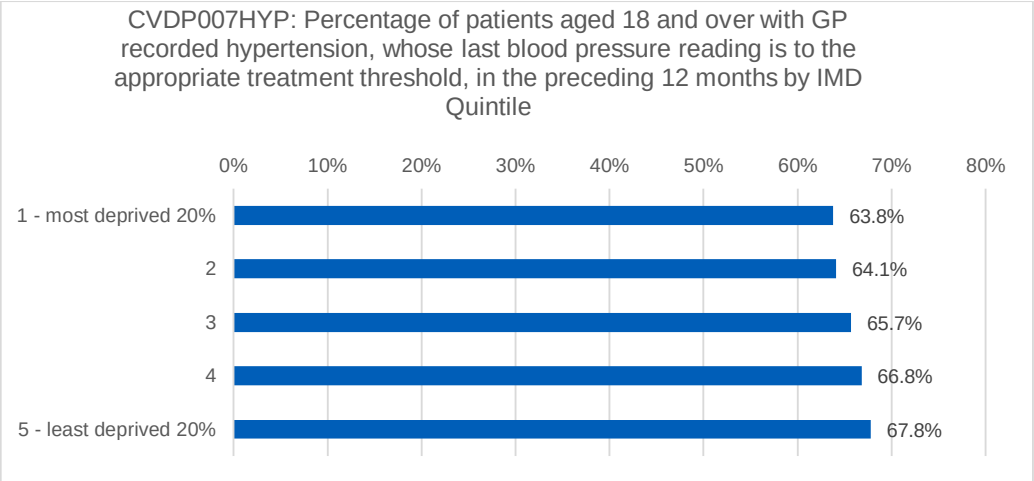


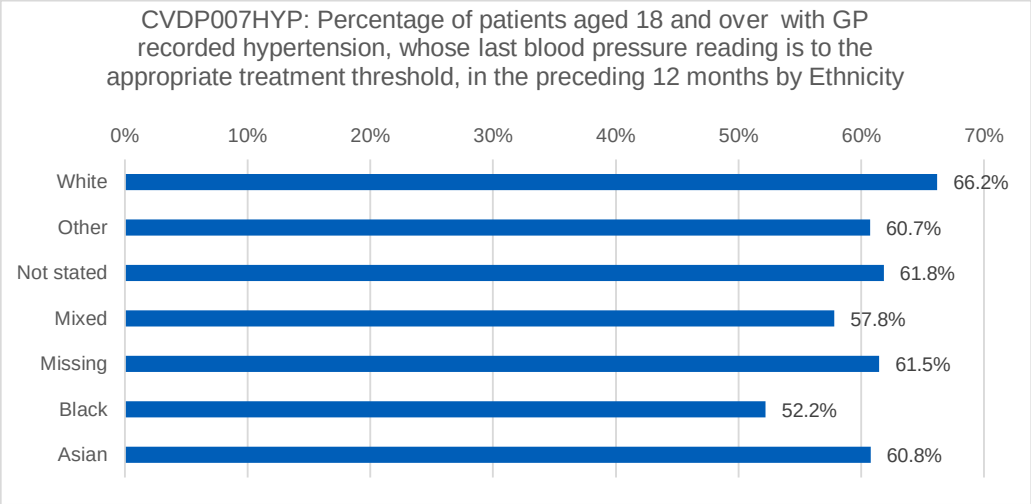
The position for primary myocardial infarction discharges in 2024/25 for ethnicity and deprivation quintiles is similar to that seen in 2023/24.

Hypertension

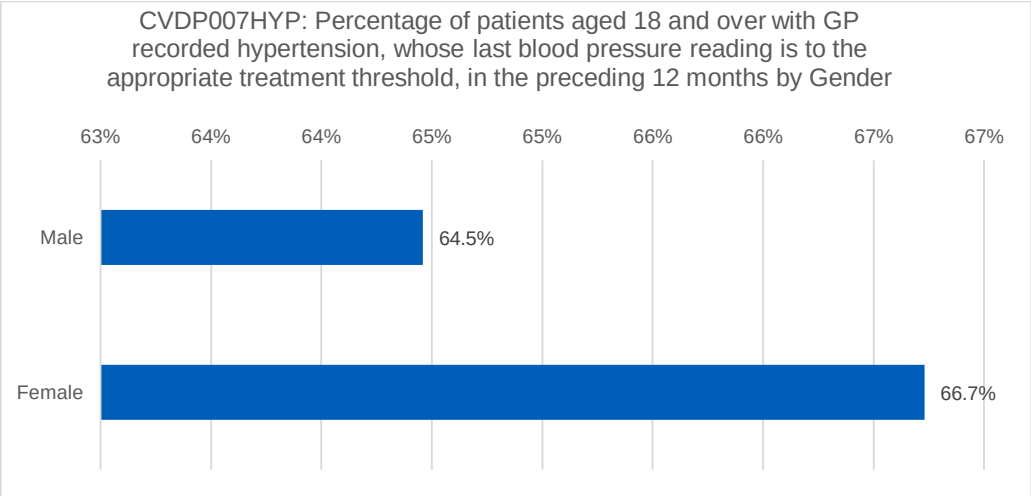
This section looks at three measures associated with hypertension, with the first being the percentage of patients aged 18 and over, with GP recorded hypertension, in whom the last blood pressure reading (measured in the preceding 12 months) is to the appropriate treatment threshold. By ethnicity there is variation for this measure, although based on small numbers, but the lower readings for non-white ethnic groups warrants further review. The national ambition for this measure is 80%.

By deprivation quintile, patients from the most deprived areas receive poorer outcomes for this measure, with a noticeable difference compared to patients from lesser deprived areas.

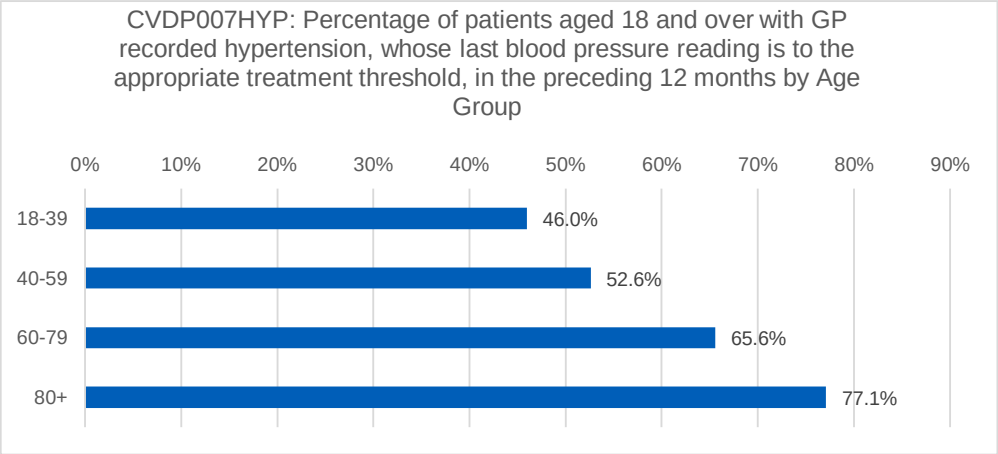




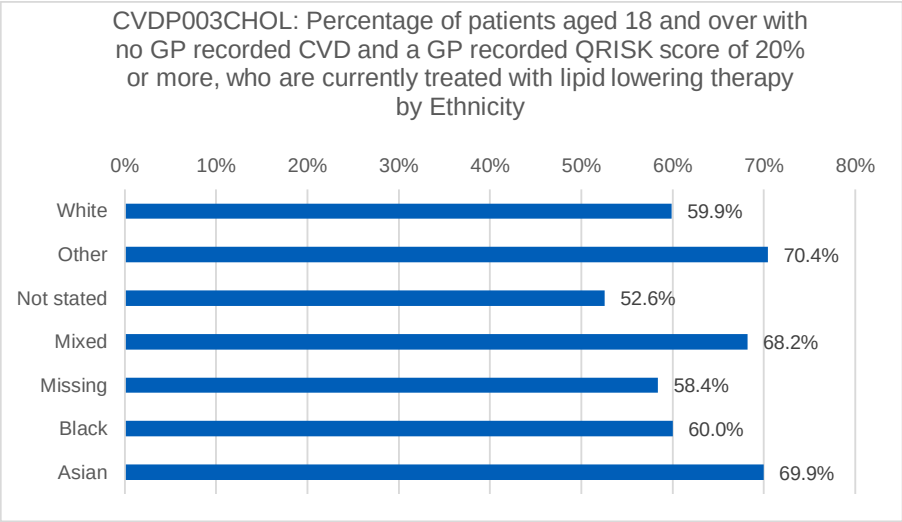
Outcomes for males are lower than for females.



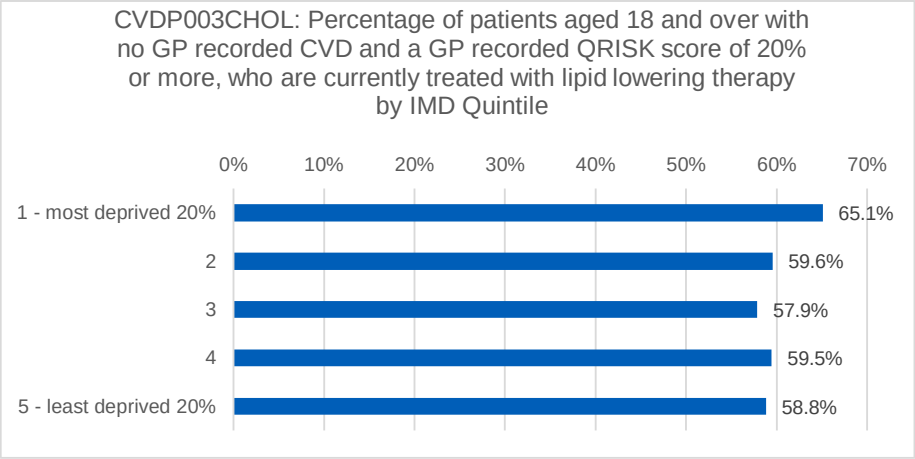
Looking by age, there is a clear increase in readings within the threshold for older people, with a progressive increase as age rises.



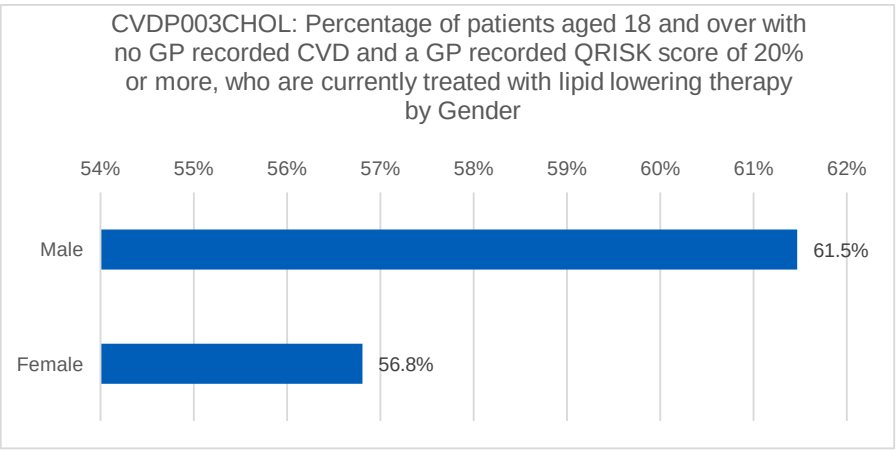
The percentage of patients aged 18 and over with no GP recorded Cardiovascular Disease (CVD) and a GP recorded QRISK score of 20% or more, on lipid lowering therapy shows general low variability when viewed by ethnicity, with the exception of higher rates for those recorded as Asian, Mixed or Other (note: higher prescribing rates are linked to better outcomes).



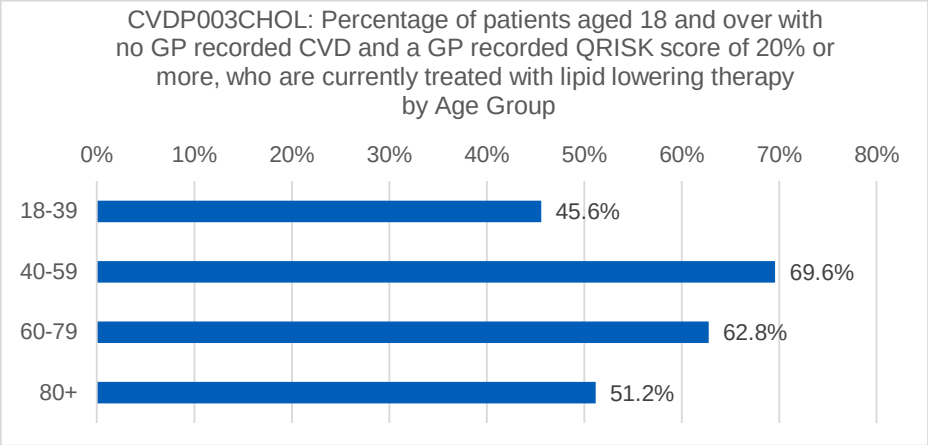
Looking at deprivation for the same measure, patients from the most deprived areas show a higher prescribing rate for appropriate LLT medication.



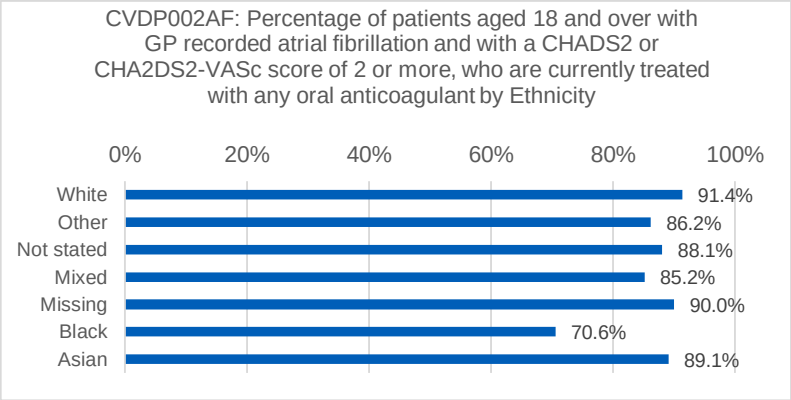
By gender, males are more likely to be prescribed appropriately for LLT medication.



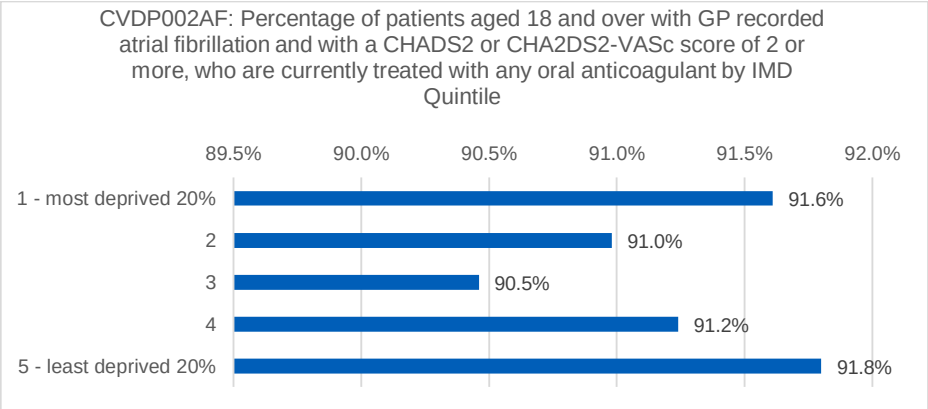
By age group, people aged 18-39 years and those over 80 years old are least likely to be prescribed appropriately for LLT medication. The proportion of 18-39 years being prescribed appropriately for LLT medication has reduced considerably compared with 2023/24 (60%).



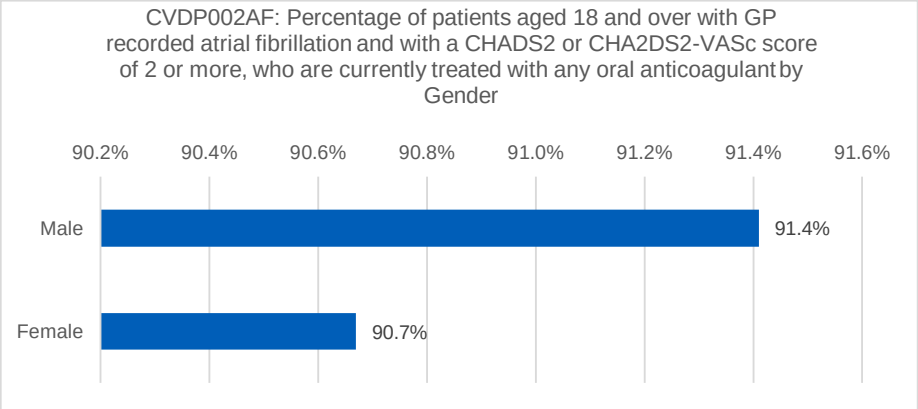
The percentage of patients aged 18 and over with GP recorded atrial fibrillation and a record of a CHADS2 or CHA2DS2-VASc score of 2 or more, who are currently treated with any oral anticoagulant is significantly lower for people with a black ethnicity compared to other ethnicities. Overall, the proportions by ethnicity are similar compared to 2023/24. However, the proportion of patients with a black ethnicity has increased from 62%.

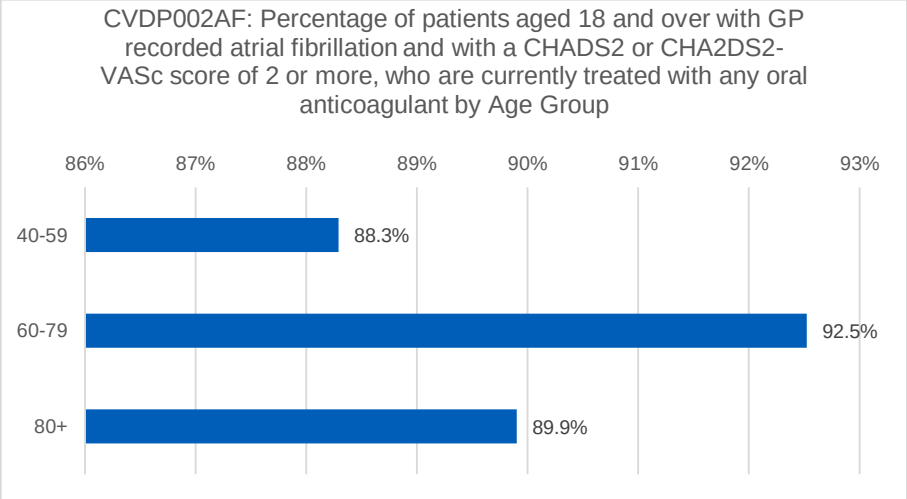


When looking by deprivation the least deprived areas have similar likelihood of being treated with drug therapy than those in more deprived areas.



By gender there is very little difference in prescribing between males and females, whilst by age group the 40-59 age range has a lower level of prescribing, but this is based on small numbers of patients and so a level of variation is to be expected. There is no data for 18-39 year olds.

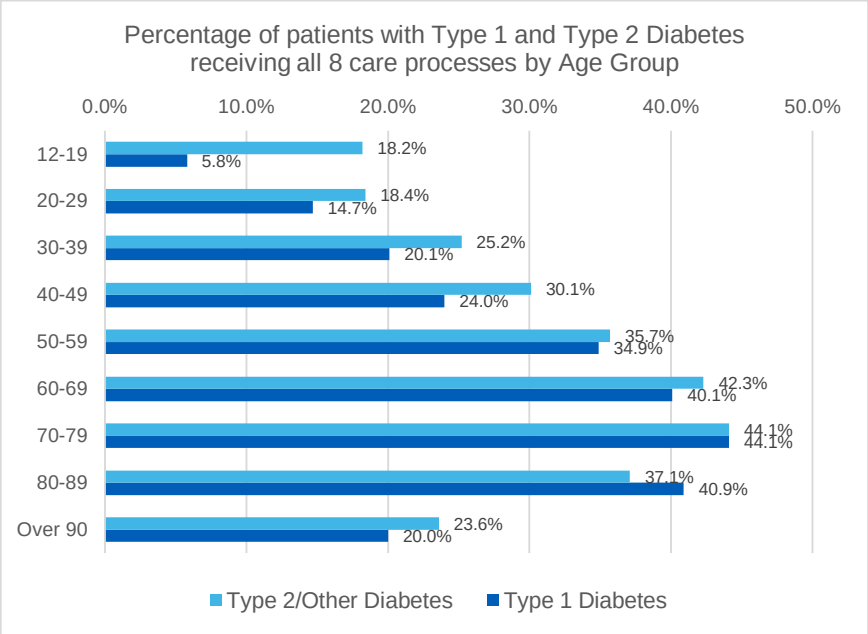




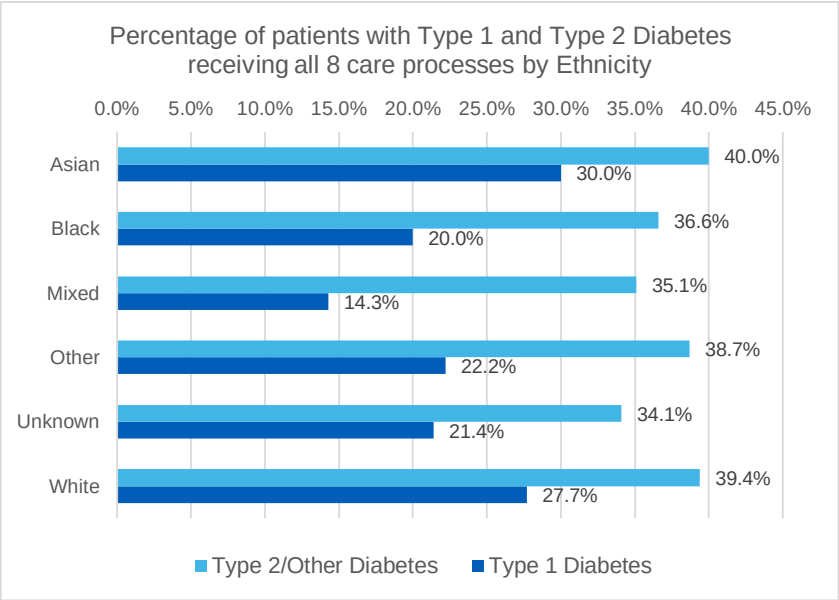
The proportions of GP recorded atrial fibrillation in 2024/25 for age, gender, ethnicity and deprivation quintiles is similar to that reported in 2023/24.

Diabetes

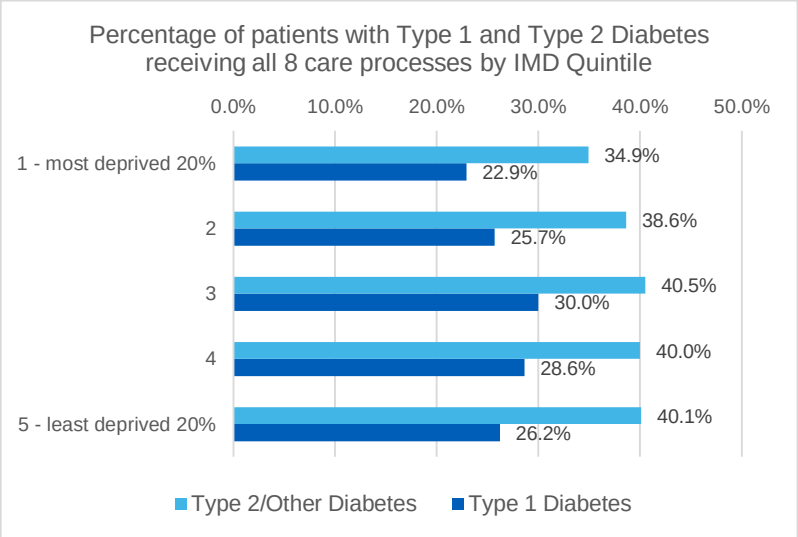
This section looks at the variation between the percentage of people with Type 1 and Type 2 diabetes receiving all eight care processes set out in national guidance. By age group the receipt of these care processes increases by age, peaking between 60 and 90 years old.



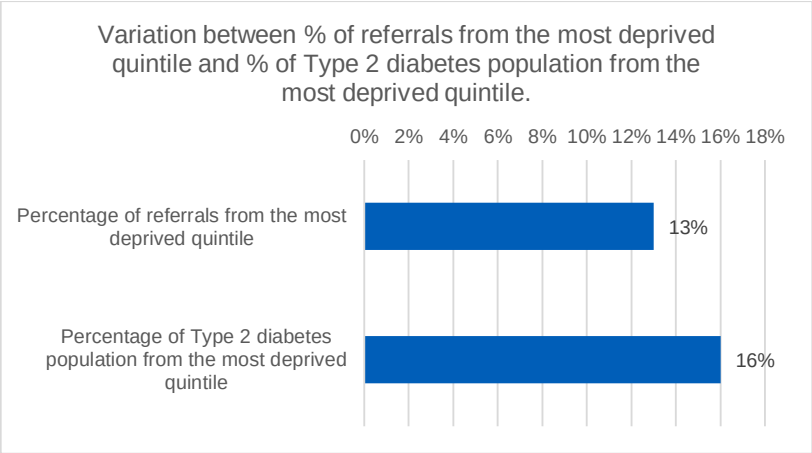
Looking at this measure by ethnicity there is a level of variation, with those with a white or Asian ethnicity seeing higher levels of care processes received compared to mixed, black or other ethnicities.



By deprivation quintile those in the most deprived areas receive the least processes.

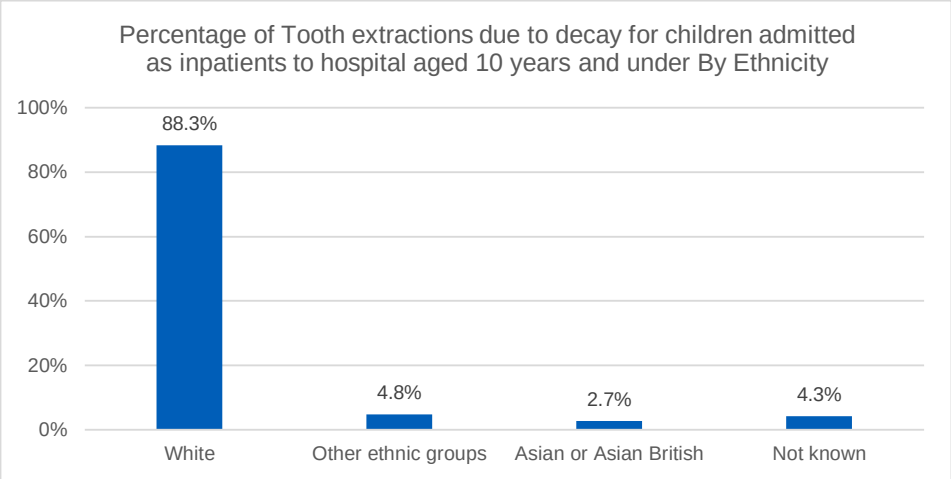


The chart below shows the variation between the percentage of referrals from the most deprived quintile and the overall share of Type 2 diabetes population from the most deprived quintile. There is a 3% difference from the expected level (less care processes received than would be expected) given the population.

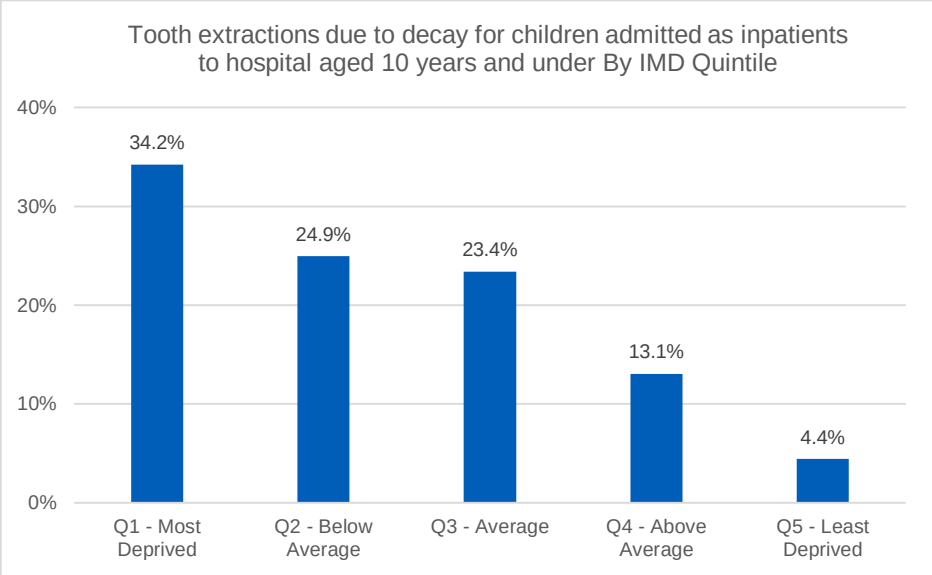


Oral health

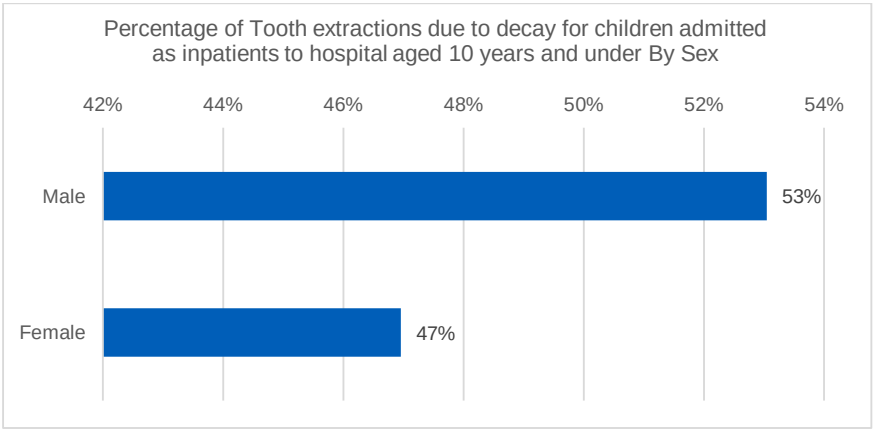
This section looks at tooth extractions due to decay for children admitted as inpatients to hospital, aged 10 years and under (number of admissions not number of teeth extracted) for the 2024 calendar year. Please note that the majority of activity in Plymouth is not recorded. By ethnicity the proportions of tooth extractions generally represent the population ethnic mix.



By deprivation quintile there is a clear pattern of the most deprived areas showing much higher rates of tooth extractions in hospital for children than the least deprived areas.



The split by gender shows boys are more likely to have tooth extractions in an acute inpatient setting than girls.



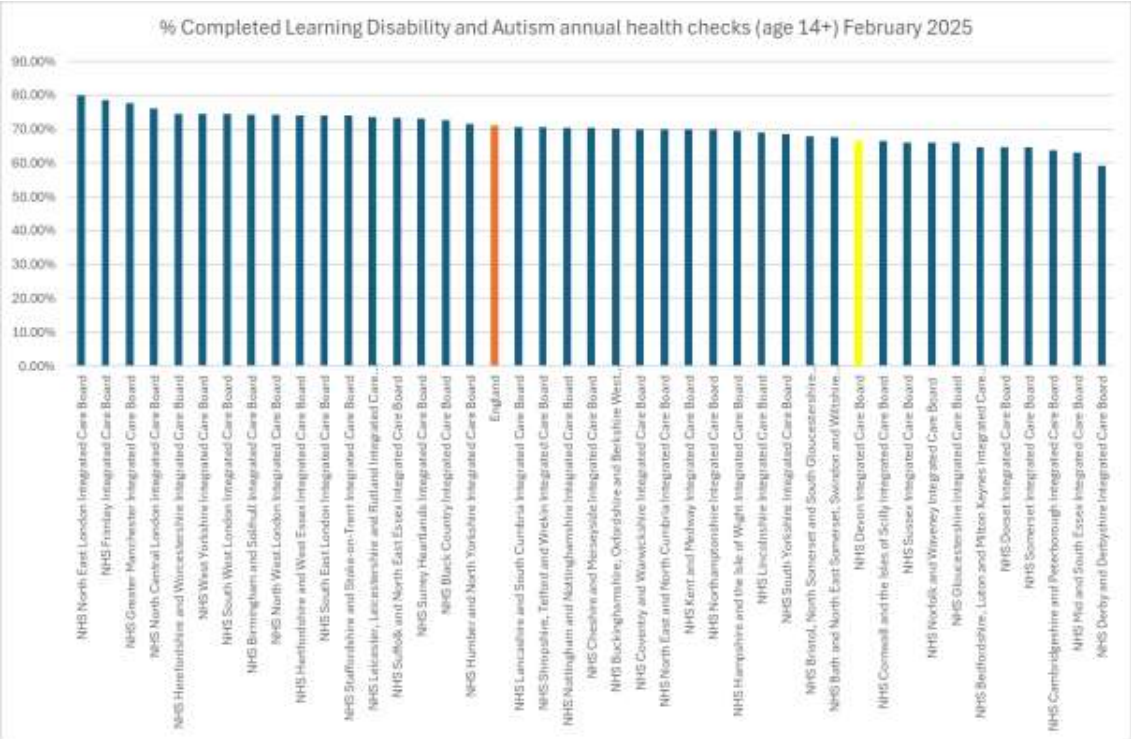
The proportions of tooth extractions in an admitted hospital setting for 10 and under in 2024/25 for gender, ethnicity and deprivation quintiles is similar to that reported in 2023/24.

Learning disability and autistic people

Annual Health Checks

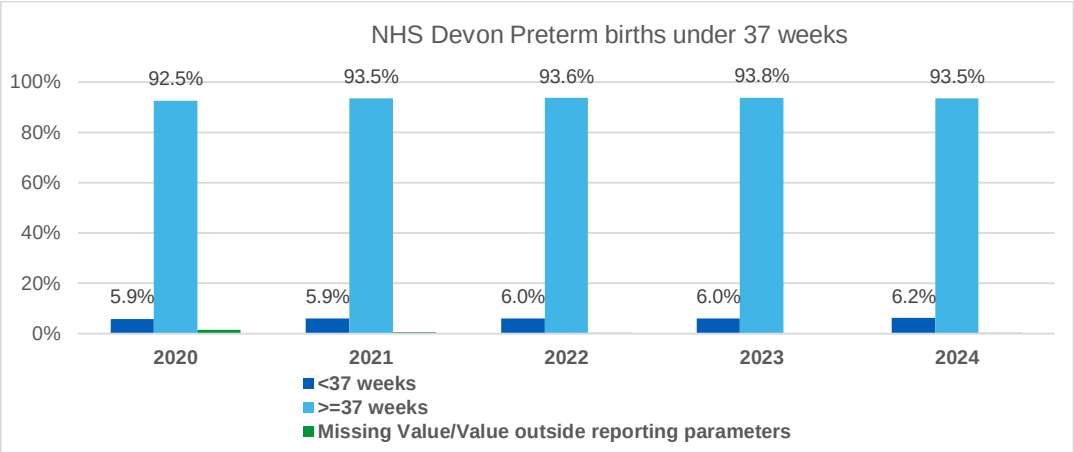
In Devon up to February 2025 66.7% of annual health checks were completed for people with a Learning Disability or Autism. This compares to the national position of 70.9%. nationally there has been a considerable increase in the percentage of annual health checks, Devon has increased in line with this development.

Devon PCN-level coverage ranged from 81.8% to 33.3%, suggesting there is scope to review variation in the timing and volume of checks offered. The national ICB comparison is shown below.



Maternity and neonatal

This section looks at pre-term births under 37 weeks. Overall, numbers have remained fairly static over the past four years, with around 6% of births being under 37 weeks.



By ethnicity black or white groups are more likely to have pre-term births, although this is based on relatively small numbers with a high level of unknown or blank ethnicities recorded which makes it difficult to produce an accurate comparison. The percentage of pre-term births for black groups has decreased from 13.9% in 2023/24.

YearOfBirthBaby	2024		
ICB	NHS DEVON ICB		
Percent	Gestation Length		
Ethnic Group	<37 weeks	>=37 weeks	Missing Value/Value outside reporting parameters
Asian or Asian British	3.8%	95.9%	0.3%
Black or Black British	6.4%	93.1%	0.5%
Mixed	5.0%	95.0%	0.0%
Other ethnic groups	3.3%	96.1%	0.7%
White	6.3%	93.4%	0.3%
(blank)	11.7%	88.3%	0.0%
Not known	33.3%	66.7%	0.0%
Grand Total	6.2%	93.5%	0.3%

By deprivation quintile pre-term births rise with increased deprivation, being over 1% higher for patients from the most deprived areas than the least deprived.

YearOfBirthBaby	2024		
Ethnic Group	(All)		
ICB	NHS DEVON ICB		
Percent	Gestation Length		
IMD_Quintile	<37 weeks	>=37 weeks	Missing Value/Value outside reporting parameters
Q1 - Most Deprived	6.3%	93.7%	0.00%
Q2 - Below Average	7.1%	92.5%	0.34%
Q3 - Average	6.3%	93.4%	0.24%
Q4 - Above Average	5.6%	94.0%	0.36%
Q5 - Least Deprived	4.7%	95.1%	0.24%
Grand Total	6.2%	93.5%	0.25%

The proportions of pre-term births in 2024/25 for deprivation quintiles is similar to that reported in 2023/24.

NHS England South West

To: Steve Moore (CEO)

cc. Kevin Orford (Chair)

South West House
Blackbrook Park Avenue
Taunton
TA1 2PX

22 July 2025

Dear Steve,

Annual Assessment of Devon ICB in 2024/25

I am writing to you pursuant to Section 14Z59 of the NHS Act 2006 (Hereafter referred to as *"The Act"*), as amended by the Health and Care Act 2022. Under the Act NHS England is required to conduct a performance assessment of each Integrated Care Board (ICB) with respect to each financial year. In making my assessment I have considered evidence from your annual report and accounts; available data; feedback from stakeholders and the discussions that my team and I have had with you and your colleagues throughout the year.

This letter sets out my assessment of your organisation's performance against those specific objectives set for it by NHS England and the Secretary of State for Health and Social Care, its statutory duties as defined in the Act and its wider role within your Integrated Care System across the 2024/25 financial year.

I have structured my assessment to consider your role in providing leadership and good governance within your Integrated Care System as well as how you have contributed to each of the four fundamental purposes of an ICS. For each section of my assessment I have summarised those areas in which I believe your ICB displays good or outstanding practice and could act as a peer or an exemplar to others. I have also included some areas in which I feel further progress and performance improvement is required. Detailing any support or assistance being supplied by NHS England to facilitate improvement.

In making my assessment I have also sought to consider how you have delivered against your local strategic ambitions as detailed in your Joint Forward Plan. A key element of the success of Integrated Care Systems will be the ability to balance national and local priorities together and I have aimed to highlight where I feel you have achieved this and where further specific work is required.

I thank you and your team for all your work over this financial year, and I look forward to continuing to work with you in the year ahead.

Yours Sincerely,

Sue Doheny
Regional Director
NHS England – South West

SECTION 1: SYSTEM LEADERSHIP AND MANAGEMENT

There is good evidence of improved governance, with defined roles and responsibilities across the ICB Board, Committees and Executive leadership. This is further supported by the implementation of the Executive Commissioning Group, One Devon System Leadership Group and there is strong evidence that the ICB has worked collaboratively with local authorities, NHS providers, and the voluntary sector to deliver on the ambitions of the One Devon Integrated Care Strategy. It's positive to see that the strategy is aligned with the four statutory aims of Integrated Care Systems (ICSs) and shows a vision of "equal chances for everyone in Devon to lead long, happy and healthy lives."

Leadership challenges continued throughout 2024/25 which have been driven by several key leadership changes in the system, the resignation of the ICBs Chief Financial Officer (CFO), and other Executive Director vacancies and changes, which collectively continue to present a leadership risk in some parts of the system.

Except for Devon Partnership NHS Trust, the ICB and Acute Trusts remained in the NHS Oversight Framework (NOF) Regional Support Programme (RSP) during 2024/25 for Leadership, Strategy, Elective Care, Urgent and Emergency Care and Finance with agreed exit criteria set and an expectation that the ICB and Acutes would exit RSP at the end of Quarter 1, 2024/25.

At the end of March 2025, the System's assessment of performance against the exit criteria, which was supported by the region, showed that in terms of Strategy, the system had worked through the Peninsula Acute Provider Collaborative to deliver the agreed Phase 2 programme of work and that whilst joint working had remained positive, progress in delivering tangible changes in the disposition of acute services remains slow due to a lack of resources dedicated to delivering the programme and variable commitment and ability to drive difficult service change between and across organisations.

It was also reported that the lack of an overall clinical strategy for Devon had increasingly become a barrier to change. It was positive to see that Devon ICB has acknowledged the need to accelerate development of the whole-system strategy to articulate the future shape and role of out-of-hospital care and the associated disposition of acute services. Supported by clear strategic commissioning intentions, this will inform the future shape of hospitals to support service and financial sustainability going forward. The agreed timescale for completion of this work is September 2025 to align with the refresh of the MTFP and release of the 10-year plan.

In line with the exit criteria measures, Phase 2 of the Programme has been delivered but the evidence to support a compliant position for the elimination of unwarranted duplication of specialist DGH services remained outstanding.

The Leadership exit criteria and measures remained on-track or complete and it is encouraging that system architecture has been strengthened but noting to date, there is no agreed mechanism for how the financial implications of service change will be managed across the system.

The system has continued to face significant pressures in urgent and emergency care, elective recovery, and finance, although it is acknowledged that progress has been made in some areas.

Feedback from the Devon Health and Wellbeing Boards has demonstrated that the ICB has fully engaged with members of and officers supporting the Devon Health and Wellbeing Boards to directly contribute to the Integrated Care Strategy, Joint Forward Plan, and wider ICB strategy and policy documents, establishing a direct link between HWB and ICB strategies.

Devon's refreshed Joint Forward Plan meets all 17 legislative requirements and is described as a response to the Integrated Care Strategy. It retains the same three themes as the previous iteration, with updated delivery areas. The plan includes NHS and Council recovery details, and references a broad range of strategic objectives, aims, and priorities, showing progress in some areas. Going forward, ICBs must set measurable, trackable outcomes which can be tracked annually. Additionally, the ICS development team and regional leads will provide ongoing support once the 10-year plan is released.

Key next steps:

- Ensure demonstrable delivery of the disposition of acute services and the elimination of unwarranted duplication and variation in specialist DGH services.
- Develop and implement a Clinical Strategy that is underpinned by clear strategic commissioning intentions.
- Secure agreement on how financial implications of service change will be managed across the system.
- Complete and deliver the refreshed MTFP by September 2025.
- Improve the structure of the JFP by ensuring there are aligned and streamlined goals, strategic objectives, themes and delivery areas so that it is possible to track the progress made to achieve the aims set in the Integrated Care Strategy.

SECTION 2: IMPROVING POPULATION HEALTH AND HEALTHCARE

It’s evident that Devon ICB has taken a strategic and data-driven approach to improving population health and the establishment of the Population Health Improvement Committee (PHIC) and the development of the One Devon Dataset are significant achievements.

It’s encouraging to see that progress has been made in delivering against the Core20PLUS5 framework, with targeted initiatives for children and young people, people with severe mental illness, and those experiencing homelessness or domestic abuse. The Joy App, which supports social prescribing and community referrals, is a notable innovation that has shown positive outcomes in reducing GP re-attendance and improving patient wellbeing.

The ICB has been proactive in embedding a culture of transparency and inclusivity. The establishment of the One Devon Involvement Platform and the integration of Healthwatch into governance structures are commendable steps toward meaningful public engagement. The ICB has also made progress in embedding Equality, Diversity, and

Inclusion (EDI) principles, with clear targets for workforce representation and inclusive recruitment practices.

In terms of service delivery, the ICB has implemented a range of programmes to improve access and outcomes. These include virtual wards, community diagnostic centres, and enhanced primary care services. The ICB has also invested in digital transformation, with efforts to standardise GP websites, expand the use of the NHS App, and implement electronic patient records (EPRs).

While the ICB has articulated a strong commitment to prevention and early intervention, there is an opportunity to strengthen the link between strategic planning and operational delivery, particularly in areas such as cardiovascular disease (CVD) prevention, falls and frailty, and long-term condition management.

In respect of improving services, it is important to acknowledge that progress has been made in the RSP exit criteria during 2024/25 but significant challenges remain:

- Elective performance greatly improved, particularly in respect of the long waiting times. Whilst original trajectories have not been met for 78ww or 65ww, all providers are close to meeting revised trajectories and have de-escalated from Tier 1 national oversight.
- Demonstrable progress has been made against the majority of the UEC metrics although standards are not yet being met. The UHP ‘One Plan’ is delivering more sustainable improvements, albeit from a low baseline.
- The system delivered its revised forecast position for the financial year 2024/25 – a £19.8m overspend after the receipt of £80m of deficit support funding.
- Joint working through the Acute Provider Collaborative has continued with Phase 2 milestones met. Focus has increased on delivering solutions for fragile services and the first cut in data modelling work for the longer-term programme has been completed.
- System architecture has been strengthened with greater oversight through Locality Delivery meetings and the System Leadership Group. This has increased the visibility of performance issues and been an enabler for seeking more joined-up solutions.
- The 2025/26 planning process and the establishment of the Transforming Devon Programme has facilitated the development of several system-wide programmes aiming to increase efficiency and reduce costs including collaborative corporate services.

<u>Key next steps:</u>

- Strengthen the link between strategic planning and operational delivery for cardiovascular disease (CVD) prevention, falls and frailty, and long-term condition management.
- Focus on delivery of the 2025/26 plan, with an enhanced grip on urgent and emergency care, elective care and finance.

- Ensure that assessments of timescales, capacity and expertise are realistic for delivering service-change programmes.

SECTION 3: TACKLING UNEQUAL OUTCOMES, ACCESS AND EXPERIENCE

Devon ICB has made tackling health inequalities a central pillar of its strategy. The Core20PLUS5 Steering Group, Inclusion Health Steering Group, and Oral Health Steering Group provide a strong foundation for targeted action. The ICB has also invested in community-based initiatives, such as the Ilfracombe Poverty Truth Commission and the Health Inequalities Fellows Programme, which empower local voices and support co-production. Initiatives also target children and young people, people with severe mental illness, and those experiencing homelessness or domestic abuse.

The ICB's approach to EDI is well-structured, with clear objectives, measurable targets, and a focus on inclusive recruitment and leadership. The integration of EDI into governance processes and the development of staff networks are positive steps toward a more inclusive culture.

The ICB has also demonstrated a commitment to improving access and experience for underserved populations. Examples include the expansion of the Big Brush Club for oral health, targeted smoking cessation programmes, and the development of culturally competent services for migrant and refugee communities.

Whilst the ICB has delivered a wide range of initiatives, the evidence of impact is variable. There is a need for more consistent evaluation of how these initiatives are reducing inequalities in access, experience, or outcomes. For example, while the ICB has implemented targeted programmes for children and young people, there is limited data on how these have improved school readiness, mental health, or long-term outcomes

Although it is encouraging that the ICB has made progress in reducing out-of-area placements and improving physical health checks, further work is needed to ensure equitable access to high-quality care across all settings.

<u>Key next steps:</u>

- Strengthen evaluation process to better understand how initiatives are reducing inequalities in access, experience, or outcomes.
- Embed equitable access to high-quality of care across all settings.

SECTION 4: ENHANCING PRODUCTIVITY AND VALUE FOR MONEY

The system delivered its forecast 2024/25 position and reported reductions in the run-rate in the last quarter, however, it's important to recognise that this delivery relied upon significant non-recurrent resources and concern remains about sustainability of the position going forward and in the longer term.

Your updated MTFP produced at the end of 2024 did identify a route to break-even as required by the RSP exit criteria. However, this was overtaken by the 2025/26 operational planning process which demonstrated further deterioration against the revised planning

guidance resulting in the need to redevelop the MTFP to align with the breakeven requirement. The target date for completion of the revised MTFP is the end of Quarter 2.

The systems final submission of its financial plan for 2025/26 does meet the requirement to deliver break even (after the £53.8m of deficit support funding) but the risks to delivery, even after the systems proposed mitigations are significant.

The maturity of the CIP programmes remains an area of concern and the system being off trajectory in Month 1 and 2 is disappointing, but the reasons behind it are understood and actions are in place to get back on track.

The ICB continues to face challenges in elective recovery, with long waiting times for planned care and the impacts of the implemented super clinics and community diagnostic centres, on reducing the backlog is not yet fully realised and there is a need to strengthen the link between financial planning and service transformation.

Whilst the ICB has articulated a clear vision for integrated care, the alignment of budgets, incentives, and outcomes across the system remains work in progress.

In respect of research and innovation the ICB's partnership with the Peninsula Research and Innovation Programme and the development of the Research, Innovation, and Improvement (RII) team are commendable and have supported the adoption of evidence-based practices and the scaling of successful innovations.

Digital transformation is another area of strength and it's encouraging to see that the ICB has invested in virtual wards, robotic process automation, and digital social care records. These initiatives have the potential to improve efficiency, reduce duplication, and enhance patient experience.

Key next steps:

- Continue assurance on the delivery of the 2025/26 financial plan.
- Strengthen financial oversight with a higher proportion of savings delivered recurrently to improve the underlying financial position.
- Focus on strengthening the link between financial planning and service transformation.
- Continue the work on aligning of budgets, incentives, and outcomes across the system.

SECTION 5: HELPING THE NHS SUPPORT BROADER SOCIAL AND ECONOMIC DEVELOPMENT

Devon ICB has embraced its role as an anchor institution, using its assets, influence, and partnerships to support broader social and economic development. The Anchor Organisations Steering Group and the Anchor Strategy provide a clear framework for action, with a focus on employment, procurement, and community engagement.

It's positive to see that progress has been made in supporting inclusive employment, with targeted programmes for young people, people with disabilities, and unpaid carers. The Talented Me partnership and the expansion of supported internships are positive examples of how the ICB is creating opportunities for those facing barriers to work.

The ICB has also taken steps to support local procurement and social value. The Green Plan includes commitments to buy locally, reduce waste, and promote sustainable practices and it is encouraging to see that you are working with your local authorities to address housing-related health issues, including fuel poverty, homelessness, and poor housing conditions.

Your commitment to environmental sustainability is evident in the Green Plan, which sets out a pathway to net zero by 2040. The plan includes actions across travel, estates, procurement, and clinical practice, with a focus on reducing emissions, improving air quality, and promoting active travel.

Whilst you have articulated a strong vision, the evidence of impact is still emerging and could be strengthened with more consistent reporting on outcomes, particularly in relation to employment, housing, and environmental sustainability.

You should also consider how you can further leverage your role as a system leader to influence wider determinants of health, including education, transport, and economic development.

Key next steps:

- Continue your excellent work in supporting the Green Plan commitments and inclusive employment programme.
- Improve monitoring and measurement of impacts on initiatives supporting health outcomes and economic development.
- Continue to explore how you can further leverage your role as a system leader to influence wider determinants of health, including education, transport, and economic development.

CONCLUSION

This has been a year of both opportunity and challenge for Devon ICB, and the ICB has made meaningful progress in fulfilling its statutory duties and contributing to the four core purposes of an Integrated Care System. Achievements in 2024/25 reflects a system that is maturing in its approach to integrated care, a commitment to collaboration, and a growing emphasis on prevention, innovation, and equity. As the system moves into the next phase of development, it will be important to build on the foundations laid this year, with a continued emphasis on delivery, accountability, and impact.

At the end of Quarter 4, 2024/25 the ICB and Acute Trusts remained in the NHS Oversight Framework (NOF) Regional Support Programme (RSP). On the 17th June 2025, QPC reviewed Devon's progress against the RSP exit criteria, the findings of which were detailed in the letter from the South West Regional Director that was shared with you on the 25th June 2025. In Summary it was considered that:

- Devon ICB: Sufficient progress to support exiting RSP for leadership, UEC, and elective performance at the end of Q1, with further RSP support on finance being provided during Quarter 2.

- Royal Devon University Healthcare NHS Foundation Trust: Sufficient progress made against all exit criteria to support exiting RSP at the end of Q1, with continued financial advice and oversight of finance and elective into Q2.
- University Hospitals Plymouth NHS Trust: Good progress made in most areas but with risks in finance, UEC, and elective performance into 2025/26. Review at end of Q2 to determine support for RSP exit.
- Torbay and South Devon NHS Foundation Trust: Insufficient progress in all areas to support exit. Targeted support will be required throughout 2025/26 with a review in Q4.

The letter also confirms that we will continue to hold the monthly SIAG meetings, with a focus on:

- in year delivery against your submitted 2025/26 plan by exception
- specific focus on those areas still within the Recovery Support Programme, and;
- the ongoing strategic work you are doing to make sure that the Devon system can create the conditions for delivery of high quality, sustainable and affordable services to your population.

This will all be subject to review once the implication of the new role of ICBs in its clustered form and the impact of the new Oversight Framework have been fully worked through.

In addition to the above, the year ahead is going to see ICBs having to deliver plans to reduce their costs, with the recently published ICB blueprint document ‘Model Integrated Care Board’ marking the first steps in a joint programme of work to reshape the focus, role and functions of ICBs with a view of laying the foundations for delivery of the 10 Year Health Plan.

The ask on you, your teams and your partners is going to be significant as you work to maintain effective oversight of the delivery of 2025/26 plans, build the foundation for neighbourhood health and manage the local changes involved with ICB redesign and cost reductions in both the ICB and provider, including supporting your staff through engagement and consultation.

My team and I will continue to work alongside you, so jointly we become familiar with the new NHS architecture and ways of working, alongside continuing to support and guide you through what is going to be an extremely challenging transformational year.

In the interim, please share my assessment with your ICB leadership team and consider publishing this alongside your annual report at a public meeting. NHS England will also publish a summary of the outcomes of all ICB performance assessments in line with our statutory obligations.

To:

Steve Moore, Chief Executive Officer

Kevin Orford, Chair

Devon Integrated Care Board

Mark Brassington
Director of Operational Improvement and
Recovery Support Programme
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2025

Dear Steve and Kevin,

Formal notice of Devon Integrated Care Board's exit from the Recovery Support Programme (RSP).

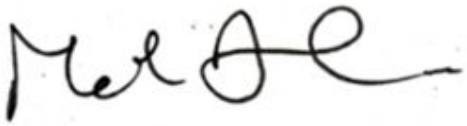
As you will be aware, a paper was considered by NHS England's Quality and Performance Committee (QPC) to recommend that Devon ICB should transition out of the Recovery Support Programme, having demonstrated sufficient progress against all exit criteria for leadership, UEC and elective performance. I am pleased to confirm that QPC approved this recommendation on 15 August 2025. Please accept this letter as formal notification that Devon ICB will now exit the RSP, with continued regional support provided on finance and strategy, through Quarter 2.

Thank you for all the hard work that you and your teams have contributed to improve the quality of care for the people of Devon in a sustainable way. You have made promising strides towards tackling the complex challenges that led to the decision to support your organisation via the RSP, and while there is much more to do to continue improving services for your patients, I hope you will feel able to take a moment to acknowledge the improvement you have already achieved.

It is important to acknowledge that significant challenges still remain. As part of an agreed transition package, regional colleagues will continue to work with you to ensure you are able to build on the progress you have made during your time in RSP, with key priorities as you transition being delivery of the 2025/26 plan, and agreement of a medium-term financial plan and service strategy by the end of September.

If you wish to discuss the above or any related issues in more detail, please contact myself, or Sue Doheny, South West Regional Director, in the first instance.

Kind regards



Mark Brassington
Director of Operational Improvement and Recovery Support Programme
NHS England

Copy:

Glenn Burley, Financial Reset Director and Accountability Director, NHSE

Sarah Jane Marsh, Urgent and Emergency Care and Operations Director, NHSE

Elizabeth O'Mahoney, Chief Financial Officer, NHSE

Sue Doheny, South West Regional Director, NHSE

Lorna Gibson, Improvement Director, National Recovery Support Teams, NHSE