PUBLIC - NHS Devon Clinical Commissioning Group (CCG) Governing Body

MS Teams - refer to formal invite for joining details.

24 February 2022 09:30 - 24 February 2022 11:45

AGENDA

#	Description	Owner	Time
1	To note *Regular breaks will be taken during this meeting		
2	Patient Experience Verbal	Andrew Moreman, Young Devon	09:30
3	Welcome and apologies and questions from members of the public Verbal	Chair	09:50
4	Register of Interests (ROI) Paper DOI NHS Devon CCG Governing Body @ 09 Feb... 6	Chair	
5	Minutes of the last meeting and action log Paper 1 Draft Public GB minutes 25.11.2021 v1.docx 10 Master Action Log - PUBLIC v3 nc.xlsx 19	Chair	
6	Clinical Chair's Report Verbal	Clinical chair	09:55
7	Accountable Officer's Report Paper AO report Feb 22.docx 20	Accountable Officer	10:05
8	PROGRAMME OF WORKS - items for recommendation, decision and assurance		
8.10	Devon Integrated Performance and Quality Report Paper Cover sheet IQPR FP.docx 31 Devon FP Committee IPQR report Feb 2022.pptx 34	Chief Nurse	10:15

#	Description		Owner	Time
8.20	Month 10 Finance Report Paper FPC_Report_FPC_Month 10_FINAL_2021-22 (GB... FPC_Report_FPC_Month 10_FINAL_2021-22 (GB)...	96 99	Finance Director	10:25
8.30	Funding Transfer Agreement - section 256 Paper 0 Governing Body Report s256 Agreements 21-22.... 1 CCG Integrated care s256 21-22 (Devon) v2.docx 2 CCG Integrated care s256 21-22 (Plymouth) v2.d... 3 CCG Integrated care s256 21-22 (Torbay) v2.doc... 4 CCG Enhanced Care Home Staffing s256 21-22 (... 5 CCG Nursing Home Residential Workforce Susta... 6 CCG Peripatetic Care Home Staffing Team s256... 7 CCG Winter Workforce Sustainability Personal C... 8 CCG Winter Workforce Sustainability Personal C... 9 CCG Winter Workforce Sustainability Personal C... 10 CCG Targeted Equipment s256 21-22 (Devon) v... 11 CCG Personal Discharge Budgets s256 21-22 (... 12 CCG Critical Thinking s256 21-22 (Devon) v2.do... 13 CCG Shared Care Record s256 21-22 (Devon) v... 14 CCG Shared Care Record s256 21-22 (Plymout...	116 120 128 135 143 149 155 161 167 173 179 185 191 198 204	Finance Director	10:35
8.40	Continuing Healthcare – Update to NHS Devon CCG constitutional financial limits Paper Devon CCG Cover sheet template Jan 2021.docx SBAR Schemes of Delegation Feb 2022 v2.docx	210 212		10:45

#	Description	Owner	Time
8.50	Inequalities Progress Update Paper 1. HI Position Statement Feb 2022.docx 214 2. HI position statement.docx 216	Director of Public Health, Torbay	10:55
8.60	Integrated Care System for Devon - update Paper 1 ICS Board Update cover sheet.docx 224 2 ICS for Devon update for Boards - January 2022.... 226 3 ICS for Devon update for Boards - February 2022... 229	Associate Director of HR and OD	11:05
8.70	Winter Taskforce Briefing Paper 1 Winter Taskforce Update cover sheet.docx 235 Winter Taskforce Briefing for ICS partner Boards - J... 237	Associate Director of HR and OD	11:10
9	LOCAL CARE PARTNERSHIP (LCP) REPORTS Paper - South LCP (January 2022) v3.docx 247 Eastern Jan-Feb 2022.docx 250 Northern Locality January - February 2022.docx 255 Plymouth Update Report - February 2022.docx 258 Plymouth-West Devon APPROVED.docx 262	Locality Directors	11:15
10	ASSURANCE COMMITTEE CHAIRS' REPORTS including items of escalation	Assurance Committee Chairs'	
10.1	Finance Paper Finance Committee Chair Report February 2022 v1... 265		11:30
10.2	Primary Care Commissioning Paper PCCC Public Chair report - February 2022 KR revie... 269		11:35

#	Description	Owner	Time
10.3	Quality Paper [P] QAC Chair Report Part 1 17 February 2022.docx 271		11:40

Declaration of Interests Register - NHS Devon Governing Body
Register updated and generated by the Governance Team - 09 February 2022

Register last updated 09 February 2022

Title	Surname	First name	Role or Position held with the CCG	Committees attended	Interests	Interests - Partner or Family	Date Interest from	Date Interest to	Date interest updated	Type of Interest	Is the interest direct or indirect?	Action taken to mitigate risks	Employer Organisation
	Allcorn	Darryn	Chief Nurse Caldicott Guardian	Member of Governing Body Member of Quality Assurance Committee Senior Leadership Team (SLT) Joint Executive Team Meeting Commissioning Committee (CC DOI) Member of Audit Committee Member Devon Joint Clinical Effectiveness Group (JCEG) Member of Finance and Performance Committee	Honorary Associate Professor University of Exeter Seconded to NDHT (to 18 September 2020) Strategic Chief Nurse, Nightingale Hospital Exeter System Chief Nurse, Devon STP		11/05/2020		01/02/2022	Direct	Direct	Where a piece of CCG work or an item on a CCG 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 CCG
	Appleby	Gaynor	Non Executive Lay Member (Allied Health Professional)	Member of Governing Body Member of Quality Assurance Committee Member of Remuneration and Workforce Committee Primary Care Commissioning Committee (PCCC)	CQC Specialist Advisor		01/11/2019		27/05/2021	Non Financial	Direct	Where a piece of CCG work or an item on a CCG 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 CCG
	Atherton	Glynis	Non Executive Lay Member- Quality Geographical remit - Eastern	Member of Governing Body Member Quality Assurance Committee (Chair) Member Primary Care Commissioning Committee (PCCC) Member of Remuneration and Workforce Committee	Consultancy for FORCE cancer charity – not CCG funded but has a relationship with RD&E hospital Volunteer for Hospiscare, Exeter – helping at events and proof reading applications to charitable trusts Volunteer for University of Exeter – mentoring students Member of the Labour party Member of the Devon Ethical Reference Group		14/05/2019		18/01/2022	Financial / Non Financial Personal	Direct	Where a piece of CCG work or an item on a CCG 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 CCG
	Ball	Nick	Vice Chair/Non Executive Lay member - Finance and Governance. NHS Devon CCG Lay Member - Governance and Probity NHS Devon CCG Conflict of Interests Guardian for NHS Devon CCG Geographical remit - Western	Member of Governing Body (Vice Chair) Member of Audit Committee (Chair) Member of Finance and Performance Committee Member of Remuneration and Workforce Committee Attendee Primary Care Commissioning Committee (PCCC) non voting	Appointed Chair of Audit Committee for NEW Devon CCG (Dec 2016) Director of the B4 project Director of Community Interest Company: 11319536 , Heavens Thunder C.I.C, Cornwall from 19 April 2018	Virgin Care (spouse/partner was a Portage Home Visitor to 2015)	22/09/2016		19/11/2020	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG 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 CCG
	Brown	Steven	Director of Public Health (DCC)	Member of Governing Body Strategic Commissioning Partnership STP Directors ICS Partnership Board Primary Care Commissioning Committee (PCCC)	No interests declared		19/11/2020		19/11/2020				Devon County Council
	Chilcott	Ben	Associate Director of Finance	Strategic Medicines Optimisation Group Attendee of Finance and Performance Committee Planned Care Programme Board Primary Care Strategic Meds Group Senior Leadership Team (SLT) Member of Primary Care Commissioning Committee (PCCC) Primary Care Operational Group (PCOG) Member of Governing Body (Deputy for CFO) Member of Vacancy Control Panel Crediton Hub Project Group	CCG representative board member of Resound Health, Plymouth LIFT partner Member of ACRA (Advisory Committee on Resource Allocation) CCG representative shareholder for Delt School Governor for Tavistock Primary and Nursery School	Partner is employed by Livewell Southwest in position of influence	26/09/2017		02/02/2022	Non-Financial Personal Interest	Direct	Where a piece of CCG work or an item on a CCG 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 CCG
	Coles	Anna	Locality Director - Plymouth	Senior Leadership Team (SLT) Member of Governing Body (Deputy for Director of Commissioning) Strategic Commissioning Partnership	No interests declared		12/03/2019		22/10/2020				Plymouth City Council
	Coombes	Nikki	Senior Executive Assistant, Corporate Office	Attendee Governing Body Attendee Remuneration and Strategic Workforce		Close relative is Head of Implementation, Devon Doctors Group Clsoe Relative is Project Support Officer, NHS Devon CCG	12/08/2015		14/04/2021	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG 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 CCG
	Davis	Alison	Associate Non-Executive Director	Member of Governing Body Attendee Quality Assurance Committee Member of Remuneration and Workforce Committee Member Primary Care Commissioning Committee (PCCC)	Plymouth City Council – Foster panel Chair Torbay Council- Foster panel Chair (ended 28 Feb 2021) Pathway Care Fostering- Ashburton- Independent Reviewing Officer University of Exeter – student mentor Somerset County Council- casual employee		19/10/2019		22/03/2021	Personal, Professional & Financial	Direct	Where a piece of CCG work or an item on a CCG 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 CCG
	Doble	Clare	Head of Governance Deputy Senior Information Risk Owner (SIRO)	Attendee of Audit Committee Quality Assurance Committee Primary Care Commissioning Committee (PCCC) Governing Body (ad hoc) Health and Safety Group Joint Chair Staff Partnership Forum Data Protection Steering Group	Member of Taunton & Somerset NHS Foundation Trust Godmother to member of governance team's daughter Trustee for Lyme Disease Action Charity (an accredited charity that offers information and advice to the public, patients and healthcare professionals in relation to lyme disease) Charity registration number: 1100448	Partner employed by NHS Devon CCG Daughter is an apprentice at one of the Devon GP practices	22/08/2017		02/07/2021	Non-Financial, Financial and Personal Interests	Indirect/ Direct	Where a piece of CCG work or an item on a CCG 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 CCG
	Dowell	John	Chief Finance Officer	Member of Governing Body Member of Finance and Performance Committee Joint Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee Commissioning Committee (CC DOI) Primary Care Commissioning Committee (PCCC)	Vice chair of the HfMA South West Branch Vice Chair of the HfMA Commissioning Faculty.		14/08/2015		20/10/2020	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG 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 CCG

	Finn	John	Interim Executive Director of in-hospital commissioning to 31 May 2021 Substantive post Associate Director of Commissioning, Northern, Planned Care and Cancer	Member of Governing Body Exec Meeting Commissioning Committee (CC DOI) Northern Integrated Delivery Meetings System Restoration and Transformation Group Planned Care Programme Board Senior Leadership Team (SLT) Member of Finance and Performance Committee	No interests declared		19/01/2017	23/03/2021	Personal	Indirect	Where a piece of CCG work or an item on a CCG 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 CCG
Dr	Fox	Matthew	Governing Body Locality GP NHS Devon CCG	Member of Governing Body A & E Delivery Board (SD&T)	GP principle, Barton Surgery, Dawlish. Director, Dawlish Medical Group Associate Medical Director TSDFT from 1 April 2019 Barton Surgery have rented a room to Chime. University of Exeter Medical School, Academic tutor and student teacher GP Locality Clinical Director Primary Care Network - The Coastal Network F2 academic tutor through the Deanery	Spouse is a co-owner of Barton Surgery Pharmacy Building	22/09/2016	17/04/2021	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG 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.	Torbay and South Devon NHS Foundation Trust
Dr	Greenwell	David	Governing Body Locality GP	Member of Governing Body Member of Finance and Performance Committee Remuneration and Workforce Committee(Non exec rem) Member Devon Joint Clinical Effectiveness Group (JCEG)	GP partner at Southover medical practice Member of an independent cooperative that provides out of hours medical cover to Devon Prisons Shareholder in Devon Doctors on Call Member of Upton Vale Baptist Church (personal interest) Member of Clinical Cabinet Primary Care Network - Torquay	Spouse is freehold owner of Southover Pharmacy	20/08/2015	22/10/2020	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG 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 CCG
	Hargadon	Judy	Non Executive Lay Member - Primary Care and Prevention Geographical remit - Southern	Member Governing Body Member Audit Committee Member of Primary Care Commissioning Committee (PCCC) (Chair) Member of Remuneration and Workforce Committee Equality, Diversity and Inclusion Group IUCS Procurement Oversight Group (Chair)	Member of Women's Equality Party New management board chair at PenARC, – the National Institute for Health Research (NIHR) Applied Research Collaborations (ARCs) South West Peninsula	Spouse is Chair of Dartington Hall Trust Brother is GP in Cornwall	01/05/2019	25/05/2021	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG 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. Will not be involved in decisions about the CCG funding academic research	NHS Devon CCG
Dr	Harrell	Ruth	Director of Public Health, Plymouth City Council	Devon STP Clinical & Professional cabinet NHS Devon CCG Governing Body Member Devon Joint Clinical Effectiveness Group (JCEG) Member of Strategic Commissioning Partnership Primary Care Commissioning Committee (PCCC)	Director of Public Health for Local Authority		26/10/2016	18/08/2020	General	Direct	Where a piece of CCG work or an item on a CCG 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.	Plymouth City Council
	Harris	Penny	Strategic Advisor - Long Term Plan	Attendee of Governing Body CCG Execs and Clinical Chairs Senior Leadership Team (SLT) Strategic Commissioning Partnership Joint Executive Team Meeting Strategic Commissioning Programme Board Commissioning Committee (CC DOI) System Restoration and Transformation Group Devon Urgent Care Board	Director of KERR Darnley Ltd Providing commissioning advice to variety of CCGs and Coaching/contract training Director of Kerr Mediation ltd - working alongside LMC law taking on primary care mediations commissioned by the LMC.		23/07/2019	29/10/2020	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG 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.	KERR Darnley Ltd
Dr	Johnson	Paul	Clinical Chair NHS Devon CCG Interim Medical Director ICS Devon	Member of Governing Body (Chair) Member of Remuneration and Workforce Committee Attendee Primary Care Commissioning Committee (PCCC) non voting Commissioning Committee (CC DOI) Strategic Commissioning Partnership Attendee Devon Joint Clinical Effectiveness Group (JCEG) Planned Care Programme Board Attendee of Finance and Performance Committee	GP Partner, Cricketfield Surgery (ceased August 2019) Salaried GP, Cricketfield Surgery (ceased December 2019) Member of Templar Care PCN (ceased December 2019) Locality Clinical Director at Torbay and South Devon NHS Foundation Trust (Nov 2016 to 28 March 2017) Church Warden Holy Trinity Church (ceased 2018) Non executive director role on the board for the South West Academic Health Science Network (SW AHSN)	Spouse works in emergency department at RDE and for Exeter Medical School	21/08/2015	15/09/2021	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG 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 CCG
Dr	Kennedy	Nick	NHS Devon CCG Governing Body Secondary Care Clinician	Member of Governing Body Member of Quality Assurance Committee Attendee Remuneration and Workforce Committee Member of Primary Care Commissioning Committee (PCCC) QEIA Panel Member of Audit Committee Member Devon Joint Clinical Effectiveness Group (JCEG) Member of Devon Clinical Cabinet System Restoration and Transformation Group	Governing Body Independent Clinician BNSSG CCG Member South West Clinical Senate Council Consultant Anaesthetist, Taunton and Somerset NHS Trust Member of national Independent Funding Request Panel NHS England Non-Executive Director GO-OP, GO-OP is a Multistakeholder Co-operative Society (Somerset Rules), registered under the Co-operative and Community Benefit Societies Acts. GO-OPGO-OP will be the UK's first co-operatively owned and run Training Operating Company Introduced PPE supplier (Orthofix International) to Devon CCG. Company part owned by my cousin Non-Executive Director of a start up limited company called LinkExec, an online business aimed at promoting start up businesses and investors. April 2020 working one day a week for Somerset CCG on their Clinical Strategy and the Taunton/Yeovil merger strategy (11 Feb 2021) Trustee of St Margaret's Hospice Somerset Non Executive Director Go-Op Learn. A Co-operative organisation providing training opportunities (May 2021) Member of Western Provident Association on Anaesthesia (May 2021)		26/09/2017	12/03/2021	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG 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 CCG

Dr	Kerr	Simon	Governing Body Clinical Lead – Eastern.	Member of Governing Body Member of Quality Assurance Committee Attendee Remuneration and Workforce Committee Attendee of Audit Committee Member Strategic Commissioning Programme Board Commissioning Committee (CC DOI) Eastern Locality Delivery Group	Chair of East Devon , Exeter and Mid Devon GP Members Forums GP Exec. Partner Coleridge Medical Centre Shareholder in Devon Health GP member of East Devon Health Federation GP Partner in Honiton , Ottery , Sidmouth Primary Care Network	Spouse works for Exeter Social Services	14/02/2017	28/04/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG 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 CCG
	Masters	Susan	Deputy Chief Nursing officer	Quality Assurance Committee (QAC) Member of Audit Committee Member fo Governing Body (Deputy for CNO) Member of Primary Care Commissioning Committee (PCCC) Member Vacancy Control Panel Senior Leadership Team (SLT)	Trustee Director of HQIP (Health Quality Improvement Partnership)		01/03/2021	24/08/2021	General Interest	indirect	Where a piece of CCG work or an item on a CCG 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 CCG
Dr	McCormick	Shelagh	Lead Clinical Representative (Western) – CCG Governing Body Strategic Clinical lead - Maternity Clinical Lead - Western Locality Clinical lead - Mental Health	Member of Governing Body Member of Quality Assurance Committee Member of QEIA Panel Member of Remuneration and Workforce Committee Member of Primary Care Commissioning Committee (PCCC) Member of Individual Packages of Care Panel (IPOC) Member of Local Maternity System (LMS) Board and Operational Committee	Elected member (and Deputy Chair from September 2019), South West Regional Council of BMA GP Appraiser (NHS England) Shareholder GlaxoSmithKline Working at Church View Surgery as self-employed sessional GP Elected to the Medical managers Committee of the BMA from September 2019	Partner is: Medical Secretary and Board member of Devon LMC GP Partner, Church View Surgery, Plymstock Clinical Director of Mewstone Primary Care Network(PCN) Clinical Director of Mayflower Primary Care Network (PCN)	26/09/2017	04/01/2022	Financial, Professional & Personal Interests	Direct & Indirect	Where a piece of CCG work or an item on a CCG 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 CCG
	Milligan	Jane	Chief Executive of the Integrated Care System for Devon (ISCD) and NHS Devon Clinical Commissioning Group (CCG)	Member of Governing Body Joint Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee	Non Executive Peabody Housing Association House of St Barnabas Charity member	Partner Trustee for Action for Stammering	31/12/2020	29/04/2021	Personal	indirect	Where a piece of CCG work or an item on a CCG 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 CCG
	Millward	Andrew	Devon System Director of Communications and Engagement. Chief Communications, IT and People Officer, NHS Devon CCG Senior Information Risk Owner (SIRO)	Member of Governing Body Joint Executive Team Meeting Staff Partnership Forum Senior Leadership Team (SLT) Attendee Audit Committee Member of Remuneration and Workforce Committee Member of Vacancy Control Panel Equality, Diversity and Inclusion Group	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University DELT Board Member, CCG Devon nominated director		19/06/2018	14/04/2021	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG 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 CCG
	Pearson	Nick	Chief of staff Office of the accountable officer for the ISCD and CCG	Senior Leadership Team (SLT) Commissioning Committee (CC DOI) Patient Engagement Group Primary Care Operational Group (PCOG) Attendee of Governing Body Joint Executive Team Meeting	Member of Exeter City Football Club Advisory Board Director, Centre for Health Communication Research, Buckinghamshire New University	Spouse is owner of Pearson Creative	13/01/2017	29/03/2021	Non-Financial Personal Interest	Direct & Indirect	Where a piece of CCG work or an item on a CCG 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. Will not be commissioned by employee	NHS Devon CCG
	Sargeant	Lincoln	Co-opted member of Governing Body	Member of Governing Body Member of Strategic Commissioning Partnership Member of Primary Care Commissioning Committee (PCCC)	Director Public Health, Torbay Council		24/02/2021	24/02/2021			Where a piece of CCG work or an item on a CCG 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.	Torbay Council
	Snaith	Ginny	Board Secretary	Attendee of Governing Body (non voting) Attendee of Quality Assurance Committee Attendee of Finance and Performance Committee Attendee of Audit Committee Attendee of Remuneration and Workforce Committee Attendee of Commissioning Committee (CC DOI) Attendee of Primary Care Commissioning Commitee (PCCC) Joint Executive Team Meeting Senior Leadership Team (SLT) Working with Industry and Sponsorship Group System Restoration and Transformation Group Member of Strategic Commissioning Partnership Attendee Devon Joint Clinical Effectiveness Group (JCEG)	No interests declared		22/03/2019	10/08/2020				NHS Devon CCG
	Tapley	Simon	Deputy CEO for ICS for Devon and NHS Devon CCG Strategic Lead Commissioner for NHS Devon CCG	Member of Governing Body Strategic Commissioning Partnership Joint Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee (Audit Committee) Commissioning Committee (CC DOI) West LCP Executive Group Member Vacancy Control Panel Attendee of Finance and Performance Committee		Spouse is employed by TSDFT (ICO) 31/03/2017 Brother in Law is employed as Strategic Engagement Manager, NHS Devon CCG Step-son has started working as a health-checker	01/11/2016	05/05/2021	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG 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 CCG
	Tetley	Piers	Associate Director of HR and Organisational Development	Attendee of Remuneration and Workforce Committee Staff Partnership Forum Senior Leadership Team (SLT) Attendee of Governing Body/Member Governing Body (Deputy for Director of Communications) Member of Vacancy Control Panel CCG R&T Project Team meeting	No interests declared		16/10/2018	19/10/2020				NHS Devon CCG

	Turl	Jo	Executive Director of Commissioning - Out-Of-Hospital	A & E Delivery Board Senior Leadership Team (SLT) Mental Health Team Meeting Member of Strategic Commissioning Partnership Member of Governing Body Attendee Audit Committee Member of Finance and Performance Committee (occassional attendee) Member of Primary Care Commissioning Committee (PCCC) Joint Executive Team Meeting Strategic Commissioning Programme Board Commissioning Committee (CC DOI) Quality Assurance Committee Crediton Hub Project Group	No interests declared		13/08/2015	19/10/2020	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG 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 CCG
	Turner	Graham	Non Executive Lay Member-Finance	Member of Governing Body Member of Finance and Performance Committee (Chair) Member of Audit Committee Member of Remuneration and Workforce Committee (Chair)		Son employed by Care Quality Commission as an Information Analyst	16/10/2019	04/05/2021	Indirect interest		Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and	NHS Devon CCG
	Walling	Alex	Director, Grant Thornton UK LLP – external auditor	Attendee of Audit Committee Attendee of Governing Body	No interests declared		08/11/2018	08/09/2021				Grant Thornton
Dr	Wollaston	Sarah	Chair Designate Integrated Care Board for Devon	Attendee Governing Body, NHS Devon CCG	Trustee of Landworks, a Dartington based charity that works with ex offenders and people at risk of going to prison to support them into employment and reduce the risk of reoffending GP who works occasional locum sessions including as part of the COVID vaccination response	Spouse is president of the Royal College of Psychiatrists and a consultant forensic psychiatrist employed by Devon Partnership Trust Relative is a registrar in Obstetrics and Gynaecology on the South West training scheme (currently on maternity leave) but will be returning to RD&E in late 2022. Relative is a registrar in Anaesthetics on the south West training scheme and currently based at RD&E	01/12/2021	13/12/2021	Non-Financial Personal Interests	Indirect	Where a piece of CCG/ICSD work or an item on a 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 CCG/ICSD
Dr	Womersley	John	Governing Body Clinical Lead – Northern Locality	Member of Governing Body Attendee of Audit Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) Remuneration and Workforce Committee (Non exec rem) Northern Integrated Delivery Group	Member of One Ilfracombe Board Chair of One Northern Devon Partnership Board		14/02/2017	28/09/2020	Personal	Indirect	Where a piece of CCG work or an item on a CCG 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 CCG

NHS Devon Clinical Commissioning Group

NHS Devon Governing Body Meeting
DRAFT minutes held in Public

Date: 25 November 2021 Time: 11:30 – 14:09 Location: Via Microsoft Teams

Item	Discussion	*Action*
1	These minutes are a precis of the meeting which was streamed live. If you would like to view the recording of this meeting please click here. **Patient Experience** The chair welcomed Kristy Cooper (KC) who agreed to join this meeting to share her experiences on behalf of the Deaf (British Sign Language BSL users) community across Devon, and she was joined by her interpreter Tim Griffin (TG) KC thanked the members for inviting her to the board to look at how deaf people can be supported better and she shared her experience on booking a phone appointment with a GP with the support of the video relay service, this is when two parties in two separate locations are connected remotely via a sign language interpreter. KC also touched on the issues with GP systems that hold medical information where it would be of a huge benefit if the patient record identified if the patient was deaf and how they preferred to communicate such as through an interpreter, lip reading or written communication. KC drew the members attention that there are low numbers of deaf people that use the complaints procedure as unfortunately there are not enough staff that are trained to support deaf people in making complaints about services. KC suggested that access for mental health counselling for the deaf in Devon needs to be reviewed, as people are struggling to access services. There are only two people qualified to provide counselling for the people in Devon and only around 25-30 qualified counselors in the United Kingdom that are trained to level 6. KC referred to Video Relay Directory (access to services for deaf BSL users) and that it would be nice if Devon GP practices' home page had a link or logo to this directory to support people with access and connection with GPs. KC mentioned the vaccination programme and the changes to government social distancing measures and that it was hard for deaf people in keeping up with the changes and where Sign Video UK can provide instant access to BSL interpreting through video conferencing. SK thanked KC for sharing her experience and suggested that messaging to GP practices in updating their websites for services to support deaf people could be done through collaborative board clinical directors.	

	AM felt that some of the issues outlined by KC could easily be solved with effort and proposed that the Primary Care Webinar could be the forum to promote the use of Sign Video UK. CB wondered if KC needed to access services in an emergency and what was the experience. KC explained when she accompanied her mother in A&E in the Torquay area where staff were worn. Some staff removed their masks to communicate via lip reading with others not removing masks. She talked through the inability to book an interpreter at short notice and referred to Sussex and Hampshire who have rolled out the use of iPads and was this something that could be considered in Devon. SMC wondered whether the clear masks would be more helpful for deaf people and KC acknowledged that they would be helpful in certain situations, but it was an individual choice for people to wear these. KC informed the members that she had worked with deaf people for 12 years and was trained as a deaf advocate and has recently taken on a new project support the deaf community as a vaccination champion. JM thanked KC and acknowledged that there were some actions that the CCG can take away from her experience and that we will make a Devon commitment to follow these up as a cultural shift to further understand the work we are developing around health inequalities. DA, chief nurse was pleased to hear that KC was a vaccination champion as there has been some challenges in our pop-up centers' but was pleased to report that the use of a video system had worked well and had been successful in some of our clinics. NB thanked KC for sharing her experience and TG for joining as interpreter. *Kristy Cooper and Tim Griffin left the meeting.*	
2	**Welcome and Apologies** NB welcomed everyone to the business section of the meeting, and the following apologies were recorded for Gaynor Appleby and Ruth Harrell	
3	**Register of Interest (ROI)** There were no amendments or new declarations made.	
4	**Minutes of the last meeting** NB led a page-by-page review of the minutes of the last meeting held on 28 October 2021, and these were approved as a true and accurate record of the meeting. Actions 1. The recovery support group action notes had not been shared with the Governing Body and ST asked NC to take this action forward. *Post meeting update this action has been completed.* 2. In hand, and underway. 3. Feedback has been taken on board and there is confidence that the CCG is confident aiming high in terms of green national standards 4. This action was completed and formally closed 5. This action is part of a bigger piece of work of the primary care strategy refresh and this would be covered at development session next week on 2 December	

	Matters arising NB drew the members attention that Devon CCG and the Integrated Care System for Devon would be losing two extraordinary individuals. CB has been a member of the Governing Body for the past two and half years and represented several groups across the NHS such as mothers and children. She has brought a completely different perspective to the Governing Body in a different way and challenged and raised the profile of maternity services and spoken up for patients. On behalf of the Governing Body NB thanked CB for her contribution and wished her well for the future This was also the last meeting for DSL who had served for around three and half years undertaking and impossible roles as the ICS chair for Devon, and that he had done a fantastic job of bringing health and social care people together as a fantastic communicate. DSL thanked the Governing Body and staff for their professionalism and personal kindness in allowing DSL to attend more recently the Governing Body meetings and she was optimistic for the future of the ICS having secured Jane Milligan and Dr Sara Wollaston's leadership in supporting the wider system leadership in moving forwards. NB was pleased to record in the minutes that Jane Milligan has been confirmed in post as CEO for the Integrated Care System for Devon and officially welcomed her to the ICS.	
5	**Clinical Chairs Report** PJ did not propose to go through his report in detail, but also conveyed his thanks to DSL and congratulations to JM, which was good news and was pleased that Dr Sarah Wollaston would take up her new role as designate Chair of the ICS for Devon from the beginning of December. PJ was delighted to have co-presented the staff awards ceremony recently and was important in rewarding great work from staff that have been working in tough circumstances. He thanked staff that not only won, but those that were nominated which represented a small proportion of the hard work that has happened over the last year. **The Governing Body received and noted the contents of the clinical chairs report.**	
6	**Accountable Officers Report** JM personally thank DSL for the support she had given JM since April 2021. JM was also pleased that Dr Sarah Wollaston would be taking up her role office from the 1 December and that an induction programme was being set up. JM noted that the Integrated Care Partnership has moved forward but not without challenge, and this was due to changing national guidance for the health and social care bill. JM gave thanks to DA and the wider team for the challenging and amazing amount of work that had been undertaken to support the vaccination programme. The vaccination rates were fantastic although there will still some gaps more work still to do. Mental health was a challenged time for the NHS and we are refreshing our collective approach in this area working across health and social care.	

	JM also touched on the staff awards where time was given to take stock and thank people and she was pleased to have been involved in this event. SK asked about the vaccination plans for the housebound and DA confirmed this is being picked up through the roving pop-up models of the programme.	
7	**Financial plan for 1st October 2021 to 31st March 2022 (H2 of 2021/22** JD presented the financial plan budget for Devon CCG for the second half of 2021-22 and referred to page 33. JD noted the noted the changes in allocation for H1 and H2 which was set out at the bottom of page 35. He added that the impact of the pay award made across the system had been fully funded in the allocated and that we were working through the impact of a shortfall, but this will be managed through our overall allocation. The COVID funding has started to reduce by 6% but funds were still available in H2 to deal with additional COVID costs. Efficiency driver are at 0.28% for the fist half of the year and a further reduction in resources for the system furthers away from the financial target. He signposted the members to page 36 and the funding for targeted support for the elective recovery fund which is available and supporting our plan but was not part of our financial envelope. The hospital discharge plan will continue for H2 but will come to the end of H2 and with are working with our local authority on the financial impacts and sources of funding. JD referred to table 1 and gave context around the overall allocation for the system set alongside H1 and a reduction of funding for H2. He directed the members to table 4 the allocation for the system and noted that we are planning for some surpluses and deficits aggregates for the total system and this was a good illustration of true system working. JD highlighted table 7, 8 and 9 and mentioned the efficiency savings programme and mechanisms that have been reinstated to deliver that and noted that that It was a challenging environment to achieve those savings. JT explained the risks and ST described the actions being taken and that there was confidence with the savings plan which is being monitored through the oversight group which has been set up. Savings have been identified in the independent sector for the fist six months, with continuing healthcare (CHC) being challenged and work was continuing the hospital discharge programme around additional capacity. DG asked about the suspension of elective care and JD described the flow of funds and noted there was variability. SK queried the surplus deficit and savings not realized and JD replied that it was expected the delivery of the plan with system wide commitment. ST described the process for hospital discharge monies and the process for assessments and GT thanks JD and the wider team for their work and the work that had been undertaken with our system partners.	

	NB wondered if there was a providers version of table 7 (21/22 H2 operational budget) and JD confirmed there was an equivalent of this for each part of the system and took and action to share this with the Governing Body. **ACTION:1** **JD to share the system 21/22 H2 operational budgets with the Governing Body.** **Following discussion, the Governing Body:** • **Approved the budgets set for the CCG for H2 of 21/22** • **Approved the level of efficiency requirements as set out** • **Noted the risks and mitigations that have been identified**	
8	**Devon Integrated Performance and Quality Report** DA presented the latest iteration of the integrated report and that we are now starting to see the state of Devon narrative based on this data. He warned the members that the presentational format will continue to evolve and acknowledged there were some gaps with regards to safeguarding and the community and this continues to reflect the pressures in the teams for the acute trusts, mental health and primary care settings which has been sustained since last winter. He highlighted the following • Infection prevention and control, there has been a focus in this area since the pandemic and we have seen challenges with E-coli, and we are starting to look at the impact of supporting the system • Urgent care pathways this remains a challenge along with referral to treat times • We have seen an increase in diagnostic requests but the increase in capacity for the accelerator programme we will see an improved picture. • Discharges flows is challenged and is an area of focus across health and social care • Children and young people and families remains a concern particularly autism referral rates and this is being reviewed through the Quality Assurance Committee • We have seen an increase in demand with Maternity and these relate to shifts for nursing or midwifery birth ratios – • Never event has also seen an increase and we are now reviewing thematic analysis • Workforce figures is a continued challenge where we have seen a moderate increase in sickness SM queried as to whether we are missing an opportunity to be more directive with flu jabs in care settings and are we confident we are doing enough to support care homes. DA responded that the flu programme has been brought together with the care provision cell using nurses, videos, and local communities to support vaccination hesitancy. DA gave an example of the domiciliary care pathway and the further development of resources. AD raised concern for children and autism spectrum disorder (ASD) rates which remained the same as back in April. DA agreed that trajectory had remained static but would be further discussed at the Quality Assurance Committee in December.	

	CB asked if the maternity multifaceted pathway had been looked at in detail. DA confirmed that a deep dive had not been undertaken but this was an area of concern and committed to investigate this area with more depth. GAth wondered about the voluntary sector and how this could be resourced. DA was pleased to report there were good models in Western Devon that had been developed and that we are working with the local authorities, local community groups and other models from Somerset to test. NK enquired as to how quickly meaningful results would be produced for community urgent services and DA was hoping this would be report in December. DG referred to the ambulance handover figures and how are we keeping people safe where evidence shows people are waiting longer and not coming to harm. DA explained the process and assured the Governing Body there was a continued focus in this area and we are starting to articulate the potentials of harm. SK noticed that referrals appeared to be down compared to 2019-20 and DA confirmed that the data is being validated for understanding and JT explained how GP practices record activity. **The Governing Body:** • **Received and noted the contents of the Devon Integrated Quality and Performance Report** • **Noted the issues highlighted and actions being undertaken**	
9	**Emergency Preparedness, Resilience and Response (EPRR) Core Assurance Standards** AM presented this report which was an annual report detailing compliance on these standards for Devon CCG and our partner organisations. He added that he had recently met with the NHS England lead responsible for EPRR Ian Phillips who fully endorsed this assessment. AM noted that the CCG had undertaken a self-assessment and were fully compliant and that there was a range of compliance by organisation. Torbay and South Devon (TSD) were partially compliant achieving 36 out of 46 core standards, this was due to not having an EPRR lead personnel in place and some concerns with the incident planning elements, but this has now been addressed. The CCG has since met with TSD and were confident with the new lead in place this will help them move forward over the course of the year. NK asked whether there was confident that TSD would be able to respond to a major incident. AM responded to confirm that adjustments have been made and there will be follow up meetings but was confident that TSD was in a better place to respond to a major incident than they may have done in the past. GT wondered if there was a formal system response process in place for EPRR mutual aid, and it was confirmed this was in place for all organisations and does extend regionally. **The Governing Body:**	

	• **Received and approved the position statement of its compliance with the NHS England Emergency Preparedness, Resilience and Response (EPRR), Core Standards 2021.** • **Received the assurance ratings of our provider organisations and that these outcomes are being presented to each providers' Board**	
10	**Plymouth West End Wellbeing Hub** JT introduced this item which was to provide the Governing Body with a general progress update. The business case was underway with the project now in the design phase with the timetable leading to the business case submission planned for mid-August with anticipated planned completion in 2024. She talked through the model of care vision and the reasons for the models of care for those that had not been included. JT confirmed that the CCG would be the owners of the wellbeing centre which in turn would be owned by the ICS and this will not impact on any contracts or employed practice staff they would merely be working in a different model of care in an integrated way. Clive Shore (CS) talked through the economic case summary process and how we arrived at the preferred option and the new building mandated and funding by the NHS. He referred to the proposed summary of service mix which were subject to approval, but the signs were encouraging. CS went through the proposed site and floor plans. SMC asked for assurance that the building was disabled friendly and would have the right accessibility. CS responded to confirm that there had been an independent design panel involved in the process including the Royal National Institute for the Blind (RNIB) and other to ensure all accessibility angles have been covered. JWo liked the middle floor but wondered if there was enough waiting space and CS explained there would be an observational waiting area which would also include a technical element that could be used as appropriate. SK wondered if the local community may see this new wellbeing hub as an opportunity for a 'walk in' facility and would there be resuscitation equipment available. CS confirmed that thorough assessment has been undertaken with regards to equipment and it was being considered as to where signage and direction will be placed in the building. CS described the commercial summary and walked the members through the P22 nine step process. BC explained the capital, revenue, and affordability costs, and that the revenue was affordable based on a set of assumptions, but there would be revenue consequences. JH queried the benefits of cash releasing changes, expenditure and depreciation and was there verifiable commitment from other providers. BC responded to confirm that a meeting was planned with Livewell Southwest to walk through any implications. Gath asked if the assumptions had been confirmed by the national panel, and BC said this had not been confirmed in wiring at this stage but there had been encouraging signs from NHS England who are working with the national team.	

	JT drew the Governing Body to the recommendations and, **The Governing Body:** • **Confirmed that the health and wellbeing centre planning application can be submitted on condition that the National Panel also gives approval at its meeting on 6th December.** • **Approved Devon CCG as P22 Contracting Authority** • **Agreed that John Dowell or Ben Chilcott can have delegated authority to confirm the selection of the P22 contractor.**	
11	**Local Care Partnership Reports** There was nothing further to add to these reports included in the board pack, but DG added there was limited capacity for non-urgent care referrals and made a plea for the maximum use of communications, advice, and guidance to support the public and he made a commitment to speak with the Southern LCP chair.	
12	**Chairs Reports – confidential assurance committees** <u>Finance</u> There was nothing to add to this report. <u>Audit</u> There was nothing to add to this report. <u>Primary Care</u> There was nothing to add to this report. <u>Quality</u> There was nothing to add to this report. <u>Commissioning</u> There was nothing to add to this report.	
13	**Review of the public and private sessions focused on the objectives set out for the meetings** This item was not discussed.	
14	**Any other business** None	
15	**The meeting closed at 14:09**	

Attendees (attended** / apologies A)	
Name and initials	*Title and organisation*
Alison Davis (AD) **	Associate Non-Executive Director, Devon CCG
Andrew Millward (AM) **	Devon System Lead Director of Communications and Engagement; and Director of Communications and Human Resources, Devon CCG
Charlotte Burrows (CB) **	Non-Executive Director/ Lay Member – Patient Public Involvement, Devon CCG
Darryn Allcorn (DA) **	Chief Nurse, NHS Devon CCG

David Greenwell – Dr (DG) **	Clinical Lead Representative, Southern Locality, Devon CCG
Ginny Snaith (GS) **	Board Secretary, Devon CCG
Gaynor Appleby (GApp) A	Non-Executive Director/ Lay Member – Allied Health Professional, Devon CCG
Glynnis Atherton (GAth) **	Non-Executive Director/ Lay Member – Quality Assurance of Services, Devon CCG
Graham Turner (GT) **	Non-Executive/ Lay Member – Finance and Remuneration, Devon CCG
Jane Milligan (JM) **	Chief Executive of the Integrated Care System for Devon (ICSD) and NHS Devon Clinical Commissioning Group (CCG)
John Dowell (JD) **	Chief Finance Officer, Devon CCG
John Finn (JF) **	Interim Director of Commissioning – in hospital, Devon CCG
John Womersley – Dr (Jwo) **	Clinical Lead Representative, Northern Locality Devon CCG
Jo Turl (JT) **	Director of Commissioning – out of hospital, Devon CCG
Judith Hargadon (JH) **	Non-Executive Director/ Lay Member – Primary Care
Lincoln Sargeant (LS) **	Director of Public Health, Torbay Council
Matt Fox (MF) A	Clinical Representative, Southern Locality, Devon CCG
Nick Ball (NB) **Vice Chair** **	Non-Executive/ Lay Member – Financial Management and Audit, Devon CCG
Nick Kennedy – Dr (NK) **	Secondary Care Doctor, Devon CCG
Paul Johnson – Dr (PJ) **Clinical Chair** **	Clinical Chair, Devon CCG
Penny Harris – (PH) A	Director, Devon CCG
Ruth Harrell – Dr (RH) A	Director of Public Health, Plymouth City Council
Simon Kerr – Dr (SK) **	Clinical Lead Representative, Eastern Locality, Devon CCG
Shelagh McCormick – Dr (SMc) **	Clinical Lead Representative, Western Locality, Devon CCG
Simon Tapley (ST) **	Interim Accountable Officer, Devon CCG
Steve Brown (SB) **	Director of Public Health, Devon County Council
In Attendance	
Nikki Coombes (NC) ** **Minute Taker**	Executive Assistant, Devon CCG
Dame Suzi Leather (DSL) **	Chair of the Integrated Care System for Devon (ICSD)
Kristy Cooper (KC) ** item 1	Living Options
Tim Griffin (TG) ** item 1	Interpreter
Clive Shore (CS) **	Estates Adviser, Integrated Care System for Devon
Ben Chilcott (BC) **	Deputy Finance Director, Devon CCG
Rebecca Peer (RP)**	NHS Graduate Management Trainee, Devon CCG
Minutes approved Date:	Signed by chair:

GOVERNING BODY - PUBLIC ACTION LOG										
Action Number	**Date of Meeting**		**Target Date**	**Lead**	**Progress on action**	**Assurance required to close action**	**Date Closed**	**By whom**	**Reported to Committee**	**OPEN/CLOSED**
Actions should be listed in sequential order	State the date of the meeting	Set out the actions needed in order to deal with the issue identified by the group and be narrate so that if minutes are not available the action is very clear to the owner and the committee members	State the expected date for completing the action	Name of person responsible for completing the action	The most up to date information to be provided to the group on the actions undertaken Yes/No confirmation if all actions	The most up to date information to be provided for assurance that all elements of the action have been completed.	Date action formally closed	This will be the lead or person to whom the action was designated	Confirmation that committee that raised the action is content the action has been completed	Confirmation if action complete
1	25-Nov-21	JD to share the system 21/22 H2 operational budgets with the Governing Body.	23-Dec-21	John Dowell						OPEN

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Accountable officer report				
Date of committee: 24 February 2022 **Date report produced:** 16 February, 2022				
Author (s) Name and Title: Nick Pearson, Chief of Staff		**Supporting Executive:** **Name and Title:** Jane Milligan, CCG Accountable Officer and Chief Executive of the Integrated Care System in Devon **Contact Details:**		
		Report Approved by: **Name and Title:** Jane Milligan, chief executive **Date:** 16 February, 2022		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This report contains updates on:

1. **Integrated Care System development and transition**
2. **COVID-19 and vaccination latest**
3. **Vaccination as a condition of employment**
4. **System pressures remain high**
5. **Blueprint to address waiting times**
6. **Celebrating diversity**
7. **Plymouth secures new primary care provision]**
8. **Winter wellbeing**

9. Award recognition
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.
Committees that have previously discussed/agreed the report and outcomes:
N/A
Key recommendations and actions requested:
This report is for information only.
Impact on our objectives
(Delete as applicable) 1. Commission high-quality and safe services that reduce health inequalities and improve health outcomes 2. Improve service performance 3. Achieve financial sustainability 4. Effective, well-led organisation with an empowered and inclusive workforce 5. Lead the system's response to the coronavirus pandemic
Reference to other documents or accompanying papers:

Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	No
Quality of Services		x
Health Inequalities		x
Equality (staff or		x
Resource and Finance		x
Legal		x

Engagement and Consultation		x
Risk		x

The CCG has made every effort to ensure this report does not have the effect of discriminating, directly or indirectly, against employees, patients, contractors or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability.

Accountable Officer's Report

1. Integrated Care System development and transition

I'd like to provide the following overview of ICS development.

Programme Development

A new date to transition from CCG to ICB has been announced, recognising the demands on local systems during the latest stage of the pandemic.

Subject to legislation, which is progressing through the Lords as write, the new establishment date has moved from April 1 to July 1, 2022.

In line with this, a new local ICS establishment timeline has been published.

Many of the dates have remained in line with the April deadlines, however the delay has given workstream leads the opportunity to increase the level of engagement with clinical and operational colleagues.

A key planning document was published early this month. The Government's white paper *Joining up care for people, places and populations (2022)* sets out proposals that "aim to provide better, more joined-up health and care services at 'place' level."

It confirmed what had been reported for many months that there should be a single person accountable for the delivery of the shared plan and outcomes in each place or local area. It also signaled that he NHS and social care would be supported to do more to align and pool budgets at a local level with an expectation that the approach will become more widespread in future.

Critical Path (Governance and People Transition)

A revised Constitution has been issued to reflect the new establishment date.

This was submitted to NHSEI on 3rd December with a final submission due in March. HSEI have offered continued support with its development.

NHS Devon Integrated Care Board (ICB) has appointed three Non-Executive Directors (NEDs) to its new Board.

Dr Thandiwe Hara, Professor Hisham Saleh Khalil and Professor Sheena Asthana will join over the coming weeks, giving them time to be inducted and settle in before the ICB formally launches.

Dr Thandiwe Hara – NED for Citizen and Community Involvement

Thandi is currently the University of Oxford's Strategy Development Executive alongside being a non-executive Board member of the NIHR SW Clinical Research network and a trustee for the Plymouth Racial Equality Council. Thandi has extensive experience in community engagement, health inequalities and local government strategy and policy.

Professor Hisham Saleh Khalil – NED for Quality and Performance

Hisham is a practising ear, nose and throat (ENT) consultant at University Hospitals Plymouth NHS Trust and Associate Dean and Faculty Head of the Peninsula Medical School. A current University Hospitals Plymouth NHS Trust NED, Hisham has held a similar role at the Royal Devon and Exeter NHS Foundation Trust. Hisham is an active clinical researcher with an interest in new models of healthcare delivery and ENT.

Professor Sheena Asthana – NED for Health Inequalities and Population Health

Sheena has been the director of the Plymouth Institute of Health and Care Research since 2020 where her research focused on closing inequality gaps in access to health care, education and other public services. Throughout her career, Sheena has been active in advocating for, and informing policy change in, health inequalities.

Over the past few years, Devon has put a greater focus on equality, diversity and inclusion, and it is positive to see the Board beginning to better reflect the rich diversity and culture in Devon.

The ICB will have six NEDs in total, with further appointments hopefully announced towards the end of February.

The ICB is also making good progress on appointing the ICB Board and Executive roles.

Other workstreams

January saw the first LCP Workshop take place and momentum continues to be built.

We have been developing a local maturity assessment to better understand where each LCP current is in terms of its development, with the aim of producing a bespoke plan for each area.

Provider collaboratives

We are developing baseline and scope for further provider collaborative development.

Risks to delivery include:

- ICS Establishment Timeline
- Complexities with Partner member selection
- LCP progress

All in all, a lot of good progress to report on the ICS development front but still much to do. I look forward to providing more update as we travel towards the July 1 establishment deadline.

2. Covid 19 and vaccination latest

It is now a month since England moved to plan A measures.

Local directors of public health are still able to recommend face coverings in communal areas only in education settings within their area, but only where the department and public health experts judge the measures to be proportionate.

And of course, face coverings should still be worn in healthcare settings, including in primary care and pharmacies.

It is still a legal requirement for those with COVID-19 to self-isolate for 10 days with the option to end self-isolation after 5 full days following two negative LFD tests.

Thankfully restrictions on the number of people that care homes has been removed – meaning groups of friends and relatives can now finally see their loved ones. What a joy.

All in all, there are positive signs that the situation in Devon is turning but the rate of COVID-19 infection remains stubbornly high.

As I write, the latest figures (to Feb 11) show that the case rates per 100, 000 people in the following selected local authority areas are Plymouth 907 (down from 1,181), Exeter 924 (down from 1,452), Torbay 787 (down from 1,176) and North Devon 690 (down from 1, 095).

The average in England for comparison is 873.

Thankfully, we are experiencing a fall in hospitalisations from a peak a few weeks ago. Staff absences due to COVID are also showing declines.

Much has been made of the vaccination programme nationally – and with good reason. People are 85 per cent less likely to be admitted to hospital if they are vaccinated so the vaccination programme has proved to be a real gamechanger, preventing the NHS and care system from becoming overwhelmed.

People in Devon have certainly heeded the vaccination call, with thousands upon thousands getting the jab over the last few months.

In Devon, a total of 2,675,432 doses were given between 8 December 2020 and 30 January 2022. This includes 986,761 first doses, 928,551 second doses and 757,494 boosters/third dos

I am pleased to report that virtually all (c100 per cent) of 75–79-year-olds have received their booster and nine out of ten people aged over 80, 70-74 and 60-64. Even the under 60s are close to nine out of ten, falling to about 56 per cent in the 30-34 age group.

As I have said many times before, it is testament to the hard work of our nurses, doctors, administrators and volunteers that we have managed to vaccinate quite so many people. That said, we can always go further. If you know someone who hasn't yet been vaccinated or received their booster, it isn't too late.

I must acknowledge, however, that not everyone agrees with the vaccination programme. There has been an increase in anti-vaccination activity, with attempts to shut down vaccination sites and serve 'legal papers' at some sites, including in Devon.

The documents they attempt to 'serve' have no legal standing and staff are at NO risk of any legal action. The vaccination programme is completely lawful and has the full backing of the British Government and the British Legal system.

It is clearly difficult for our staff and volunteers, and we have reached out to them to make sure that anyone experiencing abuse or harassment gets the support they need. Devon and Cornwall Police are also monitoring the situation, supporting as required.

Finally, I would draw the Governing Body's attention to new films featuring Devon's Vaccine Ambassadors, produced by the CCG's communication team.

The films came about after feedback from community leaders suggested that trusted voices would be important in encouraging uptake of the vaccine among diverse communities.

Devon has 20 Vaccine Ambassadors, recruited from across health and social care, local authorities and charities since March 2021 and some of them feature

in the films. They can be viewed and shared from YouTube or downloaded to share on other social media platforms.

3. Vaccination as a condition of deployment (VCOD)

I would like to update the board on the Vaccination as a condition of deployment for all healthcare workers.

As you know the Government passed legislation requiring vaccination as a condition of deployment. This was was due to come into force from 1 April 2022.

However, at the end of January we received notification that the Secretary of State had reconsidered this.

We would like to thank all those colleagues who have taken up the offer of a Covid vaccination along with all those who have supported them to do so.

Huge effort in Devon has been put in to increasing the already high take-up among NHS staff, whether through one-to-one conversations or the many other methods deployed. This is very much appreciated.

The Government's decision is subject to Parliamentary process and will require further consultation and a vote to be passed into legislation.

The change means that staff affected by the VCOD regulations will no longer be served notice of termination.

I would personally like to thank everyone for their leadership during this time.

Vaccination remains the most important defence against the virus.

4. System pressures remain high

The system in Devon remains under huge pressure.

A "normal" winter would see our urgent and emergency care under significant pressure. But this year, as last, has been significantly more complex due to the ongoing pandemic situation.

Our Winter Task Force, effectively a virtual command centre where all our providers meet to discuss the issues, has been operating well.

This has seen hospitals in Devon cooperating to ensure that as many people as possible receive the care they need.

I would like to thank everyone involved for their determination to put patients first in what has been an incredibly difficult time.

I cannot emphasise enough how proud I, and fellow leaders, are of frontline colleagues, the “back office” staff who provide support for them – and of course our colleagues in social services.

Despite the pressure we have seen over the last couple of months, our staff have worked tirelessly to maintain services – COVID, emergency and routine – for people who needed them, supported each other.

As we begin to leave the worst of the winter behind – and I emphasise the word begin, because it is not over yet, our minds are very much on the task of down waiting times for elective care.

5. Blueprint to address waiting times

Earlier this month the NHS and government set out a blueprint to address the waiting times for elective care – backlogs built up during the COVID-19 pandemic.

It outlines an expansion of tests, checks and treatments.

The “Delivery plan for tackling the COVID-19 backlog of elective care” give patients greater control over their own health and offer greater choice of where to get care if they are waiting too long for treatment.

The plan, developed with Royal Colleges, patient groups and health charities, sets out how the NHS staff will make the best use of additional government funding to begin to address the COVID backlog.

Our staff have been working hard to recover services while dealing with the rise of Omicron and sustained numbers of COVID hospitalisations, high levels of staff absence due to COVID, all while accelerating the booster rollout.

Here in Devon, we are already making use of additional funding from the government to increase the number of elective patients being treated.

We have increased the number of orthopaedic operations that can take place at the former Nightingale Hospital in Exeter with the use of new operating theatres there and there are also other initiatives rolling out to tackle ophthalmology waits in the Plymouth area.

We welcome the announcement and look forward to treating people as quickly as our staff are able.

And finally a reminder.

As we have said throughout the pandemic, it is vitally important that anybody who has health need continues to come forward

6. Celebrating diversity

February is LGBT+ History Month.

The NHS and social care system has been busy highlighting the major contributions our LGBT+ colleagues make every day.

LGBT+ History Month aims to increase the visibility of lesbian, gay, bisexual and transgender (LGBT+) people, their history, lives and experiences.

There have been lots of events people to get involved with during the month – whether be information sessions about bisexuality, LGBT+ history, gender variance culture and history and understanding the lives of older LGBT+ people.

I'd like to thank everyone who has joined in the celebration. I'd also like to thank those LGBT+ colleagues who work in the health and care system in Devon. You are amazing, thank you. Glad to have you with us.

7. Plymouth secures new primary care provision

Local health and care provider, Livewell Southwest, has been named as the new organisation responsible for the running of the Mayflower Medical Group of GP practices in Plymouth from April 2022.

The Group, which covers five sites in Plymouth, is responsible for providing GP services for nearly 40,000 people in the city.

The current arrangements, with provider Access Health Care are due to come to an end on 31 March and Livewell Southwest has stepped in to take on this large service, ensuring that people can continue to receive local GP services.

8. Winter wellbeing

A winter wellbeing guide, produced by the NHS and local authorities in Devon, is being sent to more than 100,000 local homes.

The guide contains information and advice to help people stay well, as well as contact details of organisations that may be able to help those that are struggling.

Hard copies of the guide are being sent to households close to Devon's four A&E departments to promote alternative services and reduce unnecessary attendances

9. Award recognition

I usually highlight the great work that the NHS and social care are doing in the county. But this month I wanted to highlight a charity – as they've been doing some great work.

Devon-based charity, Westbank, has been presented with the Queen's Award for Voluntary Services for the support they have provided during lockdown.

The organisation was recognised for its Neigbourhood Friends scheme which helps vulnerable or frail adults, from Exeter, East and Mid Devon, to stay out of hospital or to have shorter hospital stays.

The project matches volunteers with people who need help, for example, moving furniture to make room for hospital beds or equipment in their home, installing key safes so care workers can gain access, and providing company and a warm drink to people following a stay in hospital.

Congratulations on the well-deserved award Westbank.

I love to celebrate our work in Devon. If your team or organisation has won an award and you would like to see it featured please let me know.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Devon Integrated Quality & Performance (ICS) Report				
Date of committee: 24 February 2022 **Date report produced: 14 February 2022**				
Author (s) Name and Title: **BI content: Karen Helliwell** **Performance summary: Lisa Heard** **Quality summary: Sara Wright**		**Supporting Executive: Darryn Allcorn** **Name and Title:** **Chief Nurse** **Contact Details:** **darryn.allcorn@nhs.net** **Report Approved by: Darryn Allcorn** **Name and Title:** **Chief Nurse** **Date: 14/02/22**		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:
This report provides a consolidated update on key measures of outcomes, performance, quality and activity to provide the necessary assurance to the Governing Body. The report includes escalation of key issues from LCPs and system groups, highlights any significant risks and includes further detail on any areas requested by the Board.

Outcomes
The outcomes report looks at indicators of the health of the population (the health status of the population and whether equitable outcomes are being achieved) and the health of the ICS (whether people are being appropriately and equitably supported by the ICS).

Whilst the ICS compares well to the national position for the majority on indicators there are a number where performance is lower or where there is significant variance across the system. These will be subject to quarterly exception reporting providing further context and detail around the headline indicator, key actions and timescales for improvement and any issues for escalation.

Management of Conflict of interests:
Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.

Committees that have previously discussed/agreed the report and outcomes:

None

Key recommendations and actions requested:

Members of the F&P Committee are asked to:

- **Receive and note the contents of the report**
- **Note issues highlighted and actions undertaken**

Impact on our objectives

(Delete as applicable)

1. Commission high-quality and safe services that reduce health inequalities and improve health outcomes
2. Improve service performance
3. Achieve financial sustainability
4. Effective, well-led organisation with an empowered and inclusive workforce
5. Lead the system's response to the coronavirus pandemic

Reference to other documents or accompanying papers:

Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	**No**
Quality of Services	Includes details of areas where there are quality concerns	
Health Inequalities	Outcomes framework includes comparators on data	
Equality (staff or public)		N
Resource and Finance		N
Legal		N
Engagement and Consultation		N
Risk	Report highlights risks in performance & quality	

The CCG has made every effort to ensure this report does not have the effect of discriminating, directly or indirectly, against employees, patients, contractors or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability.

Together for Devon

Health and care working with local communities in Plymouth, Torbay and the rest of the county

Integrated Quality & Performance Report

Date of issue: February 2022

#TogetherForDevon

Executive Summary

This report provides a consolidated update on key strategic issues and measures of outcomes, performance, quality, finance, recovery and activity to provide the necessary assurance to the ICS, at both place and system level.

The Devon system remains under extreme pressure in all areas. Multiple factors have contributed to this position of increased risk, including sustained urgent care activity, delayed discharges due to poor community capacity and COVID related staff absences. This has led to pressures in Emergency Departments (EDs) due to poor patient flow resulting in a further stepping down of some planned procedures.

Covid infections in Devon rose sharply from late December. Since then, rates have remained volatile and high, mainly focused in younger age groups and particularly school-age children. Covid hospitalisations increased from the last week in December as Omicron began to impact. However, this number has started to reduce and Covid patients in intensive care beds remain very low. UHP continues to have the highest number of Covid patients (105 as at 7th February).

Key Risks & Priorities

Quality

- **Planned Care:** risk to patients, due to long waits.
- **Urgent & Emergency Care**: risk of long waits across whole pathway; 111, 999, ambulances through to EDs.
- **Primary Care:** impact on PC workforce and capacity, due to long waits within planned and urgent care.
- **Community Care:** risk due to discharge delays and long waits for packages of care.
- **IPC**: Emerging variants of concern; omicron

Performance

- **Planned Care:** risk to RTT, diagnostic & cancer target delivery, including 104 week waits due to urgent care pressures and increase in omicron cases.
- **Urgent & Emergency Care:** ED 4 hour under-performance and 60 minute handover delay breaches at all four acute providers.
- **Discharge:** delays continue to impact on flow through the entire system
- **IUCS:** 111 and Out of Hours service seeing continued capacity problems.
- **Childrens & Mental Health:** improvements in performance relating to some of the key metrics.

Workforce

- Staffing continues to be challenging across the whole healthcare sector with the following issues all impacting on each other.
- **Sickness:** Covid-related absences increased in December as Covid prevalence rose and are now levelling off.
- **Turnover:** Turnover has remained static in recent months (11.8%), although it is higher than this time last year (9.3%).
- **Agency Spend:** Agency spend remains high compared to prior years.
- **Vacancies:** In many areas higher than previously seen.

Finance

- As at month 9 the Devon ICS had a surplus of £5m which is £5m favourable variance to plan. (M8 £0.7m)
- The forecast to the year end is £0.1m surplus (M8 £0.1m) which is £2.3m favourable against the £2.2m planned deficit. (M8 £2.3m)

Together for Devon

Health and care working with local communities in Plymouth, Torbay and the rest of the county

Performance & Quality Context

2022/23 Operating Plan

A System Transformation and Efficiency Committee (STEC) workshop was held on 21 January to agree the system approach to operational planning for 22/23. The group included provider Directors of Strategy and other leaders from across the system.

The following principles were agreed:

- Must strengthen collaboration from the outset.
- Need clear governance and approval process.
- Not writing another plan – the Devon Plan will provide the narrative. The only narrative produced will be that required nationally, per guidance.
- Need to agree Devon's priorities and what is achievable against the national requirements.

A system Operating Plan Oversight Group has been established. The key functions of the group will be triangulation, escalation, moderation and assurance. The Group is multi-disciplinary and, in addition to all Deputy CEOs, will include members representing Local Authorities, Chief Nursing Officers, HR Directors, Chief Operating Officers, plus a clinical lead.

A Technical Group will support the Oversight Group to drive the planning process, with representation from finance, quality, workforce, BI, commissioning and localities. The Group will:

- Drive production of all elements of the plan (both the narrative template and technical submissions)
- Ensure alignment between all elements of the plan
- Ensure timely sign-off of all submissions

Workstream leads are currently meeting with the system PMO to review the delivery plans for the Long Term Plan 'Game Changers' and the national Operating Plan priorities.

Three further workshops, involving a wide range of system leaders, will review the plans at key points in the process, to ensure full system oversight and to make key decisions.

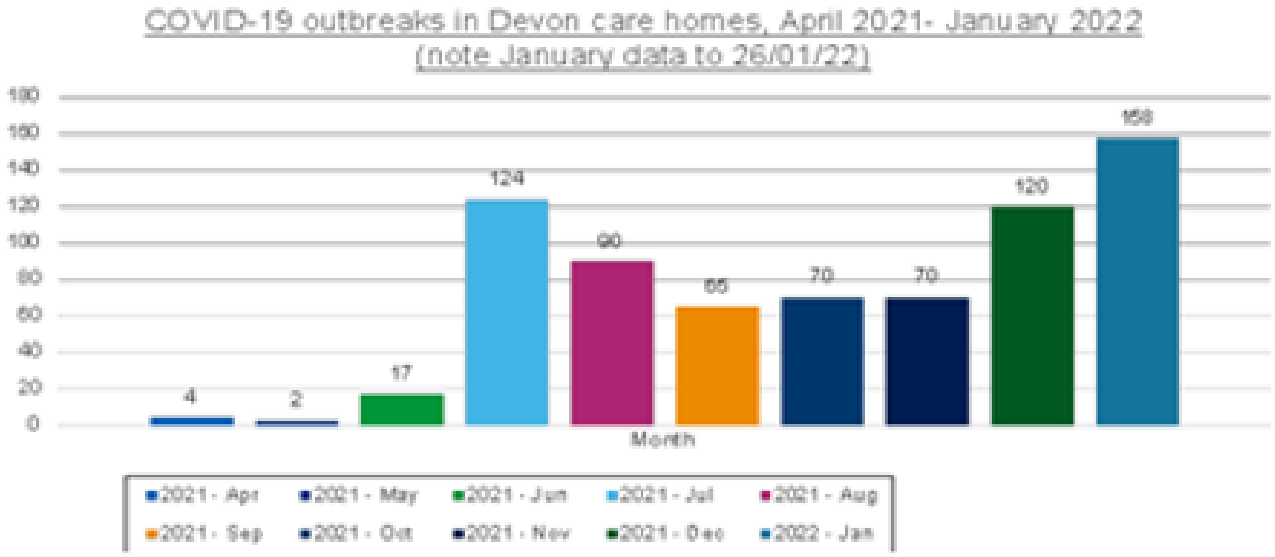
Infection Prevention & Control

Avian flu:

The case of confirmed avian flu in Devon led to internal and external learning regarding the correct procedural processes for potential high consequence infectious disease scenarios.

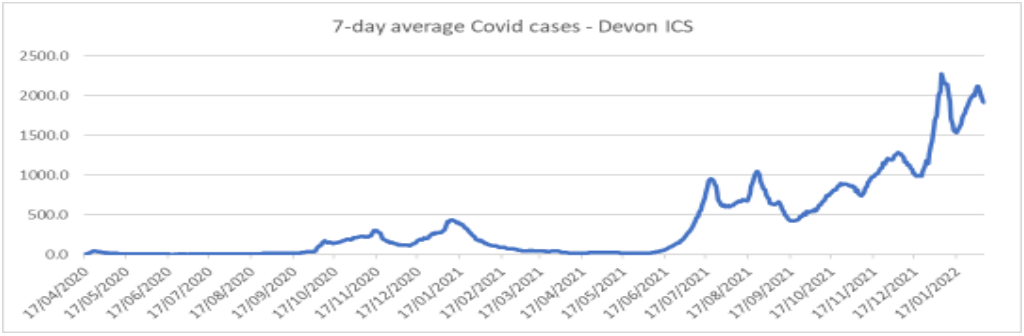
COVID-19:

Care home outbreaks have increased over December 2021 and January 2022, with a pattern of increased transmission and lowered acuity in comparison to previous COVID-19 waves. High numbers of care home outbreaks have meant that the community infection management service have prioritised outbreak control team meetings and infection control walkarounds, due to a lack of capacity.

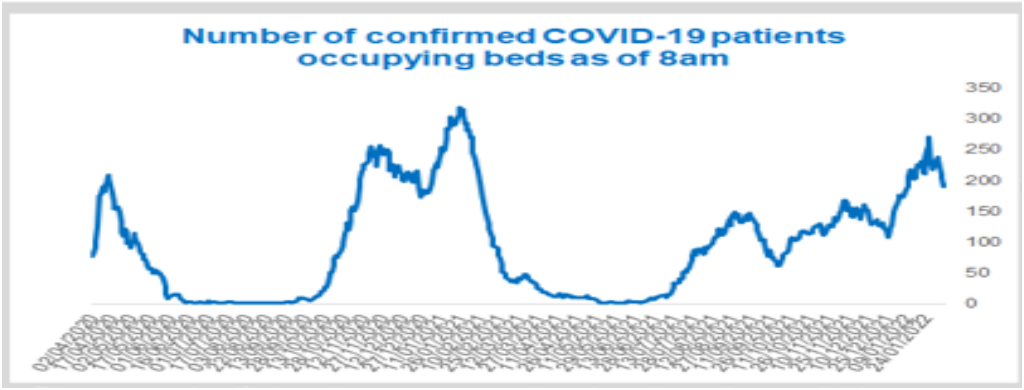


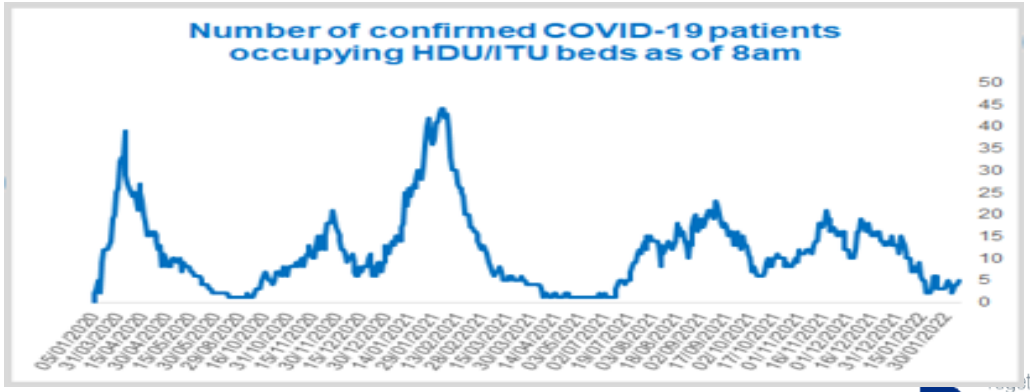
Covid Update

Covid infections in Devon rose sharply from late December. Rates remain volatile and high, mainly focused in younger age groups and particularly school-age children.



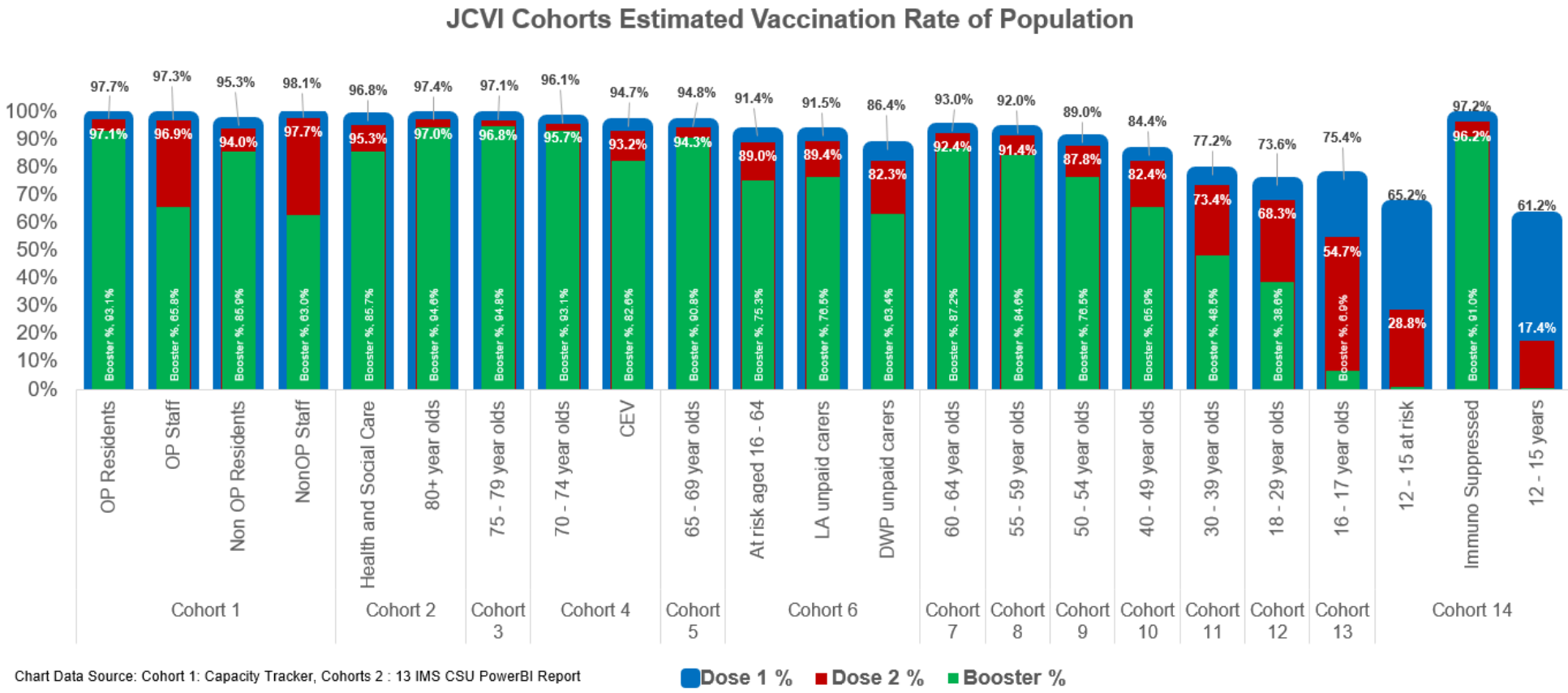
Following falls in admissions in early December associated with reducing Delta cases, Covid hospitalisations increased from the last week in December as Omicron began to impact. However, this number has started to reduce and Covid patients in intensive care beds remain very low. UHP continues to have the highest number of Covid patients (105 as at 7th February).



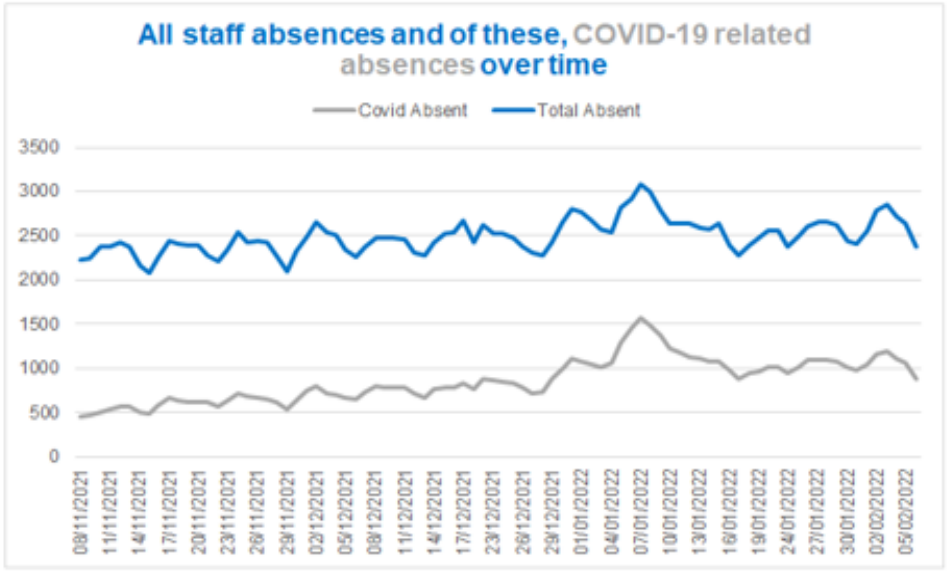


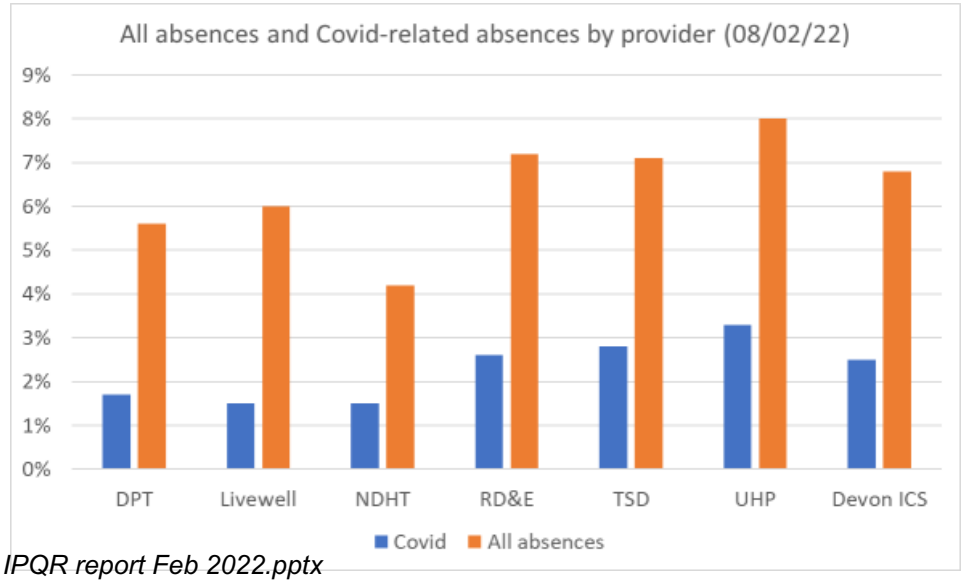
Covid Update - Vaccinations

80% of the eligible Devon population have received one vaccination dose and 76% both doses. 61% of 12-15 year-olds have received a vaccination and 86% of eligible people have received a booster (all figures as of 8th February)



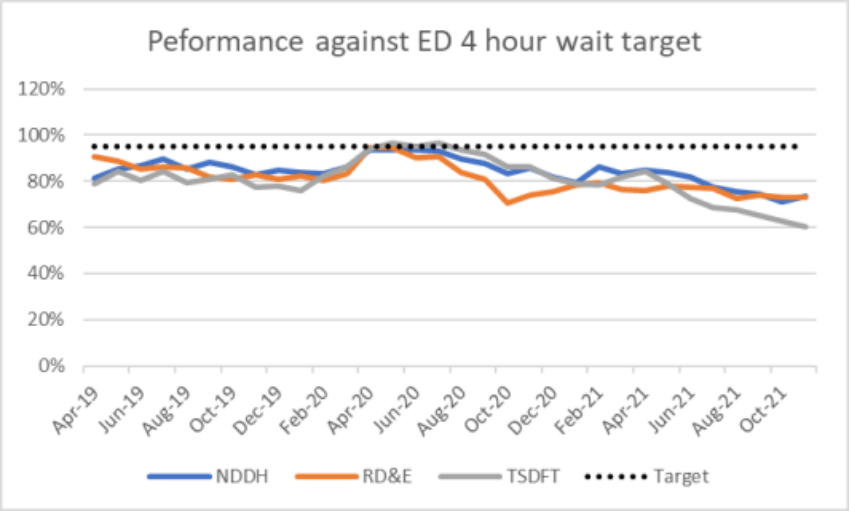
Covid Update – Staff Absences





Covid related absences peaked in early January but have remained at a stable level since then. Latest figures from 8th February show 6.8% of staff were absent in total across Devon's providers, 2.5% of which were Covid-related

Urgent & Emergency Care: Urgent Care



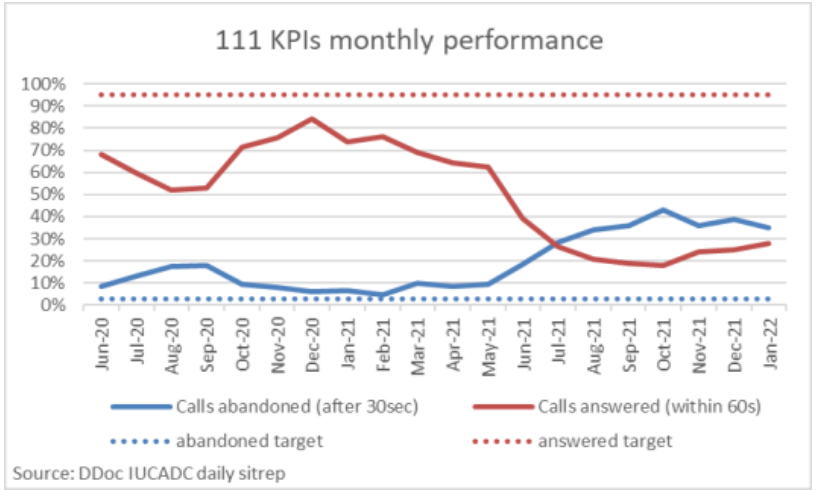
All systems remain under extreme pressure at all points of the urgent care pathway. Although 999 calls and ambulance handover numbers have reduced and ED attendances are lower than previously experienced, the pressure continues with high numbers of hours lost in ambulance handovers at some trusts. ED performance against the 4 hour target is to the right. (UHP do not report against this standard as they are part of a pilot for a revised set of metrics).

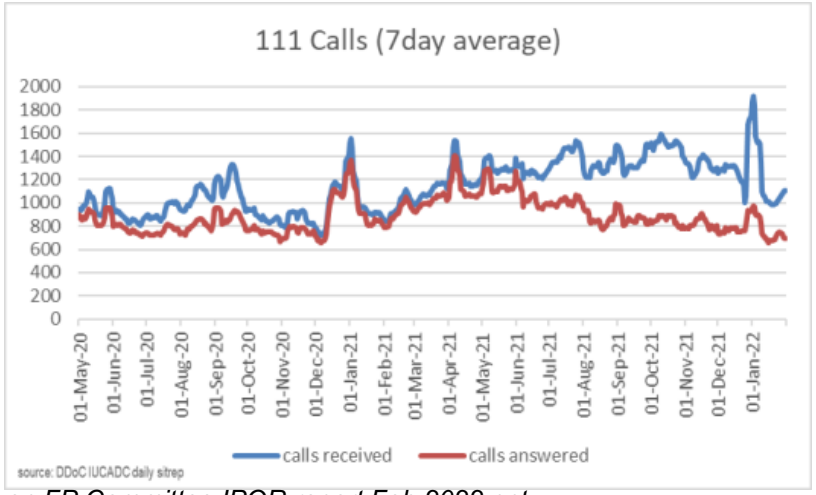
- 12- hour decision to admit (DTA) breaches are monitored and reported daily with detail of circumstances and mental health 12-hour breaches are discussed at daily system calls.
- Flow out of ED and within the hospitals has been severely compromised by the impact of covid. This combined with the high level of care home outbreaks has created a highly constrained system.
- Many of the mitigating schemes in the winter escalation plan, such as “care hotels” have had a positive impact, but questions around managing infection control are arising. There are capacity constraints in the private sector with care home closures being managed. Availability of specialist dementia care home capacity is especially challenging.
- There continues to be a very challenging position in relation to post discharge workforce although the numbers of people waiting each month for care is decreasing, an increasing level of acuity means that all new capacity in the market is quickly absorbed.
- The Western locality is engaging with the national team concentrating on the challenged discharge position and continues to have regulator presence to support the recent CQC outcomes.

Urgent & Emergency Care: Integrated Urgent Care Service (IUCS)

including NHS 111, Clinical Assessment Service & Primary Care Out of Hours

111:





111 metrics continue to show a very slight improvement although remain a significant distance from target and below the England average. At end of January DDOC were 35th out of 35 for calls abandoned in 60s and call answering.

Poor performance is due to low call answering capacity as a result of unplanned absence and insufficient establishment. Significant recruitment has taken place in recent weeks and therefore rota fill will be improving as staff complete the 6 week training programme.

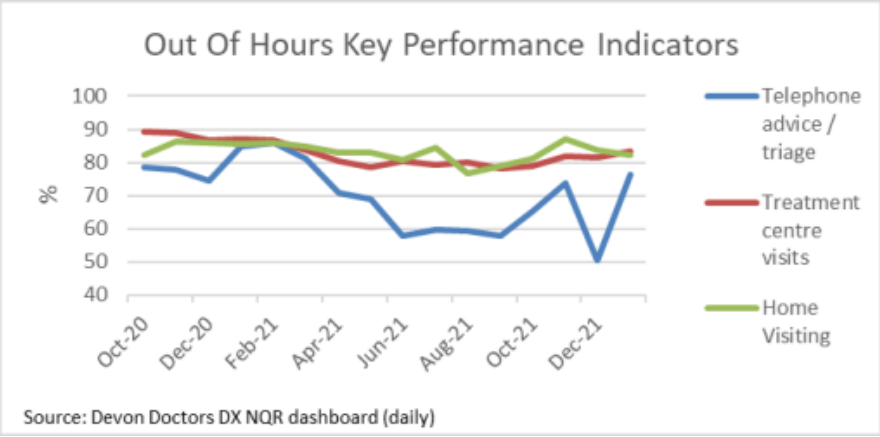
Call volume has reduced since the second week of January. This trend has been seen nationally although it is difficult to forecast if this will continue

Validation of initial outcomes from 111 remains a key focus. In January:

- 90% of all 999 outcomes were validated with almost 60% resulting in not requiring an ambulance equating to over 37 a day.
- over 70% of ED outcomes were validated resulting in circa 20 patients a day given an alternative to attending an ED.

Urgent & Emergency Care: Integrated Urgent Care Service (IUCS)

Out of Hours Service:



In January performance remained static for treatment centre and home visiting and shows triage performance recovered from the December position

Out of hours 'respiratory pathway' sites, previously known as 'hot sites', continue to be operational within the western, southern and eastern localities with 538 patients seen in December and 610 patients in January. Plans continue to be progressed for the northern locality.

A number of improvement initiatives are in place including:

- Continued implementation of Enhanced Clinical Validation to ensure patients who receive an initial 111 outcome of go to ED or transfer to 999 are reviewed by a senior clinician. Filling shifts remains a challenge.
- Ongoing recruitment to improve shift fill of the service rotas including initiatives to improve recruitment and retention of non-clinical call handlers which will be supported by the CCG through use of H2 non recurrent funding.
- Broadening the range of different staff types working within the service in line with clinical workforce strategy.
- Working in partnership across the ICS to deliver the national 111 First initiative, whereby patients are encouraged to call 111 and be directed to the right service for their needs, securing an appointment for them wherever appropriate.

Urgent & Emergency Care: DDoC CQC Report

The CQC have published their inspection report following on from an announced comprehensive inspection in November 2021. The service has been rated as “requires improvement” overall. Of the 5 domains, 4 were rated as “requires improvement” whilst “caring” was rated as “good”. The previous inspection in December 2020 rated the service as “inadequate” overall and resulted in conditions on license. These condition have now been removed, although two requirement notices were issued;

1. Regulation 17 HSCA Regulations 2014 Good governance: Infection control processes were not consistently followed at all bases.

- The registered person was unable to demonstrate that an annual infection control report was in place.
- There were mixed reports from staff on how learning from significant events and complaints was shared.

2. Regulation 18 HSCA Regulations 2014 Staffing: There were mixed reports from staff on training provision and opportunities for professional development.

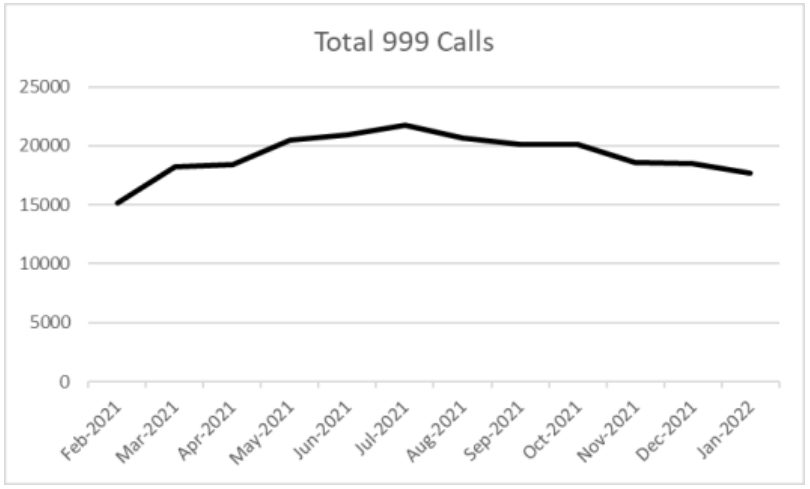
The service was also given 8 “Should-do” actions including using complaints as internal intelligence, identifying Freedom to Speak Up Champions, training compliance and communicating policy changes.

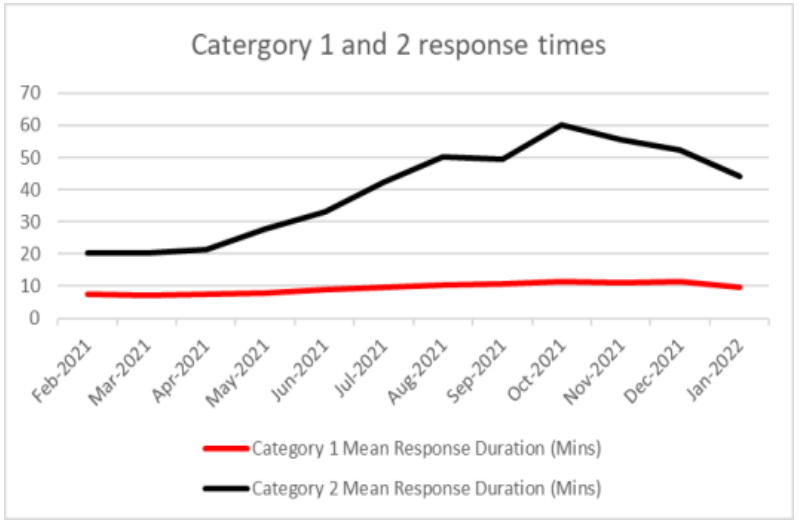
The service has been taken out of special measures which was imposed in December 2020, due to significant improvements within clinical governance systems. This included prioritising safeguarding training, improving recruitment processes and monitoring staffing levels and performance.

The CQC noted that the reconfiguration of the board and governance structure was a positive change with systems and processes for good governance becoming embedded across the service. CQC found that patients were treated with kindness respect and compassion.

The CCG continues to work closely with DDoC’s governance team, attending quality committees, incident review meetings and end to end reviews to assure their processes and learning mechanisms are appropriate. The CCG receive clinical and staffing weekly updates providing evidence of learning being shared.

Urgent & Emergency Care: Ambulance Services





In January SWAST remained in critical incident, REAP 4 status .

There were 18,083 999 incidents in Devon; very similar to December (18,543). Across SWAST, activity levels are now below the same period 2020 and 2021.

The mean time to answer 999 calls across the south-west was 23 seconds, a significant improvement compared to December which was 112 seconds.

The call stack (the number of patients that have called 999, been triaged and are waiting for an ambulance / clinical advice) continues to cause concern. However, the stack is now spiking at 200 incidents at any one time across the southwest; compared to 400 in November.

Mean response times for Devon category 1 incidents have improved slightly, at 10 minutes (target is 7 minutes). Category 2 mean response time improved to 45 minutes, compared to 54 minutes in December (target 18). Response times in category 2 and 3 are still more than double the national ambulance response standards.

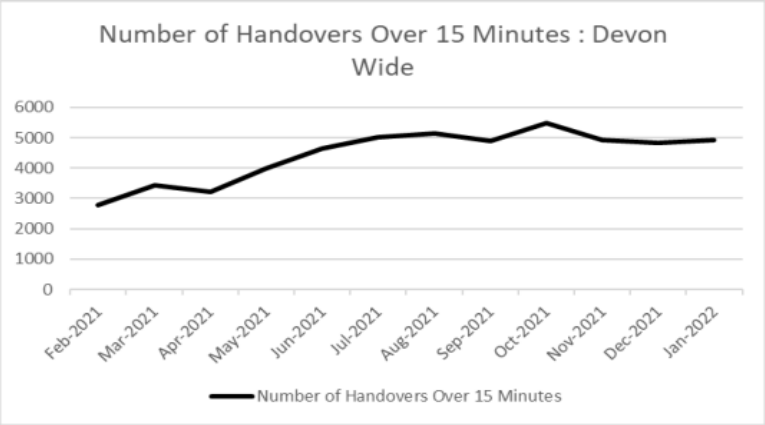
Conveyance rates to ED were stable at 41% which is below the England average of 50%. 17% of were incidents managed by Hear and Treat in the clinical hub.

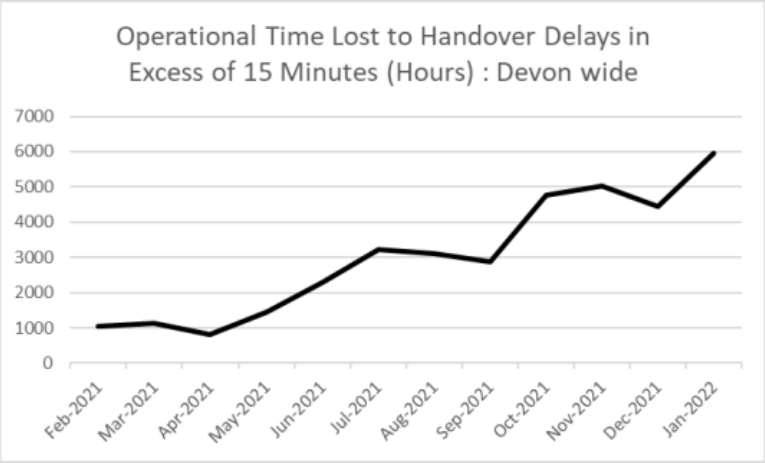
Conveying resources (double crewed ambulance and patient support vehicles) remained above establishment, to offset resources lost to hospital handover delays.

Urgent & Emergency Care: Ambulance Services

- Slow call-answering (below the national standard of within 5 seconds) and response times increases the risk that patients will suffer unnecessary harm. Given the emergency nature of ambulance work, it is not always possible to identify whether harm would or would not have occurred irrespective of the delay. It has been agreed by all joint commissioners for SWAST to undertake a system SI from incidents identified as being caused by system pressures . This will follow principles of the forthcoming Patient Safety Strategy and SWAST are being supported by the Director of Patient Safety Science.
- The timeline previously provided for the final investigation and improvement plan has been delayed to April 2022. The CCGs will work across the system to implement these plans.
- SWAST have in place an active recruitment process to increase the number of emergency call takers by 136 WTEs (to cover required uplift and attrition). The position improved through January with 176 WTEs in place, against a requirement of 199 WTE (based on forecast against activity). The numbers completing training are increasing, although abstractions and attrition remain an issue.
- Additional clinical support has been identified as a priority for the control room. There have been challenges recruiting, however from December 10 WTE front line clinicians were seconded to the hub. Clinicians in non-front-line roles have also been supporting clinical triage in the hub. Hub GP support has proved difficult to increase, but this will be prioritised in Q4 with a mix of zero hours contracts and sessional roles on offer. Specialist paramedic resources have increased, with 13 commencing training in January.

Urgent & Emergency Care: Ambulance Handovers





Ambulance handover delays remains a focus nationally. All Trusts and systems were required to respond to a request for information on how they will reduce the time lost through delays and this will be followed up closely, particularly in relation to UHP and T&SDT. The majority of the actions are based on the work already taking place between UHP and the CCG and recommended by NHSE to roll out to other providers for learning.

There is a comprehensive improvement plan at UHP and one is in development for T&SDT with weekly meetings locally and every three weeks a system wide meeting chaired by the ICS with representation from NHSE/I. There are 16 actions on the plans with a focus on alternatives to ED conveyance, improvements in ED processes and creating capacity to avoid exit block.

Through January, SWAST gave notice to no longer staff patient cohorting areas. UHP and TSD are looking at commissioning alternative solutions for this and the CCG is supporting them with an offer of £80k.

The impact of actions taken to date has been hard to measure as the benefit has been offset by, covid attendances and delayed discharges which creates an issue of flow within the hospital. Further work is now being done to measure the overall impact.

Planned Care: Elective Care

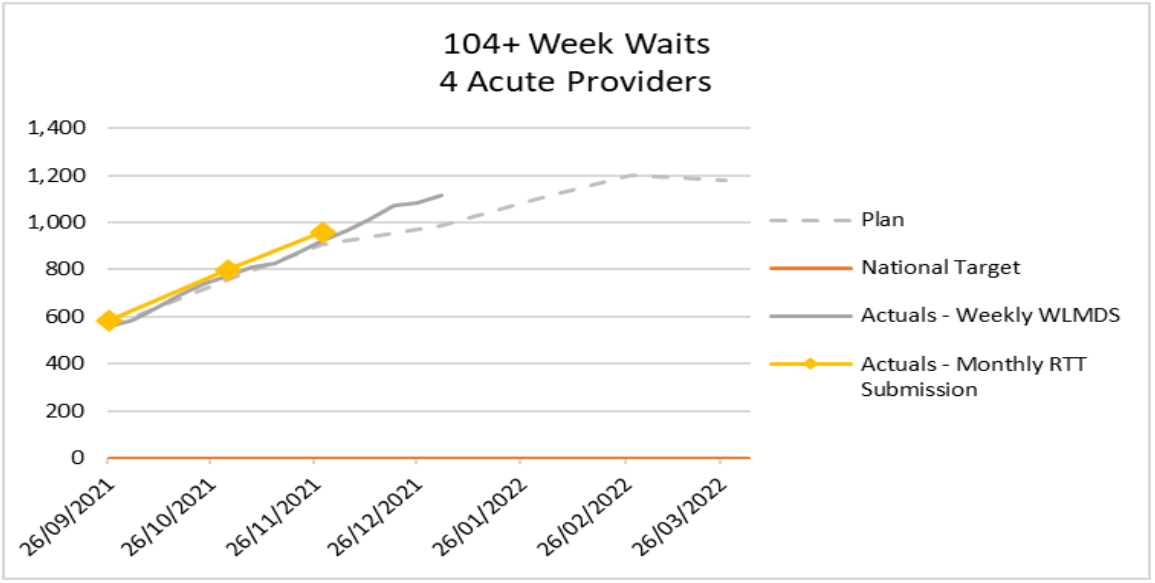
- The elective position has deteriorated further since December 2021, due to stepping down more services in response to the Prime Ministers announcement for an NHS turbocharge booster programme against Omicron. This includes the longest waiting patients, with Devon's 104 week position increasing from 920 at 28th November 2021 to 1,324 at 30th January 2022

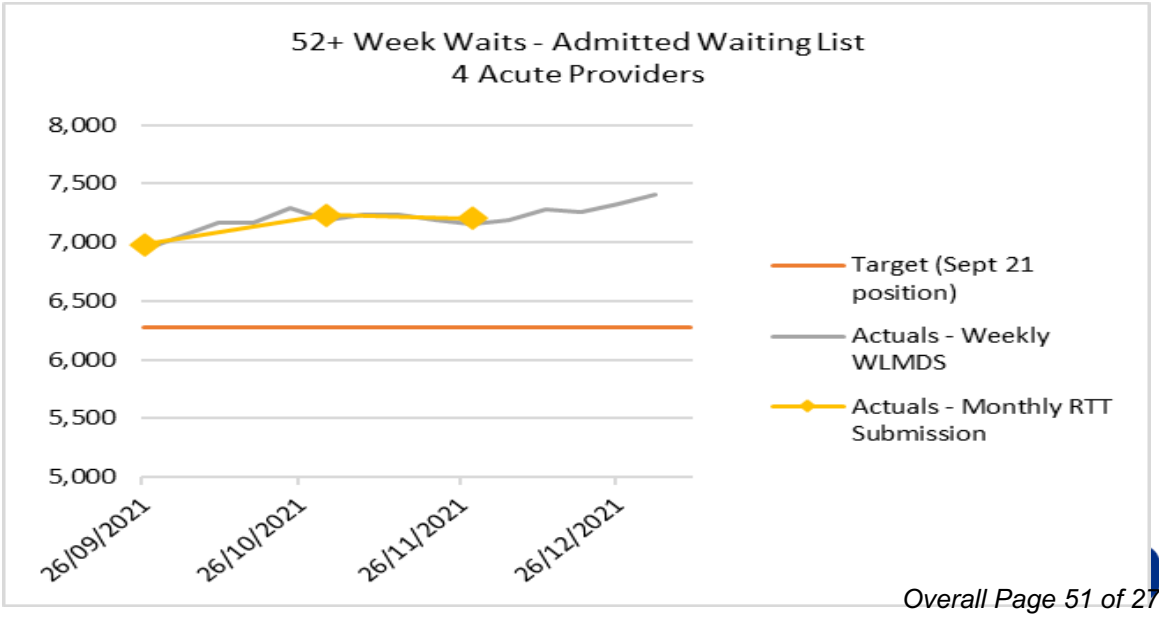
- After the further stepping down of services, NHS Devon CCG subsequently undertook a system risk assessment (RA) to identify impact and risk of this action, but also describe mitigation that potentially reduces the associated risk. The RA overarching findings were that the de-prioritisation of elective procedures does not adequately consider current and future impact on patients who may experience a range of harm and position of inequity, as they experience long waits.

- Therefore the planned care long wait risk on the CCG corporate risk register remains at 25 which is the highest level available to reflect likelihood and impact. It should be noted that this risk was added in 2021 and assessed at a risk scoring of 25.

Planned Care: Elective Care

- Most deliverables are currently off track – the key specialties impacted are ophthalmology and orthopaedics.
- The Nightingale is a critical part of the Devon system's overall plan to get back on track with delivering orthopaedic, ophthalmology, and diagnostic services to patients on a waiting list, playing a vital role in the national delivery plan for tackling the COVID-19 backlog of elective care.
- We continue to offer patients a range of diagnostic services from the Nightingale site, including CT, MRI, X-ray and fluoroscopy, and glaucoma and medical retina screening services (ophthalmic diagnostic services) are also now online.
- The Royal Devon and Exeter NHS Foundation Trust's rheumatology department have relocated to the Nightingale and are now operating an outpatient rheumatology and infusions centre, and over the next few weeks, a full range of ophthalmology pathways and orthopaedic services will come online.
- The NHE will require a blended workforce position including the utilisation of current staffing, agency and on-going recruitment. Due to the current workforce pressures, this position remains flexible, with RDET as host Trust working with system colleagues to provide assurance on the operational position.





Planned Care: Elective Care

- Devon submitted a revised trajectory for 104 week waits (ww) in January 2022. The revised forecast moved from 1,679 down to 1,458 by end of March 2022, but is still higher than the original H2 Plan of 960.

- With the current operational pressures, UHP have been struggling to manage cancer surgery demand and as part of the NHS Q4 Independent Sector contract in term of pre-surge, UHP requested to move some urology and breast cancer surgery to Nuffield and Practice Plus Group (PPG). These moves would result in further deterioration on the 104ww position as this will displace elective work.

- The Regional team have contracted with PWC to provide support with the delivery of the elective recovery plans for 22/23 by March and work is being undertaken to understand the support required for the Devon System.

No.	Ambition	Outcome	Target Deadline	Target	as at w/e 30/01/22	Difference
1	TOTAL WL	Stabilise the waiting list to the level seen at September 2021	Mar-22	151,724	157,839	6,115
2	52+	Hold or where possible reduce the number of patients waiting over 52 weeks	Mar-22	12,298	13,200	902
3	104+	Eliminate waits of over 104 weeks by March 2022 except where patients choose to wait longer (P5/6)	Against Monthly Plan (Currently Jan 22)	1097	1324	227

No.	Ambition	Outcome	Target Deadline	Target	Dec 21	Difference
4	NF2F	Retain remote delivery of 25% of Outpatient attendances where clinically appropriate	Monthly	25%	23.30%	-1.70%
5	PIFU	PIFU - discharging at least 1.5% of Outpatient attendances to PIFU pathways by Dec 21 and 2% by March 22	Dec-21	1.50%	1.95%	0.45%
6	PIFU	Ensure PIFU is in place for 5 major specialties (based on EROC submission) per Provider	Monthly	4 Providers	4	0
7	A&G	Increase the advice and guidance offer by ensuring that by March 22 a minimum of 12 A&G requests should be delivered per 100 first outpatients	Mar-22	12%	WIP	WIP

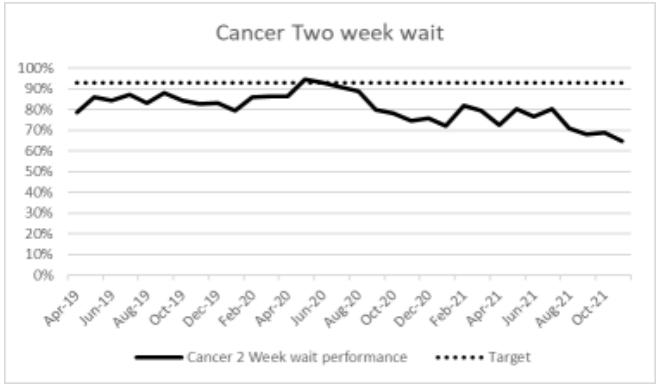
Planned Care – Elective Care

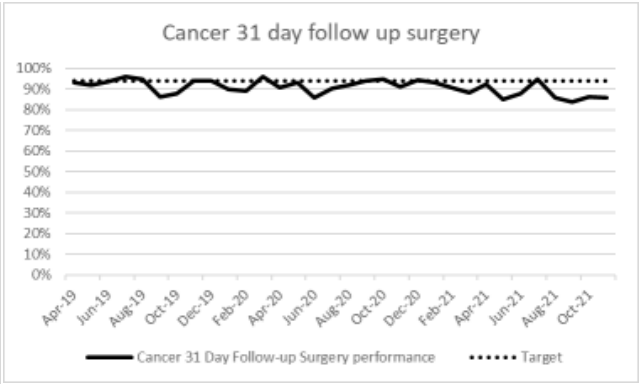
Actions to Deliver H2 Ambitions

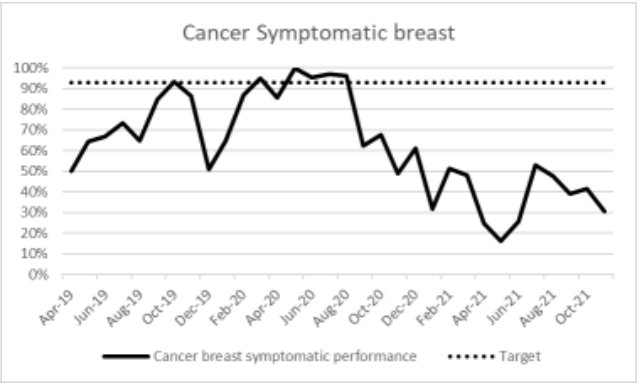
- Early discussions at system level regarding how to protect orthopaedic capacity for complex patients who cannot be seen in independent sector or Nightingale.
- Devon system-wide meeting arranged with national GIRFT (Getting IT Right First Time) HVLC (High Volume, Low Complexity) team on 24th February to discuss local issues impacting elective recovery across the 6 high volume, low complexity (HVLC) specialties – orthopaedics, ophthalmology, general surgery, gynaecology, ENT, and urology. The intention of this session is to ensure as rapid a recovery of services as possible as the Omicron wave subsides.
- Exploring the opportunities for outpatient clinics in the high street for patients attending services that do not require to be sited within the acute setting continues. Progressing options appraisal for running ophthalmology services on the high street.
- Linking with local Community Diagnostic Centre (CDC) workstream to explore opportunities to include ophthalmology imaging in the North Devon CDC programme at Green Lanes.
- Progressing the opportunities for post-screening children's vision services to be run by high street optometrists.
- Exploring opportunities for a pilot with RNIB for a multi-agency approach to long term vision support in line with the work underway in Greater Manchester.
- Long waiting squint patients transferred from UHP and now seen at NDDH – significant reduction in potential 104ww (as at end of March).
- A series of 'sharing transformation' sessions at the Outpatient Steering Group will be held over the next 4 weeks. Each Trust will present on good practice/transformation that has not already been shared.

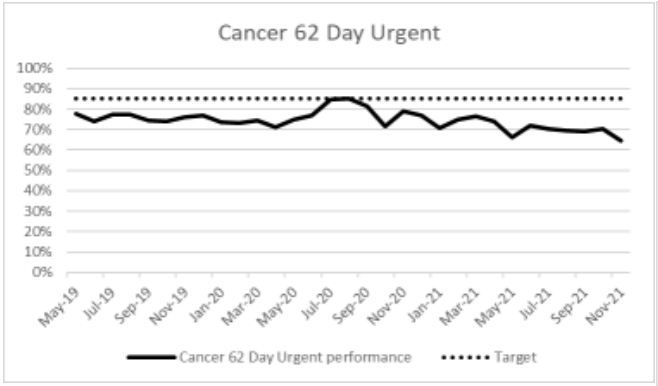
Planned Care – Cancer Performance v Target

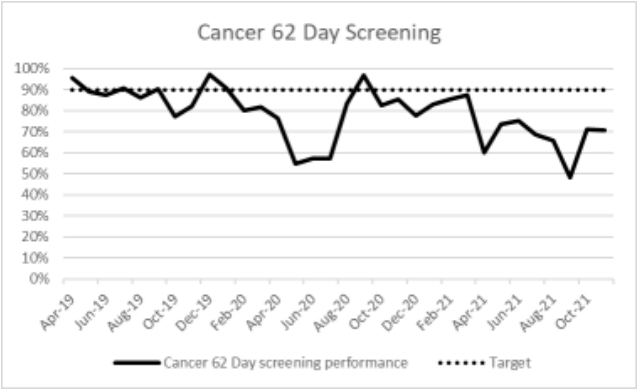
Many of the cancer targets remain unachieved across the ICS. Cancer services are competing with emergency demand for the available resources which is adding delays into patient pathways particularly for bed, outpatient capacity and diagnostics. Particular challenges in meeting the two week wait, symptomatic breast and 62 day targets

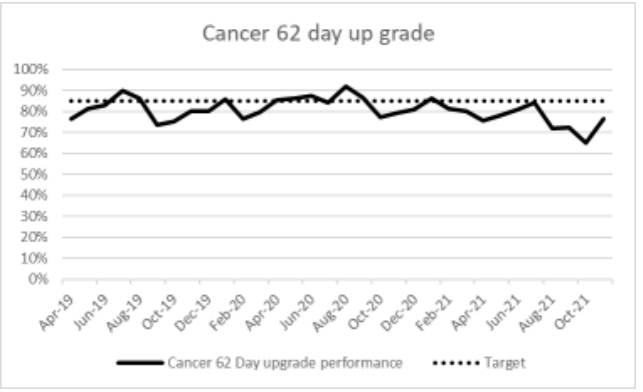












Planned Care - Cancer

- Staffing and bed capacity is an ongoing concern in each Trust to maintain cancer treatment pathways. Options to manage and maintain cancer surgical treatments across the Peninsula are being worked through.

- A deep dive into breast referrals , conversion and cancers found that the conversation rate which which is at around 11% at 3 our of the 4 trusts which is in line with the expected rate. North Devon has a lower rate of 5%. Work is taking place to revalidate the data and then do some further investigation into why this is the case. Achieving the expected rate indicates that referrals being received are valid despite the increase in referrals which at some points has been 180% of the norm.
- Gynaecology performance at RD&E has continued to deteriorate . The average weekly demand is 37 slots per week, and frequently exceeds 40. Baseline capacity is 28. Over the past few months, the department has employed many strategies to address this shortfall, namely:
    - Waiting list initiatives
    - Converted theatre capacity where elective lists have been cancelled with a couple of days' notice into two week wait (2WW) capacity
    - Converted non urgent outpatient capacity into 2WW slots
    - Instigated a nurse led service for post-menopausal bleeding patients (PMB) on a 2WW pathway.

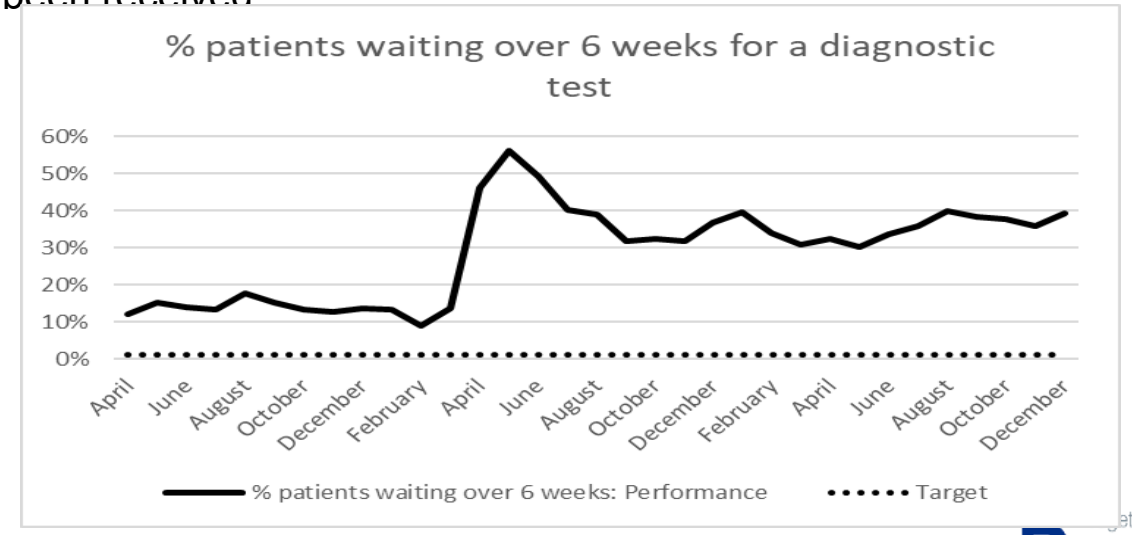
This has held the position, but further solutions that require funding are being presented to the Trust Board.

Planned Care - Diagnostics

Diagnostic performance remains poor with all providers failing the national target of less than 1% patients waiting over 6 weeks for a diagnostic test. This aligns to the national performance. However, there is some additional capacity coming on line:

- Increased CT and MRI capacity at the NHE
- RD&E board approved 'at risk' spending to retain additional leased scanner for another 6 months.
- TSDT have secured short term agency staff with funding from the Targeted Investment Fund (TIF).
- Non-Obstetric Ultrasound support is in place via the CCG Any Qualified Provider (AQP) contract and TIF funding for RD&E and NDHT providing an additional 1,950 scans by 31/3/22
- Elective Recovery Funding+ funding for UHP to utilise spare scanning capacity linked to the Lung Health check pilot available from 1/4/22 for a two year period.
- Mobile urology unit funded via TIF is clearing cystoscopy waiting lists at TSDT and NDHT.
- ECHO recovery plans for UHP have been received

A demand capacity gap analysis was completed for January Planned Care Programme Board. A summary of options to close the gap completed with associated trajectory of impacts will to be presented in February for decision on options and funding.



Hospital Discharge

Hospital Discharges remain a specific area of concern and continue to significantly impact on system flow across the CCG patch.

Patients are discharged on one of 4 different pathways:

Pathway 0 P0 simple discharge with no input from health/social care
Pathway 1 P1 support from health and or social care to recover at home
Pathway 2 P2 rehabilitation in a bedded setting
Pathway 3 P3 home is not an option at point of discharge, long term care required

The current position as of 3rd February 2022 is set out below. This shows a split against the pathways and reflects a total position of 383 individuals medically fit for discharge on P1-3 with no identified plan. This is against a Devon System target of 125 and is a significant increase from the 276 reported as at last month's report. This is driven by challenges in care home and home care availability

	Number of patients	Average length of delay (days)	longest length of delay (days)
patients medically fit for discharge p1-3	383		
patients medically fit for discharge p1-3 planned for today	44		
patients medically fit for discharge with a future planned discharge date	18		
Number of patients discharged yesterday	31		
P1 patients medically fit for discharge with no planned discharge	66	4.36	43
P2 patients medically fit for discharge with no planned discharge	200	13.18	204
P3 patients medically fit for discharge with no planned discharge	57	11.98	83

Hospital Discharge

NHS Incident Level 4 - System Discharge Response

- The CCG were required to submit a trajectory for delivery against the 30% reduction in individuals with No Criteria to reside by 31st January, and this is shown below.
- The Devon system has not met this target and exceeded it by 171. Further progress will need to made in delivering against the 50% target by 31st March 2022. Actions are described on the next slide

Providers	Number in NCTR beds not discharged 13/12	Target 30% reduction on number in NCTR beds discharged from 13/12 to end Jan	Actual 11/1/2022	Trajectory 17th Jan	Actual 17/1/2022	Trajectory 24th Jan	Actual 24/01/22	Trajectory 31st Jan	Actual 31/01/22	Target number NCTR beds not discharged by end Jan
Northern Devon Healthcare NHS Trust	63	19	73	70	54	61	53	44	49	44
Royal Devon and Exeter NHS Foundation Trust	86	26	119	113	101	95	141	60	102	60
Torbay and South Devon NHS Foundation Trust	54	16	65	62	68	54	56	38	50	38
University Hospitals Plymouth NHS Trust	138	41	151	146	120	130	194	97	209	97
Devon	**341**	**102**	**408**	**391**	**343**	**340**	**444**	**239**	**410**	**239**

Hospital Discharge

NHS Incident Level 4 - System Discharge Response

- As part of the Level 4 system response, all Systems are required to reduce the numbers of individuals with no criteria to reside by 30% by the end of January 2022 and by 50% by the end of March 2022. This represents a significant challenge requiring creation of significant bedded community capacity (circa 240 additional beds) along with improved P0 and P1 discharges across all areas.
- A local action plan has been developed that considers all existing capacity created and sets out a number of other actions/interventions at will seek to deliver additional capacity January to March. Local plans include:
  - Block purchase of care home beds to enable opening of currently closed capacity.
  - Deployment of agency workers into care homes to enable currently closed beds (due to staffing constraints to be re-opened).
  - Creation of a peripatetic support team to be deployed to offer 1:1 support for short periods on discharge
  - Increased ‘Care Hotel’ capacity within Plymouth and creation of P1 Care Hotel type capacity within other settings in all other localities (currently focused on underutilised Care Homes).
  - Investment in VCSE capacity and interface with acute system to support hospital discharge
  - Implementation of a hospital discharge PHB grant available to support personalised and innovative arrangements to enable discharges.

The ability for the actions to deliver the capacity required is being impacted by an increasing number of patients with no criteria to reside. Acute trusts are now developing actions plans for supporting improved delivery with a particularly focus on pathway 0 discharges (especially at weekends)

Hospital Discharge

Further actions to improve discharge performance

- To support the reduction in individuals with No Criteria to Reside (NCTR) occupying hospital beds, all systems undertook a 'discharge audit' on 14th January 2022 to review reasons for delays for delayed patients. The outcome, reviewed at system and local level, demonstrated variances in recording/reporting and identified practical steps that could support system improvements. As a result, locality action plans have been produced which will be monitored through the weekly System Flow meeting. It is anticipated that a further audit will be required to be undertaken in February
- Building on this work NHSE announced a 'perfect weekend' on 26th and 27th January. This required a case-by-case review of individual not discharged over that weekend to understand the barriers to weekend discharge. The outcome of this has been shared through the system flow meeting and delivery of agreed actions as a result will be monitored on an ongoing basis
- A programme of improvement actions has been set out to increase the quality of patient discharges from hospital to care homes. Initial actions included ensuring a senior discharge team member was responsible for the accuracy of discharge planning and information to care homes and that a point of contact and follow up call to the care home was made. A broader quality improvement programme has now been set out to enhance this further which aims to build care home confidence in accepting resident admissions from hospitals by March 2022 and includes:

  - Initial data capture with care home market focusing on a sample of homes accepting the most admissions and those accepting the least. This will provide a baseline confidence level, enable review of the immediate improvement actions and identify key difficulties that arise on or soon after admission
  - Independent deep dive into 4 cases identifying opportunities to improve discharge practices and learning from hospitals
  - Building on locality work reviewing Trusted Assessment process already underway to establish a core minimum standard of what care homes can expect as part of the discharge process
  - Establishing a system working group to include registered care home managers, hospital discharge lead from each locality and health & social care representative who will support and oversee the quality improvement programme.

Mental Health

Perinatal Mental Health

- Services continue to recover from the impact of Covid- 19 which reduced referral volumes. Against an access rate target of 7.9%, in November 2021 we achieved 8.1%, an improvement from the 7.9% reported in the previous month. This trend is expected to continue as referrals return to previous levels. The access rate target will increase to 8.6% in Q4 2022/23.

Children & Young People's Mental Health: Eating Disorder Services

- The context for increased demand and acuity of need was shared in the deep dive report (Nov 2021).
- Performance against the 95% urgent access target is 75.8%. This is a deterioration from 79.4% reported in the previous period. Performance against the 95% routine access target is 52.0%. This is a deterioration in performance compared to the previous period where achievement was 56.7%. The system aim to achieve these targets is by March 2022/23 for urgent access and by year end 2023/24.
- Currently, there are concerns relating to the accuracy of the data due to issues relating to start/stop timings leading to potential inconsistences when comparing local and national reporting. Work has commenced to clarify and improve data quality and this should see improvements from March 2022.
- Across the system, additional capacity is being recruited and trained.

Mental Health

Improving Access to Psychological Therapies (IAPT)

- ICS Devon continues to achieve the wait times for IAPT. In terms of the 95% 18-week wait time target achievement remains at 100%. In terms of the 75% 6-week wait time target achievement is 97%. Regarding the 50% recovery target achievement is 50%.
- As set out in the deep dive report (Nov 2021), access is lower than expected, due to decreased referrals (observed regionally and nationally) and we are not achieving the access volumes required. Access volumes increased by 4% between Q2 and Q3. The national 'Help!' marketing campaign is also now under way and a local marketing campaign has been underway with Devon Partnership Trust and Livewell Southwest to promote TALKWORKS and Plymouth Options.

Physical Health Checks for Adults with Severe Mental Illness

- In October 26.50% of people with severe mental illness had received a complete physical health check compared to 26.6% in the previous period. We are working to ensure that at least 41.0% of people with severe mental illness receive a physical health check by the end of 21/22. Early indicators suggest improvement in the subsequent month is expected, and thereafter we anticipate that the impact of commissioning a third sector provider should further improvement performance.

Mental Health

Inappropriate Out of Area Placements

- Inpatient occupancy remained high throughout January causing both providers to remain at OPEL level 3/4. Wards have also been impacted by Covid-19 related restriction and total capacity has been adversely impacted by Covid-19 outbreaks in provider settings.
- Historically (Nov 2019), ICS Devon was the worst performing system nationally in terms of number of people placed out of the area inappropriately. The system has worked to improve this position and in August 2021, 27 people were placed out of area, compared to December 2021, where this had dropped further to 16.This improvement bucks the national trend of deterioration.
- Progress has continued against this deliverable with additional capacity becoming operational (March 2022), based on current progress we are on trajectory to achieve the elimination of inappropriate out of area placements in Q1 2022/23.

Dementia Diagnosis Rate

- In ICS Devon the dementia diagnosis rate has been consistent, but below the target level for most of the year, 56% (December) against a national target of 66.7%; this is in line with national experience. Impact of NHS Level 4 incident response on current capacity is being assessed. Assessment of current services and improvement opportunities taking place February CCG-led, with providers, LAs and Alzheimer's Society.

Women, Children & Young People

Torbay SEND Inspection

- Ofsted and CQC jointly inspected the Torbay local area in November to see how well health, care and education have fulfilled our responsibilities for children and young people with special educational needs and/or disabilities (SEND). The inspection found eight areas of significant concern:

  1. Lack of a suitably ambitious SEND strategy.
  2. Parents and carers uninvolved in strategic and local decision making due to cultural issues.
  3. Lack of joint working between services.
  4. Varied SEND responses leading to inequitable access and outcomes.
  5. Poor range of opportunities, in particular education and employment, when transitioning to adulthood.
  6. Wide quality variation in Education, Health and Care plans.
  7. Poor joint commissioning arrangements.
  8. Lack of impact and resilience to sustain improvement of recent initiatives.

- Throughout the report, key themes highlight the need to develop joined up services, improve dialogue with parents and carers, and reduce inequalities, particularly with families within areas of deprivation. The CCG and Torbay local authority are charged with producing a written statement of action, within 70 days (21st April 2022), to address these concerns. The IPQR will provide progress updates in forthcoming months.

The full Ofsted and CQC report can be accessed here.

Safeguarding

- T&SDT have reported 3 serious incidents relating to slips, trips and falls on one ward. Assurance has been sought by the CCG safeguarding adult team (SGAT) from the T&SDT safeguarding adult team regarding actions taken to mitigate risk. A ward level action plan has been devised and will be monitored by the Trust to determine if action is required from a safeguarding adult perspective.
- Livewell have experienced difficulties completing Court of Protection community deprivations of liberty safeguards application documents in a timely way for clients in the community whose care is funded though NHS Continuing Healthcare, with a potential consequence that restrictions to the clients' liberty may not be legally authorised. The SGAT are working with Livewell to review and support development of their internal processes.
- Assurance has been received from RD&Ethat all Section 42 enquiries that were outstanding prior to April 2021 have been completed and subsequently closed by Devon County Council as meeting the Care Act requirements.
- A business case is being developed by Child Family Health Devon (CFHD) to ensure there is adequate health resource in Devon Multi Agency Safeguarding Hub (MASH) to gather health information to support appropriate triaging of child protection referrals.
- The local authorities have not requested any Initial Health Assessments (IHA) from health care providers within the standard of 5 days of any child entering care. This impacts on the ability of healthcare providers to complete assessments within 20 days. There are now monthly meetings between designated professionals and the three LAs where compliance will continue to be raised.

Serious Incidents & Patient Experience

- There have been no new never events reported since (December 2021). At the time of writing this report (26/01/2022), January has seen a decrease in the number of serious incidents (SI) being reported; 23. This monthly decrease is not consistent with previous years for January; 44 reported last year.
- The CCG continues to monitor the 60-day performance target for completion of SI investigations for all providers. Although monitored locally, the national reporting of the 60-day performance target remains suspended. Updates from the national team relate this to the nationally identified staff shortages making it more difficult to undertake (SI) investigations; clinical investigators undertaking patient care. There is a balance to maintain between patient care and timely, proportionate investigations.
- The CCG continues to be actively involved in supporting the system with complex multi-agency investigations involving different hospitals, mental health providers, our urgent and emergency care system providers and primary care. There are currently 11 multi-agency investigations taking place, which are being monitored by the use of round table meetings and reviews of cases.
- Members of the safety systems team continue to work with Devon Partnership NHS Trust (DPT), including gaining weekly assurances on their overdue SI position; it is slowly decreasing (35). Weekly assurance will continue until DPT's overdue status of root cause analysis (RCA) reports is reduced further and the CCG's risk is tolerated (current risk score of 8).
- SWAST system investigation SI has been delayed. A total of 26 system-pressure incidents have been reported by SWAST, of which 6 are regarding patients within Devon. The final report is due beginning of April (was February).

Serious Incidents & Patient Experience

- Due to the increased number of never events reported in this financial year, the safety systems team is currently writing a paper reviewing those reported for identified learning. This will then be shared within the next Devon Patient Safety Specialist Collaboration Meeting.
- The below table which illustrates all open serious incidents by Provider and status:

Provider	In date	In date, report received	Report received past B/F date	Report due & overdue	Overdue review re-review RCA report	Extension agreed	Pending external report	Deletion request	Report reviewed, further information required	Total
NHS Devon CCG	1	0	0	1	0	0	0	0	0	2
Providers without Access to STEIS	8	0	0	3	0	0	1	0	5	17
TSDFT	18	6	2	3	0	0	2	1	1	33
RDEFT	11	0	1	9	0	0	4	0	0	25
NDHT	5	2	0	5	0	0	1	0	0	13
SWASFT	9	0	0	4	0	0	0	0	0	13
LWSW	6	0	0	12	0	3	0	0	1	22
UHPNT	21	2	0	2	0	0	1	0	7	33
DPT	22	0	2	35	1	9	1	0	16	86
DDOC	6	1	0	0	0	0	0	1	1	9
Out of area - Our Patient	0	0	0	2	0	0	0	0	1	3
Total	107	11	5	76	1	12	10	2	32	256

Workforce

- The Devon ICS People Programme Board meet monthly to address Devon wide challenges:

Vacancies

- We have reviewed long standing consultant vacancies, and these will form the focus of a system medical recruit campaign in April 2022 which aims to attract medical colleagues from outside of the system to work in Devon.

- High rates of vacancies for nursing in DPT remain compared to the rest of the system. The International pipeline remains healthy, and we are now seeking to recruit overseas nurses into mental health and social care settings on behalf of these providers.

- A Livewell /Social care recruitment pilot to commence in December for social care vacancies – this pilot is on track to start marketing 100 vacancies from the end of January 2022.

- The Trusts are currently attempting to over recruit into rapid response teams to aid discharge . The aim is to fill circa 80 vacancies , however at present we have only filled 15 to date due to a very competitive jobs market.

Workforce

Bank and agency spend

- Agency spend remains high although there has been a small decrease this month. Staffing continues to be challenging across the whole healthcare sector. A task and finish group has just been established in order to assess how to reduce off framework agency bookings and general agency usage. A plan for this is expected during Q4 for implementation in 2022/23.

Workforce Strategy

- Two clinical workshops took place in November with high level agreement that service redesign/transformation was needed at scale and pace across the system. The aim is that the Workforce Strategy principles are agreed by April for final ICS Exec approval in May 2022 and that financial challenges are understood with high level plans proposed to improve this position. Work then starts with LTP workstreams to agree plans consistent with the Strategy aim and principles, once finalised.

Other

- Turnover has slightly increased since the last report (11.5% to 11.8%) and is higher than this time last year. (9.3%)
- Current Trust sickness has increased this week to 8.0% with COVID absence sitting static at 3.3%. T&SDT, RD&E and UHP are in the stages of completing deep dives on sickness absence data to understand where the hot spots are in order to develop further supportive measures to assist staff back to work, where possible. Devon sits around the midway point across the 42 systems for rolling absence at circa 5.0%.
- Staffing hub set up to agree methods of increasing availability of staff to respond to pandemic – meeting twice weekly.

Workforce

Information for December 2021

	Consultant vacancies		Nursing vacancies		HCA vacancies		AHP vacancies	
	ICS		ICS		ICS		ICS	
vacancies	95.0		611.1		343.8		133.4	
substantive workforce	1,274.5		7,130.8		3,698.7		2,054.8	
vacancy as % of Establishment (31/03/2021)	7.1% ⇔		8.3% ↑		8.5% ↑		6.8% ↑	
	NDHT	RD&E	NDHT	RD&E	NDHT	RD&E	NDHT	RD&E
vacancies	14.8	9.1	92.9	74.0	42.4	61.0	61.1	32.0
substantive workforce	109.9	388.3	772.6	2,139.2	310.9	1,075.2	235.4	632.7
vacancy rate	12.0% ↓	2.3% ⇔	10.7% ↑	3.5% ↑	12.0% ↑	5.4% ↑	20.5% ↑	5.8% ↑
	TSDFT	UHP	TSDFT	UHP	TSDFT	UHP	TSDFT	UHP
vacancies	14.4	38.7	139.1	147.9	98.4	171.5	33.8	26.4
substantive workforce	237.3	455.4	1,271.5	2,158.8	557.9	1,250.1	527.3	442.8
vacancy rate	6.0% ↑	8.3% ↑	10.5% ↓	7.0% ↑	15.0% ↓	12.1% ↑	6.9% ↑	6.1% ⇔
	DPT	LSW	DPT	LSW	DPT	LSW	DPT	LSW
vacancies	18.0	N/A	157.3	N/A	-29.5	N/A	-19.8	N/A
substantive workforce	83.6	N/A	788.8	N/A	504.6	N/A	216.6	N/A
vacancy rate	18.6% ↓		17.1% ⇔		-6.2% ↑		-10.3% ↓	

In each case the percentages are calculated from the reported vacancies in the cells immediately above

Sub group	Description	Unit	Current month	Previous month	This month-last year
1.Temporary Staffing	a)Total agency spend	£'000	3559	3644	2571
	b)Off-framework nursing agency spend[1]	£'000	304	270	206
	c)Bank as share of temporary workforce	%wte	74%	77%	77%
2. Best Place to Work	a)Average turnover rate[2]	%	11.8%	11.5%	9.3%
	b)Average sickness absence rate[2]	%	5.1%	5.0%	4.4%
3.Recruitment	a)Consultant vacancies[3]	wte	95.0	94.8	89.9
	b)Nursing vacancies[3]	wte	611.1	561.5	390.8
	c)HCA vacancies[3]	wte	343.8	259.9	179.3
	d)AHP vacancies[3]	wte	133.4	118.6	70.6

Together for Devon

Health and care working with local communities in Plymouth, Torbay and the rest of the county

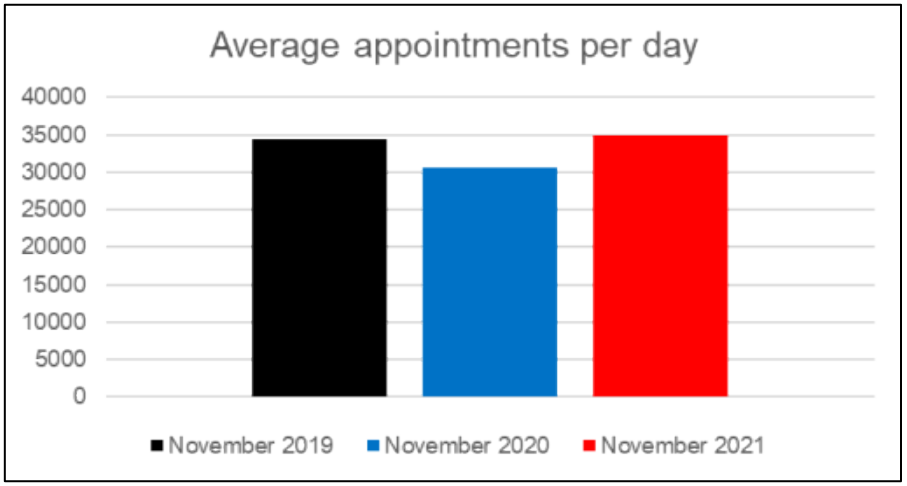
Performance Deep Dive: Primary Care

Primary Care: Key Highlights

- System pressures across all health settings have meant that an incident response (including emergency NHSE directive to focus on provision of vaccination/booster programme and urgent medical care) footing has been maintained, which has required suspension of some planned work activities
- Winter Access Fund workstreams are benefitting the most challenged practices, including over 27,000 hours of additional capacity for most challenged practices, who have also been prioritised for locum sessions through digital locum pilot
- Major mobilisation exercise to support new incoming GP provider underway for Plymouth practice in readiness for 1st April 2022
- GP Strategy Refresh commenced; all GPs/Primary Care Networks/Collaborative Boards/Local Care Partnerships/local providers will have an opportunity to take part and feed in their views, aiming for submission to July Primary Care Commissioning Committee
- 119/121 practices have formal CQC ratings of good/outstanding; the Primary Care Team continues to work with the 2 rated inadequate
- Annual patient survey results published July 2021 show 88% patients described their experience as “good” against national average of 83% (2% improvement on previous year)

Primary Care: Access to General Practice

Local target: 4% increase on the number of available GP appointments (allowing for the additional roles scheme) on pre-pandemic levels)

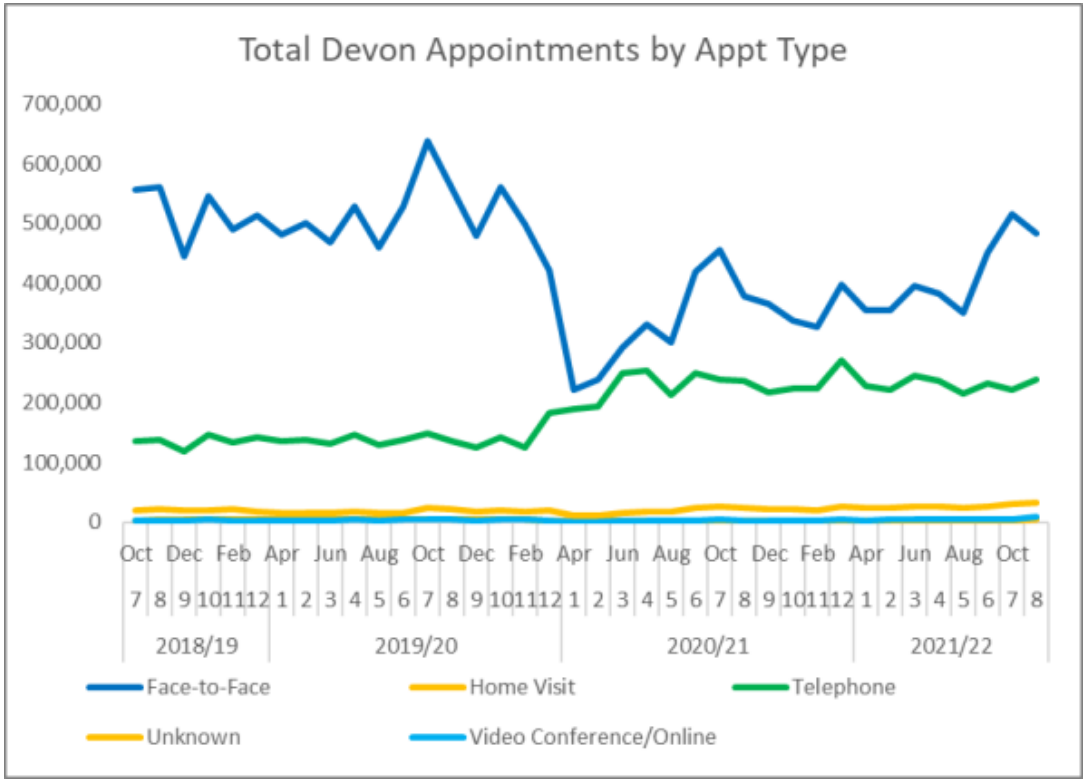


- A 1% increase per working day was seen in November 2021 compared to November 2019;
- This is due to practices being refocused on booster programme per national directive.
- It is anticipated that there will be a gradual increase in appointment data as booster activity declines, unless JCVI proposes General Practice involvement in more boosting.

Local target: Number of online/video consultations against target of 1 million for the year 2021/22

- Total year to date 2021/22 (up to end January 2022): **555,545**
- The pandemic has led to many practices having to switch off eConsult
- At end of month 10 we are at just over half of the target, meaning it is unlikely our local target will be met.

Primary Care: General Practice Devon Appointments by Appointment Type



The data shows changes in pattern of appointment type with more consultations taking place over the telephone.

Face to face appointments are increasing but are still below pre pandemic levels

Primary Care: Patient Satisfaction

Local target: 65% patients satisfied with the online consultation service

- Patient satisfaction with online consultations has increased throughout the third quarter of the year and exceeded the 65% target. The figure of 70% in December 2021 is a new high for patient satisfaction.
- Around 1,000 surveys are completed each month, giving a good sample size.
- 100% practices have access to online GP consultations

Primary Care: Workforce

Local target: PCN meeting national expectation of 7-8 roles each, target is to increase the number of roles for PCNs at the bottom end of the range – to all having at least 3 Additional Roles Reimbursement Scheme (ARRS) roles

- At December 2021, overall, there were 335.77 WTE roles across Devon employed under ARRS
- The average number of ARRS roles per PCN in December was 10.8 WTE

Local target: Continue to utilise the ARRS scheme including implementation of the plan to recruit 31 Mental Health Practitioners in 2021/22

- There are currently 5 Mental Health roles in post (all under Livewell)
- There are 14 Mental Health roles out to recruitment (2 for Livewell, 12 for DPT) and a further 7 roles for DPT not yet out to advert

Primary Care: Population Health Management

Target: 100% PCNs to have confirmed inequalities lead and confirmed smoking cessation lead

- Population Health Management has largely paused at present owing to the requirement to focus on urgent medical need and vaccination; refocus anticipated during 2022/23

Primary Care: Commissioning and Quality

Target: NHS 111 direct booking into practice appointments at a rate of 1 (minimum) appointment available a day for every 3,000 patients

The NHS Digital reporting tool only allows reporting on 20 practices at a time. The report was run on 7th January 2022 (on 20 practices) showed Primary Care offering 1040 against a target of 421. However, 22 practices are showing as not offering any appointments, this is being investigated.

Primary Care Networks

Local target: 100% PCNs to be at step 2 of the Maturity Matrix domains by March 2022

- Most recent temperature check shows some PCNs at step 2 and **all** are on trajectory to achieve this

Local target: 100% PCNs have agreed development plans through Collaborative Boards by end July 2021 (% against target)

- Active involvement in PCN development reduced owing to current workload pressures in both CCG and practices/PCNs
- Development plans will be agreed at Collaborative Board level with aligned MOUs

Local target: 1.14% patients referred to social prescribing

- As at November 2021 (data collection point), 0.48% patients referred to social prescribing. Considerable work taking place to promote this, however, some social prescribers re-purposed to support booster campaign

Primary Care: Infrastructure

Local target: 100% utilisation of Minor Improvement Grant budget with minimal revenue impact

- 100% MIG funding allocated with minimal revenue linked to agreed level at Primary Care Oversight Group

Local target: All ARRS staff housed within appropriate community setting

- Work is ongoing to maximise all available space before any consideration of additional funding for housing roles. Significant pressure on existing space anticipated owing to successful recruitment
- Significant estates toolkit programme to be enacted over next 6 months, which will include ARRS pressures

Primary Care: Quality

- The Patient Safety & Quality (PSQ) and Safety Systems teams joint work schedule has been agreed following attendance at Eastern, Northern and Southern Locality meetings. Locality leads have communicated with the team for further training and share purpose of incident reporting within PCN`s. PISIRF and Safety Strategy objectives will also be shared at these meetings. In response to this, a PITCH process training video to be completed and circulated via the LMC to support the process as per Primary Care leads request. Monthly reporting of themes will also be circulated via CCG Comms.

- The PSQ Team has now completed an initial review with the LMC with an agreement of shared data and terms of reference for mutual oversight of incidents and timely responses regarding system wide risks and workload shift. Data received as of 25th January within PITCH shows these risks are not currently being reported. Feedback to LMC on lack of reporting is now planned.

- Collaboration with Mid Devon, Plymouth and Northern Medical Examiners leads has been agreed; PSQ attendance will proceed with the System meetings. Integration of the Medical Examiner hospital process within an Eastern Practice has commenced, and there is a plan for the PSQ team to work initially with this practice as a pilot. The role will be to support Primary Care with identified moderate and severe incidents identified by the Medical Examiner. This planned work stream with the Safety Systems team is to incorporate PISIRF and the Safety strategy within the remit of the Medical Examiner enquiries.

Primary Care: Quality

- Positive engagement within three PCN`s has identified appointment of new Safety and Quality leads with robust procedures, analysis, and dissemination of learning. In addition, appointment of a new pharmaceutical lead within the Plymouth locality has resulted in improved monitoring and prescribing pathways for patients and identification of two Serious incidents that are now being investigated.

- Individual practices continue to be supported by the PSQ team as highlighted at planned communication meetings with CQC locality leads, concerns regarding Patient Safety and reporting processes within Primary Care sites continues as a theme.

- Continued collaboration with NHSEI has identified additional concerns within a Plymouth PCN and further Cold chain incidents. This has been formally reviewed within a multi-disciplinary meeting and reported back to the PCT and CQC.

- PSQ has supported isolated GP practices within Mid-Devon with multiple SEA submissions and sought assurance for continued engagement. Due to an absence of further communication and increased CQC concerns (regarding incident reporting, lack of robust processes and completion of QOF targets), an action plan has been agreed to review CQC concerns and initiate an audit within the locality to review an identified cohort of patients to gain assurance on the monitoring and case finding within the PCN population.

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ICS Performance & Quality Outcomes

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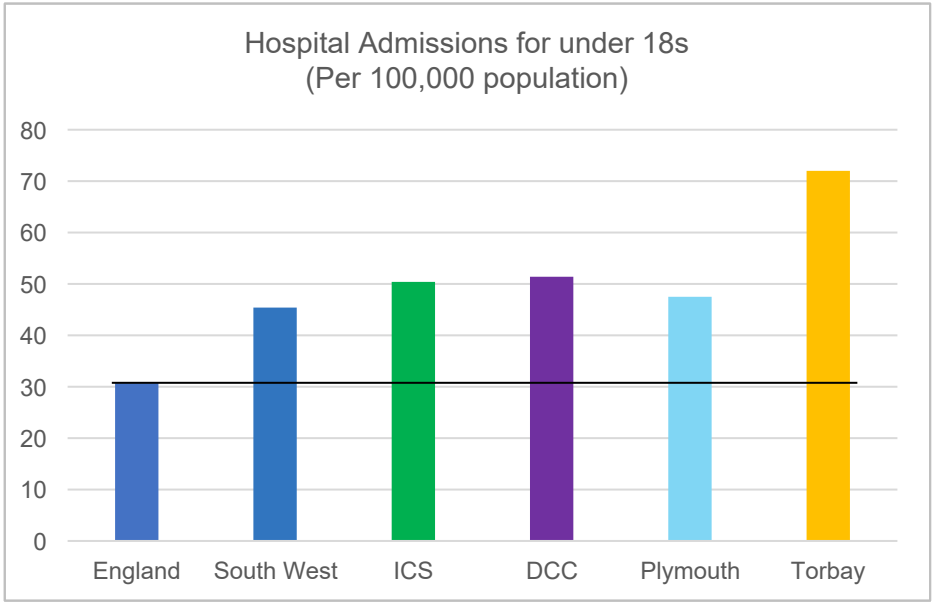
Strategic Outcomes

Devon ICS Strategic Outcomes Framework

	Domain		latest period	England Latest	England trend	STP latest	STP Trend	SW Region Latest	SW region trend	Devon County Council Latest	Devon County Council Trend	Plymouth County council Latest	Plymouth County Council Trend	Torbay County council Latest	Torbay County Council Trend
Health of the Population	Early Years	Breast feeding prevalence at 6-8 weeks after birth	2020/21 Q4	49.5%						56.0%		41.0%		40.0%	
	Young people	Admission episodes for alcohol-specific conditions - Under 18s (Crude rate per 100,000 population)	2021/22 Q3			12.0				9.5		13.3		12.0	
	Older Adults	Admission episodes for alcohol-specific conditions - Over 65s (Crude rate per 100,000 population)	2021/22 Q3			336.9				266.4		327.7		384.3	
Health of the ICS Are people being appropriately and equitably support by the	Early Years	Take-up of health visitor checks Proportion of new birth visits completed within 14 days	2020/21 Q4	85.9%				80.2%		41.2%		81.6%		89.4%	
	Younger people	Children and young people accessing mental health services	2021/22 Q1	41%		45%									
		Service users with crisis plans % of people in contact with mental health services	2019/20 Q2	12%		3%									
		Hospital admissions as a result of self harm (10-24 years) Directly standardised rate per 100,000	2019/20	439		600.1		659.9		635.0		668.8		700.7	
	Working Age	Out of area placements (mental health and learning disability)	December			2238				2238		615			
		Proportion of eligible adults with a learning disability having a health check (%) (target 75%)	2021/22 Oct			67.0%									
		Access to IAPT services: people entering IAPT (in month) as % of those estimated to have anxiet/depression	December			1.3%				1.3%		1.2%			
		Admission episodes for alcohol-specific conditions (Crude rate per 100,000)	2021/22 Q3			255.2				213.6		199.8		367.4	
	Older Adults	Bed Occupancy Rates (Acute Hospitals excludes covid beds)	2021-22 Q2	86%		86%				86%		86%		85%	
		Dementia: Recorded prevalence (aged 65 years and over)	December			56%									
		Emergency admissions aged 65 and over (rate per 1000 population) <1	2021/22 Q3			5621.2				5076.1		3968.5		5896.1	

Outcomes – commentary by exception

Alcohol-related admissions to hospital for under 18s are above the national average in all local authorities. Torbay is the highest at over twice the national average.



The Alcohol Harm Reduction Working Group brings together colleagues and partners from across the health and care system, including VCSE, with the broad aim of preventing and reducing alcohol-related harm.

There is focus across the system to understand this metric. One of the key immediate priorities is to develop the data and intelligence picture locally to be able to formulate an action plan that will be aligned to policy & evidence e.g. the OHID Recovery Framework, DCC Recovery & other relevant local and national policy and guidance. The action plan key priorities will be shared once finalised

Quality Outcomes*

*Data collection in development for new metrics

Quality indicators

Domain		Definition	Target/Direction	latest period	ICS/CCG		RDEFT/Eastern		NDHT/Nothern		UHP/Western		TSDFT/Southern		DPT		Livewell	
Individuals in receipt of funding from the NHS/CCG due to a statutory responsibility	Continuing Healthcare assessment are completed within 28 days	Number of referrals concluded within 28 Days	80%	Q3 2021/22	76%													
	Continuing Healthcare assessments take place within an acute hospital	Less than 15% of Continuing Healthcare assessments take place within an acute hospital	15%	Q3 2021/22	0%													
	Assessment for Continuing Healthcare determination over 12 weeks	Number of assessment for Continuing Healthcare determination over 12 weeks	0	January	1													
Primary care	Asthma RCP assessment	Proportion of GP assesment including Asthma RCP assessment	Higher is Better	2018/19			0.778		0.785		0.729		0.768					
	Mental Health comprehensive care plan	Annual Proportion of GP assesment including Mental health care plan	Higher is Better	2020			0.688		0.656		0.664		0.683					
	Diabetes BP reading 140/80 mmHg or less	Annual Type 1 Proportion of GP assesment including Diabetes BP reading	Higher is Better	2019			0.771		0.761		0.718		0.775					
		Annual Type 2 Proportion of GP assesment including Diabetes BP reading					0.717		0.717		0.709		0.738					
	Needs met at last GP appointment	Annual Proportion of GP assesment including Needs met	Higher is Better	2020			0.964		0.972		0.947		0.955					
	Cancer review within 6 months of diagnosis	Annual Proportion of GP assesment including Cancer reviews	Higher is Better	2020			0.918		0.937		0.882		0.905					
	Females, 25-64, attending cervical screening within target period	Proportion of GP assesment including Cervical screening 25 - 49	Higher is Better	Q4 2020/21			0.742		0.761		0.727		0.752					
		Proportion of GP assesment including Cervical screening 50 - 64					0.775		0.764		0.763		0.764					
	Persons, 60-69, screened for bowel cancer in last 30 months	Annual Proportion of GP assesment including bowl cancer	Higher is Better	2020			0.691		0.676		0.686		0.680					
	Child Imms DTaP/IPV/Hib/HepB (age 1 year)	Proportion of GP assesment including immunisations	Higher is Better	2020			0.944		0.955		0.960		0.952					
	CQC rating	Latest Care Quality Commission rating	Higher is Better					Good (Apr 2019)		Requires improvement (Nov 21)		Requires improvement (Jan 22)		Good (Jul 2020)		Good (Sep 2021)		Good (Jan 2020)
ICS	C-Diff	Healthcare onset – healthcare associated	Lower is Better	January	12		3		0		6		4					
		Community onset – healthcare associated	Lower is Better	January	4		1		0		1		2					
		Community onset- indeterminate association	Lower is Better	January	2		0		1		0		1					
		Community onset-community association	Lower is Better	January	6		0		1		4		3					
	MRSA	Community onset – healthcare associated	Lower is Better	January	0		0		0		0		0					
		Community onset-community associated	Lower is Better	January	0		0		0		0		0					
	MSSA	Healthcare Associated	Lower is Better	January	2		1		0		2		1					
		Community onset-community associated	Lower is Better	January	11		4		0		7		2					

Quality Outcomes

Quality indicators

Domain		Definition	Target/Direction	latest period	ICS/CCG	RDEFT/Eastern	NDHT/Nothern	UHP/Western	TSDFT/Southern	DPT	Livewell
ICS	E.coli	Healthcare associated	Lower is Better	January	28	11	7	4	6		
		Community onset-community associated	Lower is Better	January	38	13	4	18	10		
	Klebsiella	Healthcare associated	Lower is Better	January	10	8	0	1	1		
		Community onset-community associated	Lower is Better	January	8	5	0	4	1		
	Pseudomonas	Healthcare associated	Lower is Better	January	3	2	0	0	1		
		Community onset-community associated	Lower is Better	January	2	0	0	2	1		
	Hospital COVID 19 outbreaks	Snap shot of Definite Hospital acquired cases Transferred from another ward on the 1st on the month	Lower is Better	December		1	0	4	0		
		Staff cases snapshot as at 1st of the month	Lower is Better	February		46.7%	45.5%	41.3%	42.0%		
		Council Snap shot of Care Homes Reporting COVID Cases	Lower is Better	February				24	16	66	
Mental Health	Inappropriate Out of Area placements	Number of inappropriate Out of Area placements across specialities (Adults) (numbers of patients requiring adult acute mental health inpatient care	Lower is Better	December	2238					2238	615
	Annual Physical Health Checks for those with SMI	% of completed comprehensive annual Physical Health Checks for those with SMI	Higher is Better	December	30%						
	Dementia Diagnosis rate	Proportion of patients with dementia, ages 65+	66.70%	December	56.0%						
	% of people discharged from in-patient units who receive follow up at 48hrs	% of people discharged from in-patient units who receive follow up at 72hrs	Higher is Better	September	60.0%					84%	72%
	% of people discharged from in-patient units who receive follow up within 7 days	% of people discharged from in-patient units who receive follow up within 7 days	Higher is Better	December							100%
Childrens	Autism Ax	Mean wait from referral to assessment Childerns number of Weeks data from Chrildren and family Health Devon	Lower is Better	December	78.7						
	Eating Disorders:- routine	Children and Young people Eating disorders waiting times (routine 4 weeks)	Lower is Better	Q2 2021/22	55%				72.7%	58%	38%
	Eating Disorders:- urgent	Children and Young people Eating disorders waiting times (urgent 1 week)	Lower is Better	Q2 2021/22	65%				77.8%	79%	33%
	CAMHS: - Routine	CAMHS DPT waiting over 18 weeks Livewell within 18 weeks	Lower is Better	November						713	288
	CAMHS: - Urgent	Urgent CAMHS referrals seen within 1 week DPT (local target) Livwell 24hr	Lower is Better	November						89%	100%
	Mean wait for SALT	Mean wait from referral to assessment	Lower is Better	December							27
Community	End of Life measure Death in place of choice	Proportion of deaths in usual residence	Higher is Better	20/21 Q3 - 21/22 Q2	58.31						

Quality Outcomes

Quality indicators

Domain		Definition	Target/Direction	latest period	ICS/CCG		RDEFT/Eastern		NDHT/Nothern		UHP/Western		TSDFT/Southern		DPT		Livewell	
Safety systems	Number of open Serious Incidents	Total number of Open Incidents	Lower is Better	December			21		13		40		31		86		23	
	Number of Serious Incidents that are overdue	Total number of Serious Incidents that are overdue	Lower is Better	December			8		4		4		4		40		11	
	Number of Never events in last twelve months	Total number of Never events withina roling 12 month period	Lower is Better	December			0		1		0		0		0		0	
	PALS: Number of open complaints	Total number of open complaints	Lower is Better	December			0		0		1		1		0		1	
Safeguarding	Number of children receiving CP medicals			October			10		2		17							
	Domestic abuse and sexual violence victims and perpetrators referred to specialist services.			December			0		15		44							
	Percentage of CIC receiving RHA's within timescales (this is 6 monthly for U5s and annually for Over 5s)			December											44%		13%	
	Percentage of CIC receiving IHA's within 20 working days of coming into care.			Q2 2021/22			0%		57%		26%		50%					
	Number of safeguarding adult enquiries (S42) regarding the service			December			18		9		5		4		11		0	
Maternity	Breast feeding rates	Proportion First feed breast milk	Higher is Better	October			67%		67%		69%		71%					
	Homebirth rate	Proportion of home births	Higher is Better	October					4%				6%					
	Midwife to Birth ratio		Higher is Better	December					71%		49%		65%					
	Still births/ Neonatal deaths	Number of still Births	Lower is Better	December					0		3		1					
	C/S rates	Proportion of Elective and emergency Caesarean section births	Lower is Better	October			26%		39.1%		27.9%		22.9%					
People	Sickness rate	Average sickness absence rate	Lower is Better	December			4.8%		4.1%		5.6%		4.7%		6.1%			
	Turnover rate	Average staff turnover rate rate	Lower is Better	December			12%		13%		11%		12%		13%			
	Bank as share of temporary workforce		Lower is Better	December			62%		83%		98%		67%		70%			
	Consultant vacancies	Total number of vacancies	Lower is Better	December			9.1		14.8		38.7		14.4		18.0			
	Nursing vacancies	Total number of vacancies	Lower is Better	December			74.0		92.9		147.9		139.1		157.3			
	HCA vacancies	Total number of vacancies	Lower is Better	December			61.0		42.4		171.5		98.4					
	AHP vacancies	Total number of vacancies	Lower is Better	December			32.0		61.1		26.4		33.8					

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Recovery & Activity

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Performance Key Targets

Performance Key Targets														
			RDEFT			NDHT			UHP			TSDFT		
Indicator	Date range	Target/Plan	Previous	Latest	Change	Previous	Latest	Change	Previous	Latest	Change	Previous	Latest	Change
Accident & Emergency type 1&2	JANUARY 2022-23	95%	61%	64%	π	70%	70%	θ	[illegible]	[illegible]	[illegible]	44%	43%	θ
Accident & Emergency All	JANUARY 2022-23	95%	74%	71%	θ	70%	70%	θ	[illegible]	[illegible]	[illegible]	63%	61%	θ
Accident & Emergency 12 hour	JANUARY 2022-23	0	18	6	θ	1	4	π				162	132	θ
Referral To Treatment - Incompletes	DECEMBER 2021-22	92%	52%	51%	θ	61%	60%	θ	64%	62%	θ	57%	56%	θ
Referral To Treatment 52+ week waiter	DECEMBER 2021-22	0	6288	6683	π	1235	1196	π	2855	2859	π	2146	2091	π
Diagnostics	DECEMBER 2021-22	99%	64.8%	62.7%	θ	48.2%	46.4%	θ	69.6%	67.9%	θ	67.7%	62.1%	θ
Cancer 28 day faster diagnostic	DECEMBER 2021-22	75%	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Cancer 2 Weeks	DECEMBER 2021-22	93%	68%	70%	π	76%	78%	π	76%	81%	π	45%	44%	()
Cancer breast symptomatic	DECEMBER 2021-22	93%	11%	8%	()	4%	2%	()	3%	3%	()	83%	85%	π
Cancer 31 Day First	DECEMBER 2021-22	96%	91%	93%	π	83%	87%	π	94%	93%	()	97%	98%	π
Cancer 31 Day Follow-up Drug	DECEMBER 2021-22	98%	100%	99%	()	97%	96%	()	99%	100%	π	100%	100%	() π
Cancer 31 Day Follow-up Surgery	DECEMBER 2021-22	94%	79%	72%	()	92%	56%	()	84%	84%	()	97%	100%	π
Cancer 31 Day Follow-up Radiotherapy	DECEMBER 2021-22	94%	97%	100%	π	[illegible]	100%	[illegible]	99%	95%	()	100%	100%	() π
Cancer 62 Day Urgent	DECEMBER 2021-22	85%	66%	67%	π	61%	55%	()	71%	62%	()	58%	67%	π
Cancer 62 Day screening	DECEMBER 2021-22	90%	15%	14%	()	80%	88%	π	77%	85%	π	85%	78%	()
Cancer 62 Day upgrade	DECEMBER 2021-22	85%	81%	86%	π	76%	82%	π	32%	58%	π	0%	100%	π

Performance Key Targets

			Devon Partnership trust			Livewell Southwest			STP		
	Date range	Target/Plan	Previous	Latest	Change	Previous	Latest	Change	Previous	Latest	Change
People with severe mental illness receiving a full annual physical health check	December	41%							26.5%	29.8%	π
Children and Young people ED waiting times (urgent)	Q2 2021/22	95%	84%	79%	0	27%	33%	π	66%	55%	0
Children and Young people ED waiting times (Routine)	Q2 2021/22	95%	74%	58%	0	46%	38%	0	68%	55%	0
Perinatal Mental Health (women accessing services)	December	7%							8.1%	8.2%	π
Improving Access to Psychological Therapies Roll out (access)	December	7.1% (quarter)	5.2%	4.8%	0	3.8%	3.9%	π	4.8%	4.6%	0
Out of area placements	December	0	2,327	2,238	0	495	615	π	2,327	2,238	0
Percentage of people on CPA who were followed up with in 7 days of discharge	November	95%	89%	100%	π	100%	96%	0	96%	97%	π
Proportion of adults in settled accommodation in contact with secondary mental health services	November	60%	69.0%	69.6%	π						
Proportion of adults in contact with secondary mental health services in paid employment	November	10%	6.4%	6.8%	π						
Adults Care Programme Approach review within 12 months	November	95%	85.8%	87.0%	π	93.8%	92.5%	θ	87.3%	88.0%	π
Percentage of discharges followed up within 48 hours	November	95%	90.0%	84.1%	θ	100.0%	88.9%	θ	91.8%	84.9%	θ
Improving Access to Psychological Therapies - The percentage of people who are "moving to recovery"	December	50%	50.3%	52.7%	π	47.4%	58.1%	π	49.8%	53.7%	π
% of Improving Access to Psychological Therapies clients who started treatment within 6 weeks of referral	December	75%	99.1%	98.7%	θ	92.2%	93.1%	π	97.4%	97.2%	θ
Dementia diagnostic rate	December	67%							56.1%	56.0%	θ

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Activity vs Plan

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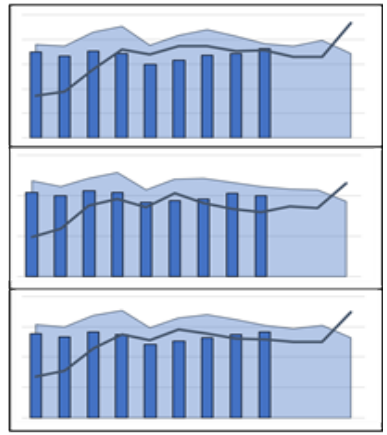
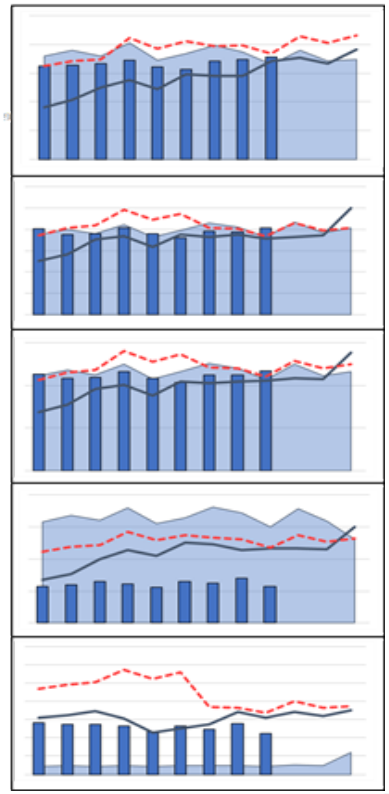
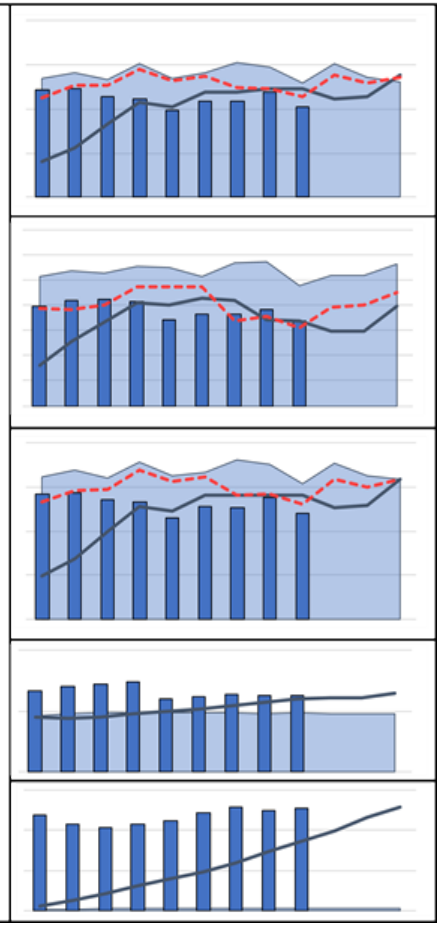
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DEMAND	GP REFERRALS	2019/20	18,912	18,664	21,395	22,588	18,834	20,849	21,945	20,686	19,160	18,555	19,719	17,129
		2020/21	8,601	9,461	13,879	17,890	16,960	18,685	18,689	17,602	17,731	16,405	16,512	23,269
		2021/22	17,396	16,536	17,690	17,035	14,930	15,782	16,813	17,147	18,163			
		Growth vs 19/20	-8%	-11%	-17%	-25%	-21%	-24%	-23%	-17%	-5%			
	OTHER REFERRALS	2019/20	11,851	11,172	12,178	12,844	10,780	12,059	12,151	11,643	11,148	10,818	10,753	9,333
		2020/21	4,920	5,951	8,843	9,644	8,592	10,298	9,104	8,352	7,947	8,696	8,456	11,508
		2021/22	10,421	10,026	10,623	10,402	9,171	9,420	9,651	10,298	10,067			
		Growth vs 19/20	-12%	-10%	-13%	-19%	-15%	-22%	-21%	-12%	-10%			
	TOTAL REFERRALS	2019/20	30,763	29,836	33,573	35,432	29,614	32,908	34,096	32,329	30,308	29,374	30,472	26,462
		2020/21	13,521	15,412	22,722	27,534	25,552	28,983	27,793	25,954	25,678	25,101	24,968	34,777
		2021/22	27,817	26,562	28,313	27,437	24,101	25,202	26,464	27,445	28,230			
		Growth vs 19/20	-10%	-11%	-16%	-23%	-19%	-23%	-22%	-15%	-7%			



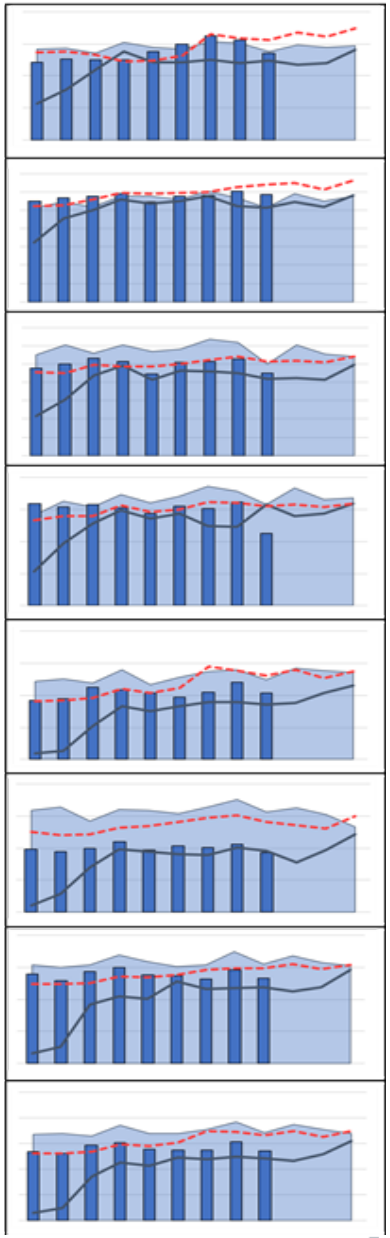
OUTPATIENTS	Consultant led first outpatient attendances	2019/20	36,047	37,903	35,832	40,596	34,665	36,709	39,826	37,519	33,033	38,045	34,127	34,791
		2020/21	17,965	20,544	25,081	27,533	24,492	29,621	29,107	29,134	34,145	35,346	33,318	38,322
		Plan	32,569	34,175	34,903	42,460	38,601	41,152	39,554	39,802	36,903	42,921	40,577	43,303
		2021/22	32,602	32,866	33,361	34,543	32,276	31,289	34,115	34,764	35,592			
		Plan vs 19/20	90%	90%	97%	105%	111%	112%	99%	106%	112%			
		Actual vs 19/20	90%	87%	93%	85%	93%	85%	86%	93%	108%			
	Consultant-led follow-up outpatient attendances	2019/20	74,917	79,688	76,240	84,618	73,046	79,254	86,105	82,389	73,141	87,013	76,991	81,548
		2020/21	50,368	56,401	70,669	73,249	63,795	75,207	73,048	75,411	71,489	72,741	74,331	99,976
		Plan	74,250	81,349	83,464	98,044	88,909	94,829	81,297	80,385	73,553	85,840	78,979	81,599
		2021/22	80,512	75,471	76,057	81,418	76,053	72,424	77,932	77,580	81,387			
		Plan vs 19/20	99%	102%	109%	116%	122%	120%	94%	98%	101%			
		Actual vs 19/20	107%	95%	100%	96%	104%	91%	91%	94%	111%			
	Total Outpatient attendance	2019/20	110,964	117,591	112,072	125,214	107,711	115,963	125,931	119,908	106,174	125,058	111,118	116,339
		2020/21	68,333	76,945	95,750	100,782	88,287	104,828	102,155	104,545	105,634	108,087	107,649	138,298
		Plan	106,819	115,524	118,367	140,504	127,510	135,981	120,851	120,187	110,456	128,760	119,556	124,902
		2021/22	113,114	108,337	109,418	115,961	108,329	103,713	112,047	112,344	116,979			
		Plan vs 19/20	96%	98%	106%	112%	118%	117%	96%	100%	104%			
		Actual vs 19/20	102%	92%	98%	93%	101%	89%	89%	94%	110%			
	Total outpatient attendances - Face to face	2019/20	158,653	168,235	160,210	179,794	155,885	164,882	180,844	171,837	150,710	178,111	158,845	131,239
		2020/21	67,109	76,713	99,542	114,575	104,735	125,517	123,298	114,651	116,161	116,498	115,504	150,877
		Plan	111,454	118,714	122,417	142,331	129,383	137,122	133,623	130,511	117,994	137,721	127,374	132,726
		2021/22	57,879	59,630	65,140	61,897	56,484	64,635	62,835	70,173	57,911			
		Plan vs 19/20	70%	71%	76%	79%	83%	83%	74%	76%	78%			
		Actual vs 19/20	36%	35%	41%	34%	36%	39%	35%	41%	38%			
	Total outpatient attendances - Telephone/Virtual	2019/20	4,466	4,888	4,450	5,026	4,492	4,588	5,000	4,882	4,441	5,342	4,982	11,853
		2020/21	30,793	32,160	34,512	30,537	23,029	25,126	27,518	34,272	30,773	34,146	31,745	35,177
		Plan	47,017	49,130	50,537	57,143	52,266	55,832	36,773	36,530	33,703	40,145	36,501	37,259
		2021/22	28,379	27,191	27,354	26,520	23,465	26,706	24,898	28,020	22,399			
		Plan vs 19/20	1053%	1005%	1136%	1137%	1164%	1217%	735%	748%	759%			
		Actual vs 19/20	635%	556%	615%	528%	522%	582%	498%	574%	504%			



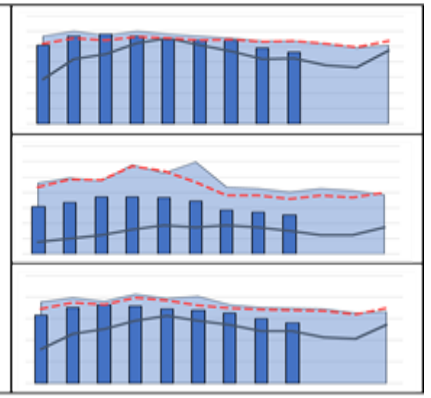
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
ELECTIVES	Total Elective Admissions - Day Case	2019/20	13,510	14,183	13,382	15,103	13,542	14,106	15,270	14,716	12,966	15,130	13,647	13,031
		2020/21	4,124	5,595	8,287	10,711	10,264	11,933	11,970	12,349	12,330	11,117	11,449	13,928
		Plan	11,343	12,681	12,746	14,571	13,208	13,769	12,439	12,382	11,443	13,897	12,920	13,608
		2021/22	12,251	12,278	11,453	11,179	9,815	10,929	10,882	11,901	10,278	#N/A	#N/A	#N/A
		Plan vs 19/20	84%	89%	95%	96%	98%	98%	81%	84%	88%			
		Actual vs 19/20	91%	87%	86%	74%	72%	77%	71%	81%	79%			
	Total Elective Admissions - Ordinary	2019/20	2,571	2,685	2,624	2,775	2,754	2,568	2,848	2,870	2,379	2,579	2,583	2,803
		2020/21	801	1,289	1,665	2,055	2,005	2,127	2,087	1,697	1,683	1,474	1,482	1,989
		Plan	1,927	1,907	2,002	2,369	2,373	2,369	1,683	1,786	1,544	1,963	1,997	2,242
		2021/22	1,989	2,088	2,110	2,070	1,711	1,810	1,811	1,921	1,687	#N/A	#N/A	#N/A
		Plan vs 19/20	75%	71%	76%	85%	86%	92%	59%	62%	65%			
		Actual vs 19/20	77%	78%	80%	75%	62%	70%	64%	67%	71%			
	Total Elective Admissions	2019/20	16,081	16,868	16,006	17,878	16,296	16,674	18,118	17,586	15,345	17,709	16,230	15,834
		2020/21	4,925	6,884	9,952	12,766	12,269	14,060	14,057	14,046	14,013	12,591	12,931	15,917
		Plan	13,270	14,588	14,748	16,940	15,581	16,138	14,122	14,168	12,987	15,860	14,917	15,850
		2021/22	14,240	14,366	13,563	13,249	11,526	12,739	12,693	13,822	11,965	#N/A	#N/A	#N/A
		Plan vs 19/20	83%	86%	92%	95%	96%	97%	78%	81%	85%			
		Actual vs 19/20	89%	85%	85%	74%	71%	76%	70%	79%	78%			
	RTT Incomplete pathways	2019/20	92,215	95,238	96,319	96,979	98,176	97,636	97,368	96,283	96,899	95,777	96,157	94,760
		2020/21	90,579	88,030	90,090	94,617	99,428	103,521	108,999	114,168	120,683	121,377	122,332	128,734
		2021/22	133,890	139,801	143,499	147,480	120,377	122,741	126,570	125,991	125,063			
		Growth vs 19/20	45%	47%	49%	52%	23%	26%	30%	31%	29%			
	RTT 52 Week wait	2019/20	203	188	234	268	361	356	338	328	286	294	237	293
		2020/21	618	1,228	2,166	3,124	3,942	4,796	5,972	7,413	8,626	9,856	11,665	12,916
		2021/22	11,918	10,809	10,378	10,705	11,256	12,140	12,829	12,524	12,807			
		Growth vs 19/20	5771%	5642%	4329%	3894%	3018%	3310%	3695%	3718%	4385%			

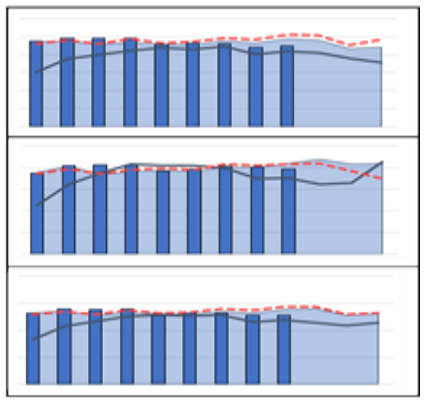


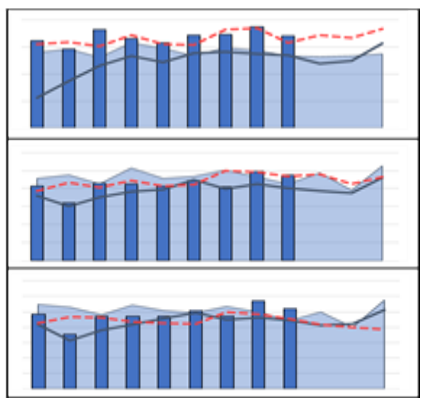
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DIAGNOSTIC TESTS	MAGNETIC RESONANCE IMAGING	2019/20	5,655	5,705	5,423	6,099	5,773	5,682	6,128	6,040	5,517	5,939	5,755	5,887
		2020/21	2,281	3,112	4,389	5,491	4,864	4,848	4,982	4,784	4,947	4,701	4,794	5,607
		Plan	5,481	5,524	5,304	4,866	4,948	5,271	6,604	6,358	6,242	6,678	6,447	6,968
		2021/22	4,856	5,069	5,006	5,010	5,498	5,959	6,475	6,232	5,424	#N/A	#N/A	#N/A
		Plan vs 19/20	97%	97%	98%	80%	86%	93%	108%	105%	113%			
		Actual vs 19/20	86%	89%	92%	82%	95%	105%	106%	103%	98%			
	COMPUTED TOMOGRAPHY	2019/20	10,297	10,870	10,368	11,555	11,583	11,179	12,081	11,368	10,281	11,782	10,974	11,501
		2020/21	6,511	9,060	10,047	11,175	10,729	11,008	11,533	10,498	10,238	10,930	10,398	11,643
		Plan	10,421	10,565	11,215	11,887	11,793	11,861	11,986	12,550	12,801	13,028	12,296	13,290
		2021/22	10,996	11,366	11,526	11,794	10,868	11,528	11,667	12,074	11,721	#N/A	#N/A	#N/A
		Plan vs 19/20	101%	97%	108%	103%	102%	106%	99%	110%	125%			
		Actual vs 19/20	107%	105%	111%	102%	94%	103%	97%	106%	114%			
	NON-OBSTETRIC ULTRASOUND	2019/20	11,040	12,078	11,148	12,063	11,398	11,659	12,760	12,334	10,009	12,071	11,095	10,855
		2020/21	4,357	6,111	8,783	9,794	8,249	9,271	9,153	9,005	8,414	8,458	8,314	9,906
		Plan	9,122	9,056	9,892	9,755	9,759	9,966	10,454	10,788	10,251	10,369	10,149	10,862
		2021/22	9,521	10,006	10,662	10,274	8,883	10,196	10,279	10,592	9,053	#N/A	#N/A	#N/A
		Plan vs 19/20	83%	75%	89%	81%	86%	85%	82%	87%	102%			
		Actual vs 19/20	86%	83%	96%	85%	78%	87%	81%	86%	90%			
	ECHOCARDIOGRAPHY	2019/20	2,818	3,264	3,079	3,480	3,220	3,421	3,727	3,562	3,150	3,675	3,314	3,371
		2020/21	1,075	1,949	2,565	2,987	2,716	2,890	2,482	2,454	3,159	2,810	2,889	3,180
		Plan	2,658	2,795	2,796	3,136	2,930	3,005	3,237	3,208	3,112	3,157	3,074	3,197
		2021/22	3,181	3,090	3,156	3,057	2,884	3,116	3,025	3,226	2,259	#N/A	#N/A	#N/A
		Plan vs 19/20	94%	86%	91%	90%	91%	88%	87%	90%	99%			
		Actual vs 19/20	113%	95%	103%	88%	90%	91%	81%	91%	72%			
	COLONOSCOPY	2019/20	1,215	1,253	1,191	1,400	1,172	1,281	1,372	1,402	1,243	1,423	1,387	1,365
		2020/21	100	138	524	838	757	826	892	903	854	888	1,036	1,158
		Plan	905	920	959	1,107	1,038	1,122	1,448	1,384	1,304	1,401	1,265	1,372
		2021/22	917	945	1,128	1,093	1,037	975	1,047	1,200	1,035	#N/A	#N/A	#N/A
		Plan vs 19/20	74%	73%	81%	79%	89%	88%	106%	99%	105%			
		Actual vs 19/20	75%	75%	95%	78%	88%	76%	76%	86%	83%			
	FLEXI SIGMOIDOSCOPY	2019/20	635	656	570	642	634	615	656	703	626	653	609	530
		2020/21	42	116	281	391	379	361	356	404	381	308	386	483
		Plan	499	480	487	527	538	561	588	604	561	543	523	597
		2021/22	395	377	396	439	386	413	402	423	374	#N/A	#N/A	#N/A
		Plan vs 19/20	79%	73%	85%	82%	85%	91%	90%	86%	90%			
		Actual vs 19/20	62%	57%	69%	68%	61%	67%	61%	60%	60%			
	GASTROSCOPY	2019/20	1,534	1,503	1,536	1,688	1,588	1,507	1,539	1,746	1,555	1,680	1,583	1,519
		2020/21	156	257	915	1,044	1,010	1,277	1,166	1,178	1,185	1,129	1,188	1,465
		Plan	1,240	1,243	1,258	1,359	1,339	1,379	1,462	1,483	1,481	1,550	1,472	1,541
		2021/22	1,394	1,298	1,436	1,503	1,383	1,376	1,322	1,465	1,326	#N/A	#N/A	#N/A
		Plan vs 19/20	81%	83%	82%	81%	84%	92%	95%	85%				
		Actual vs 19/20	91%	86%	93%	89%	87%	91%	86%	84%	85%			
	TOTAL SCOPES	2019/20	3,384	3,412	3,297	3,730	3,394	3,403	3,567	3,851	3,424	3,756	3,579	3,414
		2020/21	298	511	1,720	2,273	2,146	2,464	2,414	2,485	2,420	2,325	2,610	3,106
		Plan	2,644	2,643	2,704	2,993	2,915	3,062	3,498	3,471	3,345	3,493	3,259	3,510
		2021/22	2,706	2,620	2,960	3,035	2,806	2,764	2,771	3,088	2,735	#N/A	#N/A	#N/A
		Plan vs 19/20	78%	77%	82%	80%	86%	90%	98%	90%	98%			
		Actual vs 19/20	80%	77%	90%	81%	83%	81%	78%	80%	80%			



			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&E	TYPE 1 & 2	2019/20	28,522	30,086	28,559	29,922	29,139	28,329	27,862	26,878	26,935	26,021	24,551	25,560
		2020/21	14,502	20,922	22,659	26,096	27,714	25,599	23,449	20,964	21,154	18,866	18,367	23,657
		Plan	25,957	27,701	27,111	28,227	27,782	26,972	27,219	26,699	26,787	25,966	24,867	26,819
		2021/22	25,595	28,446	29,126	28,446	27,354	27,182	27,045	24,621	23,146	#N/A	#N/A	#N/A
		Plan vs 19/20	91%	92%	95%	94%	95%	95%	98%	99%	99%			
		Actual vs 19/20	90%	95%	102%	95%	94%	96%	97%	92%	86%			
	TYPE 3 & 4	2019/20	9,256	9,832	9,552	11,599	10,485	11,978	8,681	8,554	8,041	8,524	8,265	7,684
		2020/21	1,538	2,052	2,469	3,175	3,753	3,502	3,719	3,489	3,044	2,479	2,431	3,431
		Plan	8,727	9,710	9,577	11,417	10,765	9,352	7,659	7,594	7,173	7,598	7,334	7,992
		2021/22	6,184	6,686	7,448	7,461	7,330	6,864	5,766	5,451	5,048	#N/A	#N/A	#N/A
		Plan vs 19/20	94%	99%	100%	98%	103%	78%	88%	89%	89%			
		Actual vs 19/20	67%	68%	78%	64%	70%	57%	66%	64%	63%			
	TOTAL A&E ATTENDANCES	2019/20	37,778	39,918	38,111	41,521	39,624	40,307	36,543	35,432	34,976	34,545	32,816	33,244
		2020/21	16,040	22,974	25,128	29,271	31,467	29,101	27,168	24,453	24,198	21,345	20,798	27,088
		Plan	34,684	37,411	36,688	39,644	38,547	36,324	34,878	34,293	33,960	33,564	32,201	34,811
		2021/22	31,779	35,132	36,574	35,907	34,684	34,046	32,811	30,072	28,194	#N/A	#N/A	#N/A
		Plan vs 19/20	92%	94%	96%	95%	97%	90%	95%	97%	97%			
		Actual vs 19/20	84%	88%	96%	86%	88%	84%	90%	85%	81%			
NON ELECTIVE	+1 LENGTH OF STAY	2019/20	9,470	9,536	9,128	9,384	9,156	9,095	9,484	9,271	9,726	9,606	8,668	8,852
		2020/21	6,010	7,482	7,935	8,411	8,778	8,619	8,892	8,080	8,380	8,212	7,589	7,087
		Plan	9,217	9,584	9,216	9,781	9,294	9,403	9,816	9,675	10,190	10,148	9,066	9,679
		2021/22	9,521	9,861	9,794	9,843	9,092	9,259	9,211	8,856	8,955	#N/A	#N/A	#N/A
		Plan vs 19/20	97%	101%	101%	104%	102%	103%	104%	104%	105%			
		Actual vs 19/20	101%	103%	107%	105%	99%	102%	97%	96%	92%			
	ZERO DAY LENGTH OF STAY	2019/20	3,766	4,057	3,690	3,806	3,880	3,819	4,050	4,017	4,195	4,392	4,154	4,203
		2020/21	2,266	3,237	3,748	4,171	4,099	4,095	3,971	3,495	3,533	3,222	3,288	4,275
		Plan	3,710	3,940	3,716	3,921	3,960	3,896	4,150	4,086	4,179	4,183	3,847	3,487
		2021/22	3,731	4,106	4,137	4,126	3,849	3,942	4,061	4,022	3,927	#N/A	#N/A	#N/A
		Plan vs 19/20	99%	97%	101%	103%	102%	102%	102%	102%	100%			
		Actual vs 19/20	99%	101%	112%	108%	99%	103%	100%	100%	94%			
	TOTAL NON ELECTIVES	2019/20	13,236	13,593	12,818	13,190	13,036	12,914	13,534	13,288	13,921	13,998	12,822	13,055
		2020/21	8,276	10,719	11,683	12,582	12,877	12,714	12,863	11,575	11,913	11,434	10,877	11,362
		Plan	12,927	13,524	12,932	13,702	13,254	13,299	13,966	13,761	14,369	14,331	12,913	13,166
		2021/22	13,252	13,967	13,931	13,969	12,941	13,201	13,272	12,878	12,882	#N/A	#N/A	#N/A
		Plan vs 19/20	98%	99%	101%	104%	102%	103%	103%	104%	103%			
		Actual vs 19/20	100%	103%	109%	106%	99%	102%	98%	97%	93%			
CANCER	URGENT CANCER REFERRALS (2 WEEKS)	2019/20	5,579	5,835	5,252	6,301	5,932	5,345	5,960	5,758	5,344	5,309	5,326	5,495
		2020/21	2,256	3,480	4,609	5,362	4,890	5,522	5,629	5,477	5,401	4,757	4,967	6,295
		Plan	6,228	6,398	6,052	6,866	6,237	6,179	7,281	7,395	6,330	6,868	6,658	7,359
		2021/22	6,483	5,835	7,280	6,646	6,322	6,894	6,959	7,506	6,861	#N/A	#N/A	#N/A
		Plan vs 19/20	112%	110%	115%	109%	105%	116%	122%	128%	118%			
		Actual vs 19/20	116%	100%	139%	105%	107%	129%	117%	130%	128%			
	CANCER TREATEMENT VOLUMES (31 DAY FIRST)	2019/20	911	953	852	1,029	912	933	1,002	930	849	973	778	1,049
		2020/21	715	604	705	761	786	895	794	846	801	772	750	918
		Plan	771	869	810	892	824	840	996	981	935	957	852	930
		2021/22	828	638	859	849	830	885	818	989	947	#N/A	#N/A	#N/A
		Plan vs 19/20	85%	91%	95%	87%	90%	90%	99%	105%	110%			
		Actual vs 19/20	91%	67%	101%	83%	91%	95%	82%	106%	112%			
	PATIENTS WAITING 63+DAYS AFTER REFERRAL (62 DAY URGENT)	2019/20	548	529	480	544	507	494	533	498	442	496	400	575
		2020/21	416	315	382	416	460	492	450	462	443	414	421	514
		Plan	428	467	461	436	426	421	499	483	452	415	400	384
		2021/22	484	353	470	472	472	508	471	572	520	#N/A	#N/A	#N/A
		Plan vs 19/20	78%	88%	96%	80%	84%	85%	94%	97%	102%			
		Actual vs 19/20	88%	67%	98%	87%	93%	103%	88%	115%	118%			







NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: FINANCIAL PERFORMANCE REPORT				
Date of committee: 24th February 2022 **Date report produced: 17th February 2022**				
Author (s) Name and Title: Kevin Wheller, Associate Director of Finance (Northern and Eastern), Mark Adamson, Senior Accountant (Accounting and Reporting) **Contact Details:**		**Supporting Executive:** John Dowell **Name and Title:** John Dowell, Director of Finance **Contact Details:** **Report Approved by:** John Dowell **Name and Title:** John Dowell, Director of Finance **Date:** 17th February 2022		
Public or Private (Governing Body only):	**Public**		**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

The presentation of the Clinical Commissioning Group's (CCGs) financial position in this report seeks to provide the necessary assurance to the Governing Body.

The report details the financial position for the period ending 31 January 2022, as well as the forecast outturn (FOT) for the year ending 31 March 2022. It includes the impact of the COVID-19 pandemic and the financial consequences for the CCG during 2021/22.

The Devon Integrated Care System funding envelope, for the first half of the year (H1), is comprised of an adjusted CCG allocation, CCG primary medical care allocations, a system top-up and a COVID fixed allocation, all based on the second half of 2020/21 funding (the NHS Model).

The CCG received notification of the funding for the period H2 (October 2021 to March 2022). H2 system funding envelopes, including system top-up and Covid-19 fixed allocation, have been calculated based on the H1 2021/22 envelopes adjusted for inflation, efficiency requirements and policy priorities, including the 3% pay uplift for system providers.

On top of this the CCG will be reimbursed for eligible COVID costs, for example the hospital discharge programme (HDP) and for elective recovery costs.

On the above basis the CCG has received an allocation of £2,516m, including £38.7m for elective recovery and £136.6m for COVID, for the period to 31 March 2022 together with an expectation that budgets are set within the parameters stipulated by the NHSE Model. At the end of November, the system submitted a plan that delivers a breakeven position for H2 and consequently the whole year.

Within the system plan the CCG is expected to deliver a £5.3m surplus. Whilst systems are expected to breakeven, organisations within them will be permitted by mutual agreement across their system to deliver surplus and deficit positions.

Included in the £136.6m COVID allocation is a £16.0m HDP reimbursement relating to the period 1 April to 30 September 2021.

With the expectation that the CCG will be reimbursed fully for HDP costs, the Winter Access Fund (WAF) costs and the Additional Roles Reimbursement Scheme (ARRS), we are reporting a forecast surplus of £5.3m for the year ending 31 March 2022 in line with the plan.

Management of Conflict of interests:

Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.

Committees that have previously discussed/agreed the report and outcomes:

None.

Key recommendations and actions requested:

The Governing Body is requested to:

Consider, review and discuss the month 10 financial position.

Impact on Strategic Objectives

(Delete as applicable)

1. Improve service performance
2. Achieve financial sustainability
3. Lead the system's response to the coronavirus pandemic

Reference to other documents or accompanying papers:

Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	No
Quality of Services		√
Health Inequalities		√

Equality (staff or public)		√
Resource and Finance	Risk to delivery of CCG control total	
Legal		√
Engagement and Consultation		√
Risk	Risk to delivery of CCG control total	

The CCG has made every effort to ensure this report does not have the effect of discriminating, directly or indirectly, against employees, patients, contractors or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability.

NHS Devon Clinical Commissioning Group

NHS Devon Clinical Commissioning Group

Finance Report

Month 10 – 2021/22

Contents

Appendices

1. Executive Summary

The presentation of the Clinical Commissioning Group's (CCGs) financial position in this report seeks to provide the necessary assurance to the Governing Body.

The report details the financial position for the period ending 31 January 2022, as well as the forecast outturn (FOT) for the year ending 31 March 2022. It includes the impact of the COVID-19 pandemic and the financial consequences for the CCG during 2021/22.

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Within the system plan the CCG is expected to deliver a £5.3m surplus. Whilst systems are expected to breakeven, organisations within them will be permitted by mutual agreement across their system to deliver surplus and deficit positions.

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With the expectation that the CCG will be reimbursed fully for HDP costs, the Winter Access Fund (WAF) costs and the Additional Roles Reimbursement Scheme (ARRS), we are reporting a forecast surplus of £5.3m for the year ending 31 March 2022 in line with the plan.

Financial Position

The following detailed report reflects the budget set by the NHSE model compared with our expectations of commitments against that budget for the period to 31 January 2022 and year ending 31 March 2022.

	Budget £'000	Actual £'000	Variance £'000	Additional HDP etc adjustments £000	Revised Variance £'000
Year to date position	2,072,997	2,077,613	4,616	8,133	3,517
Year end forecast	2,515,601	2,528,766	13,165	18,440	5,275

Overall, subject to the CCG receiving the expected reimbursement from NHSE for the HDP costs, the Winter Access Fund (WAF) costs and the Additional Roles Reimbursement Scheme (ARRS), we are reporting a forecast surplus of £5.3m for the year ending 31 March 2022.

The year-to-date variances mainly arises due to additional costs linked to the COVID pandemic and Additional Roles Reimbursement Scheme (ARRS). COVID costs are detailed in section 4.

The remaining variances are detailed in the sections below.

Savings and Efficiency Plans

The CCG's first 6-months (H1) savings requirement of £0.8m was met predominantly through prescribing. Now that the CCG has been informed of its funding for the second half (H2) of the year the H2 plan requires savings of £14.4m which the CCG is on track to deliver.

Risk

At the H2 planning stage we identified financial risks of £15.5m due to a number of factors. A reminder of these risks is set out in section 6 of the report.

Our assessment on 31 January 2022 is that there is a high level of confidence that these risks will not now materialise.

Integrated Care System (ICS)

As at month 9 the Devon ICS had a surplus of £5m which is £5m favourable variance to plan. The forecast is a £0.1m surplus against a £2.2m deficit plan. This includes £25.4m confirmed ERF funding in H1 and a forecast of £18m in H2.

Within the system plan the CCG is expected to deliver a £5.3m surplus. Whilst systems are expected to breakeven, organisations within them will be permitted by mutual agreement across their system to deliver surplus and deficit positions.

2. Financial Assurance Dashboard

NHS England's oversight framework for 2021/22 includes key lines of enquiry for the CCG assessment system covering 5 domains.

- Quality of care, access and outcomes
- Preventing ill-health and reducing inequalities
- People
- Leadership
- Finance and use of resources

The finance and use of resources domain look at how the CCG is remaining in financial balance and is securing good value for money for patients and the public from the money it spends. Indicators are:

- Evidence that the CCG has delivered its break-even target in-year and contributed to the reduction of system deficits.
- Evidence that the CCG has delivered the Mental Health Investment Standard (MHIS).

The indicators below are based on the 2021/22 plan and the oversight framework.

NO.	INDICATOR	Devon CCG
Financial Plan Ratings detail		RAG
1	Planned £5.3m surplus	GREEN

NO.	INDICATOR	Devon CCG		%	RAG
		Plan/Target	Actual/Forecast		
In Year Financial Performance		£'m	£'m		
2	Year to Date position (including the expected reimbursements from NHSE e.g. for HDP costs)	3.517	3.517	0.0%	GREEN
3	Forecast Outturn (including the expected reimbursement from NHSE e.g. for HDP costs)	5.275	5.275	0.0%	GREEN
4	Running Costs	23.7	22.1	93.2%	GREEN
5	Risk adjustment to deficit (% of allocation)	0.0	0.0	0.0%	GREEN
6	Cash Position (% drawn down)	83.3%	81.4%	97.7%	GREEN
7	BPPC (% paid - value)	95.0%	99.1%	104.3%	GREEN

NO.	INDICATOR	Devon CCG
Achievement of MHIS		RAG
8	Planned delivery of MHIS	GREEN

3. Detailed Financial Performance

The year to date outturn by main service heading is as follows.

2021/22 FINANCE BOARD REPORT FOR THE PERIOD FROM 01 APRIL 2021 TO 31 JAN 2022 Month 10 January	DEVON CLINICAL COMMISSIONING GROUP									
	Year To Date					Current Year Forecast				
	Budget	Non Covid Actual	Covid Actual	Total Actual	Variance (Adv) / Fav	Budget	Non Covid Forecast	Covid Forecast	Total Forecast	Variance (Adv) / Fav
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
COMMISSIONED SERVICES										
Acute Services	1,035,535	1,030,637	3	1,030,640	4,895	1,229,138	1,223,503	35	1,223,538	5,600
Mental Health Services	213,595	211,857	-	211,857	1,738	255,987	253,894	-	253,894	2,093
Community Health Services	272,801	256,685	23,952	280,637	(7,835)	322,470	306,440	29,151	335,591	(13,121)
Placements	109,977	110,926	299	111,225	(1,248)	133,110	133,163	336	133,500	(390)
All Other Healthcare	43,192	43,693	(378)	43,315	(123)	51,255	51,973	(365)	51,609	(354)
Primary Care Services										
Prescribing	173,982	172,122	-	172,122	1,860	209,680	206,544	-	206,544	3,136
Delegated Commissioning	155,304	157,300	-	157,300	(1,996)	186,423	190,535	-	190,535	(4,112)
Other Primary Care	45,806	41,916	3,056	44,972	834	54,417	52,684	3,180	55,864	(1,447)
Primary Care Subtotal	375,092	371,338	3,056	374,394	699	450,519	449,763	3,180	452,943	(2,423)
Commissioned Services Subtotal	2,050,192	2,025,135	26,932	2,052,067	(1,875)	2,442,479	2,418,737	32,338	2,451,075	(8,596)
CORPORATE										
Running Costs	19,975	18,933	45	18,978	997	23,710	22,044	49	22,093	1,617
EARMARKED RESERVES AND CONTINGENCIES										
Other Reserves	(686)	6,568	-	6,568	(7,254)	44,137	55,598	-	55,598	(11,461)
TOTAL COMMISSIONED SERVICES	2,069,481	2,050,636	26,977	2,077,613	(8,132)	2,510,326	2,496,379	32,387	2,528,766	(18,440)
Resource Allocation	2,072,997	2,053,348	19,649	2,072,997	-	2,515,601	2,495,689	19,912	2,515,601	-
Expected Additional Allocations		804	7,328	8,132	(8,132)		5,965	12,475	18,440	(18,440)
2021/22 Surplus/(Deficit)	3,517	3,517	-	3,517	0	5,275	5,275	-	5,275	(0)

Further detail of the budgets making up the main service areas is provided in appendix 3.

3.1 Acute Services

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

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

At month 10 there is an overall YTD underspend of £4.9m and a FOT underspend of £5.6m. The majority of the underspend is driven by a lower level of independent sector activity compared to budget, where COVID has had an impact on staffing levels. See appendix 3 for details.

Elective Recovery Fund

The Elective Recovery Fund has been extended into H2 to continue to incentivise the delivery of additional elective activity (over and above normal levels). For H2 this will be focussed on completed referral to treatment (RTT) pathway activity rather than total cost weighted activity which was used in H1. The thresholds for the scheme have been recalculated so that they are on a comparable basis to the 95% threshold for the ERF in Q2.

In addition to the main ERF the system has received £38.7m to de-risk some of the elective recovery plans, provide additional diagnostic capacity and support other plans that aid recovery.

Details of delivery and distribution of the H2 ERF will be detailed once activity information has been confirmed.

3.2 Mental Health Services

The Mental Health budget commissions services for adult, children and young people. The main contracts for the services are with Devon Partnership NHS Trust (DPT) and Livewell Southwest with the CAMHS service for Northern, Eastern and Southern localities being provided by Children and Families Health Devon through a contract with Torbay and Southern Devon NHS Foundation Trust. This section also includes spend relating to adult placements for mental health and learning disability services.

In 2021/22 the CCG has planned to invest £9.6m (4.04% increase) in Mental Health Services based on the Mental Health Investment Standard target.

At month 10 there is a YTD and FOT underspend of £1.7m and £2.1m respectively. The FOT is a result of an £1.1m overspend in Section 117 cases which is offset largely by an expected £3.1m underspend in individual patient placements.

3.3 Community Health Services

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

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

At month 10 there is a YTD and FOT overspend of £7.8m and £13.1m respectively. The overspend relates to COVID costs which are eligible for reimbursement under the hospital discharge programme.

3.4 Placements

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

The Placements position shows a month 10 forecast overspend of £0.4m which is a result of Torbay and South Devon CHC spend but partially offset by lower than anticipated CHC numbers in North, East & West. The latter also mitigates the cost pressures in HDP breaches, a high-cost child placement and some continued COVID costs.

There is underlying risk that requires robust financial management. The key risks relate to the backlog of CHC assessments and breaches of the 6-week Hospital Discharge Programme funding (4 weeks in quarter 2).

The reported forecast outturn position is an estimate regarded as the likely scenario, but it is recognised that a range of factors exist which could potentially result in significant financial risk/benefit to that estimate.

Some examples include:

- Fluctuations in the number of clients eligible for financial support
- Assessments exceeding 28 day (NHSE/I situation report monitoring trajectory to return to 80% within 28 days and zero over 12 weeks by Q4 21/22)
- Unexpected exceptional levels of support required for some clients
- Responsible commissioner cases

The CHC control centre will continue to provide senior oversight to manage the financial position.

3.5 All Other Healthcare

All Other Healthcare picks up the remaining community-based provision of healthcare services including hospice care and other voluntary sector grant based commissioned services. This area also includes Patient Transport and NHS 111.

At month 10 there is a YTD overspend of £0.1m and a £0.4m FOT overspend. This is due to additional costs for NHS 111, Patient Transport Services and Other Commissioned Services.

3.6 Primary Care Services

Primary Care includes expenditure on primary care prescribing, GP Medical Services (delegated from NHSE), enhanced services, Out of Hours and other primary care related expenditure including GP IT.

Prescribing

Based on November's Prescribing Monitoring Document (PMD), produced by NHS Business Services Authority, the CCG is currently forecasting an underspend of £3.1m. We are still accessing the current risk of this forecast changing and spend increasing.

There is currently some No Cheaper Stock Obtainable (NCSO) risk included in the forecast, in total £0.3m. There is currently no additional risk around category M drugs and the Medicines Optimisation team are helping us to monitor this.

Delegated Commissioning

As at month 10, due mainly to the Additional Roles Reimbursement Scheme the YTD and FOT are currently overspending by £2.0m and £4.1m respectively. The CCG will receive additional funding that should cover the cost of these scheme in due course.

Other Primary Care

Other primary care services include contracts for enhanced GP services, out of hours GP services, home oxygen services and provision for GP IT costs.

At month 10 there is forecast overspend of £1.4m. This is due to overspends in out of hours GP services, home oxygen services and other primary care costs, which are partially offset by an underspend in Medicine Optimisation.

3.7 Running Costs

The pay and associated costs for the CCG are categorised into administrative (running costs) and programme costs according to whether they relate to healthcare services and are solely concerned with management of the organisation.

Each year the CCG receives a specific allocation for its running costs and has an obligation to report against it separately and mustn't overspend against the limit set.

The running costs allocation for 2021-22 is £23.7m (including £1.3m for employer pension contributions) and the CCG is reporting an expected FOT of £22.1m resulting in an underspend of £1.6m.

3.8 Resource Allocation

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

Planned revenue resources 1 Apr - 31 Mar 22	£'000
Core allocation	1,870,265
Primary care commissioning	183,624
Running costs	22,412
Total recurrent revenue resources	**2,076,301**
Top-up allocation	132,856
COVID allocation	120,570
Growth allocation	16,932
Primary care commissioning	4,165
Running costs adjustments	1,308
Programme adjustments	108,774
Elective recovery fund	38,713
Out of system COVID reimbursement (Inc. HDP)	15,982
Total non-recurrent revenue resources	**439,300**
Total revenue resources confirmed	**2,515,601**

3.9 Delivering Financial Balance

The CCG is currently reporting delivery of its planned surplus for the financial year of £5.3m. The current forecast shows that a number of projected underspends are emerging and likely to remain for the remainder of the as a result lower than anticipiated costs in the following areas:

- Acute activity provided by the independent sector
- Mental health placements
- GP prescribing
- Management Costs
- Non-reimbursable COVID expenditiure

Additionally our assessment of the financial risks that were identified at the H2 planning stage are unlikley to materialise.

A number of additional allocations have been made during H2 of this financial year, to support elective recovery, seasonal pressures and discharge and the ongoing impact of the pandemic. As part of our operational and financial management, we have been working closely with our local authority partners with a view to targeting investment within health and social care that deliver further integration that delivers benefits to the Devon system. These investments are likely to take the form of grants under the provisions of s256 of the Health and Social Care Act 2006. A separate report on this is included on the agenda this month.

4. COVID-19 Specific Costs

The COVID pandemic has required investment in staff, equipment and in response to national initiatives to assist the transformation of health services in preparedness for the impact on the health of the population.

As at month 10 the CCG has incurred COVID costs of £27.0m with a FOT expected of £32.4m. These costs can be summarised as follows:

COVID 19 Commitment Analysis	YTD £'m	FOT £'m
Primary Care, PPE, Staffing and Other Costs	3.7	4.0
	3.7	4.0
Hospital Discharge		
Devon CCG	5.4	6.6
Torbay Council	2.4	3.1
Devon County Council	12.3	14.7
Plymouth City Council	2.7	3.5
Livewell Southwest (Social Care)	0.5	0.5
	23.3	28.4
Total	27.0	32.4

The CCG has put in controls to ensure that COVID expenditure is appropriately procured and approved before commitments are made.

The impact of the national initiative to ensure the care sector remains stable during the COVID period has had a consequential effect on the cost care packages funded through Continuing Care Homes. We continue to work with Local Authorities on the developing strategies for the market management of the care home sector.

In addition to these measures a national initiative to speed up discharge from Hospital and reduce the burden of assessment on decisions supporting discharge NHSE and Local Authority's regulators agreed a hospital discharge programme

supported by £1.3bn of NHSE funding. It allows Local Authorities to reclaim the cost of discharge packages and enhanced costs of care to prevent hospital admissions to be reclaimed via the CCG.

5. Savings and Efficiency Plans

The CCG's first 6-months (H1) savings requirement of £0.8m was met predominantly through prescribing. Now that the CCG has been informed of its funding for the second half (H2) of the year the H2 plan requires savings of £14.4m which the CCG is on track to deliver.

6. Risks

The assessment of financial risk (and mitigations) for the year ended 31 March 2022, as at the H2 planning stage and 31 January 2022, is as follows.

Devon CCG		**Plan**	**Month 10**
Risk	**Description**	**£'000**	**£'000**
Elective Recovery Funding/Accelerator Site Schemes	There is a risk that funding for the elective recovery and accelerator site schemes is inadequate to cover the costs incurred.	5,000	5,000
Savings and Efficiencies	Potential risk of shortfall in delivery of savings and efficiencies.	5,500	0
Hospital Discharge Programme	There is a risk that the additional funding required to meet the full costs of the hospital discharge programme (HDP) will not be available to the CCG as it exceeds the capped funding set aside by NHSE.	2,000	0
Prescribing	Risk that the costs outweigh the growth funding provided within the H2 allocation.	3,000	0
Total Risk		**15,500**	**5,000**
Mitigations	**Description**	**£'000**	**£'000**
Cancel Activity/Investment	Potential sources of funding to mitigate opening plan risk being agreed with system partners.	-5,000	-5,000
Local Authority Negotiations	Look for opportunities with Local Authority to provide financial flexibility.	-2,000	0
Other Programme Services	Initial reassessment of opening plan risks and potential mitigating solutions.	-8,500	0
Total Mitigations		**-15,500**	**-5,000**
Total Unmitigated Risk		**0**	**0**

Currently there is a high level of confidence that the risks identified are unlikely to materialise.

7. Other Financial Information

7.1 Statement of Financial Position

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

The CCG's position as at 31 January 2022 is shown in appendix 1.

7.2 Capital

The CCG has received the requested IT capital funding for 2021/22. This amounts to £0.4m, £0.1m for business-as-usual laptop replacements and £0.3m for capital infrastructure.

7.3 Better Payment Practice Code

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

The CCG's current performance against the target of 95% is detailed below:

	Number	£'000's
Non NHS Creditors - % of bills paid within target	99.19%	96.98%
NHS Creditors - % of bills paid within target	96.33%	99.87%

7.4 Cash

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

8 Recommendations

The Governing Body is requested to:

Consider, review and discuss the month 10 year to date performance position including the current risks.

Appendices

Appendix 1: Statement of Financial Position

AS AT 31 JANUARY 2022	DEVON CCG
STATEMENT OF FINANCIAL POSITION	**ACTUAL**
	£000's
NON CURRENT ASSETS	
Property Plant Equipment	993
Intangible Assets	0
Investment Properties	-
Trade & Other Receivables	0
Other Financial Assets	-
Total Non Current Assets	993
CURRENT ASSETS	
Inventories	748
Trade & Other Receivables - NHS	3,136
Trade & Other Receivables - Non NHS	7,004
Other Current Assets	-
Cash & Cash Equivalents	454
Non-current Assets held for Sale	-
Total Current Assets	11,341
Total Assets	12,333
CURRENT LIABILITIES	
Trade & Other Payables - NHS	- 17,661
Trade & Other Payables - Non NHS	- 151,185
Other Liabilities	- 1,053
Borrowings / Cash in Transit	- 4,648
Provisions	-
Total Current Liabilities	- 174,547
Total Assets less Current Liabilities	- 162,213
NON-CURRENT LIABILITIES	
Trade & Other Payables	-
Other Financial Liabilities	- 85
Total Non Current Liaibilities	-
Total Assets Employed	- 162,299
FINANCED BY TAXPAYERS EQUITY	
General Fund	162,299
Total Taxpayers' Equity	162,299

Appendix 2: Cash

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

Measure	Month 10
CCGs must operate within their Cash Drawdown Requirement *The Cash Drawdown Requirement is based on the revenue and capital resource limits, amended for various non-cash items like depreciation. At present NHS England has calculated this to equate to £2,521.160m for Devon CCG the year.*	81.4% of the Cash Drawdown Requirement has been utilised as at month 10 (83.3% is expected based on a straight-line trajectory at month 10).
CCGs daily and monthly forecasting accuracy and notional charges NHS England is working on implementing a regime of bank charges against CCGs based on the accuracy of daily and monthly cash forecasting*. The start date for any charges to flow through the scheme to the CCG has not yet been confirmed.	Notional charges amount to £15,598 for January.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown	The CCG has met the requirement to manage their cash balances at the bank on the last day of the month to be no greater than 1.25% of the drawdown for that month.

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

Appendix 3: Operating Expenditure

2021/22 FINANCE BOARD REPORT FOR THE PERIOD FROM 01 APRIL 2021 TO 31 JAN 2022 Month 10 January	DEVON CLINICAL COMMISSIONING GROUP									
	Year To Date					Current Year Forecast				
	Budget	Non Covid Actual	Covid Actual	Total Actual	Variance (Adv) / Fav	Budget	Non Covid Forecast	Covid Forecast	Total Forecast	Variance (Adv) / Fav
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
ACUTE CARE										
NHS Royal Devon & Exeter Foundatior	300,996	300,997	-	300,997	(0)	356,314	356,314	-	356,314	-
NHS University Hospitals Plymouth NH	285,475	284,979	-	284,979	496	337,075	336,491	-	336,491	584
NHS Northern Devon Healthcare Trust	132,100	132,100	-	132,100	0	156,967	156,967	-	156,967	0
NHS South Devon Healthcare Foundat	222,421	222,421	-	222,421	0	264,762	264,762	-	264,762	-
NHS Taunton and Somerset	8,206	8,206	-	8,206	(0)	9,841	9,841	-	9,841	0
NHS South Western Ambulance Trust	43,692	44,000	-	44,000	(307)	52,533	52,840	31	52,871	(338)
Independent Sector	27,138	23,070	-	23,070	4,068	32,573	28,077	-	28,077	4,496
Other Acute	15,506	14,865	3	14,868	639	19,074	18,212	4	18,216	858
Subtotal	1,035,535	1,030,637	3	1,030,640	4,895	1,229,138	1,223,503	35	1,223,538	5,600
PLACEMENTS										
Continuing Healthcare	98,743	99,681	299	99,979	(1,237)	119,553	119,669	336	120,005	(452)
Funded Nursing Care	11,234	11,245	-	11,245	(11)	13,557	13,494	-	13,494	63
Subtotal	109,977	110,926	299	111,225	(1,248)	133,110	133,163	336	133,500	(390)
COMMUNITY & NON ACUTE										
Livewell Southwest	12,137	11,605	1,111	12,716	(580)	11,994	11,449	1,212	12,661	(667)
Royal Devon and Exeter Community	50,460	50,460	-	50,460	-	60,725	60,725	-	60,725	-
Northern Devon Healthcare Communit	26,109	26,109	-	26,109	0	31,421	31,421	-	31,421	(0)
South Devon Healthcare Community	60,972	59,296	2,449	61,744	(773)	72,318	71,036	3,106	74,142	(1,824)
University Hospitals Plymouth Commu	31,713	31,713	-	31,713	-	40,774	40,774	-	40,774	-
Children and Families Health Devon	10,431	10,431	-	10,431	(0)	12,563	12,563	-	12,563	(0)
Individual Patient Placements	658	877	-	877	(219)	902	1,052	-	1,052	(151)
Integrated Urgent Care Service	42	31	-	31	11	50	34	-	34	16
Hospices	7,000	6,936	20	6,957	43	8,354	8,295	20	8,316	38
MIU Contracts	683	643	-	643	40	820	779	-	779	41
Plymouth Integrated Fund	13,925	9,018	2,734	11,752	2,173	15,745	10,838	3,498	14,336	1,409
Better Care Fund_Devon CC	35,539	27,971	12,255	40,226	(4,687)	41,188	33,620	14,685	48,305	(7,117)
Other Community Services	23,133	21,595	5,383	26,978	(3,845)	25,617	23,854	6,629	30,483	(4,866)
Subtotal	272,801	256,685	23,952	280,637	(7,835)	322,470	306,440	29,151	335,591	(13,121)
MENTAL HEALTH SERVICES										
Devon Partnership NHS Trust	132,501	132,501	-	132,501	0	158,297	158,297	-	158,297	0
Livewell MH Services	14,429	14,429	-	14,429	-	15,523	15,523	-	15,523	-
University Hospitals Plymouth MH	22,402	22,402	-	22,402	-	28,881	28,881	-	28,881	-
Children and Families Health Devon	12,325	12,325	-	12,325	0	14,983	14,983	-	14,983	(0)
Individual Patient Placements	10,832	8,428	-	8,428	2,404	13,166	10,112	-	10,112	3,054
Section 117	14,954	16,309	-	16,309	(1,355)	18,486	19,571	-	19,571	(1,085)
Other Mental Health	6,152	5,463	-	5,463	689	6,650	6,526	-	6,526	124
Subtotal	213,595	211,857	-	211,857	1,738	255,987	253,894	-	253,894	2,093

2021/22 FINANCE BOARD REPORT	DEVON CLINICAL COMMISSIONING GROUP									
FOR THE PERIOD FROM 01 APRIL 2021 TO 31 JAN 2022	Year To Date					Current Year Forecast				
Month 10 January	Budget	Non Covid Actual	Covid Actual	Total Actual	Variance (Adv) / Fav	Budget	Non Covid Forecast	Covid Forecast	Total Forecast	Variance (Adv) / Fav
OTHER COMMISSIONED SERVICES										
NHS 111	4,586	4,807	-	4,807	(221)	5,517	5,673	-	5,673	(156)
Better Care Fund Torbay	2,890	2,890	-	2,890	-	3,469	3,469	-	3,469	-
Patient Transport Services	8,104	7,768	359	8,126	(22)	9,747	9,349	405	9,754	(6)
All Other Commisionned Services	27,611	28,227	(737)	27,491	120	32,522	33,483	(770)	32,713	(191)
Subtotal	43,192	43,693	(378)	43,315	(123)	51,255	51,973	(365)	51,609	(354)
PRIMARY CARE										
Prescribing	173,982	172,122	-	172,122	1,860	209,680	206,544	-	206,544	3,136
Enhanced Services	15,607	13,080	2,527	15,607	0	18,245	15,718	2,527	18,245	0
Delegated Commissioning	155,304	157,300	-	157,300	(1,996)	186,423	190,535	-	190,535	(4,112)
GP Out Of Hours	11,490	11,370	549	11,919	(429)	13,776	13,655	651	14,306	(530)
Other Primary Care	18,709	17,466	(20)	17,446	1,263	22,396	23,311	2	23,313	(917)
Subtotal	375,092	371,338	3,056	374,394	699	450,519	449,763	3,180	452,943	(2,423)
TOTAL COMMISSIONED SERVICES	2,050,192	2,025,135	26,932	2,052,067	(1,875)	2,442,479	2,418,737	32,338	2,451,075	(8,596)
RUNNING COSTS										
Pay	17,597	14,580	34	14,613	2,983	20,856	17,108	34	17,142	3,714
Non Pay	2,378	4,470	11	4,481	(2,103)	2,854	5,052	15	5,067	(2,214)
Income	-	(117)	-	(117)	117	-	(117)	-	(117)	117
Subtotal	19,975	18,933	45	18,978	997	23,710	22,044	49	22,093	1,617
EARMARKED RESERVES AND CONTINGENCIES										
Earmarked Reserves										
Contingency										
Other Reserves	(686)	6,568	-	6,568	(7,254)	44,137	55,598	-	55,598	(11,461)
Subtotal	(686)	6,568	-	6,568	(7,254)	44,137	55,598	-	55,598	(11,461)
NET TOTAL OPERATING COSTS	2,069,481	2,050,636	26,977	2,077,613	(8,132)	2,510,326	2,496,379	32,387	2,528,766	(18,440)
CCG Control Total	2,072,997	2,053,348	19,649	2,072,997	-	2,515,601	2,495,689	19,912	2,515,601	-
Expected Adiitional Allocations		804	7,328	8,132	(8,132)		5,965	12,475	18,440	(18,440)
2021/22 Surplus/(Deficit)	3,517	3,517	-	3,517	0	5,275	5,275	-	5,275	(0)

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: s256 Agreements with Local Authorities 2021/22				
Date of committee: 24th February 2022 **Date report produced: 17th February 2022**				
Author (s) Name and Title: Kevin Wheller, Associate Director of Finance (Northern and Eastern) **Contact Details:** kevin.wheller@nhs.net		**Supporting Executive:** **Name and Title:** John Dowell **Contact Details:** john.dowell@nhs.net **Report Approved by:** **Name and Title: John Dowell** **Date** 17th February 2022		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This report details a number of s256 agreements that the CCG is intending to enter into with Devon County Council, Plymouth City Council and Torbay Council in 21-22. These investments include funds to improve integration through targeted investments that reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers.

Management of Conflict of interests:
Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team
via d-ccg.governance@nhs.net to update the central register.

Committees that have previously discussed/agreed the report and outcomes:
None
Key recommendations and actions requested:
The Governing Body are asked review the contents of this report and the accompanying s256 agreements and if satisfied with the agreements formally approve by they can be signed by the Director of Finance.
Impact on Strategic Objectives
(Delete as applicable) We will continue to commission safe, effective and accessible services We will work as a strategic partner in Devon We will improve the physical and mental health of our population We will make best use of our resources
Reference to other documents or accompanying papers:
None
Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	No
Quality of Services	The s256 agreements are expected to improve the quality of health and social care	
Health Inequalities	The s256 agreements are expected to improve health inequalities where possible.	
Equality (staff or public)		√
Resource and Finance	The combined s256 agreements represent a £54m investment social care that will benefit healthcare services in Devon	
Legal	S256 agreements are legal agreements	
Engagement and Consultation		√
Risk	Low financial risk	

The CCG has made every effort to ensure this report does not have the effect of discriminating, directly or indirectly, against employees, patients, contractors or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability.

S256 Agreements with Local Authorities 21/22

1. Executive Summary

This report details a number of s256 agreements that the CCG is intending to enter into with Devon County Council, Plymouth City Council and Torbay Council in 21-22. These investments include funds to improve integration through targeted investments that reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers.

Under s256 of The NHS Act 2006 allows clinical commissioning groups to make payments to Local Authorities as a contribution towards expenditure incurred or to be incurred by it in connection with any social services functions. S256 agreements differ in nature from s75 agreements in that they relate to a single transaction between the CCG and the Local Authority as opposed to a s75 agreement where both parties contribute resources to a pooled fund.

2. Detailed Agreements

The grant agreements and brief descriptions of the investments are detailed below. The actual individual grant agreements are appended to this report.

s256 Agreements 21/22		**DCC**	**PCC**	**TBC**
Description	**Note**	**£**	**£**	**£**
Integrated Care Enabling Activities	1	25,000,000	14,500,000	10,000,000
Personal Care Workforce Sustainability	2	670,000	184,000	200,000
Enhanced Care Home Staffing	2	194,500		
Targeted Equipment	2	250,000		
Nursing/Residential Home Workforce Sustainability*	2	800,000	350,000	250,000
Peripatetic Care Home Staffing	2	400,000		
Personal Discharge Budget	3	144,000		
Critical Thinking Unit	4	1,500,000		
NHSx Digital Shared Care Record	5	600,000	100,000	
		29,158,500	15,134,000	10,450,000

1. Enabling Activities

Building on agreements made in 2020/21 which are aimed at reducing demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers by making targeted investments across health and social care. The funding can also be used to underwrite additional elective capacity and discharge to assess (Hospital Discharge Programme) not funded centrally as well as supporting social care market stability and public health/health promotion.

2. Elective Recovery

Specific investments in social care capacity funded from the 21/22 national Elective Recovery Fund that provide resilience over the winter period.

*The Nursing/Residential Home Workforce Sustainability grant for Plymouth City Council and Torbay Council are still in the process of being worked up, but we expect them to be in place prior to the Governing Body meeting.

3. Discharge

Specific investment targeted to assist the discharge to assess programme over the winter period.

4. Public Health

Regional Investment in a Critical Thinking Unit managed by the Office for Health Improvements and Disparities, working to regional oversight group hosted by Devon County Council.

5. Digital

NHSx capital grant funding for Local Authorities to cover their costs incurred in development of the NHS Devon shared care record.

3. Summary and Recommendations

The Governing Body are asked review the contents of this report and the accompanying s256 agreements and if satisfied with the agreements formally approve by they can be signed by the Director of Finance.

Memorandum of Agreement

relating to the transfer of monies

under

Section 256

of the

NHS Act 2006

Memorandum of Agreement

Section 256 transfer

Title of scheme: Integrated Care Enabling Activities

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

The key outcome required is to reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers by making targeted investments across health and social care that improve integration. More details are set out in section 2.

2. Description of scheme

The programme will support the implementation of the Devon ICS [Together for Devon] single system plan, including supporting the transition and restoration of services impacted significantly by the Covid pandemic, through alignment of a number of key priority areas which benefit the population of Devon; will seek to improve the financial sustainability of both the NHS and Local Authority; and meet the strategic goals of health, public health and social care commissioners. In particular, this will involve looking across the Devon ICS [Together for Devon] work programmes for (1) Integrated Care, including discharge from hospital (2) Mental Health, LD & Autism and (3) Children's and Families, making targeted investments which improve integration:

- of services commissioned across health, social care and public health commissioners
- between statutory and VCSE health and care provider organisations
- between physical health and care; and mental health and care provider organisations
- between health and care services providers and organisations whose goals address wider determinants of health such as better housing provision, management of debt, or drug and alcohol services

The key outcome required is to reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers.

The KPIs that may be used to measure the impact are as follows:

1. Adult Acute and Community Services (Integrated Care)

    - cost weighted unplanned secondary care activity per/1000 population for Older People (emergency admissions & bed days and A&E/UTC attendances, NHS community contacts)
    - increase proportion of successful hospital discharges to home first compared to 20/21
    - the rate per/1000 population level of Priority 1, 2 & 3 planned care inpatient admission treated within NHSE clinical standards
    - the rate per/1000 population for Ambulatory Care Sensitive (ACS) conditions

2. Mental Health, LD & Autism
    - Reduced section 3 admissions
    - Reduced bed days in Out of Area LD, Acute, PICU and Locked Rehabilitation packages
    - Reduce nursing/residential care packages for LD and Autism
    - Reduced cost of s117 aftercare due to reduced demand and more cost-effective interventions

3. Children and Families
    - The Framework of Integrated Care represents a significant opportunity to support and strengthen children and young people's services across the wider Devon system. Enabling collaboration within and across those agencies, with the vision to facilitate integrated trauma-informed and responsive systems that enable Children and Young People (CYP) with complex needs to thrive.
    - and to support the development of services that prevent children needing to access high-cost placements in the NHS, reduce placements out of the Devon area and transition to adulthood and lifecycle costs
    - reduced emergency admissions for children with chronic conditions (asthma, diabetes and epilepsy)

The programme will use evidence-based interventions and benchmarking to target investment in areas where greater than £ for £ savings in NHS services will be delivered; it is expected that these investments may also deliver additional savings for public health and social care commissioned services.

The investment is intended to compliment, but not overlap with the aims of the Better Care Fund.

3. Financial details (and timescales):

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

Year(s)	Amount	Capital	Revenue
2021/22	**£25,000,000**	**£0**	**£25,000,000**

Representing a fixed contribution to the cost of the scheme.

Relationship with Better Care Fund and/or other existing section 75 pooled budget arrangements

- This fund will be discrete from Better Care Fund and/or other existing section 75 pooled budget arrangements

NHS Elective Care

- This fund will underwrite any additional NHS capacity required to ensure treatment of Priority 1, 2 and 3 elective patients. This immediate clinical risk will be prioritised over longer term admission and prevention initiatives

Hospital Discharge Fund, Discharge to Assess and Urgent Care Winter Pressures

- This fund will underwrite any ongoing NHS or Social Care costs of Discharge to Assess services that cannot otherwise be reimbursed by continuing Government Hospital Discharge Fund
- This fund will underwrite any ongoing Extra Care Housing and Pathway 3 that cannot otherwise be reimbursed by continuing Government Hospital Discharge Fund
- This fund will underwrite costs of winter schemes that cannot otherwise be reimbursed any Winter Pressure funding and not already funded elsewhere in BCF or Hospital Discharge Fund.
- The fund will not contribute to the cost of ongoing Care Act or Continuing Healthcare eligible packages of Domiciliary, Residential or Nursing Care after agreed operational standards

Market Management

- The programme will support a joint objective of stabilising social care market capacity in order to support hospital flow and to build resilience in time for autumn and winter.

Health Prevention/Promotion

- Implementation of a range of health prevention and health promotion initiatives to include pilots and pump-priming community initiatives to enable communities to continue programmes of work.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

- Benchmarking analysis prepared over a range of pathways.
- NHSE/LA guidance and policies.
- Deep dive information produced to highlight specific areas for change and to facilitate redesign of existing pathways where appropriate.
- Emerging body of UK and international evidence of the benefits of integrated care identified in the Devon ICS [Together for Devon] single system plan.
- The development of the 'System Wide dataset' that will provide outputs of combined Health and Social Care performance and financial information, such that monthly financial and activity monitoring of the outcomes of the programme can be understood.

Signed

…… for NHS Devon CCG

…… Position

…… Date

…… for Devon County Council

…… Position

…… Date

SECTION 256 ANNUAL VOUCHER

Devon County Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2022.

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	Revenue Expenditure £	Capital Expenditure £	Total Expenditure £
Integrated Care enabling activities	£25,000,000	£0	£25,000,000

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by the NHS Devon Clinical Commissioning Group in accordance with these Directions.

Signed…….

Date…….

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions)

Certificate of independent auditor

I/We have:

- Examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated)* and the related accounts and records of the ……. and
- Carried out such tests and obtained such evidence and explanations as I/we consider necessary.
  (Except for the matters raised in the attached qualification letter dated)*
- I/we have concluded that the entries are fairly stated: and
- The expenditure has been properly incurred in accordance with the relevant terms and conditions.

Signature …….

Name (block capitals) …….

Company/Firm …….

Date ……..
* Delete as necessary

Memorandum of Agreement

relating to the transfer of monies

under

Section 256

of the

NHS Act 2006

Memorandum of Agreement

Section 256 transfer

Title of scheme: Integrated Care Enabling Activities

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

The key outcome required is to reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers by making targeted investments across health and social care that improve integration. More details are set out in section 2.

2. Description of scheme

The programme will support the implementation of the Devon ICS [Together for Devon] single system plan, including supporting the transition and restoration of services impacted significantly by the Covid pandemic, through alignment of a number of key priority areas which benefit the population of Devon; will seek to improve the financial sustainability of both the NHS and Local Authority; and meet the strategic goals of health, public health and social care commissioners. In particular, this will involve looking across the Devon ICS [Together for Devon] work programmes for (1) Integrated Care, including discharge from hospital (2) Mental Health, LD & Autism and (3) Children's and Families, making targeted investments which improve integration:

- of services commissioned across health, social care and public health commissioners
- between statutory and VCSE health and care provider organisations
- between physical health and care; and mental health and care provider organisations
- between health and care services providers and organisations whose goals address wider determinants of health such as better housing provision, management of debt, or drug and alcohol services

The key outcome required is to reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers.

The KPIs that may be used to measure the impact are as follows:

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    - Reduced section 3 admissions
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    - The Framework of Integrated Care represents a significant opportunity to support and strengthen children and young people's services across the wider Devon system. Enabling collaboration within and across those agencies, with the vision to facilitate integrated trauma-informed and responsive systems that enable Children and Young People (CYP) with complex needs to thrive.
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    - reduced emergency admissions for children with chronic conditions (asthma, diabetes and epilepsy)

The programme will use evidence-based interventions and benchmarking to target investment in areas where greater than £ for £ savings in NHS services will be delivered; it is expected that these investments may also deliver additional savings for public health and social care commissioned services.

The investment is intended to compliment, but not overlap with the aims of the Better Care Fund.

3. Financial details (and timescales):

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

Year(s)	Amount	Capital	Revenue
2021/22	**£14,500,000**	**£0**	**£14,500,000**

Representing a fixed contribution to the cost of the scheme.

Relationship with Better Care Fund and/or other existing section 75 pooled budget arrangements

- This fund will be discrete from Better Care Fund and/or other existing section 75 pooled budget arrangements

NHS Elective Care

- This fund will underwrite any additional NHS capacity required to ensure treatment of Priority 1, 2 and 3 elective patients. This immediate clinical risk will be prioritised over longer term admission and prevention initiatives

Hospital Discharge Fund, Discharge to Assess and Urgent Care Winter Pressures

- This fund will underwrite any ongoing NHS or Social Care costs of Discharge to Assess services that cannot otherwise be reimbursed by continuing Government Hospital Discharge Fund
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- The fund will not contribute to the cost of ongoing Care Act or Continuing Healthcare eligible packages of Domiciliary, Residential or Nursing Care after agreed operational standards

Market Management

- The programme will support a joint objective of stabilising social care market capacity in order to support hospital flow and to build resilience in time for autumn and winter.

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- Implementation of a range of health prevention and health promotion initiatives to include pilots and pump-priming community initiatives to enable communities to continue programmes of work.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

- Benchmarking analysis prepared over a range of pathways.
- NHSE/LA guidance and policies.
- Deep dive information produced to highlight specific areas for change and to facilitate redesign of existing pathways where appropriate.
- Emerging body of UK and international evidence of the benefits of integrated care identified in the Devon ICS [Together for Devon] single system plan.
- The development of the 'System Wide dataset' that will provide outputs of combined Health and Social Care performance and financial information, such that monthly financial and activity monitoring of the outcomes of the programme can be understood.

Signed

…… for NHS Devon CCG

…… Position

…… Date

…… for Plymouth City Council

…… Position

…… Date

SECTION 256 ANNUAL VOUCHER

Plymouth City Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2022.

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	**Revenue Expenditure £**	**Capital Expenditure £**	**Total Expenditure £**
Integrated Care enabling activities	£14,500,000	£0	£14,500,000

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by the NHS Devon Clinical Commissioning Group in accordance with these Directions.

Signed…….

Date…….

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions)

Certificate of independent auditor

I/We have:

- Examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated)* and the related accounts and records of the ……. and
- Carried out such tests and obtained such evidence and explanations as I/we consider necessary.
  (Except for the matters raised in the attached qualification letter dated)*
- I/we have concluded that the entries are fairly stated: and
- The expenditure has been properly incurred in accordance with the relevant terms and conditions.

Signature …….

Name (block capitals) …….

Company/Firm …….

Date ……..
* Delete as necessary

Memorandum of Agreement

relating to the transfer of monies

under

Section 256

of the

NHS Act 2006

Memorandum of Agreement

Section 256 transfer

Title of scheme: Integrated Care Enabling Activities

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

The key outcome required is to reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers by making targeted investments across health and social care that improve integration. More details are set out in section 2.

2. Description of scheme

The programme will support the implementation of the Devon ICS [Together for Devon] single system plan, including supporting the transition and restoration of services impacted significantly by the Covid pandemic, through alignment of a number of key priority areas which benefit the population of Devon; will seek to improve the financial sustainability of both the NHS and Local Authority; and meet the strategic goals of health, public health and social care commissioners. In particular, this will involve looking across the Devon ICS [Together for Devon] work programmes for (1) Integrated Care, including discharge from hospital (2) Mental Health, LD & Autism and (3) Children's and Families, making targeted investments which improve integration:

- of services commissioned across health, social care and public health commissioners
- between statutory and VCSE health and care provider organisations
- between physical health and care; and mental health and care provider organisations
- between health and care services providers and organisations whose goals address wider determinants of health such as better housing provision, management of debt, or drug and alcohol services

The key outcome required is to reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers.

The KPIs that may be used to measure the impact are as follows:

1. Adult Acute and Community Services (Integrated Care)

    - cost weighted unplanned secondary care activity per/1000 population for Older People (emergency admissions & bed days and A&E/UTC attendances, NHS community contacts)
    - increase proportion of successful hospital discharges to home first compared to 20/21
    - the rate per/1000 population level of Priority 1, 2 & 3 planned care inpatient admission treated within NHSE clinical standards
    - the rate per/1000 population for Ambulatory Care Sensitive (ACS) conditions

2. Mental Health, LD & Autism
    - Reduced section 3 admissions
    - Reduced bed days in Out of Area LD, Acute, PICU and Locked Rehabilitation packages
    - Reduce nursing/residential care packages for LD and Autism
    - Reduced cost of s117 aftercare due to reduced demand and more cost-effective interventions

3. Children and Families
    - The Framework of Integrated Care represents a significant opportunity to support and strengthen children and young people's services across the wider Devon system. Enabling collaboration within and across those agencies, with the vision to facilitate integrated trauma-informed and responsive systems that enable Children and Young People (CYP) with complex needs to thrive.
    - and to support the development of services that prevent children needing to access high-cost placements in the NHS, reduce placements out of the Devon area and transition to adulthood and lifecycle costs
    - reduced emergency admissions for children with chronic conditions (asthma, diabetes and epilepsy)

The programme will use evidence-based interventions and benchmarking to target investment in areas where greater than £ for £ savings in NHS services will be delivered; it is expected that these investments may also deliver additional savings for public health and social care commissioned services.

The investment is intended to compliment, but not overlap with the aims of the Better Care Fund.

3. Financial details (and timescales):

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

Year(s)	Amount	Capital	Revenue
2021/22	**£10,000,000**	**£0**	**£10,000,000**

Representing a fixed contribution to the cost of the scheme.

Relationship with Better Care Fund and/or other existing section 75 pooled budget arrangements

- This fund will be discrete from Better Care Fund and/or other existing section 75 pooled budget arrangements

NHS Elective Care

- This fund will underwrite any additional NHS capacity required to ensure treatment of Priority 1, 2 and 3 elective patients. This immediate clinical risk will be prioritised over longer term admission and prevention initiatives

Hospital Discharge Fund, Discharge to Assess and Urgent Care Winter Pressures

- This fund will underwrite any ongoing NHS or Social Care costs of Discharge to Assess services that cannot otherwise be reimbursed by continuing Government Hospital Discharge Fund
- This fund will underwrite any ongoing Extra Care Housing and Pathway 3 that cannot otherwise be reimbursed by continuing Government Hospital Discharge Fund
- This fund will underwrite costs of winter schemes that cannot otherwise be reimbursed any Winter Pressure funding and not already funded elsewhere in BCF or Hospital Discharge Fund.
- The fund will not contribute to the cost of ongoing Care Act or Continuing Healthcare eligible packages of Domiciliary, Residential or Nursing Care after agreed operational standards

Market Management

- The programme will support a joint objective of stabilising social care market capacity in order to support hospital flow and to build resilience in time for autumn and winter.

Health Prevention/Promotion

- Implementation of a range of health prevention and health promotion initiatives to include pilots and pump-priming community initiatives to enable communities to continue programmes of work.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

- Benchmarking analysis prepared over a range of pathways.
- NHSE/LA guidance and policies.
- Deep dive information produced to highlight specific areas for change and to facilitate redesign of existing pathways where appropriate.
- Emerging body of UK and international evidence of the benefits of integrated care identified in the Devon ICS [Together for Devon] single system plan.
- The development of the 'System Wide dataset' that will provide outputs of combined Health and Social Care performance and financial information, such that monthly financial and activity monitoring of the outcomes of the programme can be understood.

Signed

……. for NHS Devon CCG

……... Position

…… Date

…… for Torbay Council

……. Position

……. Date

SECTION 256 ANNUAL VOUCHER

Torbay Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2022.

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	**Revenue Expenditure £**	**Capital Expenditure £**	**Total Expenditure £**
Integrated Care enabling activities	£10,000,000	£0	£10,000,000

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by the NHS Devon Clinical Commissioning Group in accordance with these Directions.

Signed…….

Date…….

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions)

Certificate of independent auditor

I/We have:

- Examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated)* and the related accounts and records of the ……. and
- Carried out such tests and obtained such evidence and explanations as I/we consider necessary.
  (Except for the matters raised in the attached qualification letter dated)*
- I/we have concluded that the entries are fairly stated: and
- The expenditure has been properly incurred in accordance with the relevant terms and conditions.

Signature …….

Name (block capitals) …….

Company/Firm …….

Date ……..
* Delete as necessary

Memorandum of Agreement

relating to the transfer of monies

under

Section 256

of the

NHS Act 2006

Memorandum of Agreement

Section 256 transfer

Title of scheme: Enhanced Care Home Staffing

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

The key outcome required is to reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers. More details are set out in section 2.

2. Description of scheme

NHS contribution to enhanced staffing at Mapleton Care Home to change the service delivery and enable the support for individuals with more complex needs (Older Persons Mental Health).

Discharges for individuals with complex mental health conditions and presentations associated with Dementia remains an area of significant challenge. Local analysis has demonstrated a gap in current service provision for a step-down service providing an enhanced assessment environment away from an inpatient ward (acute general and mental health).

This scheme therefore seeks to repurpose an existing Local Authority operated home, offer enhanced staffing and MDT wrap around support to offer a short-term placement for individuals to enable assessment and care planning in a more appropriate environment to enable onward discharge either back home or to a lower level long term residential unit.

This investment reflects the additional staffing (over and above the existing local authority employed compliment) in-order for this service to be mobilised.

The outcomes from embedding this model are to enable more individuals to return home, delivering better individual outcomes, and in addition ensure the release of current capacity for long term specialist placements to support individuals with the most complex needs – this has a direct support on system flow and pressures.

3. Financial details (and timescales):

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

Year(s)	Amount	Capital	Revenue
2021/22	**£194,500**	**£0**	**£194,500**

Representing a fixed contribution to the cost of the scheme.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

- This scheme will be monitored on a bed utilisation basis. A weekly report is compiled and is included in the weekly 'NHSE additional bedded capacity submission' completed by the CCG as a recruitment under the NHS Level 4 response
- The output of the weekly submission is also reported into the Devon System Flow and Community Surge meetings to ensure oversight of the bed utilisation
- Further detail is also being captured on the individual outcomes of the service in order to enable an evaluation of the provision in line with ambitions set out under section 2.

Signed

…… for NHS Devon CCG

…… Position

…… Date

…… for Devon County Council

…… Position

…… Date

SECTION 256 ANNUAL VOUCHER

Devon County Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2022.

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	**Revenue Expenditure £**	**Capital Expenditure £**	**Total Expenditure £**
Enhanced Care Home Staffing	£194,500	£0	£194,500

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by the NHS Devon Clinical Commissioning Group in accordance with these Directions.

Signed…….

Date…….

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions)

Certificate of independent auditor

I/We have:

- Examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated)* and the related accounts and records of the ……. and
- Carried out such tests and obtained such evidence and explanations as I/we consider necessary.
  (Except for the matters raised in the attached qualification letter dated)*
- I/we have concluded that the entries are fairly stated: and
- The expenditure has been properly incurred in accordance with the relevant terms and conditions.

Signature …….

Name (block capitals) …….

Company/Firm …….

Date ……..
* Delete as necessary

Memorandum of Agreement

relating to the transfer of monies

under

Section 256

of the

NHS Act 2006

Memorandum of Agreement

Section 256 transfer

Title of scheme: Care Home Workforce Sustainability

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

The key outcome required is to reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers. More details are set out in section 2.

2. Description of scheme

NHS Contribution to compliment The Devon County Council Workforce Capacity Fund (WCF) allocation of £4.5m to support a sustainable workforce within the nursing and residential home care sector, establishing a fund of £5.3m.

The proposal is to make a payment to all regulated care home providers (including those who serve the private fee-paying market) equivalent to £500 per member of staff (all care staff and their support teams, excluding owners and directors).

The expectation is that this investment will impact on hospital admission avoidance and facilitate timely discharge through retaining and extending the workforce available to care homes and enable them to maintain and extend the availability of beds. This is an essential component of local discharge action plans as part of the NHS level 4 response. The CCG has an identified shortfall of 191 beds required to meet the 50% reduction in NCTR and this investment will support sufficiency of care home capacity to meet this target.

Local analysis has demonstrated that paying a figure of at least £500 is essential in order to offset any reduction in universal credit and ensure the payment offers additional incomes and therefore reflects a true incentive. Topping up the Workforce Grant allocated to DCC is therefore essential to meet this level.

3. Financial details (and timescales):

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

Year(s)	Amount	Capital	Revenue
2021/22	**£800,000**	**£0**	**£800,000**

Representing a fixed contribution to the cost of the scheme.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

- Payment of the £500 payment is being managed by individual requests from providers. They will be requested to provide detail of the individual recipients. In all cases this will be validated against detail already held through returns submitted on the Capacity Tracker (completion of which is a key requirement of the grant). A selection will also be audited to ensure appropriate payments have been made.

- Delivery of the objectives set out in question 2 will be managed through regular reporting to the CCG through the system flow and workforce cell groups established as part of the local system escalation response.

Signed

…… for NHS Devon CCG

…… Position

…… Date

…… for Devon County Council

…… Position

…… Date

SECTION 256 ANNUAL VOUCHER

Devon County Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2022.

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	**Revenue Expenditure £**	**Capital Expenditure £**	**Total Expenditure £**
Care Home Workforce Sustainability	£800,000	£0	£800,000

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by the NHS Devon Clinical Commissioning Group in accordance with these Directions.

Signed…….

Date…….

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions)

Certificate of independent auditor

I/We have:

- Examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated)* and the related accounts and records of the ……. and
- Carried out such tests and obtained such evidence and explanations as I/we consider necessary.
  (Except for the matters raised in the attached qualification letter dated)*
- I/we have concluded that the entries are fairly stated: and
- The expenditure has been properly incurred in accordance with the relevant terms and conditions.

Signature …….

Name (block capitals) …….

Company/Firm …….

Date ……..
* Delete as necessary

Memorandum of Agreement

relating to the transfer of monies

under

Section 256

of the

NHS Act 2006

Memorandum of Agreement

Section 256 transfer

Title of scheme: Peripatetic Care Home Staffing Team

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

The key outcome required is to reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers. More details are set out in section 2.

2. Description of scheme

NHS contribution to the mobilisation of a peripatetic enhanced 1:1 staffing team to be deployed into Care Homes to support the service delivery and enable the support for individuals with more complex needs (Older Persons Mental Health).

Discharges for individuals with complex mental health conditions and presentations associated with Dementia remains an area of significant challenge. Local market analysis has demonstrated that current shortfalls in Care Home staffing mean that homes are often unable to support admissions for individuals whose challenging behaviours present a risk to themselves or other residents. Often individuals with this level of need will settle once in the environment, and therefore Care Homes could accept if they had an initial time limited dedicated staffing resource. Traditionally this service would have been supported by the home engaging bank workers or agency, but current constraints limits providers ability to source this locally.

This scheme therefore involves the block contracting of a team of 25 care agency workers (recruited from outside of Devon) provided with accommodation, and ready to be deployed to support individuals. The 25 care workers will be able to support 9 individuals at anyone time, but support will be limited to up to 28 days. Enhanced reviews will be provided to oversee and support managing down the support within this period. Where a longer-term need is identified, the provider will be connected to the Proud to Care and International recruitment support schemes currently available to support recruitment.

The outcomes from embedding this model are to enable more individuals to be discharges to care homes sooner, delivering better individual outcomes.

3. Financial details (and timescales):

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

Year(s)	Amount	Capital	Revenue
2021/22	**£400,000**	**£0**	**£400,000**

Representing a fixed contribution to the cost of the scheme.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

- This scheme will be monitored on a staff utilisation basis which is reported to the CCG on a weekly basis
- The output of the weekly submission is reported into the Devon System Flow and Community Surge meetings to ensure oversight of the bed utilisation
- Further detail is also being captured on the individual outcomes of the service in order to enable an evaluation of the provision in line with ambitions set out under section 2

Signed

…… for NHS Devon CCG

…… Position

…… Date

…… for Devon County Council

…… Position

…… Date

SECTION 256 ANNUAL VOUCHER

Devon County Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2022.

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	**Revenue Expenditure £**	**Capital Expenditure £**	**Total Expenditure £**
Peripatetic Care Home Staffing Team	£400,000	£0	£400,000

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by the NHS Devon Clinical Commissioning Group in accordance with these Directions.

Signed…….

Date…….

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions)

Certificate of independent auditor

I/We have:

- Examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated)* and the related accounts and records of the ……. and
- Carried out such tests and obtained such evidence and explanations as I/we consider necessary.
  (Except for the matters raised in the attached qualification letter dated)*
- I/we have concluded that the entries are fairly stated: and
- The expenditure has been properly incurred in accordance with the relevant terms and conditions.

Signature …….

Name (block capitals) …….

Company/Firm …….

Date ……..
* Delete as necessary

Memorandum of Agreement

relating to the transfer of monies

under

Section 256

of the

NHS Act 2006

Memorandum of Agreement

Section 256 transfer

Title of scheme: Winter Workforce Sustainability - Personal Care

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

The key outcome required is to reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers. More details are set out in section 2.

2. Description of scheme

NHS Contribution to The Devon County Council Workforce Capacity Fund (WCF) to support a sustainable workforce within the Regulated Personal Care market.

The proposal is to make a payment to all regulated personal care providers (including those who serve the private fee-paying market) equivalent to £500 per member of staff (all care staff and their support teams, excluding owners and directors).

The expectation is that this investment will impact on hospital admission avoidance and facilitate timely discharge through retaining and extending the workforce available to support individuals. This is an essential component of local discharge action plans as part of the NHS level 4 response to meet the 50% reduction in NCTR and this investment will support sufficiency of care capacity to meet this target.

Local analysis has demonstrated that paying a figure of at least £500 is essential in order to offset any reduction in universal credit and ensure the payment offers additional incomes and therefore reflects a true incentive. Topping up the Workforce Grant allocated to DCC is therefore essential to meet this level.

3. Financial details (and timescales):

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

Year(s)	Amount	Capital	Revenue
2021/22	**£670,000**	**£0**	**£670,000**

Representing a fixed contribution to the cost of the scheme.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

- Payment of the £500 payment is being managed by individual requests from providers. They will be requested to provide detail of the individual recipients. In all cases this will be validated against detail already held through returns submitted (completion of which is a key requirement of the grant). A selection will also be audited to ensure appropriate payments have been made.

- Delivery of the objectives set out in question 2 will be managed through regular reporting to the CCG through the system flow and workforce cell groups established as part of the local system escalation response.

Signed

…… for NHS Devon CCG

…… Position

…… Date

…… for Devon County Council

…… Position

…… Date

SECTION 256 ANNUAL VOUCHER

Devon County Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2022.

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	**Revenue Expenditure £**	**Capital Expenditure £**	**Total Expenditure £**
Winter Workforce Sustainability – Personal Care	£670,000	£0	£670,000

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by the NHS Devon Clinical Commissioning Group in accordance with these Directions.

Signed…….

Date…….

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions)

Certificate of independent auditor

I/We have:

- Examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated)* and the related accounts and records of the ……. and
- Carried out such tests and obtained such evidence and explanations as I/we consider necessary.
  (Except for the matters raised in the attached qualification letter dated)*
- I/we have concluded that the entries are fairly stated: and
- The expenditure has been properly incurred in accordance with the relevant terms and conditions.

Signature …….

Name (block capitals) …….

Company/Firm …….

Date ……..
* Delete as necessary

Memorandum of Agreement

relating to the transfer of monies

under

Section 256

of the

NHS Act 2006

Memorandum of Agreement

Section 256 transfer

Title of scheme: Winter Workforce Sustainability - Personal Care & Care Homes

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

The key outcome required is to reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers. More details are set out in section 2.

2. Description of scheme

NHS Contribution to The Plymouth City Council Workforce Capacity Fund (WCF) to support a sustainable workforce within the Care Home and Regulated Personal Care markets.

The proposal is to make a payment to all regulated personal care and care home providers up to 9% of their currently weekly commissioned activity for a 12 week period. This funding can then be used by the provider to make appropriate incentive payments to members of staff (all care staff and their support teams, excluding owners and directors).

The expectation is that this investment will impact on hospital admission avoidance and facilitate timely discharge through retaining and extending the workforce available to support individuals. This is an essential component of local discharge action plans as part of the NHS level 4 response to meet the 50% reduction in NCTR and this investment will support sufficiency of care capacity to meet this target.

Local analysis has demonstrated that paying a figure of up to 9% offers flexibility in how the funding is best deployed to support individual circumstances, and is sufficiently high to offset any reduction in universal credit and ensure the payment offers additional incomes and therefore reflects a true incentive. Topping up the Workforce Grant allocated to PCC is therefore essential to meet this level.

3. Financial details (and timescales):

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

Year(s)	Amount	Capital	Revenue
2021/22	**£184,000**	**£0**	**£184,000**

Representing a fixed contribution to the cost of the scheme.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

- Payment of the up to 9% payment is being managed by PCC
- Oversight of commissioned activity, capacity and any unmet need is reported to the CCG on a weekly basis and will support monitoring of improvements as a result of the investment
- Delivery of the objectives set out in question 2 will be managed through regular reporting to the CCG through the system flow and workforce cell groups established as part of the local system escalation response

Signed

…… for NHS Devon CCG

…… Position

…… Date

…… for Plymouth City Council

…… Position

…… Date

SECTION 256 ANNUAL VOUCHER

Plymouth City Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2022.

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	**Revenue Expenditure £**	**Capital Expenditure £**	**Total Expenditure £**
Winter Workforce Sustainability – Personal Care	£184,000	£0	£184,000

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by the NHS Devon Clinical Commissioning Group in accordance with these Directions.

Signed…….

Date…….

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions)

Certificate of independent auditor

I/We have:

- Examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated)* and the related accounts and records of the ……. and
- Carried out such tests and obtained such evidence and explanations as I/we consider necessary.

  (Except for the matters raised in the attached qualification letter dated)*
- I/we have concluded that the entries are fairly stated: and
- The expenditure has been properly incurred in accordance with the relevant terms and conditions.

Signature …….

Name (block capitals) …….

Company/Firm …….

Date ……..
* Delete as necessary

Memorandum of Agreement

relating to the transfer of monies

under

Section 256

of the

NHS Act 2006

Memorandum of Agreement

Section 256 transfer

Title of scheme: Winter Workforce Sustainability - Personal Care (Torbay)

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

The key outcome required is to reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers. More details are set out in section 2.

2. Description of scheme

NHS Contribution to The Torbay Council Workforce Capacity Fund (WCF) to support a sustainable workforce within the Regulated Personal Care market.

The proposal is to make a payment of an additional £2 per hour increase to the hourly rate paid for domiciliary care until the end of March 2022. This funding can then be used by the provider to make appropriate incentive payments to members of staff (all care staff and their support teams, excluding owners and directors).

The expectation is that this investment will impact on hospital admission avoidance and facilitate timely discharge through retaining and extending the workforce available to support individuals. This is an essential component of local discharge action plans as part of the NHS level 4 response to meet the 50% reduction in NCTR and this investment will support sufficiency of care capacity to meet this target.

Local analysis has demonstrated that paying a figure of an additional £2 per hour offers flexibility in how the funding is best deployed to support individual circumstances, and is sufficiently high to offset any reduction in universal credit and ensure the payment offers additional incomes and therefore reflects a true incentive. Topping up the Workforce Grant allocated to Torbay Council is therefore essential to meet this level.

3. Financial details (and timescales):

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

Year(s)	Amount	Capital	Revenue
2021/22	**£200,000**	**£0**	**£200,000**

Representing a fixed contribution to the cost of the scheme.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

- Payment of the up to £2 payment is being managed by TC
- Oversight of commissioned activity, capacity and any unmet need is reported to the CCG on a weekly basis and will support monitoring of improvements as a result of the investment
- Delivery of the objectives set out in question 2 will be managed through regular reporting to the CCG through the system flow and workforce cell groups established as part of the local system escalation response

Signed

…… for NHS Devon CCG

…… Position

…… Date

…… for Torbay Council

…… Position

…… Date

SECTION 256 ANNUAL VOUCHER

Plymouth City Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2022.

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	**Revenue Expenditure £**	**Capital Expenditure £**	**Total Expenditure £**
Winter Workforce Sustainability – Personal Care	£200,000	£0	£200,000

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by the NHS Devon Clinical Commissioning Group in accordance with these Directions.

Signed…….

Date…….

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions)

Certificate of independent auditor

I/We have:

- Examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated)* and the related accounts and records of the ……. and
- Carried out such tests and obtained such evidence and explanations as I/we consider necessary.
  (Except for the matters raised in the attached qualification letter dated)*
- I/we have concluded that the entries are fairly stated: and
- The expenditure has been properly incurred in accordance with the relevant terms and conditions.

Signature …….

Name (block capitals) …….

Company/Firm …….

Date ……..
* Delete as necessary

Memorandum of Agreement

relating to the transfer of monies

under

Section 256

of the

NHS Act 2006

Memorandum of Agreement

Section 256 transfer

Title of scheme: Targeted Equipment

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

The key outcome required is to reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers. More details are set out in section 2.

2. Description of scheme

NHS contribution to Devon County Council to offer the care home market loaned equipment and small targeted grants to purchase equipment or fund minor adaptations to support system flow as part of NHSE level 4 response.

The loan equipment will be deployed by enhancing the existing community equipment service (commissioned by DCC on behalf of both commissioning organisations). The additional funds will expand the criteria for access and ensure provision can be made to loan necessary equipment for individuals on discharge from hospital whilst they are supported under the Discharge to Assess pathways.

The additional grants are being offered by Devon County Council and targeted against the following agreed criteria:

- increased bedded capacity
- ability to support higher level of complexity
- reduction in 1:1 support required
- enable more timely admission from hospital

The grant scheme award process will utilise infrastructure developed through previous market grants the local authority have offered. This will ensure an equitable opportunity for all providers to apply, a robust evaluation/ award process and clear grant agreements setting out measurable outcomes.

3. Financial details (and timescales):

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

Year(s)	Amount	Capital	Revenue
2021/22	**£250,000**	**£0**	**£250,000**

Representing a fixed contribution to the cost of the scheme.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

- A monthly report of the equipment loaned is provided to the CCG to enable validation against the discharge numbers and support longer term evaluation of the scheme
- CCG staff will have oversight of the grants issued by DCC, and the agreed outcomes (against the criteria)
- Both aspects of this scheme are reported on a weekly basis through the Care Home Winter Resilience meeting (DCC & CCG joint meeting), and regularly reported back through the system flow group (established as part of the Devon system escalation response)

Signed

…… for NHS Devon CCG

…… Position

…… Date

…… for Devon County Council

…… Position

…… Date

SECTION 256 ANNUAL VOUCHER

Devon County Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2022.

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	**Revenue Expenditure £**	**Capital Expenditure £**	**Total Expenditure £**
Targeted Equipment	£250,000	£0	£250,000

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by the NHS Devon Clinical Commissioning Group in accordance with these Directions.

Signed…….

Date…….

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions)

Certificate of independent auditor

I/We have:

- Examined the entries in this form (which replaces or amends the original submitted to me/us by the authority dated)* and the related accounts and records of the ……. and
- Carried out such tests and obtained such evidence and explanations as I/we consider necessary.
  (Except for the matters raised in the attached qualification letter dated)*
- I/we have concluded that the entries are fairly stated: and
- The expenditure has been properly incurred in accordance with the relevant terms and conditions.

Signature …….

Name (block capitals) …….

Company/Firm …….

Date ……..
* Delete as necessary

Memorandum of Agreement

relating to the transfer of monies

under

Section 256

of the

NHS Act 2006

Memorandum of Agreement

Section 256 transfer

Title of scheme: Personal Discharge Budgets

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

The key outcome required is to reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers. More details are set out in section 2.

2. Description of scheme

NHS contribution to Devon County Council to provide grants to individuals that support more personalised care planning and flexible solutions for individuals and their families (£1,200 per individual)

These grants are focused on hospital discharge, targeting following individuals:

- Pathway 0 – seeking to speed up discharge times by identifying where minor adaptations or purchases may support a more rapid discharge than relying on individuals, statutory services or voluntary and community sector
- Pathway 1 – for individuals with low level needs, offering small one-off payments to purchase alternative services, adaptations or equipment will enable a tailored response that removes the need to utilise regulated care services. This will speed up discharge for the individual and release capacity to support other individuals

The timely deployment of these funds was a key rationale for this contribution made via Devon County Council as it will enable the CCG to deploy these grants in a simple and efficient way by utilising existing direct payment mechanisms.

3. Financial details (and timescales):

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

Year(s)	Amount	Capital	Revenue
2021/22	**£144,000**	**£0**	**£144,000**

Representing a fixed contribution to the cost of the scheme.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

- Utilisation of the Hospital Discharge Grants is being overseen by the CCG Community Services Team. All requests are being approved, and a daily reporting mechanism is in place. This detail is shared at a system level and reported weekly to the Devon System Flow/Discharge cell, and system surge groups.
- Each acute trust is also required to report the number of grants delivered as part of their daily NHSE sit rep reporting, and this forms part of the data pack reviewed by NHSE regional leads and the CCG as part of twice weekly system assurance calls.
- In addition to activity data, information on the discharge dates (to identify where faster discharges have been enabled) and types of spend are captured for each case. This will inform a review of the discharge grants scheduled to be completed in early April for a determination as to if they should be included as BAU, and also to identify where there may be gaps in commissioned services that would support discharge.

Signed

…… for NHS Devon CCG

…… Position

…… Date

…… for Devon County Council

…… Position

…… Date

SECTION 256 ANNUAL VOUCHER

Devon County Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2022.

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	**Revenue Expenditure £**	**Capital Expenditure £**	**Total Expenditure £**
Personal Discharge Budgets	£144,000	£0	£144,000

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by the NHS Devon Clinical Commissioning Group in accordance with these Directions.

Signed…….

Date…….

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions)

Certificate of independent auditor

I/We have:

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Signature …….

Name (block capitals) …….

Company/Firm …….

Date ……..
* Delete as necessary

Memorandum of Agreement

relating to the transfer of monies

under

Section 256

of the

NHS Act 2006

Memorandum of Agreement

Section 256 transfer

Title of scheme: Critical Thinking Unit

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

Regional Investment in a Critical Thinking Unit managed by the Office for Health Improvements and Disparities, working to regional oversight group hosted by Devon County Council.

This investment will:

- Provide a channel and coordinate multiple streams of government work working in the South West to improve, protect and level up the region's health, including through reducing health inequalities and disparities.
- Provide a resource for the Regional Health Inequalities Board to manage the multiple streams and direct agency attention to the areas of greatest need and act as a source of advice and information on current regional and national policy.
- Identify funding opportunities for projects in the region and share best practice and successes raising the profile of the South West through work in reducing health inequalities and disparities.
- To understand topic specific initiatives within multiple agencies with the aim of preventing further harms, to solve existing problems, service pressures and respond to new emerging challenges together for better outcomes and to avoid duplication

The main benefits of which are set out in section 2

2. Description of scheme

Hosting the Regional Health Inequalities Board to give cross-agency focus on the drivers of ill health, including wider determinants.

a. Giving a regional focus to addressing inequalities will provide amplification and consistency to improve health outcomes.
b. This is intended to encompass the expected actions for other government agencies as part of the Levelling Up Agenda so that action is not duplicated.

Providing analysis and evidence to address service demand issues across the South West.

c. Recognises the shared nature of service pressures across different sectors.
d. Will be tasked by the Regional Oversight Group which is a meeting of strategic leaders from a range of agencies, chaired by Devon County Council.

The unit will work to provide a collective application of intelligence and evidence information from across key agencies in the SW, led by a senior Public Health consultant.

e. At the moment, multiple agencies hold this information singly.
f. The unit will convene the analytical and evidence community efficiently.
g. The unit will answer system demand and inequalities questions across agencies assessments through Regional Oversight Group and deliver through timely and coordinated cross departmental/inter-organisational assessments of its population/s health and wellbeing.
h. Identify the underlying causes through analysis and evidence (this is through a PH lens which is different to looking at the situation as a performance problem)
i. Suggest solutions that address the current pressures but also encourage agencies to work together on root causes that will also improve population health in the longer term.
j. answer system demand and inequalities questions across agencies in Regional Oversight Group

3. Financial details (and timescales):

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

Year(s)	Amount	Capital	Revenue
2021/22	**£1,500,000**	**£0**	**£1,500,000**

Representing a fixed contribution to the cost of the scheme.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

- The CTU are currently updating Recovery Monitoring Tool (RMT) which will be used to as the key indicator to enable cross sector service planning and action.
- The RMT is primarily based on evidence of the areas that have been negatively impacted by COVID-19, either directly or indirectly; prioritisation based on COVID-19 impact and severity; exacerbations of health inequalities in populations affected, including deprived communities and BAME.
- The basis of this tool is that it amalgamates evidence-based metrics and calibration methodology used widely by the NHS and Public Health
- The CTU will shape the direction of Regional Oversight Group actions through bespoke analysis and research, to address specific issues on service demand pressures and shape action on regional health inequalities priorities.
- The CTU will receive feedback from members of the ROG on its performance though survey.

Signed

…… for NHS Devon CCG

…… Position

…… Date

…… for Devon County Council

…… Position

…… Date

SECTION 256 ANNUAL VOUCHER

Devon County Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2022.

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	**Revenue Expenditure £**	**Capital Expenditure £**	**Total Expenditure £**
Critical Thinking Unit	£1,500,000	£0	£1,500,000

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by the NHS Devon Clinical Commissioning Group in accordance with these Directions.

Signed…….

Date…….

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions)

Certificate of independent auditor

I/We have:

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- Carried out such tests and obtained such evidence and explanations as I/we consider necessary.
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- The expenditure has been properly incurred in accordance with the relevant terms and conditions.

Signature …….

Name (block capitals) …….

Company/Firm …….

Date ……..
* Delete as necessary

Memorandum of Agreement

relating to the transfer of monies

under

Section 256

of the

NHS Act 2006

Memorandum of Agreement

Section 256 transfer

Title of scheme: Shared Care Record

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

The funding will be spent primarily on a digital shared care record solution by commissioning incumbent suppliers to adapt an incumbent solution and/or third-party technical support. This will provide:

- Frontline social care staff within Devon access to clinical and social care information held within systems other than their own.

- Frontline health staff within Devon access to social care information at the point of care (generally from their existing IT solutions).

This will allow health and social care professionals to make informed decisions on an individual's care (therefore providing better safer care), as additional key information will be available to them from a single source as and when they need it, 24 hours a day 365 days of the year.

The main benefits of which are set out in section 2

2. Description of scheme

The implementation of a Shared Care Record is nationally mandated.

The majority of the benefits are anticipated to be quantative.

A Statement of Planned Benefits (SOPB) has been produced and shared with NHSE. The programme has identified an individual within the core programme team to lead the benefits work in conjunction with identified individuals within stakeholder organisations.

Identified benefits include:

- Reduction in Ambulance conveyances and/or inappropriate transfers.
- Reduction in unwanted treatment via availability of TEP's.
- Reduction in time to triage patients.
- Reduction in calls to GP's.
- Reduction in clinical time spent searching for information in multiple systems.
- Reduction in unwanted treatment via availability of TEP's.
- Reduction in the number of home visits.
- Reduction in wasted visits.
- Early identification of patients at risk and/or with complex health needs.
- Reduction in duplicate tests.

- Patients only asked for information once.
- Improved patient experience.
- Reduction unnecessary tests.
- Reduction in time searching for information in multiple sources
- Reduction in time taken searching for information

3. Financial details (and timescales):

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

Year(s)	Amount	Capital	Revenue
2021/22	**£600,000**	**£600,000**	**£0**

Representing a fixed contribution to the cost of the scheme.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

Performance will be measured against regional benchmarks and also the range and type of benefits realised within other ICS areas.

The Programme reports into the NHSE Shared Care Record National Metric on a monthly basis.

Signed

…… for NHS Devon CCG

…… Position

…… Date

…… for Devon County Council

…… Position

…… Date

SECTION 256 ANNUAL VOUCHER

Devon County Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2022.

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	**Revenue Expenditure £**	**Capital Expenditure £**	**Total Expenditure £**
Shared Care Record	£0	£600,000	£600,000

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by the NHS Devon Clinical Commissioning Group in accordance with these Directions.

Signed…….

Date…….

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions)

Certificate of independent auditor

I/We have:

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Signature …….

Name (block capitals) …….

Company/Firm …….

Date ……..
* Delete as necessary

Memorandum of Agreement

relating to the transfer of monies

under

Section 256

of the

NHS Act 2006

Memorandum of Agreement

Section 256 transfer

Title of scheme: Shared Care Record

1. How will the section 256 transfer secure more health gain than an equivalent expenditure of money in the NHS?

The funding will be spent primarily on a digital shared care record solution by commissioning incumbent suppliers to adapt an incumbent solution and/or third-party technical support. This will provide:

- Frontline social care staff within Devon access to clinical and social care information held within systems other than their own.

- Frontline health staff within Devon access to social care information at the point of care (generally from their existing IT solutions).

This will allow health and social care professionals to make informed decisions on an individual's care (therefore providing better safer care), as additional key information will be available to them from a single source as and when they need it, 24 hours a day 365 days of the year.

The main benefits of which are set out in section 2

2. Description of scheme

The implementation of a Shared Care Record is nationally mandated.

The majority of the benefits are anticipated to be quantative.

A Statement of Planned Benefits (SOPB) has been produced and shared with NHSE. The programme has identified an individual within the core programme team to lead the benefits work in conjunction with identified individuals within stakeholder organisations.

Identified benefits include:

- Reduction in Ambulance conveyances and/or inappropriate transfers.
- Reduction in unwanted treatment via availability of TEP's.
- Reduction in time to triage patients.
- Reduction in calls to GP's.
- Reduction in clinical time spent searching for information in multiple systems.
- Reduction in unwanted treatment via availability of TEP's.
- Reduction in the number of home visits.
- Reduction in wasted visits.
- Early identification of patients at risk and/or with complex health needs.
- Reduction in duplicate tests.

- Patients only asked for information once.
- Improved patient experience.
- Reduction unnecessary tests.
- Reduction in time searching for information in multiple sources
- Reduction in time taken searching for information

3. Financial details (and timescales):

Total amount of money to be transferred and amount in each year (if this subsequently changes, the memorandum must be amended and re-signed)

Year(s)	Amount	Capital	Revenue
2021/22	**£100,000**	**£100,000**	**£0**

Representing a fixed contribution to the cost of the scheme.

4. Please state the evidence you will use to indicate that the purposes described at questions 1 & 2 have been secured.

Performance will be measured against regional benchmarks and also the range and type of benefits realised within other ICS areas.

The Programme reports into the NHSE Shared Care Record National Metric on a monthly basis.

Signed

…… for NHS Devon CCG

…… Position

…… Date

…… for Plymouth City Council

…… Position

…… Date

SECTION 256 ANNUAL VOUCHER

Devon County Council

PART 1 STATEMENT OF EXPENDITURE FOR THE YEAR 31 MARCH 2022.

(if the conditions of the payment have been varied, please explain what the changes are and why they have been made)

Scheme Ref. No and Title of Project	**Revenue Expenditure £**	**Capital Expenditure £**	**Total Expenditure £**
Shared Care Record	£0	£100,000	£100,000

PART 2 STATEMENT OF COMPLIANCE WITH CONDITIONS OF TRANSFER

I certify that the above expenditure has been incurred in accordance with the conditions, including any cost variations, for each scheme agreed by the NHS Devon Clinical Commissioning Group in accordance with these Directions.

Signed…….

Date…….

Director of finance or responsible officer of the recipient (see paragraph 5(3) of the Directions)

Certificate of independent auditor

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Signature …….

Name (block capitals) …….

Company/Firm …….

Date ……..
* Delete as necessary

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Continuing Healthcare – Update to NHS Devon CCG constitutional financial limits				
Date of committee: 24 February 2022 **Date report produced: 17 February 2022**				
Author (s) Name and Title: Jo Shill, Head of Quality Assurance and Nursing (CHC) Clare Doble, Head of Governance		**Supporting Executive(s):** **Name and Title: Darryn Allcorn, Chief Nursing Officer** **John Dowell, Director of Finance** **Contact Details:**		
		Report Approved by: As above **Name and Title:** **Date 17 February 2022**		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

A recent business case has enabled the Adult continuing healthcare (CHC), Children's and Young People's Continuing Care and the Learning Disability and the Autism Partnership Team to increase management capacity to assure the quality and sustainability of proposed packages and placements, and to offer more senior challenge and decision making into the process of arranging care. To keep pace with this, it is proposed the financial limits held within the constitution and the delegated financial limits reserved for senior officers is amended to enable real-time decisions to be made once assurance has been gained on the appropriateness of the proposed package/placement.

Management of Conflict of interests:
Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.

Committees that have previously discussed/agreed the report and outcomes:

CHC Control Centre 04 February 2022

Key recommendations and actions requested:
The Governing Body is asked to approve the amendments to NHS Devon CCG constitutional financial limits as outlined in section 3.1 of the report
Impact on our objectives
(Delete as applicable) 1. Commission high-quality and safe services that reduce health inequalities and improve health outcomes 2. Improve service performance 3. Achieve financial sustainability 4. Effective, well-led organisation with an empowered and inclusive workforce 5. Lead the system's response to the coronavirus pandemic
Reference to other documents or accompanying papers:
NHS Devon CCG Constitution and Governance Handbook
Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	**No**
Quality of Services		
Health Inequalities		
Equality (staff or public)		
Resource and Finance		
Legal		
Engagement and Consultation		
Risk		

The CCG has made every effort to ensure this report does not have the effect of discriminating, directly or indirectly, against employees, patients, contractors or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability.

NHS
Devon
Clinical Commissioning Group

Report Title: Continuing Healthcare – Update to NHS Devon CCG Constitutional financial limits

1.0 Situation

1.1 Current independent sector market sufficiency issues are manifesting in increased care home fees and hourly rates requiring agreements in order to commission safe and sustainable care for eligible individuals within the NHS Devon CCG footprint. The impact of this is felt not only financially but within the increased transactional processes required in order to gain approval for the package/placement to proceed. There is a requirement for 'real-time' agreements in order to enhance system flow, to keep patients safe and to enable hospital discharge.

2.0 Background

2.1 A recent business case has enabled the Adult CHC, Children's and Young People's Continuing Care and the Learning Disability and the Autism Partnership Team to increase management capacity to assure the quality and sustainability of proposed packages and placements, and to offer more senior challenge and decision making into the process of arranging care. To keep pace with this, it is proposed the financial limits held within the constitution and the delegated financial limits reserved for senior officers is amended to enable real-time decisions to be made once assurance has been gained on the appropriateness of the proposed package/placement.

3.0 Assessment

3.1 It is proposed that an amendment is made to the financial limits section 21 line 10 held within the NHS Devon CCG constitution following approval from the Governing Body. With this approval clinical staff within the teams will then be able to agree funding. The requested changes are set out below for visibility and transparency:

Staff Band	Current funding limit within constitution	Proposed Funding Limit	Comment
Band 7	Up to £1200 per week	Up to £1200 per week	No change
Band 8a	From £1,201 up to £1,300 per week	Up to £1600 individually per week Up to £2000 per week, with two staff of the same or a higher banding	Changed arrangement
Band 8b	From £1,301 to £1,600 per week	Up to £2000 per week individually	Changed arrangement

		Up to £2200 per week when agreed with an 8a or higher	Changed arrangement
Band 8c		up to £2500 per week	Changed arrangement
Individual Package of Care policy Panel	From £1,601 to £5,000 per week	up to £6000 per week	Changed arrangement.
VSM (CNO **and** DOF or CO or COO or Director of Commissioning)		Above £6,001 per week	Changed arrangement

4.0 Recommendations

4.1 The Governing Body are being asked to approve the amendments to the constitution as outlined in section 3.1 of this report

Report author: Jo Shill, Head of Quality Assurance and Nursing (CHC) & Clare Doble, Head of Governance
Executive Lead: Darryn Allcorn, Chief Nursing Officer

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Devon Health Inequalities programme position statement				
Date of committee: 24 February 2022 **Date report produced: 11 February 2022**				
Author (s) Name and Title: **Paul Hurrell, Lincoln Sargeant, Su Smart, Helena Posnett, Lorraine Webber**		**Supporting Executive:** **Name and Title: Lincoln Sargeant, Director of Public Health for Torbay** (Devon SRO for Health Inequalities) **Contact Details:**		
		Report Approved by: **Name and Title: Lincoln Sargeant** **Date 10 February 2022**		
Public or Private (Governing Body only):	**Public**	✔	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				
Executive Summary: This report provides a current position statement in relation to the Devon Health Inequalities. It outlines the progress made in 2021/22; the impact of covid on the population and the programme itself, and the focus of the programme as we move into 2022/23.				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				
Key recommendations and actions requested:				

No recommendations. Report presented for information only.
Impact on our objectives
(Delete as applicable) 1. Commission high-quality and safe services that reduce health inequalities and improve health outcomes
Reference to other documents or accompanying papers:
Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	**No**
Quality of Services		✔
Health Inequalities		✔
Equality (staff or public)		✔
Resource and Finance		✔
Legal		✔
Engagement and Consultation		✔
Risk		✔

The CCG has made every effort to ensure this report does not have the effect of discriminating, directly or indirectly, against employees, patients, contractors or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability.

NHS
Devon
Clinical Commissioning Group

Health Inequalities position statement

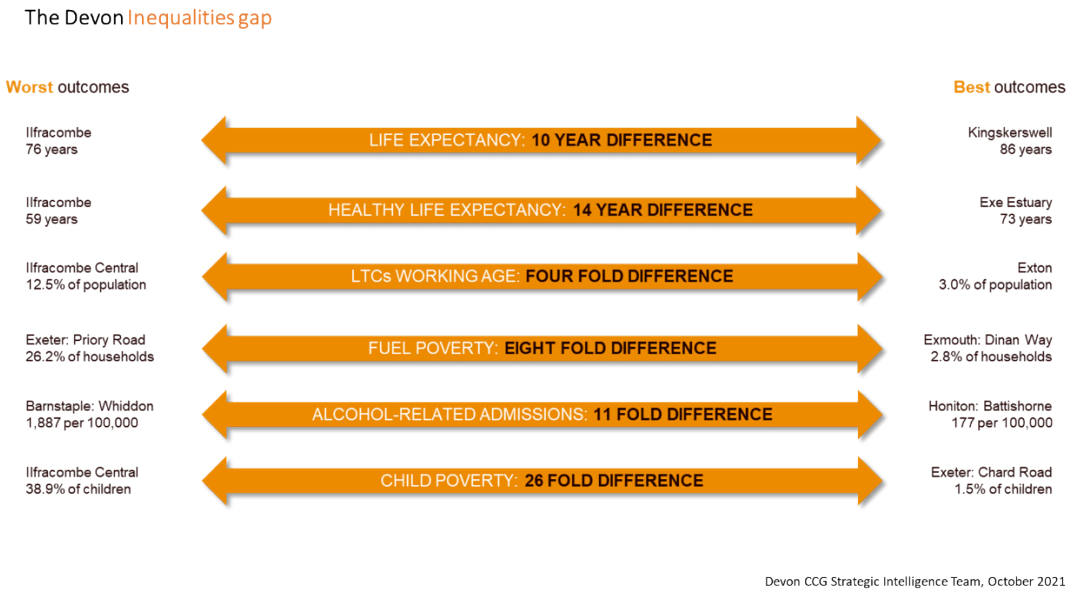
1. Introduction

The COVID-19 pandemic posed a risk to everyone, but the consequences were experienced differently according to socioeconomic status. When an effective vaccine programme was implemented, the uptake reflected long-standing patterns of differential access to health care services despite the intent that every eligible person should have the same opportunity to be protected. There is recognition of the causes and effects of health inequalities across Devon and the focus this year has been to develop a strategic programme to enable us to tackle these inequalities in a systematic and co-ordinated way as an Integrated Care System. We build on the achievements of a well-established prevention programme that demonstrates our ability to work together to take collective action on priority areas.

1.1 Leadership and support capacity to the Health Inequalities (HI) agenda at both national and regional level has increased, and we are now active participants in regular regional and national groups.

1.2 The COVID-19 pandemic continues to exacerbate existing health inequalities within Devon, also putting into stark focus the importance of the Devon system working collaboratively to address the wider determinants of health such as access to safe, stable and fit-for-purpose housing, employment and education.

1.3 In section 3.0 below, we describe the challenge of addressing the quality and completeness of data relating to the characteristics of our population and those who are, and are not, accessing our support and services. Whilst that remains one of our greatest challenges for the programme, data available demonstrates the need for us to take action to address the significant inequalities that exist within Devon.



1.4 CORE20Plus5 (see **Appendix 1**) now frames the national HI agenda, and provides useful context to the actions we are taking in Devon, with our plan aligning well within this revised context.

1.5 2021/22 has proven challenging, with the majority of our core Health Inequalities team redeployed to COVID-19 response work for a significant percentage of the year. The consequences of this have included the standing down of our HI Executive Leadership Group meetings; delays in commencing work on core projects (including delays in delivery of externally funded projects); and inability to provide targeted support to locality plans during development.

1.6 Capacity issues within provider organisations continue to impact upon our ability to progress a number of actions that will deliver changes to culture and the improvements in data quality that will embed health inequalities as part of the way in which we work.

1.7 Through 2021/22 we have seen a number of changes in key roles within the programme, including welcoming Dr Lincoln Sargeant, Director of Public Health for Torbay as our system Senior Responsible Officer for Health Inequalities and Prevention, replacing Dr Caroline Dimond upon her retirement. We have also said a fond farewell to Ginny Snaith as Programme Director upon her return to her substantive role as CCG Board Secretary.

2. Our achievements in 2021/22

2.1 We have strengthened the interrelationship between our Health Inequalities and Prevention programmes through combined programme governance arrangements. And whilst the focus and ambition for these programmes is yet to be established, the Equally Well and Anchor Institution agenda's now also form part of this governance arrangement, operating under a single work plan.

2.2 In light of the challenges the lack of good quality data relating to our population and patients present us (**see 4.1 below**), we have promoted a "do the right thing" culture within the programme to encourage positive action whilst we continue to address the underlying issue of data. We carry this "can do" attitude into 2022/23.

2.3 It has been a very successful year in terms of securing external investment into our programme to allow us to deliver a number of targeted interventions, with the CCG Prevention Fund proving invaluable in allowing us to demonstrate match funding in prospective bids. Through a number of bids and business cases, we have secured approximately **£600k**[1] of regional and national funding to further work across a number of topics areas, including:

- Long Term plan funding for 2.5 years for the treatment of tobacco dependence in those admitted to our acute and mental health hospitals, and women and their partners using our maternity services;
- Enhanced Acute Alcohol Care for Torbay patients;
- VCSE-led proactive support offer to long waiting patients;

[1] The majority of this funding is non-recurrent, for intended for activity in 2021/22. Approx £300k of Long Term Plan funding has been secured, per year, for three years to support our work on Treating Tobacco Dependency workstream.

- Building community capacity to enhancing the recovery college model in Plymouth;
- Building upon work already undertaken by the Plymouth Local Care Partnership, we are working with a national homeless charity to refresh our 2010 Homeless Health Needs Assessment across whole-Devon;
- Piloting enhanced support to patients accessing Tier 3 Weight Management Services, through a test of change project in the Plymouth system.
- Achieving national Digital Inclusion Pioneer status, we have secured both funding, and specialist support from NHSX to better understand the digital inequalities experienced by those living in our most rural communities;
- Short-term capacity funding to increase the resourcing of the Health Inequalities programme.

2.4 We continue to target investment from our prevention fund to support both whole-Devon and place-based interventions. 2021/22 has seen us invest in:

- Physical activity schemes for mid-life and older adults with type-2 diabetes, depression and anxiety, alongside those at risk of frailty;
- Sustaining the Community Infection Prevention and Control team that has proven so invaluable during the pandemic;
- Making funds available to localities to target falls and frailty
- Community asset development to support the Devon Social Prescribing programme;
- Implementation of a family therapy model to support the underlying emotional health and wellbeing of children, young people and their families; and
- Projects to understand how the system can better meet the needs of those with multiple and complex needs.

2.5 Suicide prevention has been a priority for us in 2021/22, with a significant percentage of our prevention fund invested in:

- The roll-out, across Devon, of post-vention suicide bereavement support training to support those affected by suicide;
- Targeted support those affected by suicide; and
- Suicide prevention and ligature training for front-line staff in DPT and Livewell.

2.6 The Devon system has been recognised for the maturity of our thinking and strength of local relationships in relation to our health inequalities programme. As a result, Devon has:

- been awarded funding that, against stated criteria, the Devon system should not have qualified for;
- been sought out by external organisations and agencies as a system they wish to work with; and
- secured Digital Inclusion Pioneer status as one of 10 national pioneer sites.

The strength of our close working relationship with our local Voluntary, Community and Social Enterprise sector partners on the Health Inequalities programme has been a noted strength in many of our successful bids for funding.

2.7 We are delighted to have just received confirmation of the success of our bid to secure funding to pilot the NHS England and Improvement Core20Plus5 connector initiative, which will see us strengthen links between commissioning decisions and the inequalities experienced within local communities through the establishment of a

network of health inequalities community ambassadors ("Core20Plus5 Connectors").

3. Our main challenges

We have identified two main risks to our programme of work. That of access to **good quality, timely data**, and the **cultural change and organisational development** required to embed health inequalities in everything we do.

Data quality, completeness and availability

3.1 Learning from both local and national evaluation of the impact of COVID has evidenced that the pandemic has amplified greatly existing health inequalities. COVID response work has also made increasingly visible the challenges of understanding the composition of our population, and their access to, experience of, and outcome achieved, from our services and support. Devon is not alone in this challenge, with other systems consistently reporting similar issues at both regional and national fora.

3.2 The greatest risk to our programme remains a lack of good quality data relating to the protected characteristics of our population and patients. We do not have access to data and the required intelligence support that allows us to:

- Refer to a baseline, up-to-date, picture of the composition of the population of Devon, particularly in relation to ethnicity;
- Routinely identify the characteristics of the people who are, and importantly are not, connecting with our services to identify who may be disproportionately represented and/or underrepresented in our activity data;
- Target our efforts to those experiencing unacceptable differences in access, experience and outcome;
- Be confident in understanding the impact we are having on access, experience and outcomes for those experiencing health inequalities.

3.3 There is consensus across all system partners of the importance of addressing the issue of quality and completeness of data. However, with the system remaining under pressure, capacity within our business intelligence workforce remains focussed elsewhere, and as a result we have failed to address this priority action during 2021/22.

Organisational development / embedding health inequalities

3.4 Making health inequalities part of everything we do requires significant process and cultural change.

3.5 Process changes such as improvements to the Quality and Equality Impact Assessment and the rollout of the Population Health Management approach will give us the tools required to consider health inequalities in any change. We must not overlook the cultural change required to ensure we understand the need for the application of these tools, however.

3.6 We will look to work closely with the ICS Workforce programme to establish an organisational development programme that will establish the "why" of why health inequalities matter.

3.7 Any internally facing organisational development will need to be accompanied by an outward facing plan to engage and involve, inform and influence the population.

4. Priorities for 2022/23

We approach 2022/23 from a good position, with attention to Health Inequalities within our Local Care Partnerships developing well.

4.1 We are reinstating our programme, with the core HI team now back from redeployment. 2022/23 will see us better resourced from a staffing and leadership perspective:

- **Non-Executive Director** with responsibility for Health Inequalities;
- **Alignment of PHM and Health Inequalities agenda's** under the Deputy Director of Out of Hospital commissioning
- Appointment to **Head of Health Inequalities and Population Health Management**; and
- 6-month position of **Acting Public Health Consultant for Health Inequalities**.

4.2 Outputs from a recent review of Local Care Partnership (LCP) plans demonstrated that the needs of those experiencing health inequalities are present in locality plans. **Appendix 2** provides an aggregated summary of the self-assessment responses from our locality commissioning leads in relation to the process they have made in identifying the people that are experiencing unacceptable differences in access, experience and outcome within their locality.

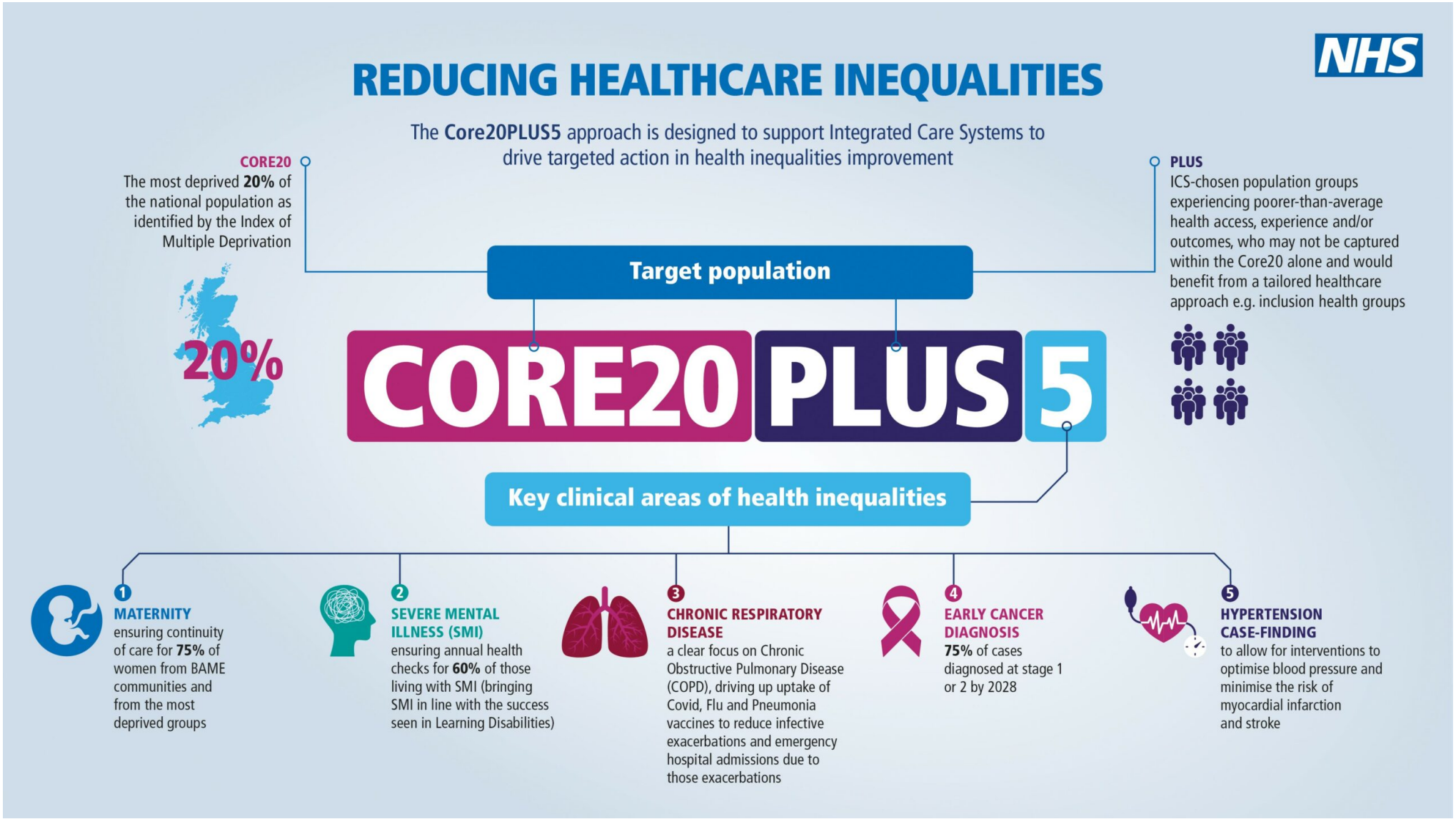
4.3 We will launch a revised Quality and Equality Impact Assessment process, designed to make it easier for anyone considering change to better understand how individuals with protected characteristics may experience inequalities as a result of any change, and what actions can be taken to mitigate or eliminate these risks.

4.4 Whilst maintaining attention on the work required to embed health inequalities across the system (including addressing the challenges described in **section 4.0** above), we will increase the emphasis of our governance to our engagement with locality structures and informing, influencing and supporting work at place.

4.5 We will continue to seek out opportunities to secure external investment in our work and, where we can, invest in delivering whole-Devon workstreams and interventions.

4.6 It is important that we ensure projects transition to "business-as-usual" arrangements upon completion of agreed pilots or investment periods to allow us to continue to use the prevention funding as a transformation fund. With investment in a number of workstreams coming to a planned end in 2022/23, we will require workstream leads to evaluate the impact of this investment to inform the business cases upon which they will secure sustained funding.

Appendix 1: Core20PLUS5 framing of the national health inequalities agenda



Appendix 2: LCP Health Inequalities planning maturity assessment

Locality	Maturity						HI Priorities for 2022/23	Support
	Level 1: Needing some help We need support to understand more about health inequalities before we take our next steps	**Level 2: About to start** We know what we need to do to identify our health inequalities, but have yet to do so.	**Level 3: Exploring** We are gathering the insight that we will use to inform where inequalities in access, experience and/or outcome exist within our locality.	**Level 4 :Planning** We know who is experiencing health inequalities within our locality, and are in the process of defining the actions we will take to address the inequalities these inequalities	**Level 5: Ready to take action** We understand who is experiencing differences in access, experience and outcome, and have plans in place to address these inequalities	**Level 6: Tackling Health Inequalities** We understand who is experiencing differences in access experience and outcome within our locality, and are taking action to address these inequalities		
Northern			✔	✔			People with complex needs Older people affected by frailty and loneliness People with mental health needs with low levels of physical activity IMD: access; maternity; CYP mental health	Closer links with system programmes (HI; Prevention; LMS; Mental Health) Data quality and completeness: Data (BAME; refugees) Best practice: refugees Increased working with VCSE partners Homeless HNA.
Eastern			✔	✔			Children and young people: alcohol and self-harm Unpaid carers Loneliness IMD: access; maternity; CYP mental health BAME: access; maternity	Closer links with system programmes (HI; Prevention; LMS; Mental Health). Data quality and completeness: Data (BAME; refugees) Best practice: refugees Increased working with VCSE partners Homeless HNA; Revised QEIA
Southern			✔				Suicide in males: priorities to be defined in the Community Mental Health Framework; Self-harm: priorities to be defined in the Community Mental Health Framework; Children in care: priorities to be defined in the Community Mental Health Framework IMD: access; BAME: not known at this point	Data quality and completeness: BAME data Homeless Health Needs Assessment

	Maturity						HI Priorities for 2022/23	Support
Western			✔				Rurally isolated people: (mental health; social isolation and loneliness; fuel poverty; food insecurity and health; affordable housing; dementia diagnosis and treatment IMD: as above	Data quality and completeness. Granular BAME data. Homeless Health Needs Assessment NHSX Digital Pioneer Rural Digital Inequalities
Plymouth			✔				Dementia: access; obesity; tobacco Carers: access SMI: access; SMI, LD & Autism; COPD; Hypertension case finding; obesity; alcohol; tobacco Veterans: access; SMI, LD & Autism; COPD; Hypertension case finding; obesity; alcohol; tobacco Childhood trauma: access; SMI, LD & Autism; Maternity; COPD; Hypertension case finding; obesity; alcohol; tobacco IMD: access; maternity; SMI; COPD; Hypertension case finding; obesity; alcohol; tobacco BAME: Maternity; COPD	Data quality and completeness: BAME data

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GOVERNING BODY

Report title: Integrated Care System for Devon Update for Board and Cabinet members				
Date of committee: 24 February 2022 **Date report produced: January and February 2022**				
Author (s) Name and Title: Andrew Millward, Director of Communications and Engagement of Integrated Care System Devon; and Director of Communications, HR, governance and IT, NHS Devon.		**Supporting Executive:** **Name and Title: Andrew Millward** **Contact Details: andrew.millward@nhs.net** **Report Approved by: Andrew Millward** **Name and Title:** **Date January 2022**		
Public or Private (Governing Body only):	**Public**	**x**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

The purpose of this regular report is to:

- **Provide a monthly update for Board, Cabinet and Governing Body meetings across ICS partner organisations in Devon, Plymouth and Torbay.**
- **Ensure everyone is aware of ICS developments, decisions, issues and news in a timely way.**
- **Ensure consistency of message amongst ICS partner organisations.**

Management of Conflict of interests:
Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via **d-ccg.governance@nhs.net** to update the central register.

Committees that have previously discussed/agreed the report and outcomes:

n/a

Key recommendations and actions requested:

To note the paper
Impact on our objectives
(Delete as applicable) 1. Commission high-quality and safe services that reduce health inequalities and improve health outcomes 2. Improve service performance 3. Achieve financial sustainability 4. Effective, well-led organisation with an empowered and inclusive workforce 5. Lead the system's response to the coronavirus pandemic
Reference to other documents or accompanying papers:
n/a
Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	**No**
Quality of Services	This development of the Integrated Care System for Devon (ICSD) will have an impact on all of these areas	
Health Inequalities		
Equality (staff or public)		
Resource and Finance		
Legal		
Engagement and Consultation		
Risk		

The CCG has made every effort to ensure this report does not have the effect of discriminating, directly or indirectly, against employees, patients, contractors or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability.

Integrated Care System for Devon Update for Board and Cabinet members

January 2022

The purpose of this regular report is to:

- Provide a monthly update for Board, Cabinet and Governing Body meetings across ICS partner organisations in Devon, Plymouth and Torbay.
- Ensure everyone is aware of ICS developments, decisions, issues and news in a timely way.
- Ensure consistency of message amongst ICS partner organisations.
- Accompany your own briefings to Board, Cabinet and Governing Body meetings. If cutting/pasting content, can this please be done in its entirety.

This Update features:

1. **National ICS launch delay**
2. **ICS development**
3. **System Oversight Framework**
4. **Devon Long Term Plan**

1. National ICS launch delayed until July

A new target date for the establishment of statutory Integrated Care Systems (ICSs) and Integrated Care Boards (ICBs) has been confirmed by NHS England and NHS Improvement.

To allow sufficient time for the remaining parliamentary stages of the Health and Care Bill, a revised target date of 1 July 2022 has been agreed. This replaces the previous target of 1 April 2022 and means the current arrangements will remain in place until 1 July.

Devon has already made significant progress, so these additional three months will provide extra flexibility to prepare for the new arrangements and manage the pandemic response, while maintaining momentum towards more effective system working.

The establishment of statutory ICSs and the timing remains subject to the passage of the Bill through Parliament.

Together for Devon

Health and care working in partnership with local communities in Plymouth, Torbay and the rest of the county

2. ICS development

The ICB Board structure has been agreed, with recruitment for most roles underway – including non-executive stakeholder panels and interviews held on 12 and 13 January with interviews later this month. Led by the ICS chair, Dr Sarah Wollaston, the Board includes executive and non-executive posts plus members from provider, local authority, primary care, and public health.

A draft Integrated Care Partnership (ICP) structure has also been produced, which Dr Sarah Wollaston is discussing with stakeholders and partners.

The ICP will bring together NHS leaders and local authorities with important stakeholders from across the system and community to generate a strategy to improve health and care outcomes and experiences, for which all partners will be accountable.

A consultation on the ICB executive structure has taken place, with adverts for four of the roles being advertised externally:

1. Chief medical officer
2. Chief delivery officer
3. Chief finance officer
4. Director of workforce strategy

The remaining roles are subject to similarity assessments with current CCG executives.

The first draft of the ICB Constitution was submitted to the regulators (NHS England and NHS Improvement) on 3 December. Feedback was received 17 December, which was largely positive. There were a small number of minor points to address, which will be completed ahead of the final deadline in March 2022 and meetings with NHS England continue to help develop the constitution.

A 'functions and decisions map' process is also being developed, which sets out where decisions are made (e.g. system, local care partnership, provider collaborative, primary care network etc…). The ICS aims to make decisions as close to patients as possible (known as 'subsidiarity').

3. System Oversight Framework (SOF)

The final exit criteria for the system to move out of level 4 of the NHS England's System Oversight Framework (SOF) have been agreed internally and approved by the region.

In early December, this was sent to Trusts and the CCG to take through their individual Boards for noting.

The detail of the improvement plan is now being finalised and there will be a Board-to-Board meeting with the regional and the national teams early in the new year.

The new regional SOF oversight arrangements for both the system and Trusts will commence in January. This will be the key vehicle for monitoring progress against the improvement plans and generating recommendations to the national committee about any changes in the SOF rating early in 2022/23 financial year.

The critical work now is to progress the actions to deliver the necessary improvements in both urgent and emergency care and financial performance.

This will require a whole-system approach and discussions are underway with Chairs and Chief Executives as to the best mechanism for collaborative working and decision-making going forward.

4. Devon Long Term Plan latest

A broad narrative that outlines how partner organisations in the Integrated Care System for Devon will need to work together to meet current day-to-day challenges and ensure that services are able to meet the challenges of the next 20 years is being developed. It will be shared more widely in due course.

The aim is that the narrative becomes a foundation for the more detailed plans of day-to-day operational function, system recovery, the Long Term Plan and New Hospitals Programme.

Separately, the Integrated Care System for Devon is working with the statutory health and adult care Overview and Scrutiny Committees at Devon County Council, Plymouth City Council and Torbay Council to explore the feasibility of a Joint Committee between the councils so that LTP work that crosses Local Authority boundaries can be considered and scrutinised collectively by representatives of each of the Scrutiny Committees in the county.

A paper providing a detailed update on the latest Long Term Plan work that seeks agreement on the joint way of working is due to be considered by each committee, starting with Devon County Council's Health and Adult Care Scrutiny Committee on 20 January 2022.

Integrated Care System for Devon
Update for Board and Cabinet members
February 2022

The purpose of this regular report is to:

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This update features:

1. **ICS development**
2. **Local Care Partnership update**
3. **Integration White Paper published**
4. **Community Mental Health Framework latest**
5. **Elective recovery plan**
6. **Mental health updates**
7. **Digital developments**

1. ICS development

NHS Devon Integrated Care Board (ICB) has appointed three Non-Executive Directors (NEDs) to its new Board. Dr Thandiwe Hara, Professor Hisham Saleh Khalil and Professor Sheena Asthana will begin work in coming weeks, giving them time to be inducted and settle in before the ICB formally launches on 1 July 2022 (subject to parliamentary approval of the Health and Care Bill).

Dr Thandiwe Hara – NED for Citizen and Community Involvement
Thandi is currently the University of Oxford's Strategy Development Executive alongside being a non-executive Board member of the NIHR SW Clinical Research network and a trustee for the Plymouth Racial Equality Council. Thandi has extensive experience in community engagement, health inequalities and local government strategy and policy.

Professor Hisham Saleh Khalil – NED for Quality and Performance

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Hisham is a practising ear, nose and throat (ENT) consultant at University Hospitals Plymouth NHS Trust and Associate Dean and Faculty Head of the Peninsula Medical School. A current University Hospitals Plymouth NHS Trust NED, Hisham has held a similar role at the Royal Devon and Exeter NHS Foundation Trust. Hisham is an active clinical researcher with an interest in new models of healthcare delivery and ENT.

Professor Sheena Asthana – NED for Health Inequalities and Population Health

Sheena has been the director of the Plymouth Institute of Health and Care Research since 2020 where her research focused on closing inequality gaps in access to health care, education and other public services. Throughout her career, Sheena has been active in advocating for, and informing policy change in, health inequalities.

Over the past few years, Devon has put a greater focus on equality, diversity and inclusion, and it is positive to see the Board beginning to better reflect the rich diversity and culture in Devon.

The ICB will have six NEDs in total, with further announcements on appointments due towards the end of February, alongside the ICB's executive team.

As well as the executive and non-executive members, the ICB Board will also have four partnership members from NHS provider, primary care, local authority and population health and prevention.

Work on the governance model - including delegations of decision-making accountability and budgets - continues. NHS Devon ICB aims to begin operating in shadow from in spring, ahead of the full launch in July 2022.

2. Local Care Partnership update

Work is underway to Local Care Partnerships (LCPs) – the foundations of ICSs that build on existing local arrangements (see also section three below).

Devon will have six Local Care Partnerships that will see partners and stakeholders working together to design and deliver more joined-up care in local areas.

1. North
2. East
3. South
4. West
5. Plymouth
6. Mental health, learning disabilities and autism

Work between system partners is underway to determine the vision, leadership, governance and budget of each LCP, with the ambition to establish each LCP by 1 July, if not sooner.

A first workshop was held recently to look at current progress and where development is needed. From this, a roadmap for development will be created so LCPs can receive the right support.

3. Integration White Paper published

The government published a white paper on 9 February 2022 setting out proposals that aim to provide better, more joined-up health and care services at 'place' level. There are six 'places' that we call Local Care Partnerships (as above).

The integration white paper focuses on integration arrangements at place level and aims to accelerate better integration across primary care, community health, adult social care, acute, mental health, public health and housing services which relate to health and social care. Children's social care is not included within the scope of the paper. The document covers:

- **Governance** - All places will be required to adopt a governance model by spring 2023.
- **Leadership** - The paper states that there should be a single person accountable for the delivery of the shared plan and outcomes in each place or local area. This may be, for example, an individual with a dual role across health and care or an individual who leads a place-based governance arrangement.
- **Budget pooling** - NHS and local government organisations will be supported and encouraged to do more to align and pool budgets, subject to both NHS and local authority partners agreeing locally what constitutes fair.
- **Oversight** - The government will set out a framework with a small and focused set of national priorities and an approach from which places can develop additional local priorities – to come into force in April 2023. Local leaders will be responsible for working with partners to develop their priorities.
- **Digital** - ICSs will be required to develop digital investment plans for bringing all organisations to the same level of digital maturity. Every ICS will need to ensure that all constituent organisations have a base level of digital capabilities and are connected to a shared care record by 2024.
- **Workforce** - ICSs will be required to support joint health and care workforce planning at place level, working with both national and local organisations. Integrated skills passports are set to be introduced to: enable health and care staff to transfer their skills and knowledge between the NHS, public health and social care; increase nurse training opportunities in social care settings; and focus on roles which can support care co-ordination across boundaries, for example link workers. DHSC will increase the number of healthcare interventions that social care workers carry out by developing a national delegation framework of nursing interventions.

Source: NHS Confederation. Further information: Local Government Association, County Councils Network

4. Community Mental Health Framework latest

Devon's Mental Health, Learning Disabilities and Autism (MHLDA) Care Partnership is leading a wide range of areas of transformation, aligned to the Long-Term Plan, including the implementation of the new Community Mental Health Framework.

In recognition of current winter and pandemic pressures, implementation of the new model of care has been adapted in recent weeks to ensure that we still move forward with those critical areas of change for our population mindful of the context that all partners have been working in. We have remained committed to transforming our community offer so that it enables better care, support and experiences for people with mental health needs and integrated person-centred care.

Multi-agency teams have now been forming in all our localities and are working together to support local people differently. These teams are evolving and learning how to work together in new models across primary and secondary care, local authorities, partners and the wider community. As part of this, working in equal partnership with the VCSE both with the emerging Devon VCSE Alliance aligned to CMHF and with the wider VCSE sector is crucial: Implementation of the new offer as part of the CMHF model has commenced.

The service level agreement supporting new mental health practitioners under the Additional Roles Reimbursement Scheme between Devon Partnership NHS Trust (DPT) and Livewell Southwest (LS) and primary care networks (PCNs) has been agreed and signed by 26 PCNs for this year. The new MH practitioners are now mostly in place (remaining vacancies are still being recruited) and embedding in their new multi-agency teams. Planning for further roles in year 2 has started, which includes co-production of roles and job descriptions across primary and secondary care, in line with national guidance and confirming funding arrangements.

5. Elective recovery plans

The NHS and government have published a 'Delivery plan for tackling the COVID-19 backlog of elective care' (8 February) with an expansion in capacity for tests, checks and treatments.

The plan, which will give patients greater control over their own health and offer greater choice of where to get care if they are waiting too long for treatment, focuses on four areas:

1. Increasing health service capacity
2. Prioritising diagnosis and treatment
3. Transforming the way we provide elective care
4. Ensuring better information and support to patients

Despite the dedication of staff across the country, the pandemic has inevitably had an impact on the amount of planned care the NHS has been able to provide, in turn meaning longer waits for many patients.

Nationally, six million people are now on the elective care waiting list, up from 4.4 million before the pandemic. These patients are at various stages of their treatment pathway, with approximately four in five waiting for care that does not require admission to hospital, such as diagnostic tests or outpatient appointments.

An expansion in diagnostic capacity will mean 95% of patients will receive a test within six weeks of referral, while no patient will wait more than a year for elective surgery by March 2025. And by March 2024, 75% of patients will either have a diagnosis or have their cancer ruled out within 28 days of being urgently referred by their GP.

Devon's planned care workstream is continuing to develop proposals to reduce waiting lists.

6. Mental health updates

Devon Provider Collaborative
In the field of mental health, learning disability and autism, we have a strong history of joint working between the NHS, local authorities, the voluntary sector and people with lived experience. During the pandemic, Devon Partnership NHS Trust (DPT) and Livewell Southwest (LSW) have worked closely together, and with their partners, to share plans and resources to ensure the delivery of high quality care. DPT has led the development of the highly successful South West Provider Collaborative – a regional project to improve the care and treatment of people using secure mental health and learning disability services. We are now building on the learning from this initiative to develop a Devon ICS MHLDA Provider Collaborative, which will include all aspects of care and support and will receive delegated budgets from April 2022.

Older People
Rising demand for older people's mental health services across the system, and the challenges created by COVID-19, have also had a significant impact on the ability to discharge people from a variety of inpatient settings when they are fit and ready to leave. It has been a particular challenge in relation to the discharge of older people – many of whom are now presenting with more serious and complex needs alongside their physical frailty. There is a lack of suitable accommodation and support in the community and a lack of specialised placements, supported living and housing options for people with a variety of mental health needs.

National campaign to increase IAPT referrals
Both DPT and LSW have been supporting the national Help Us, Help You campaign to drive up referrals to Improving Access to Psychological Therapies (IAPT) services. In Devon this service is called TALKWORKS, and in Plymouth it is called Plymouth Options – it is a free talking therapy service and people can self-refer. The two organisations are also working with Devon CCG to further bolster referrals through a local digital marketing campaign.

Pressure on Child and Adolescent Mental Health Services
We continue to see increases in demand for Child and Adolescent Mental Health Services (CAMHS) – which is a trend that has been mirrored across the country. GP practices, schools and colleges across the county are reporting increases in demand for mental health support.

We have seen higher numbers of referrals for vulnerable and at-risk children as well as increases in acuity – meaning that a higher number of people are being referred with more complex and serious needs. We also know children have suffered an increase in poor sleep, loneliness and isolation during lockdowns and post-lockdown.

There has also been an increase in acuity and numbers of children with eating disorders as well as rising numbers of children coming into the care of the Local Authorities.

There were already long waiting times for some CAMHS services prior to the pandemic and, despite the fact that extra capacity and waiting list initiatives have been successful in tackling the problem – the additional demand created by COVID-19 has significantly exacerbated the situation.

Nationally, children and young people's mental health services are the fastest growing specialty in the NHS. In an average class of 30 pupils in England, five children could have a mental health difficulty. Children and young people in Devon are at greater risk of mental health problems, compared to other children and young people in the south west and nationally. Devon also has the highest level of social emotional mental health problems in the region – and some of the highest nationally, too. Devon invests £74 per head in children and young people's mental health and wellbeing services (approximately 6% of total mental health spend). This is slightly above the England average of £72 per head. Children and young people's mental health and wellbeing services in Devon reach around 35% of the need. This equates to 12,972 children and young people in 2021/22, increasing to 15,025 by 2023/24. This means 27,903 children and young people with a mental health problem aren't receiving NHS support.

7. Digital developments

Across Devon and Cornwall, a programme of digital work is underway to transform the way services are provided by giving care providers the right information at the right time to make the best possible decisions to support local people.

The Devon and Cornwall Care Record is a new system that brings together patient data from a wide range of clinical systems and presents it as a single summary view.

It enables authorised health and care staff to see information held by other providers across Devon and Cornwall's health system – from GP practices and hospitals to hospices and social care settings.

The first organisations taking part will go live in spring 2022.

This work forms part of Devon's digital strategy, which has three key aims:

1. **Digitise** infrastructure and services
2. **Connect** systems, records and services
3. **Transform** services with digital solutions

Devon's ambition is to use technology and digital solutions to deliver a more joined-up service in which the citizen is able to take more ownership of their wellbeing and to receive care in a way that best meets their needs.

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GOVERNING BODY

Report title: Winter Taskforce: Briefing for Board and Cabinet members				
Date of committee: 24 February 2022 **Date report produced: 19 January 2022**				
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Public or Private (Governing Body only):	**Public**	**x**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				
Executive Summary: The purpose of this paper is to update all Board and Cabinet members in Devon on the important role of the Winter Taskforce. The work of the Taskforce is wide ranging and this paper outlines its areas of focus.				
Management of Conflict of interests: Conflicts of interests are recorded on the register of interests, at each committee a list of recorded declarations is provided and confirmations of declarations are requested and noted. Any new declarations must be fully recorded and included in the minutes of the meeting and notified to the Governance team via d-ccg.governance@nhs.net to update the central register.				
Committees that have previously discussed/agreed the report and outcomes:				
Winter Taskforce				
Key recommendations and actions requested:				

To note the report
Impact on our objectives
(Delete as applicable) 1. Commission high-quality and safe services that reduce health inequalities and improve health outcomes 2. Improve service performance 3. Effective, well-led organisation with an empowered and inclusive workforce 4. Lead the system's response to the coronavirus pandemic
Reference to other documents or accompanying papers:
n/a
Does this report have implications in any of the areas highlighted below?

	If Yes, please give details	**No**
Quality of Services	The role of the Winter Taskforce covers impact on services	
Health Inequalities		x
Equality (staff or public)		x
Resource and Finance	Resources are a focus of the Winter Taskforce	
Legal		x
Engagement and Consultation	The taskforce has a communications cell	
Risk	Part of the role of the Winter Taskforce is to mitigate and tackle risks associated with pressures.	

The CCG has made every effort to ensure this report does not have the effect of discriminating, directly or indirectly, against employees, patients, contractors or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability.

Winter Taskforce: Briefing for Board and Cabinet members

19 January 2022

The purpose of this paper is to update all Board and Cabinet members in Devon on the important role of the Winter Taskforce. The work of the Taskforce is wide ranging and this paper outlines its areas of focus. This paper covers:

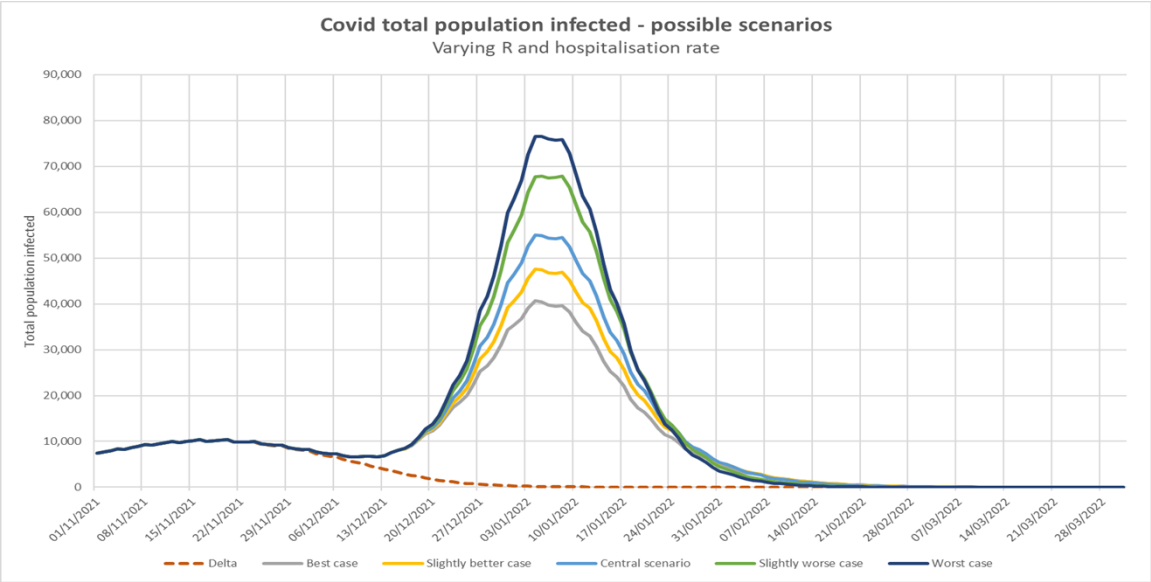
1. **The latest modelling**
2. **Vaccination update**
3. **The role of the Taskforce, including its leadership and focus**
4. **Super-surge planning and Delivery update**
5. **Covid mutual aid protocol**
6. **Ambulance dynamic conveyancing protocol**
7. **Supporting Discharge**
    - **P1-P0 protocol**
    - **Enhancement of Hospice and Hospice at Home capacity**
    - **Community**
    - **Discharge audit outcomes**
8. **Infection Control assurance on consistent approach**
9. **Consistent staffing policies, including:**
    - **Annual leave carryover**
    - **Testing (Lateral flow tests/PCR)**

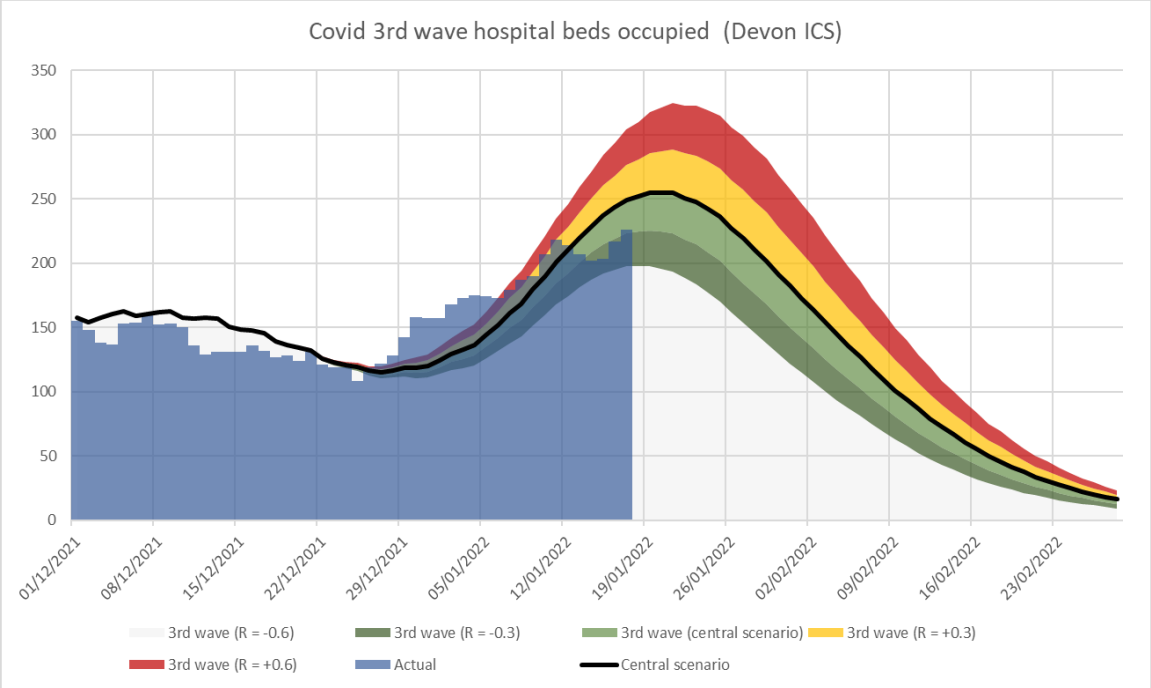
1. The latest modelling

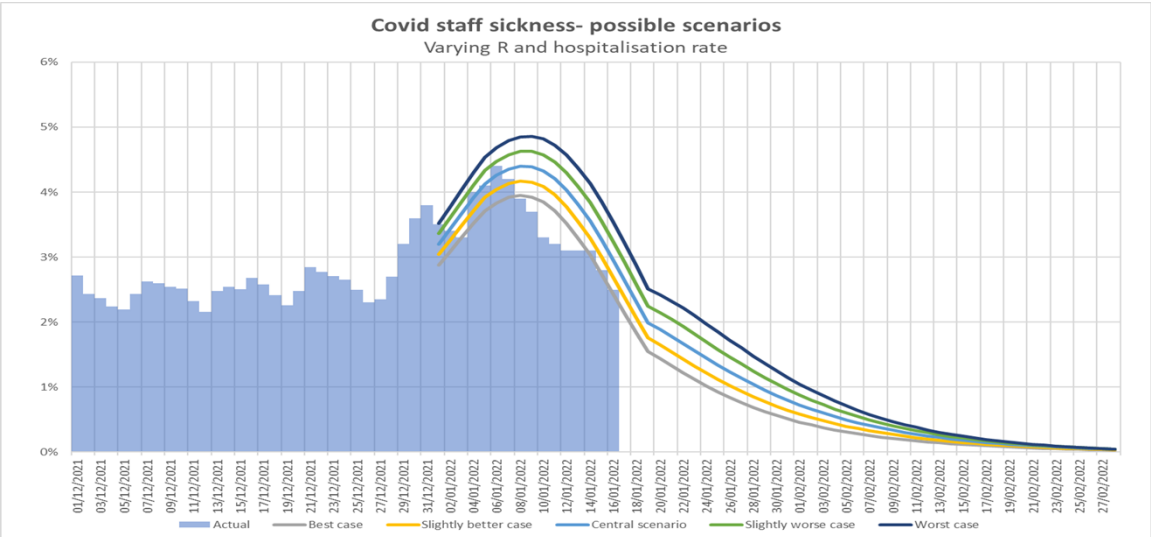
At each meeting of the Winter Taskforce and System Gold, the latest modelling is reviewed so that plans can be revised accordingly.

The most up to date modelling (shown graphically below) highlights:

- A peak around 20 January, but signs are that it could happen earlier.
- A peak of between 40,000 and 77,000 people infected.
- The worst-case scenario would see one in 18 people infected.
- A likely peak of around 250 people in hospital with COVID-19, which is towards the best case scenario.
- COVID-19 hospitalisations have increased by a third over the past fortnight.
- A peak of between 4% to 5% of staff off sick. This does not include non-covid related absence that is averaging at around 4.2%.


Covid total population infected - possible scenarios
Varying R and hospitalisation rate
Total population infected
90,000
80,000
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
01/11/2021
08/11/2021
15/11/2021
22/11/2021
29/11/2021
06/12/2021
13/12/2021
20/12/2021
27/12/2021
03/01/2022
10/01/2022
17/01/2022
24/01/2022
31/01/2022
07/02/2022
14/02/2022
21/02/2022
28/02/2022
07/03/2022
14/03/2022
21/03/2022
28/03/2022
Delta
Best case
Slightly better case
Central scenario
Slightly worse case
Worst case


Covid 3rd wave hospital beds occupied (Devon ICS)
350
300
250
200
150
100
50
0
01/12/2021
08/12/2021
15/12/2021
22/12/2021
29/12/2021
05/01/2022
12/01/2022
19/01/2022
26/01/2022
02/02/2022
09/02/2022
16/02/2022
23/02/2022
3rd wave (R = -0.6)
3rd wave (R = -0.3)
3rd wave (central scenario)
3rd wave (R = +0.3)
3rd wave (R = +0.6)
Actual
Central scenario


Covid staff sickness- possible scenarios
Varying R and hospitalisation rate
6%
5%
4%
3%
2%
1%
0%
01/12/2021
03/12/2021
05/12/2021
07/12/2021
09/12/2021
11/12/2021
13/12/2021
15/12/2021
17/12/2021
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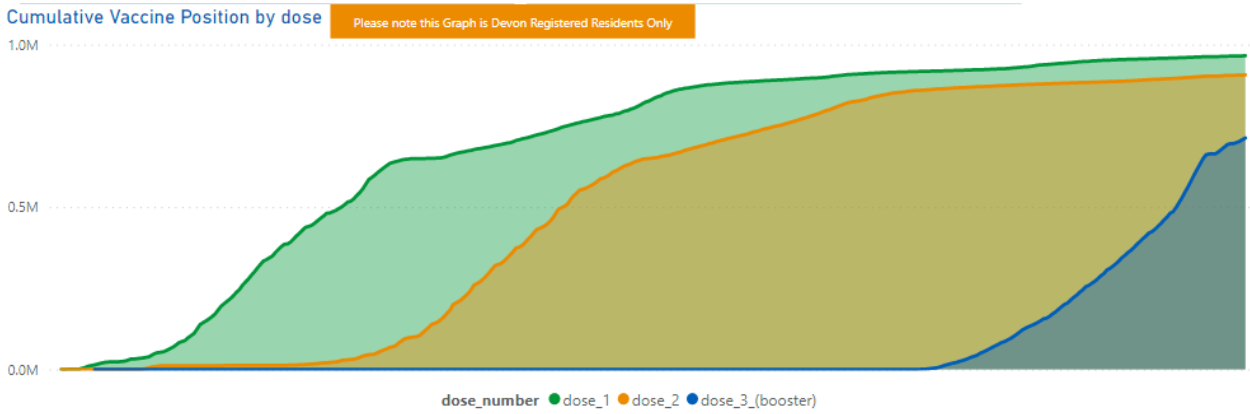
17/02/2022
19/02/2022
21/02/2022
23/02/2022
25/02/2022
27/02/2022
Actual
Best case
Slightly better case
Central scenario
Slightly worse case
Worst case

2. Vaccination update

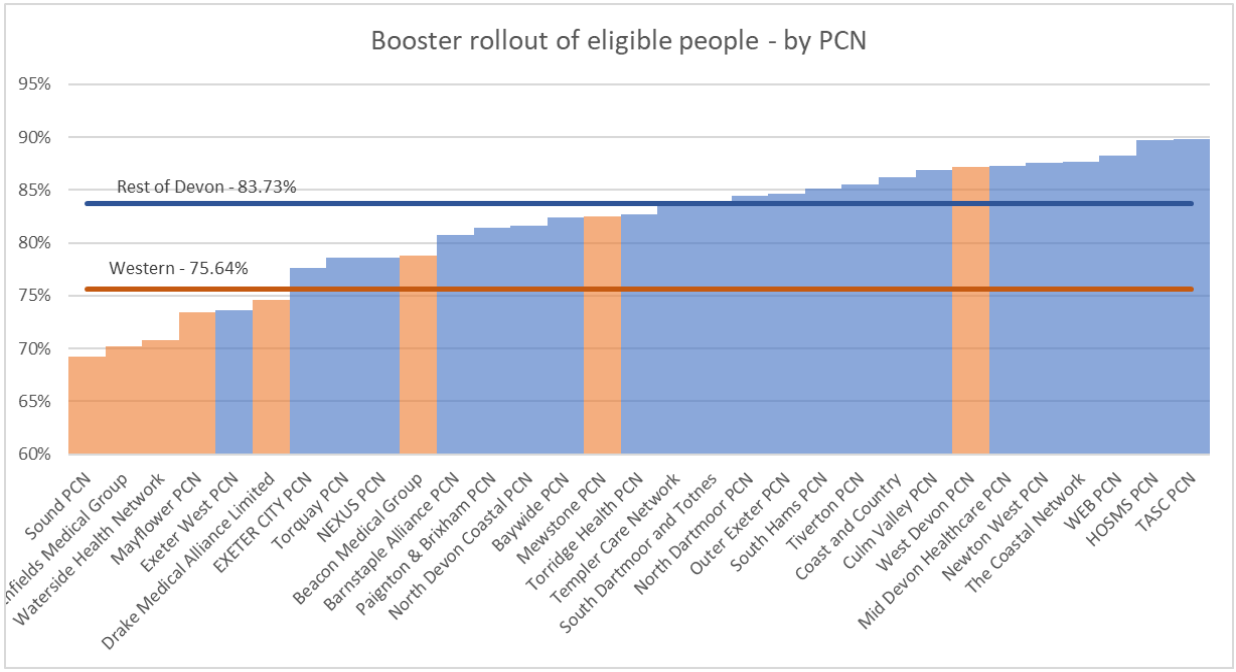
Uptake of boosters across Devon remains high with over 85% of those eligible having been boosted. The clinically vulnerable, including care homes and house bound residents, remain a focus and good numbers continue with homes being revisited through January.



Uptake has slowed significantly both locally and nationally since the Christmas weekend and the focus has shifted from fixed sites to mobile sites in underserved and high footfall areas in retail, large business and transport hubs. This will enable access to the under 40s and areas of deprivation which remain our focus and from experience are the hardest individuals to vaccinate.

The schools offer for vaccinations continue and Devon is currently at 58%, against a target of 60%. There has been increasing uptake in early January, which is expected due to high prevalence of infection in schools during October.

The lowest uptake remains in Plymouth despite high capacity of vaccination offers, and the mobile model into underserved areas is underway.



3. Role of the Winter Taskforce

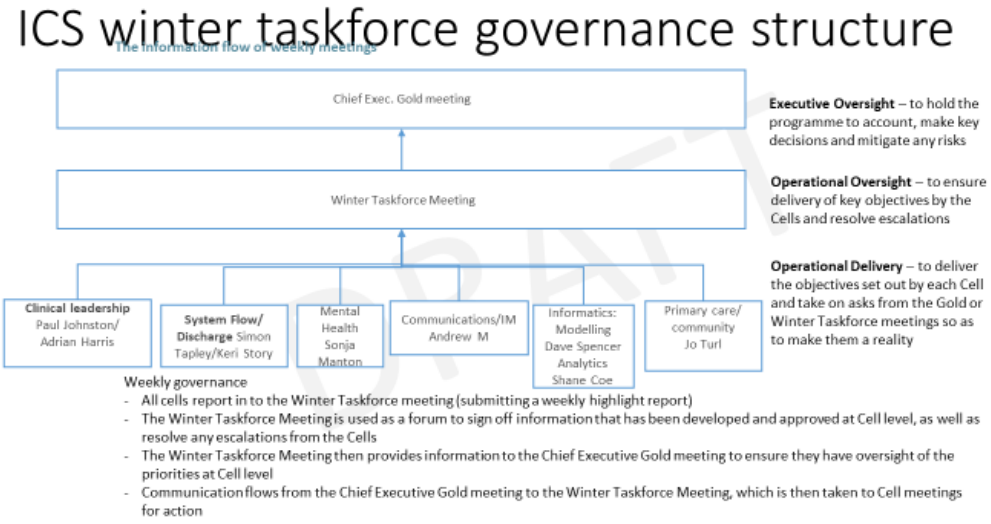
To strengthen the delivery of the Devon Winter Plan, system partners agreed to set up a Winter Taskforce.

The Taskforce is led by Mairead McAlinden and John Palmer (Chief Operating Officer, RD&E and NDHT), who are accountable to Jane Milligan ICS Chief Executive and report at least weekly to System Gold (Chief Executives and DASSs).

The Taskforce was set up on 18 November 2021, and has:

- Formed a strong senior leadership team to drive forward the areas of focus.
- Developed a programme of activity that supports the delivery of the ICS Winter Plan with a strong focus on strategic interventions to deliver change at scale; and operational grip across the entirety of the system to maintain patient flow throughout the Winter period.
- Established a supporting infrastructure (in terms of operational and information architecture) that will allow for delivery on both fronts.

The Taskforce works through a number of Cells, led by senior system leaders, with specific responsibility for service improvement:



A CCG Winter Room is in place, which includes support from a number of experienced Incident Directors, Incident Managers and two administrative roles ((i) Inbox coordinator/note taker and (ii) Loggist), operating seven days a week.

Current areas of Taskforce Focus

- Implementing the integrated surge and super-surge plan across hospital and community capacity to ensure that the system can meet the demands and pressures during the peak in covid demand alongside winter pressures.
- Implementing the System Escalation Plan agreed by Chief Executive Gold on 12 January.

- Overseeing the agreed Covid Mutual Aid protocol.
- Developing capacity in virtual ward and pulse oximetry out of hospital services and hospice capacity.
- A focus on reducing the impact of patients ready for discharge in all hospitals (with a target of reducing this by 30% by the end of January 2022).
- Establishment and review of ambulance dynamic conveyancing protocol.
- System-wide approaches to Infection Prevention and Control including risk-based cohorting of patients and managing staff affected by covid, including testing protocols.
- Developing a real time dashboard so that all partners can see where pressures lie in the system.

4. Super-surge planning

- Current modelling suggests a potential need for an additional 191 beds across the system to manage the surge in demand from Covid and winter pressures.
- All Trusts have added extra beds to super-surge since December, but not enough to cover current position. The hospital system is currently around 50 beds above the super surged bed base.
- Bed base is more compromised by COVID than anticipated at this stage, due to the more infectious nature of the omicron variant and the related nosocomial spread within hospital.
- NDHT and RD&E generally in a less challenged position than UHP and TSDT, hence the daily pattern of COVID support, diverts and transfers.
- The system is implementing the community bed surge plan, which includes additional home care, care hotel, care home and hospice capacity with plans to provide additional capacity in community hospitals, commencing with Honiton.
- A System Staffing Hub has been established to secure all available staffing to support the increases in system capacity.

5. Covid mutual aid protocol

Our responsibility of care is to the whole population of Devon, and those parts of our neighbouring counties who also rely on our hospitals for their care. Therefore, to best meet the needs of our whole population we will consider our covid bed capacity across all our hospitals as a resource available to meet the needs of our whole population.

This means that any available covid bed capacity is made available to support the wider system should it be needed. It is important to ensure that by doing so high levels of risk are not simply transferred from one hospital to another with no net benefit. Each Trust has agreed a ‘buffer’ number of beds to ensure they are able to manage the further daily demand they are likely to see in order to reduce the risk of exceeding their overall capacity as a result of accepting a transferred patient. The number of buffer is continually reviewed to take into account not only the local likely demand but also the risk that may be unmitigated elsewhere in Devon.

Each Trust has confirmed their current covid ringfenced beds and the minimum buffer of beds they require to accommodate covid admissions, based on average admission

rate, accepting that any surge in admissions above that rate may trigger a mutual aid request.

It is understood that Covid ICU capacity is a key consideration in the risk assessment of ability to accept covid ward transfers. Where covid ICU capacity is a risk for the receiving Trust, the Trust requesting ward transfers must identify only those patients unlikely to need an escalation of care to ICU (appreciating that this is a clinical assessment that is challenging to make).

An example of the active management of capacity across the Devon system is included below:

Bed Numbers	UHP	RDE	TSD	NDHT	TOTAL
Maximum Covid Ward Capacity	99 (L4)	38 (L2)	36 (L3)	18 (L1) now 17	190
Ward Bed 'Buffer' Number (point of request for MA)	10	6	2	2	20
Covid ward occupancy at 11am 18/1/22	117 total 112 covid ward; 2 ICU; 3 other	41 total; 41 covid ward, 0 ICU;	37 total 35 covid ward; 0 ICU; 2 paeds	13 total: 13 covid ward; 0 ICU	208 incl. 2 ICU: 201 on covid wards; 5 other wards
Covid Ward Bed availability for System Mutual Aid	0 due to volume of daily +ves	0	0	2	

6. Ambulance dynamic conveyancing proposal

A new agreed approach is being put in place with South Western Ambulance NHS Foundation Trust (SWASFT) for Emergency Department (ED) diverts. The levels outlined in the new Standard Operating Procedure (SOP) are as follows:

- Peripheral divert.
- Extended divert.
- Emergency divert.
- Full divert.

The agreement for how these will operate is as follows:

- ***Peripheral divert***: In many locations the patient may be equidistant from two or more hospitals, and would normally be taken to either at the discretion of the attending ambulance crew. A peripheral divert involves removing this discretion, with patients being taken to one of the equidistant hospitals which has been nominated. This divert can be agreed between the relevant Trusts and the CCG.
- ***Extended divert***: This is a new arrangement, where a divert may be agreed for incidents within postcode areas between EDs, where the travel distance to the alternative hospital/s may be longer than that of the normal destination. Trusts are expected to request a peripheral or extended divert with the SWASFT Trust Incident Manager as required. When implementation may be appropriate, SWASFT will arrange the initial joint decision meeting. The following attendees will be provided with 15 minutes notice to attend: representative from the affected hospital; representative from all nominated hospitals; SWASFT area Tactical Commander (during working hours 09:00-17:00); and SWASFT Trust Incident Manager.
- ***Emergency divert***: these are expected to take place instantaneously due to a catastrophic 'no notice' failure of an EDs' ability to provide a clinically safe service. Examples of this include fire, flooding or significant utilities failure. Any emergency diverts will be a significant / critical incident for the acute provider and consideration should be given to SWASFT declaring it as such as well.
- ***Full divert***: this is where all patients within the catchment of the requesting ED are taken to an agreed neighbouring ED. A full divert will only be considered if all the following criteria are met:
    - Hospital activity is above normal expected levels.
    - The diverting ED is physically incapable of providing the right care and resuscitation facilities in a way which is clinically safe.
    - Demand and/or delays result in delayed handovers of care between the ambulance service and ED which may be or become clinically unsafe. These would likely meet the triggers for level H4 on the handover escalation plan detailed within the Ambulance Handover Delays SOP.

The Protocol is being reviewed to support this process, including:

- Decision to divert – details of decision, including duration, number of ambulances and geography to be communicated with relevant ED clinical lead immediately after a decision is made.
- Divert clinical criteria – need to expand criteria currently in place to ensure individual patient decision to divert is appropriate, currently only considers major trauma.
- A review of outcomes of diverted patients.
- Diverts from outside EDs – all diverts from outside ED will have a senior Trust clinical decision made on appropriateness of transfer and a consultant to consultant 'handover' discussion with the accepting ED.

7. Supporting discharge

Additional Community Capacity

Plans are in place and are being implemented to enhance capacity for discharge or to help with surge as follows:

- Community Hospitals (57 beds) for Pathway 2/3. UHP have opened an additional 12 beds for the Plymouth area and Honiton (16 beds) will be opened by end of January.
- Deploying staff to support the opening-up of latent capacity within Care homes (focused on opening empty units/wards and new build extensions in existing Care Homes) (71 beds). 11 in place, 45 by end of January, and an additional 55 by end of February.
- Peripatetic Care Home support team (enabling a further 20 beds); 58 workers from mid-January.
- Live in Carer Model (15 virtual beds) for dementia/delirium/ high need care.
- Discharge Grants for families to reduce demand on discharge pathways (offering small one-off payments to support individuals to return home quicker with different and innovative approaches to support.

Extended Hospice Capacity

To support hospital discharges, where hospices have capacity to admit additional patients either to the Inpatient Unit or onto Hospice to Home Services, consideration will be given to patients who fall within some of the discharge pathways. All admissions would need discussion through the usual referral routes to ensure they are appropriately triaged and safely managed.

In addition to referrals for terminal care and complex symptom management, consideration for patient referrals from the broader end of life caseload where this would relieve pressure on acute beds but not adversely affect the hospices capacity to take more complex and very end of life patients will be made.

Discharge audit outcomes

Between 14-17 January 2022, acute and mental health providers conducted an audit of discharge reporting. The audits covered the review of current reporting processes and required close working and dialogue between Business Intelligence and Operational teams.

All providers responded that whilst it was a challenge to conduct an audit under current pressures, the exercise was very useful and uncovered opportunities for improving the capture, reporting and understanding of discharge pathways.

Analysis is still ongoing, but headlines are that on the audit day there were 1,857 patients in hospitals beds in Devon of which 1,249 met the criteria to reside (67.3%) and 608 (32.7%) did not meet the criteria to reside. Of the 608 patients with no right to reside, 234 patients were discharged that day, leaving 374 (61.5%) patients who did not meet the criteria to reside occupying a bed.

This equates to around 20% of all beds being occupied by a patient with no criteria to reside. This is highest in UHP (26%) and lowest in Torbay (14.8%).

The audit also captured the reasons why patients were not discharged despite having not met the criteria to reside: 198 patients (47%) are awaiting Pathway 2 (rehab/community bed), 99 patients (23%) are awaiting Pathway 1 (domiciliary care at home) and 54 patients (13%) awaiting Pathway 3 (care home bed). The remaining 74 patients (17%) are for other reasons.

Further intelligence is being collected on:

- Whether some delay can be attributed to patients being on a Covid ward or delayed due to covid (included or excluded)?
- Impact / performance of discharge lounges
- Any delays for patients from outside the Trusts or from other CCGs, for example, Cornwall.
- Mental Health audit.

Points to take away:

- Data quality is important.
- Uniformity and robustness of clinical review ‘criteria to reside’.
- Assurance that all ‘internal’ delay reasons are being reviewed?
- The Discharge to Assess and the Discharge Sitrep collection that supports it needs to be fully embedded into clinical workstreams/practices and align/replace/enhance any local discharge monitoring reporting.

8. Infection Prevention and Control

The Devon Network of Infection Control Directors regularly review national guidance and best practice. With the emergence of the Omicron variant, the latest national guidance remains consistently adhered to throughout the Devon Network and all providers work within this national framework. The ICS Chief Nurse meets regularly with the Network and provides further assurance on consistency of approach.

Due to differences in physical infrastructure across Devon’s hospitals, the application of this guidance may differ at times due to necessity. This is understood by the Network and is supported by local governance. Variances are now shared across the system and discussed at a system level.

Where variation, such as cohorting, is required there are processes in place to assure consistency of risk across all providers and Chief Executive sign off.

9. Consistent staffing policies

While the level of staff absence due to covid or covid-related restrictions is demonstrating a slight decrease, several system-wide actions have been agreed by System Gold to support management of absence.

Annual leave carryover

For staff who have been unable to take their leave, due to severe COVID-19 operational pressures, system partners have now agreed a consistent approach that allow line managers to authorise up to two weeks' carryover of basic contracted hours.

If a member of staff has been specifically asked to cancel their leave, this carryover may exceptionally be further increased to a maximum of four weeks of basic contracted hours, with the agreement of a senior manager/executive. Each organisation will have their own approval process.

This arrangement is an enhancement of Section 16 of the Annual Leave Policy (H31) which allows for staff to carry over one week of basic contracted hours in exceptional circumstances.

The buy-out of some level of annual leave may be offered on a case-by-case basis in some organisations in the event that it makes sense locally to do so. Buy back will only occur if people have taken at least 27 days leave in the holiday year.

Testing

The national guidance on isolation changed on 13 January 2022 with advice on ending isolation for staff who develop COVID-19 symptoms or who have tested positive on a lateral flow device (LFD) test or polymerase chain reaction (PCR) test. They can now end their isolation on the sixth day, provided they have two consecutive negative LFD tests. The guidance for staff who are contacts of a case has not changed.

Non-symptomatic positive staff confirmed on LFD no longer require to confirm with a PCR. However, most providers in Devon have opted to retain a confirmatory PCR or LAMP test.

Together for Devon

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Locality update report

Locality:	Southern Locality
Period covered by update:	January 2022
Person completing template:	Derek Blackford – Locality Director (S&W)

Key achievements/progress

Local system:
The local health and care system in South Devon & Torbay continues to be significantly challenged albeit with an easing of demand but coupled with the expectation that things are reverting to 'business as usual'. The workforce pressures across all sectors are still impacting. We put in place a local system daily tactical call to support visibility and focus for the period since Christmas.

The investment into the voluntary sector to support communities, discharge and identify and prioritise deployment of staffing resources to bring back much needed capacity, is still in place

System flow:
The focus of the system flow plan is directed toward the aspects of admission avoidance, internal hospital flow and discharge and out of hospital provision. The latest position on some of the key components is set out below:

- **Urgent Community Care:** work toward bringing the Newton Abbot Urgent Treatment Centre (UTC) in line with the national specifications; agreement of a clinical specification through the LMC and Primary care has yet to recommence.
- **Urgent Community Response (UCR):** work is underway to assess the utilisation and impact as a result.
- **High Intensity Users service:** the service identified patients frequently attending the Emergency Department, to better support their needs outside of the acute setting. Attendances had reduced by 71% for the 42 patients supported.
- **Ambulance Handover Management:** An improvement plan has been developed with system partners and the regional team of NHS England & Improvement. The plan will be owned and monitored through The South Urgent Care Board.
- An Urgent and Emergency Care improvement plan is currently with partners for consultation, along with the associated improvement metrics to monitor progress in delivery.

- **Improved Discharge Support & Co-ordination** plans to extend the current in-hospital discharge support worker arrangements with the voluntary sector are being implemented through the Discharge Cell. Other measures have been co-developed with local partners, including additional rapid response and home from hospital arrangements, Admiral nurse to support people living with dementia and their families

around transitions into and out of hospital-based care. The impact will be monitored through The Local Care Partnership (LCP) Delivery Group.

Mental Health:
The Community Mental Health Framework implementation is underway through the Local Implementation Group. The majority of PCNs have signed Service Level Agreements (SLAs) to support recruitment through the Additional Roles Reimbursement Scheme (ARRS). The focus with our Primary Care Networks is on getting roles filled which will support an effective local system way of working and on getting all the respective Multi Agency Team arrangements organised and running.

The test of change with core mental health team and their respective Primary Care Networks (PCNs) is in development with work also underway with carer/lived experience representatives to articulate and respond to 'what matters to me' throughout the plan.

Work has also been taken forward in conjunction with the Mental health Learning Disabilities and Autism system wide programme and respective commissioning leads to consider the broader agenda. An approach to reviewing the dementia diagnosis data, understanding areas of best practice, and adopting learning and improvement is being developed and will be shared with the South LCP delivery group on 1st March.

Local Care Partnership (LCP) development:
We are working to support delivery and performance and improvement through an Executive Group, a Delivery Group, and a Performance Group. Work is also underway with partners in the system including through the Health & Wellbeing Boards to better align delivery and promote visibility of impact.

A weekly 'Delivery Huddle 'was put in place to support the development and implementation of the rapid improvement initiatives responding to the challenge over the winter period. Our work focusses on personalised care, workforce, urgent services, and health inequalities, and developing a set profiled and prioritised plans. A lack of data in some cases and intelligence more broadly in support of LCPs to understand and triangulate the quality/experience, outcomes for the population and service performance for the locality is an immediate priority.

Current Leadership arrangements

The LCP leadership arrangements are in place with a review underway at present as planned. At present, Simon Tapley, Deputy Chief Executive (Integrated Care System for Devon (ICSD) and NHS Devon Clinical Commissioning Group (CCG)) is taking the role of the Chair with Liz Davenport, Chief Executive, Torbay & South Devon NHS Foundation Trust (T&SDFT) being vice-chair.

Key priorities for the next three months

The key priorities for the next three months are:

1. Working with partners supporting recovery actions given the continued pressure. A focus on workforce, discharge and sufficient capacity with local providers and investment in the voluntary sector support this agenda.
2. Refocussing the South Urgent Care Board on our Urgent & Emergency Care Improvement Plan.

3. Delivery against the local priority ambitions, the Operating Plan and Long-term plan.
4. Local performance oversight and improvement arrangements.
5. Urgent Community Care - Newton Abbot Urgent Treatment Centre and enhanced minor injuries services.
6. Urgent Community Response capacity as alternative to admission.
7. Working with ICS system leads - prevention, planned care MH, LD&A with locality level support prioritised and resourced appropriately.

Issues of concern or risk

The main areas to consider are:

- Workforce capacity, recovery, and resilience - incident response, significant operational challenges, restoration of services, development of place-based arrangements and delivery against the long-term plan priority ambitions.
- The lack of data and intelligence at LCP level to ensure that outcomes, performance/quality, and experience is visible and better informs short and longer term workplan development.

Support required and/ or barriers to progress

- Support to access Strategic, Business and Public Health Intelligence resources to inform work planning and decision-making in localities.

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Locality Update Report

Locality:	Eastern Devon
Period covered by update:	January-February 2022
Locality Director:	Tim Golby

Issues of concern or risk

- Community Urgent care – impacting on ED attendances at Royal Devon & Exeter NHS Foundation Trust (RDEFT) and on primary care urgent activity. The LCP has prioritised the development of a community urgent care delivery model including Urgent Treatment Centre development and minor injuries services and there is a strong desire and need to engage and codesign a new delivery model with the public. It has been advised that this cannot happen until the latter half of 2022 due to engagement priorities focused on the long-term plan. There is a risk that existing provider contracts will need to be further extended and the public will not have the opportunity to shape services early on in the process.

- Elective Care Recovery – RDEFT has the largest elective recovery backlog in Devon, focused on surgical specialities in the main, trauma and orthopaedics, ophthalmology, and general surgery. There is a strong desire from the LCP to be better engaged in the process of pathway redesign, bringing together primary care, community services and mental health partners as well as the elective specialities to develop new delivery models.

- Workforce – Social care market resilience to enable improved hospital and community flow. Although wider workforce review is required to understand specific challenges locally around community services, mental health services, primary care and voluntary sector

- Supporting unpaid carers – indicated by Public Health intelligence and validated by Delivery group that this is a priority area, particularly flagged by the voluntary sector. Additional data required to understand full position.

- Population Health Management action learning set shave been stood down for January due to system pressure.

- Lack of staff capacity to mobilise all programmes/projects identified and also for LCP partners to provide input into all programmes of work. LCP has five priority areas: urgent care, community services, planned care, mental health and prevention, it is a large programme of work with many strands, LCP constantly

reprioritising workload to deal with immediate pressures, hard to gain traction on the workplan and deal with new requirements/ gaps e.g. long-term conditions.

- Risk for the LCP around lack of business intelligence to accurately assess and prioritise performance/quality/outcomes for population. Performance function at CCG is developing an LCP performance management approach and dataset which will help.

Key achievements/progress

Urgent and Emergency Care

- The Devon system continues to experience sustained levels of demand, with all areas of the urgent and emergency care sector challenged including RDEFT. Incident management processes are in place and RDEFT have worked closely with system partners to provide mutual aid where possible. RDEFT has continued with higher than average ambulance arrivals but remains amongst the Trusts with the lowest levels of handover delays. Flow remains a pressure, but all released beds are shared between incoming demand to RDEFT as well as to support other parts of the system where possible.

Community Services and Flow

- Following new national targets relating to numbers of patients waiting in hospital who are medically fit for discharge, a system-wide discharge support plan has been formulated. Resources in East continue in line with those listed within the winter plan around increased staffing and availability of Urgent Community Response, care agency support for home support packages, three end of life care beds at The Dales in Exeter, seven block booked dementia support beds (also for use by the Franklyn Hospital) and maximising the use of hospice capacity.
- Additional funding to support the voluntary community and social enterprise (VCSE) sector to support patient discharges has also been made available countywide. This funding will support alternative patient transport, block book capacity from Hospiscare, provide specialist discharge support for young people through Young Devon, and also discharge support personal health budgets. An Eastern locality plan is also being worked up, focusing on expanding existing VCSE support services for discharge.
- Enhanced Health in Care Homes (EHICH) – work is ongoing to develop the spending and implementation plans with a number of new temporary roles being considered to support medicines management, better discharge support for care comes and project management to co-ordinate a number of ‘in development’ workstreams, including a ‘virtual’ red bag.

Long Term Conditions

- A North and East Locality Diabetes Delivery group has been formed and is meeting bimonthly.
- The group has had its second meeting and widened its membership to ensure that all professional groups who work with diabetes patients are included.
- This Delivery Group has been overseeing the use of Diabetes Transformation funds from NHS England.

- Projects funded by these monies continue to be developed including:
    - An 18-month pilot for a Diabetic Inpatient Pharmacist role led by the Royal Devon and Exeter NHS Foundation Trist. This role will work across North and East Devon to undertake medication review of patients with diabetes with a view to improving management of HbA1c, blood pressure and lipids
    - A project Pharmacist to undertake a review the evidence of the impact of a Pharmacist working with diabetic patients across Primary Care Network
    - A Root Cause Analysis of minor and major amputations.
    - Foot care pathway task and finish group

- The February meeting has invited proposals for use of monies for the next financial year and will discuss and agree spending and clinical leadership.
- A system wide service review of Structured Education for diabetes continues with input from the Eastern Locality Commissioning Team.
- A review of patient referrals for Spirometry that have been held and growing in the East since July 2021 has been completed and an outcome on them being sent back to practice alternative diagnostic tests or sent to RDEFT for formal Spirometry alongside a consultant-led clinic is underway. Discussions are still required to understand the long-term plans to develop a community Spirometry offering following the change in guidance on delivery this, that came into effect in April 2021 which has seen North, East and South Devon Localities without a service.

Prevention

- A VCSE reference group met this month to discuss the outcomes from the LCP conference. It was agreed that several groups would be established with membership across the VCSE and Statutory sector to progress this work.
- The Eastern Locality has two refugee bridging hotels for those on Afghan resettlement schemes, based in Exmouth and Exeter. In the last month an asylum seeker bridging hotel has also been established in Tiverton. Coordination of health screening is now being led from the locality. There has been excellent clinical engagement from all areas of the health system, Primary Care, Public Health, Public Health Outreach Teams, Public Health Nursing, Mental Health Services and Secondary Care who have worked together to ensure health screening as appropriate for these populations.

Mental Health – Community Mental Health Framework (CMHF)

- Additional Role Reimbursement Scheme (ARRS) monies – ongoing recruitment action underway for ARRS vacancies and for secondary roles. A draft service level agreement is under development and, once agreed, will begin engagement with Primary Care Networks (PCNs) for year 2 of the programme and recruitment to additional roles.
- Exeter realignment of Community Mental Health Teams (CMHTs) – the realignment of teams is ongoing, supported by a transition lead.
- In-reaching to the PCNs – colleagues in Exmouth have been the first mental health teams to begin to in-reach to Woodbury, Exmouth & Budleigh (WEB) PCN surgeries, building up relationships and seeing mental health patients.

- Engagement – the team attended a community & voluntary sector event (Sid Valley Help) in January to promote the CMHF and promote integrated working across primary, secondary and third sector organisations.
- Multi-agency team (MAT) meetings – ongoing development across the locality.

Planned Care Recovery

Diagnostics

- Reviews on capacity is being undertaken;
  - To support capacity issues, CT's and MRI's are just starting at the Nightingale.
- There has started to be a growth in backlogs, and these are monitored weekly against 4 modalities.

Ophthalmology

- Digital options are to be explored, with learning being taken from Gloucester along with the Cancer Alliance Lead to look at how image sharing between hospitals, opticians etc. can be more efficient.
- It was agreed that referrals from optometrists to contain only one condition per referral be requested, to ensure that the right pathway for the patients can be used.
- Request was made for Ophthalmology facilities to be ringfenced; discussions to take place with TSDFT and RDEFT.

Demand Management

- Following approval to use Consultant Connect, a further company has been identified to offer this service. Options appraisal to be undertaken to ensure contracting is appropriately undertaken.

Outpatient Transformation

- It was noted that the system is currently meeting the deliverable for implementation of patient initiated follow-up (PIFU) of 2% for December.
- The percentage of non face-to-face outpatient activity is still below 25%.

Key priorities for the next three months

- To continue to focus on discharge and flow to support the surge response through the winter period.

- To act within the Devon-wide Winter Response team, responding to escalation and pressure within Urgent and Emergency Care.

- To progress the overarching workplans of the Eastern LCP for the 5 thematic areas, aligned to the ICS Strategic Outcomes Framework.

- To continue progress made by the Diabetes Transformation Programme and work across the local system.

- To continue progress of the locality prevention priorities and PHM programme.

Support required and/ or barriers to progress

- The need for an on-going staffing capacity to support and co-ordinate locality development and delivery, particularly in relation to urgent care.
- Managing the demands of covid incident response alongside the daily developmental work within the LCP

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Health and care working in partnership with local communities in Plymouth, Torbay and the rest of the county

Locality Update Report

Locality:	Northern Devon
Period covered by update:	January – February 2022
Locality LCP Chair:	Jennie Stephens
Report prepared by:	Tim Golby

Issues of concern or risk

Urgent Care Risk
Increased demand on ED across both ambulance and walk-in coupled with poor-internal flow driven by a shortfall in community capacity has led to a deterioration in several system metrics. The over-crowding risks of ED has possibly led to poor clinical outcomes based on previous studies but not shown yet in the LCP

Community capacity is impacting on ED attendances at NDHT and on primary care urgent activity. North LCP has delivered considerable work on the development of a community urgent care delivery model including considerations of UTC development and replacement minor injuries services as per national guidance. There is a strong desire and need to engage and codesign new delivery model(s) with the public. This cannot happen until the latter half of 2022 due to engagement priorities focused on the long-term plan. There is a risk that existing provider contracts will need to be further extended and the public will not have the opportunity to shape services early on in the process. The long-term closure of both MIU is leading to mistrust in communities where the community hospital has already had inpatient beds removed. This is being managed pro-actively but could involve the LCP in a loss of reputation.

Planned Care/ elective recovery
NDHT is managing their long-waiters proactively and planning the delivery of a community-based Ophthalmology Unit – in the design phase now. There is a strong desire to be better engaged in the process of pathway redesign, bringing together primary care, community services and mental health partners as well as the elective specialities to develop new delivery models.

Workforce
Social care market resilience to enable improved hospital and community flow. Although wider workforce review is required to understand specific challenges locally around community services, mental health services, primary care and voluntary sector.

Supporting unpaid carers
Indicated by Public Health intelligence and validated by Delivery group, particularly flagged by the VCSE– data required to understand full position
Generic

Lack of staff capacity to mobilise all programmes/projects identified and also for LCP partners to provide input into all programmes of work. LCP has five priority areas: urgent care, community services, planned care, mental health and prevention, it is a large programme of work with many

strands, LCP constantly reprioritising workload to deal with immediate pressures, hard to gain traction on the workplan and deal with new requirements/ gaps e.g. long-term conditions.

Risk for the LCPs around lack of business intelligence to accurately assess and prioritise performance/quality/outcomes for population. Performance function at CCG is developing an LCP performance management approach and dataset which will help.

Updates

Prevention

- The Population Health Management (PHM) - A new data extraction solution is being sought due to limitations and issues with the current offer. New IG agreements will need to be written and signed by all organisations that feed into the One Devon Dataset, this is anticipated to be ready from April 2022 once testing has taken place.

Urgent Care

- MIUs remain closed with staff re-deployed in ED due to Covid streams management. This is currently in place until 1st April 2022 for planning purposes. ED Leader (consultant and Nurse) met with local stakeholders in Ilfracombe to discuss issues of footfall, local need, and clinical sustainability. Work able to be used across the system for market-town settings. However, there is no current plan for post April 1st.
- Community Urgent Care (CUC) moved forward with re-designed Minor Injury Primary Care LES going to LMC for input. This is not currently supported by the LMC, and Northern PCN's have indicated the need for the LMC to approve before further work is undertaken.

- Urgent Community Response (UCR) started and looking at system support to maximise benefit.
- Recent VCSE funding has allowed for new discussions in how the VCSE can help maintain potential admission in their own homes and support with unregulated support for discharges. The work remains new and not all outputs are in place, but the conversational journey is proving very beneficial and NDHT's use for both the Devon-wide VCSE schemes: - the £1,200 discharge budget and the car discharge support shows both are having a beneficial effect.

Community Services and Flow

Planned Care

- Community Spirometry services within the Northern Locality remain a challenge, the locality commissioners have fed back to the CCG that the funding and capacity issues with offering the service need to be reviewed with a decision being made on how to progress this. East and South localities are in the same position of not having an offer for their population.

Mental Health

- North Devon Coastal and Barnstaple Alliance PCN signed ARRS SLA for 2021/22; recruitment process for a Specialist Clinical Practitioner being led by DPT
- Discussion about ARRS roles for 2022/23 in infancy – awaiting for final National steer on scope

- DPT Service alignment to PCN “neighbourhood” boundaries for Core Mental Health Service in Adult and OPMH on track to be in place by start of April 2022.
- Dynamic Local Implementation Team meeting (LIT) conversation about physical health inequalities and proposing working on a small test of change with One Northern Devon’s High Flow cohort to improve access annual health checks.
- Conversations with PCNs about widening attendee list to LIT to support engagement and create additional capacity – focus on Wellbeing Teams in PCN.

Long Term Conditions

- Two Task and Finish groups for Footcare Pathways and Root cause analyses for lower limb amputations have been set up and meet for the first time in early February. The aims of these groups are to utilise the Diabetes Transformation Funding available to make some meaningful changes and improvements to footcare within the localities.
- The North and East Diabetes Delivery Group met to discuss plans for 2022/23 priorities and clinical leadership for the Diabetes Transformation Funds. Proposals for projects were presented and the commissioning managers will be reviewing these in February and March ready to sign these off within April’s meeting.
- A system wide service review of Structured Education for diabetes continues with input from the Northern Locality Commissioning Team. An early draft of the specification has been developed and is currently being updated following feedback from the review group.

Key priorities for the next three months

- Contribute and finalise the Devon wide Structured Education for Type 2 Diabetes Specification
- Develop a solution at either locality or system level for Community Spirometry
- Plan a Northern Locality Conference for all partners with a view to exploring Health Inequalities across the area

Support required and/or barriers to progress

- The need for an on-going staffing capacity to support and co-ordinate locality development and delivery, particularly in relation to urgent care.
- The need for partners to engage in workstreams to progress work and meet deadlines

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Locality update report

Locality:	Plymouth
Period covered by update:	January 2022
Person completing template:	Anna Coles

Risks

Key risks and performance issues

- Demand for urgent care, continued to reduce during December with average daily ED attendances down by 7%, Ambulance Handovers down by 4.8% and GP out of hours cases down by 1.4%. Average daily emergency admissions were down by 5% and UTC attendances were down by 12% per day. This is in line with normal seasonal variation, although the split between ambulance and walk in arrivals is different with a greater proportion of walk-in patients and a much lower proportion of ambulance arrivals than in previous years.

- Time to initial assessment in ED continued to improve through December. The growth in the number of ambulance handovers over 15 minutes reduced by 1%. There was a 20% improvement in the number of hours a day lost to handover delays from a daily average of 103 in November to 82 in December. There was also a 5% improvement in 12-hour decision to admit breaches (trolley waits) from 143 in November to 135 in December

- The percentage of patients with a length of stay (LOS) of over 14 and over 21 days rose again in December. The percentage of patients with a LOS of 21 + days increased by 2% to 21%. The percentage of patients with a 14+ LOS also increased by 2% to 32%. Delays to discharge continue to be an issue with an average of 131 patients whose discharge is delayed over 24 hours per day. The largest number of delayed patients are those waiting to be discharged to the Plymouth Local Authority area. This is to be expected as Plymouth residents represent the high percentage of patients in UHP. However, the longest delays are experienced by those being discharged to Devon.

- Delays to discharge from Mental Health beds have reduced but there are still challenges with the discharge of patients with complex needs which means some individuals are waiting a long time

- Cancer two week wait performance improved slightly in December. There are still challenges in performance against the two week wait standard for symptomatic breast however some improvement is forecast for January.

- Waiting lists continue to increase particularly in Orthopaedics and Neurosurgery. At end of December, the number of patients waiting over 52 weeks was 2,980 which is 7.4% of the total number on waiting lists. This number is forecast to increase over the coming months.

- The percentage of patients waiting over 6 weeks for a diagnostic test increased in December at 32.1%. Modalities with the largest numbers of patient breaching 6 weeks are MRI, CT, and Echocardiography.

- There continue to be long waits for the following community services:

    - podiatry,
    - Waiting times for children's speech and language therapy
    - child and adolescent mental health services

- UHP CQC report has been published with an overall rating of "Requires Improvement." The report noted significant concerns and challenges in urgent and emergency and medical care, impacted by wider challenges in the health and social care system. A section 28(3) notice of a decision to impose conditions has been served requesting detailed updates on health and social care system actions and data pertaining to the urgent and emergency care pathway, performance and flow.

Delivery Highlights

Priority 1- Building a Compassionate and Caring City

- Project Board on 18/1/22. Agreed to align and codify existing charters. Awareness and training being prioritised. Cities of Learning action (volunteering passport/accreditation) also identified. Also agreed to focus on joint commitments and avoid overlap and duplication. Looking at joint events calendar.
- Commitment to Carers governance continues to progress through PCC process.

Priority 2 - Developing a sustainable system of Primary Care

- Investing resources into Primary Care where feasible e.g. winter access fund
- Ensuring decisions making considers impact on whole system

Priority 3 - Empowering Communities to help themselves and each other

- Workshop re: implementation of Fair Shares (prevention and wellbeing) scheme took place on 25/1/22.
- LGA peer review scheduled for February 2022.
- Food Aid – report due imminently and outcomes/proposals to be shared. Plan will follow.

Priority 4 - Ensuring the Best Start to Life through "A Bright Future"

- Family Hub/Early Help Partnership – first planning workshop with partners scheduled for early February.

- Family Hubs transformation fund – National funding decision due in March 2022.
- Strategic system leadership board – inaugural meeting scheduled for February 2022.

Priority 5- Relentless focussing on Homelessness Prevention

- The Homelessness Crisis Task Force is asking all Registered Providers in Plymouth to provide 10 properties per year to direct match to homelessness and 3 properties as temporary accommodation to meet immediate crisis also exploring acquisitions and modular accommodation for people who are homeless.
- Systemic Inquiry work – a set of recommendations have been made based on learning. To be discussed at Partnership Forum.
- Operational pressures persist – use of temporary accommodation still under significant pressure. Alliance action plan in place and Homelessness Crisis Task Force established.

Priority 6 - Integrating Care to deliver "the right care, at the right time, in the right place"

Urgent and Emergency Care

- Review of existing Western Urgent Care Board (WUCB) Improvement plan in light of CQC Report and conditions on System Partners
- Data analysis has indicated improvement work required to ensure validity, CCG have provided budget for additional BI capacity to develop WUCB SOF 4 Exit dashboard.
- Continued system escalation, managing high levels of demand, acuity and constraints.
- Additional investment received for VCS from NHS to support discharge using for carers identification and support, homeless, support for care homes- settling in and care navigation.
- Community in reach model of care to support pulling people from hospital and maximising the available community capacity key deliverable to assist with improved flow
- UTC – Temporary reduction in opening hours being evaluated for impact.

Integrated Care Partnership

- Transformation plans now underway

Ageing Well Programme

- MDT's underway working as part of implementation of iCOPE
- Finalising EHCH investment plan

Community Mental Health Framework

- Additional Roles Reimbursement Scheme (ARRS) Service Level Agreements (SLA) issued to Primary Care, all 7 now returned. Year 2 ARRS discussions with primary care taking place. Multi Agency Teams (MAT) are developing and MAT meeting planning in progress. Exploring new roles to progress addressing inequalities work.

Caring for Plymouth

- Working with Age UK and ILP to establish Plymouth Independent Living Service

Population Health Management (PHM)

- PHM roll out postponed for several months with delay due to system pressures and opportunity to improve sign up

Focus of "Together for Plymouth" – February 2022

Delivery Group

- Family Hubs/Early Help Partnership update
- Investment into Social Prescribing
- Health & Wellbeing Inequalities
- Community pharmacy
- Fair Shares:

- Delivery of approved schemes

Executive Group

- Peer challenge
- CQC report – System Response
- Key developmental proposals – workforce and website
- Communication and Engagement – LCP newsletter

Key priorities for the next three months

Priorities for the next three months:

1. Review, implementation and monitoring of UEC delivery plans
2. Delivery of Fair Shares and Changing Futures schemes
3. Development of local Workforce (health and care skills) plan
4. Development of End of Life delivery plan
5. Address gaps in LCP plans
6. Continue delivery of post incident support to Keyham community with partners
7. Work with Primary Care on same day urgent care capacity and PHM roll out (when re-started)
8. Full business case sign off for West End Health and Wellbeing Hub

Support required and/ or barriers to progress

- Capacity to support the delivery of improvement programmes for which funding has been successfully achieved
- Development and delivery of plan to improve resilience of 111/DDoCs and Primary Care across the whole wider system.
- Delivery of workforce strategy and plan

NHS Devon Clinical Commissioning Group

Locality update report

Locality:	Plymouth/Western Devon
Period covered by update:	FEBRUARY 2022
Locality clinical representative:	Dr Shelagh McCormick
Locality Director:	Anna Coles/Derek Blackford
Locality non-executive representative:	Nick Ball

Key achievements/progress

Plymouth:

- West End Wellbeing Centre – PCC Planning Application in December 2021; communication and engagement approach being finalised.
- Plymouth LCP Executive maintaining focus on whole system pressures.
- City College staff being deployed to support Care Homes, and Volunteers supporting Care Homes to settle discharges from hospital.
- Continued pressure related to delayed discharges with a combination of workforce gaps and infection control in home care and care homes pathways.
- Woolwell Dementia Assessment Unit will be operational from mid-February providing a short-term facility to increase the potential to avoid long term placements from hospital.
- The commencement of a dynamic decision group for partners to oversee system decision making and supporting the escalation process.
- Tactical command approach in place for community provision to reduce over prescribing of care, maximise use of voluntary sector and manage finite Domiciliary Care capacity in Plymouth.
- Planning and implementation of investment further to CCG Executive approval of recurrent investment into services for people with Complex Needs and a range of services to enhanced Wellbeing, Prevention and Community Empowerment.

Plymouth & West Devon

- COVID vaccination programme continues to demonstrate positive examples of integrated working between PCNs, community and acute providers. COVID Booster programme underway
- Independent Sector (IS) providers working well with the NHS and supporting treatment of long wait patients.
- Planning started as a system for the 2021/22 operating plan and Phase 4 Recovery and Restoration.
- Continued working with the Integrated Care Partnership on Transformation programmes.
- System Pressures – continuation of work on same day urgent care, pathway transformation.
- Planning investment to prevent falls and fractures using Prevention Funding
- Planning investment to continue implementation the Enhanced Health in Care Homes programme as part of Ageing Well.
- Admiral nurses for Plymouth and West LCPs in partnership with Dementia UK
- Investment into additional VCS services to support admission avoidance and discharge.

West LCP

- NHS England and Improvement ICS Development at Place discovery interview session planned for 04/02/2022.
- Engagement session 12/01/2022 with Tavistock Health and wellbeing alliance on priority areas
- Ageing well proposal to support Community teams to provide equity of service for both West Devon and South Hams, supporting PCNs and practices with the identification and treatment of osteoporosis.
- Review of strength and Balance programmes and support for population of West LCP, working with partners to understand options for piloting evidence-based programme accessible for West LCP population as part of frailty/falls prevention pathway
- Restore2 training in care homes and wider training for Care home staff under main Enhanced Care in Care Homes Framework
- VCSE roles to support hospital discharge now proposed to include x2 discharge/Co Ordinator roles in both Tavistock and South Hams hospitals to provide Single Point of Access for all West LCP discharges at L0 or potentially 1 where extended VCSE support can enhance support package and facilitate discharge.
- Secured Admiral Nurse in conjunction with Dementia UK, to be hosted by Livewell South West to support discharge for dementia patients into Care homes and own homes.
- Confirmation of ability for Urgent Community response team to access Acute GP Service if required outside of duty doctor arrangements. Confirmation of funding for x2 additional pieces of equipment to support UCR services further.

Key priorities for the next three months

Plymouth:

- Retaining social care workforce and managing significant unmet community demand through ongoing risk stratification.
- Implementation of community in-reach approach to discharges from UHP in partnership with increased voluntary sector capacity.
- Remodelling of older people's mental health (OPMH) offer to support admit avoidance and care home liaison for discharge maximisation
- Focus on system resilience through winter for patient safety, quality and experience, wellbeing of workforce and performance
- Completion of patient engagement of three surgeries linked to the Wellbeing Centre and quality and equality impact assessments (QEIAs).
- Mobilisation of any additional capacity including the short-term care centre (Feb 22), Woolwell House DE Step Down (Jan 22) and additional beds following capital works circa (15 DE late Dec/Jan).
- A review of needs, inequalities, outcomes, priorities and opportunities in order to inform key areas of Equity Funding investments as agreed by LCP Delivery Group

West LCP:

- Develop West LCP relevant dataset to enable review of performance/quality/position against emerging priorities.
- Produce engagement plan to further develop year 1 and longer-term project plans to deliver against priorities
- Take forward NHS England and Imrpvement Place development programme, outputs from discovery session into tailored programme
- Continue to support PCNs in West LCP through the next stages of the Population Health Management programme to ensure ability to sign up to Data sharing agreement. Work with stakeholders to identify known cohorts to start to target and tailor interventions

- Implement proposals around known funding pots for schemes identified as described above

Plymouth/West Devon:

- Embedding the governance for the Integrated Care Partnership with system governance
- Delivery against Urgent Care Locality improvement plan with particularly focus on SDEC and Discharge.
- Further develop Performance and Improvement group for LCPs
- Implementation of initiatives funded using Fair Shares funding (Complex Needs, Wellbeing, Prevention and VCSE)
- Continuation and further development of work for Place based Population Health Management when appropriate for both LCPs (timetable for which has been amended given service pressures and operational priorities)
- Aiming to treat elective patients according to clinical need and secondly by priority. Additional capacity coming online over the next few months to include modular theatre provision and outsourcing support.
- Focus on reducing potential 104-week waiters for elective care.
- Locality involvement in Devon-wide Operational Planning
- LCP level information to provide baseline assessment against priorities and ongoing monitoring of progress against KPIs. There is no analytical support to provide this LCP level information for the West in particular and most data is not currently captured at a West footprint level.
- As part of the Devon Population Health Management Programme, aiming for sign-up of all organisations for the programme which is due to commence c spring 2022.

Issues of concern or risk

- Staffing capacity across the whole system
- Community capacity across all areas
- Levels of unmet need in community including significant levels of Dom Care waiters
- Urgent and Emergency care demand impacting on the restoration of planned care services.
- Clinical workforce capacity at MMG
- GP and Pharmacy capacity gaps impacting on flu immunisation.
- Lack of data and analytical support at LCP level to ensure full understanding of baseline position across priorities and to generate robust benefits realisation plans
- Lack of sign up from West LCP PCNs to the Population Health Management data sharing agreement for Primary Care.

Support CCG/system or barriers to progress

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee

Date of Governing Body: 24 February 2022

Dates of Committees covered in this report: 17 February 2022

(Minutes of these committee meetings to be available as an addendum)

Chair's Name and Title: Graham Turner, Non-Executive Director, Finance & Remuneration

Contact Details: g.turner5@nhs.net

Reports discussed and assurances received

- **Risk Register Reports** – see Risk Register review below.
- **Quality & Performance Report** –This report provided a consolidated update on key measures of outcomes, performance, quality and activity, including escalation of key issues from LCPs and system groups, and highlighting any significant risks.
- The Committee noted that the Devon System remains under extreme pressure in all areas. Multiple factors have contributed to this position of increased risk, including sustained urgent care activity, delayed discharges due to poor community capacity and COVID related staff absences. This has led to pressures in Emergency Departments (EDs) due to poor patient flow resulting in a further stepping down of some planned procedures.
- The following areas were highlighted: -
    - Quality
        - Planned Care: risk to patients, due to long waits.
        - Urgent & Emergency Care: risk of long waits across whole pathway; 111, 999, ambulances through to EDs.
        - Primary Care: impact on workforce and capacity, due to long waits within planned and urgent care.
        - Community Care: risk due to discharge delays and long waits for packages of care.
        - IPC: Emerging variants of concern; Omicron
    - Performance
        - Planned Care: risk to RTT, diagnostic & cancer target delivery, including 104 week waits due to urgent care pressures and increase in Omicron cases.
        - Urgent & Emergency Care: ED 4 hour under-performance and 60-minute handover delay breaches at all four acute providers.
        - Discharge: delays continue to impact on flow throughout the entire system.
        - IUCS: 111 and Out of Hours service seeing continued capacity problems.
        - Children's & Mental Health: improvements in performance relating to some of the key metrics.
    - Workforce
        - Staffing continues to be challenging across the whole healthcare sector with the following issues all impacting on each other.
        - Sickness: Covid-related absences increased in December as Covid prevalence rose and

are now levelling off.
    - Turnover: has remained static in recent months (11.8%), although it is higher than this time last year (9.3%).
    - Agency Spend: remains high compared to prior years.
    - Vacancies: In many areas higher than previously seen.

Reports received and noted

- **Devon CCG Monthly Finance Report** – At the end of November the system had submitted a plan that delivers a breakeven position for H2 and, consequently, the whole year, within which the CCG is expected to deliver a £5.3m surplus.
- With the expectation that the CCG will be reimbursed fully for Hospital Discharge Programme (HDP) costs, the Winter Access Fund (WAF) costs and the Additional Roles Reimbursement Scheme (ARRS), a forecast surplus of £5.3m for the year ending 31 March 2022 was predicted, in line with the plan.
- **ICS Monthly Finance Report** – presented for information to the Committee, outlining the position at Month 9. The NHS financial framework has provided a fixed settlement for the second half of the financial year (H2) in line with H1 values but with an additional efficiency requirement and a 5% reduction to COVID in envelope funding. At month 9 the Devon ICS had a surplus of £5m, which is £5m favourable variance to plan (M8 £0.7m). The forecast to the year-end is £0.1m favourable against the £2.2m planned deficit.
- As at month 9 the ICS had made efficiency savings of £21.8m (M8 £17.7m) of which £6.2m (M8 £5.3m) are recurrent. The system forecasts to achieve savings of £43.5m (M8 £45.2m) of which £11.2m (M8 £14.5m) is recurrent. At the planning stage, £40.8m of efficiency savings were required, £17.0m were fully developed but £12.5m were still unidentified.
- As at month 9 the ICS was: -
    - underspent on substantive staff by £13.1m (M8 £10.8m). The forecast underspend at year end is £11.3m. (M8 £7.9m)
    - overspent on agency by £0.5m (M8 £0.7m underspend). There is a forecast overspend on agency of £1.7m. (M8 £1.7m). All trusts are in breach of the agency ceiling apart from University Hospitals Plymouth.
    - overspent on bank by £5.6m (M8 £5.0m). The forecast overspend at month 9 is £6.2m. (M8 £5.3m)
- **Operational Planning 2022/23** – the Committee received an update presentation and noted that there will be a move back to financial planning for a whole year, with a 'glidepath' from current system revenues to fair share allocations, assisted by a 'convergence' adjustment to gradually bring systems to their fair share. At a system level, and indicatively for organisational planning, the size of the challenge for 2022/23 after convergence is at least 6% of system allocation.

Risk Register Review (changes and areas of concern)

- There have been no risks recommended for closure, and no risk score movement. One new risk has been added to the corporate risk register - Risk 160, 2022/2023 Operational Plan. There is a risk that the operational plan for 2022/23 is not deliverable within the resources allocated to the system and this jeopardises the wider system plan.
- The impact of this is that the ICB would fail one of its key financial duties resulting in reputational damage, adverse assurance rating and the need to cut expenditure in an unplanned way, jeopardising other key deliverables in its corporate objectives. In particular this would have an impact on the Strategic Oversight Framework exit plan from level 4.
- The Committee resolved to draw the Governing Body's attention to this new risk.

Committee Decisions

- **Section 75 Agreement for Health and Local Authority Transport Services** – The Committee approved a proposal for a section 75 agreement for health and local authority transport services, for a

period of 5 years up to 31 March 2027, with an option to extend for a further 3 years. This is to replace the previous NHS Standard Contract for the provision of a patient transport advice service with a more integrated approach.

- The Committee noted that governance of the Section 75 Agreement would be through a new Board, which will be established to oversee the Agreement. The Devon Integrated Transport Board (DITB) will escalate CCG/ICB issues to the Finance and Performance Committee.
- **Contracting and Procurement Update** – at its meeting in November 2021, the Committee was informed that a significant amount of procurement was handled differently to usual to allow an effective response to the COVID-19 pandemic in a proportional and effective way.
- The Committee was informed that there was incomplete record keeping in relation to the procurement process, decision-making processes and conflicts of interest. The Contracting Team was asked to follow up these concerns.
- At its February meeting, the Committee was informed that the Executive had agreed a Covid Spend Review Process, which addresses the missing information and offers some additional assurance. No issues had been identified with Declaration of Interest forms for CCG staff. The Committee received assurance that this is a proportionate response to the situation and the current capacity restraints on the organisation.
- The Committee was reminded that publication of the Procurement Registers for 2019-2020 and 2020-2021 had awaited the completion of this work and, whilst noting that they could still not be fully completed and would therefore be in breach of statutory requirements, approved their publication.
- The Committee noted the following for information: -
    - Single Action Waivers and Declarations of Interest
    - An update on Non Clinical Procurement
    - The Committee approved the setting up of a small Executive group tasked with designing the implementation of the Provider Selection regime in the ICB, with a further report on the proposed process coming back for consideration and approval.

Recommendations for Governing Body

- **Risk 160, 2022/2023 Operational Plan** – That Governing Body notes the addition of this new risk and its potential impact on the Strategic Oversight Framework exit plan from level 4.
- **Section 256 Agreements with Local Authorities 2021/22** – The Committee received a report detailing a number of proposed s256 agreements that the CCG is intending to enter into with Devon County Council, Plymouth City Council and Torbay Council in 21-22. These investments include funds to improve integration through targeted investments that would reduce demand & growth in resources for secondary healthcare, such as avoidable planned and unplanned admissions and referrals to specialist mental and physical health providers. The agreements represent a £54m investment in social care that will benefit healthcare.
- The Committee reviewed the contents of the s256 agreements and **recommended they be approved by the Governing Body**. They are the subject of a separate report on this agenda.

Recommendations for other Committees

- None.

Terms of Reference or other committee effectiveness issues

- None.

Management of Conflict of interests:

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central register.

The CCG has made every effort to ensure this report does not have the effect of discriminating, directly or indirectly, against employees, patients, contractors or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Primary Care Commissioning Committee (Public)

Date of Governing Body: 24th February 2022

Date of Committee covered in this report: 3rd February 2022

(Minutes of this committee meetings to be available as an addendum)

Chair's Name and Title: Judy Hargadon

Contact Details: judy.hargadon@nhs.net

Recommendations brought to Committee for approval or agreement

None

Reports brought to Committee for information, review, discussion and to be noted

The **Deputy Director's report** highlighted:

- that a number of LMC workstreams are moving forward satisfactorily
- that there is still concern around the interface for transfer of work issues between Secondary and Primary Care
- that further work is needed on Local Care Partnership maturity

Finance Report detailed the financial position to 31st December 2021 (month 9).

Seven areas were highlighted:

- The Devon ICB has received draft allocations for the 2022/23 financial year.
- All numbers are draft and indicative until confirmation of allocation by Parliamentary Bill.
- The draft growth value for Delegated Primary Care is £12.5m (6.8%).
- Convergence adjustment: Our allocation will recurrently increase by £1.6m as part of the movement towards our target fair share allocation.
- Operational issues with Primary Care Support England (PCSE) have eased with regard to CCG interaction but there are some issues with GP pensions.
- There is a risk that not all Additional Roles money will be able to be used
- There is £400k in the contingency fund for this year due to over/under accruals

The **Risk Report was** discussed at the meeting, and it was noted that it has been necessary to raise the risk score with regard to the Sustainability of General Practice due to the increased number of practices with resilience issues. The protocol for mitigating the risk regarding antiviral Prophylaxis for care homes has been

put to the test by an outbreak of flu and the Primary Care Network local to the care home responded well. The primary care data sharing risk has been acted upon to encourage Practices to submit their data.

The **Primary Care Strategy Implementation Progress Report** updates were presented and closely inspected by the Committee members,

General Practice Strategy Refresh Proposed Plan and Timeline:
The proposed process for undertaking the Primary Care Strategy Refresh was described to the meeting; it includes timescales for identified phases, culminating in anticipated readiness for sign off for July PCCC. The committee members discussed possible problems due to the change-over to ICS and that there will be very little non-executive director (NED) and clinical role continuity. It was agreed that the current committee would look at this new strategy in June so as to give a considered statement to the new committee.
Ongoing development of National strategy and guidelines was also discussed.

Recommendations for Governing Body
None
Recommendations for other Committees
None
Terms of Reference or other committee effectiveness issues
None

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GOVERNING BODY

Report title: Committee Chair Report – Quality Assurance Committee (QAC) Public Part 1

Date of Governing Body: 24 February 2022

Dates of Committees covered in this report: 17 February 2022

Chair's Name and Title: Gaynor Appleby Non-executive lay member for Assuring Quality of Services, NHS Devon CCG deputising for Glynis Atherton.

Contact Details: g.appleby@nhs.net

Reports discussed and assurances received

The Committee received updated reports as detailed below

Reports received and noted

Quality and Safety Report
University Hospitals Plymouth NHS Trust (UHP)
The CQC inspection report of urgent, emergency care and medical care services and the well-led domain for the trust overall has been published, with the overall rating of services remains as requires improvement. Due to operational pressures several of the system meetings that provide ongoing oversight and assurance around the improvement and action plans have been stood down. It is recommended that a discussion as to how best to manage the oversight of a significant number of action and improvement plans occurs moving forward into ICS.

Torbay and South Devon NHS Foundation Trust (TSDFT)
The Trust have completed an executive review of their CQC compliance. The Trust has closed a lot of their "should do" actions whilst nine of their "must do's" remain open. Six of the actions relate to mandatory training compliance for staff.

At the Quality Improvement Group, it was escalated that insufficient Endoscopy procedures are undertaken to ensure Joint Advisory Group on Gastrointestinal Endoscopy (JAG) reaccreditation, an options appraisal is being undertaken to assess next steps.

Risk Register Review Updates

Quality Risk & Assurance Report including Risk Register:
Risk Register Review (changes and pertinent areas). Data was extracted for this report on the 2 February 2022 of which it informs the Committee of any changes since the last Quality Assurance Committee (QAC) on the 20 January November 2021. There are **eleven** risks that report to QAC.

- **Risk 139** - Infection control team capacity has been increased in score from 9 to 16. Increase in score being due to staffing and an increase in disease prevalence.
- There are no risks for closure.
- There are no new risks to report.

Due to the standing down of the Commissioning Committee it has been agreed that risks which reported to this committee will be presented to the Quality Assurance Committee for oversight. Data for this report was extracted on 03 February 2022. There are six risks reporting to the Commissioning Committee.

- **Two** new risks have been added in the reporting period.
- **Risk 156** DRSS Referral Review/triage delays. Risk score 15.
- **Risk 159** Population Health Management System Implementation. Risk score 16.
- **Three risks** have reduced in score this includes new risks 156 and 159 as above and risk 149 below.
- **Risk 149** Eating Disorders Physical Health the risk score has been reduced from 20 to 16.

The committee raised concerns about the down grading of the risk 149. This is a commissioned service gap and this has not been clearly articulated in the risk. The committee requested oversight of the risk as it is an commissioning risk with significant safety implications.

Committee Decisions

- Nil to note

Items of concern to be escalated to the Governing Body

- Risk 149 Eating Disorders Physical Health.

Recommendations for Governing Body

To note the reports received and positions of assurance by the Quality Assurance Committee.

Recommendations for other Committees

- None

Terms of Reference or other committee effectiveness issues

- None

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