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

MS Teams - please refer to calendar invitation for joining details

27 May 2021 11:00 - 27 May 2021 13:00

AGENDA

#	Description	Owner	Time
1	Patient Experience Verbal	Neomi Alam, Director, Inclusive Exeter	11:00
2	Welcome and apologies and questions from members of the public Verbal	Chair	11:20
3	Register of Interests (ROI) Paper DOI NHS Devon CCG Governing Body @ 19 May... 5	Chair	
4	Minutes of the last meeting and action log Paper 1 Draft Public GB minutes 29.04.2021 v2.2 nc.docx 10 Copy of Master Action Log - PUBLIC v3 nc.xlsx 21	Chair	
5	Schedule of what the Governing Body is to achieve at this meeting Paper Schedule of what GB is to achieve .docx 22	Chair	11:25
6	Chair's Report Paper 1 cover sheet chair's report.docx 25 2 Chairs Report May 2021.docx 27	Chair	11:30
7	Accountable Officer's Report Paper AO report June v2.4.docx 29	Accountable Officer	
8	PROGRAMME OF WORKS - items for recommendation, decision and assurance		11:45

#	Description	Owner	Time
8.10	Integrated Care Partnership (ICP) Western Contract Award Paper 1 ICP GB May 2021 v1.docx 35 2 ICP Contract Award Recommendation Report Pu... 38 Appendix A_WA002829_Procurement Approach_v... 56 Appendix B_ICP Risk Log.pdf 66 Appendix C_Regulation 84(1) Report – Contents C... 67	Executive Director SRO for ICP Western	
8.20	Understanding the experiences of health and care in Devon for BAME communities and staff: Final report and proposed implementation plan Paper 1 NHS Devon CCG report cover sheet - Nous repor... 69 2 Nous project GB paper 25 May 2021.docx 72 3 Experiences of health and care in Devon for BAM... 76 4 Nous recommendations - Implementation and acc... 132 5 NOUS Final report communications plan.docx 137	Chief Officer, Communications, IT and People	
9	LOCAL CARE PARTNERSHIP (LCP) REPORTS Paper(s) 1 Northern Locality Update - April 2021.docx 140 2 Locality Update - Eastern Apr-May 2021.docx 144 3 Locality Update (Southern) - April 2021 v2.docx 148 4 Locality update Plymouth April 2020 Final (002).d... 151 5 Western Devon Locality Report for GB - MAY 20... 154		12:20
9.10	Deep Dive - Plymouth 2021-05-27 GB pack - 1.pdf 157	Locality Directors	
10	ASSURANCE COMMITTEE CHAIRS' REPORTS including items of escalation Paper(s)	Assurance Committee Chairs'	12:45

#	Description	Owner	Time
10.10	Finance and Performance [P] Finance and Performance Committee Chair Report... 178		
10.20	Primary Care Commissioning [P] Committee Chair Report -May 21 Public PCC - Ma... 180		
10.30	Commissioning [P] May GB - Commissioning Committee Report 13.05.... 182		
10.40	Quality [P] v2.0 QAC Chair Report Part 1 20 May 2021.docx 185		

Declaration of Interests Register - NHS Devon Governing Body
Register updated and generated by the Governance Team - 19 May 2021

Register last updated 19/05/2021

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) CCG Executive Team Meeting Member of Devon JCEG Commissioning Committee (CC DOI) Member of Audit 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		27/08/2020	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	CQC Specialist Advisor Therapy Lead for Health and Social Care for North Devon		01/11/2019		05/05/2020	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 Trustee for St. Margaret's Hospice, Somerset 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		01/09/2020	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
	Burrows	Charlotte	Non Executive Lay Member - Patient and Public Involvement Geographical remit - Northern	Member of Governing Body Member of Quality Assurance Committee Member of Remuneration and Workforce Committee Member Primary Care Commissioning Committee (PCCC)	Self-Employment business consultant from September 2019 Associate for Research In Practice Feb 2020 Associate for Research In Practice Supplier/Associate for SWAHSN (Feb 2020) Within my role as SWAHSN associate will be part of their project team which is supporting the Think 111 project Associate for Devon Communities Together		04/04/2019		04/08/2020	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
	Carroll	Jayne	Interim Chief Operating Officer (to 01 June 2021)	Member Governing Body Member of Senior Leadership Team (SLT) Commissioning Committee (CC DOI) Member of Finance and Performance Committee Devon Urgent Care Board	Independent member of Fostering Panel for Pathway Care.		08/08/2020		08/08/2020	Professional	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. No line management responsibility from effective date of interest	NHS Devon CCG
	Chilcott	Ben	Deputy Director of Finance	Strategic Medicines Optimisation Group Member of Finance and Performance Committee 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 Planned Care Programme Board	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		17/09/2020	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	Member Vacancy Control Panel 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	Attendee Governing Body	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 Director for Lyme Disease Action Charity 08 March 2021 to 06 June 2021 Interim Company Secretary University Hospitals Plymouth NHS Trust		22/08/2017	26/11/2020	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 CCG 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 Working with Industry and Sponsorship Group	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 of Devon 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.	Spouse is Chair of Dartington Hall Trust Brother is GP in Cornwall	01/05/2019	15/04/2021	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	Harrell	Ruth	Director of Public Health, Plymouth City Council	Devon STP Clinical & Professional cabinet NHS Devon CCG Governing Body Member of Devon 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 CCG Executive Team Meeting Finance and Performance Committee 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	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	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)	Spouse works in emergency department at RDE and for Exeter Medical School	21/08/2015	21/10/2020	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
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 of Devon JCEG Commissioning Committee (CC DOI) Member of Devon Clinical Cabinet System Restoration and Transformation Group	Governing Body Independent Clinician BNSSG CCG Member South West Clinical Senate Council Advisor to Western Provident Association, Medical Insurer 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 Train 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		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
Dame	Leather	Suzi	Independent Chair Devon ICS	Attendee Governing Body, NHS Devon CCG	Chair Independent Adjudicator for Higher Education in England and Wales Deputy Lieutenant of Devon 2009 Patron UK Clinical Ethics Network 2020 - Advisory Board for Social Mobility in the South West April 2021 Chair Devon Ethical Reference Group Member Labour Party Vice President Hospiscare Fellow ad eundem Royal College of Obstetricians and Gynaecologists Honorary Fellow Royal Society for Public Health	Close relative is a GP in Exeter Close relative is a psychiatrist in Manchester and Brize Norton Close relative - Director of Global Health, Kings College, London Relative is a psychiatrist in London	06/04/2021	06/04/2021	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
	Masters	Susan	Associate Director of Nursing Deputy Caldicott Guardian	Quality Assurance Committee (QAC) Member of Audit Committee Member fo Governing Body (Deputy for CNO) Member of Primay Care Commissioning Committee (PCCC)	Trustee Director of HQIP (Health Quality Improvement Partnership)		01/03/2021	01/03/2021	General Interest	indirect		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)	26/09/2017	20/10/2020	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 CCG 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	Member of Governing Body CCG Executive Team Meeting Joint Staff Partnership 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 CCG 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) CCG Executive Team Meeting Senior Leadership Team (SLT) Working with Industry and Sponsorship Group System Restoration and Transformation Group Member of Strategic Commissioning Partnership	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 CCG Executive Team Senior Leadership Team (SLT) Attendee Audit Committee (Audit Committee) Finance and Performance Committee Commissioning Committee (CC DOI)		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 Joint Staff Partnership 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 Member of Primary Care Commissioning Committee (PCCC) CCG Executive Team Meeting Strategic Commissioning Programme Board Commissioning Committee (CC DOI) Quality Assurance Committee	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 experience but not participate in the final decision/vote.	NHS Devon CCG
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 Board	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

Wooldridge	James	Associate Non Executive Lay Member	Attendee Governing Body	Managing Director of Recovery Devon CIC which is directly funded by Devon Partnership NHS Trust (DPNHST) Proprietor of Positive Notions. A private consultancy providing mental health training services to various organisations including but not limited to: DPNHST, University of Exeter, University of Plymouth, Livewell Southwest There may be an increased reputational benefit to my Positive Notions consultancy through membership of Devon CCG. I will advocate for various mental health groups and organisations including Recovery Devon CIC, that may be in receipt of commissioned funding from Devon CCG In receipt of individually funded treatment My general interest lies in mental health, wellbeing and recovery. I intend advocating for groups and organisations that adopt and demonstrate the values and principles associated with the recovery approach	28/10/2019	14/04/2021	Financial /non Financial Professional Interests/ 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.	NHS Devon CCG

NHS Devon Clinical Commissioning Group

NHS Devon Governing Body Meeting
DRAFT minutes held in PUBLIC

Date: 29 April 2021 Time: 09:30 – 11:43 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. The chair welcomed everyone to the Devon Clinical Commissioning Group (CCG) meeting which was held in public and reminded the members for discussions to be verbal and only to use the chat bar function if there was a need to draw the Chair's attention. **Patient Story** PJ was pleased to welcome Janine Law (JL), Primary Care Network operations manager and Andres Mesa Cruz (AMC) who were in attendance to share their experience in supporting the vaccination programme. JL described the issues for staffing vaccination clinics in Barnstaple with volunteers that had put them forward to support this and how she set up the organisation of this. She explained that a scheduling shift app had been developed which published shifts that were available that volunteers could choose from, and as well as the scheduling app a volunteer pack had been produced. JL noted there were around 139 volunteers in Barnstaple and that the volunteers also provide support in managing the shift app as well as organising the volunteers JL referred to the numbers of volunteers required per shift and the numbers of clinics that have been undertaken not including individual Primary Care Network clinics and the savings to date in staffing costs was around £80k. AMC described how he came to be a volunteer for the vaccination programme and how he supports securing additional volunteers and JL in covering the volunteer schedules and shifts and alerting volunteers when shifts are available. PJ thanked JL and AMC for their presentation and acknowledged their contribution to supporting the vaccination programme. PJ asked about the first cohort of the vaccination programme and the over 80's who had not been out for some time. AMC responded to say that preparations and a process was put in place which guided them through every-step, and they were well supported, and how the volunteers went about the process really made a difference. JH asked how we could get volunteers to share their experience and learning and how we can use this in future. JL agreed and was pleased to say that Ilfracombe have a	

	great community-based support including the Roundtable and Rotary Club and that learning from the volunteers will be used and drawn upon for the future. AM highlighted that we have Darin Halifax (DH), who works closely with the voluntary, community and social enterprise sector and felt that the NHS would struggle without volunteers. He offered to link with DH to discuss how we better recognise the role that volunteers play in services that are delivered. **ACTION 1** **AM to link with DH to discuss how we better recognise the role that volunteers play in services that are delivered.** DA as senior responsible officer for the vaccination programme thanked JL, AMC and all the volunteers for their contribution as without them the vaccination programme would not have been such a success. JW was also encouraged that volunteering had made a difference and that we need to build on the opportunity to promote volunteering as a socially responsible thing to do in all communities. PJ further thanked JL and AMC and was proud of what they had achieved as a team.	
2	**Welcome and Apologies** Welcomed Andrew Girdher, clinical chair, Bath and North East Somerset, Swindon and Wiltshire CCG who joined the meeting observing as a useful experience to see how Devon CCG operate and to share learning from each other. The following apologies were recorded for: Charlotte Burrows Gaynor Appleby	
2.1	**Question from members of the public** Paul Walker submitted a question in advance of this meeting as follows: **''What provisions have been made to outsource and liaise with private providers to help reduce cataract waiting lists following the introduction of the Increase capability (capacity) framework which is being funded by NHS England?''** **Devon CCG's response:** The Increasing Capacity Framework (ICF) has been set up by NHS England to provide Commissioners and Trusts with a quick and easy route to contract and sub-contract for acute elective services on standard terms and conditions with Independent Sector providers appointed to the ICF. The ICF adheres to procurement law and has been designed to reduce the burden of individual end-to-end procurement processes and negotiations. The ICF can be used to place all contracts and sub-contracts for in-scope services, whether they are to replicate pre-March 2020 arrangements.	

	NHS Devon CCG is utilising the ICF which has only been in place since January 2021. We are currently working on our approach to realise greatest benefit across the broad range of in scope services, including ophthalmology and cataracts services.	
3	**Register of Interest (ROI)** PJ referred to the ROI included in the pack and none were declared. There were no conflicts of interests declared pertaining to the agenda items scheduled for this meeting. **The Governing Body received and noted the ROI**	
4	**Minutes of the last meeting** PJ led a page by page review of the minutes of the last meeting held on 25 March 2021. Subject to minor wording changes amendments these were approved as a true and accurate record of the meeting. JH suggested that following guest speakers and patient stories we have an agreed action formally recorded for feedback as habit, so members don't lose sight of any learning. **ACTION 2** **New action to be opened feedback and learning from the patient experience/ story re volunteers for the vaccination programme.** **Action Log** • 1 update on minor injury units added to the forward planner for June, and action to remain open. **Matters arising** JT gave a brief update on the patient story from the meeting held in March and noted that a short-written briefing had been developed and this would be circulated to the Governing Body. JT was pleased to report that there had a been a helpful follow-up meeting with Debbie Frances and this has resulted in a series of actions which includes: • Debbie has been invited to participate in the development of the community and mental health framework. • Review of personal health budgets for mental health to improve uptake. • Open dialogue with Devon Partnership Trust around the support on offer to return to employment and care coordination for young people affected by mental health issues. **PJ gave his thanks to JT, ST, and DSL for meeting with Debbie Frances.** **ACTION 3** **JT to circulate briefing following further meeting with Debbie Frances re young people affected by mental health issues.** ***Post meeting update this action has been completed.***	
5	**Schedule of what the Governing Body is to achieve at this meeting** PJ highlighted the summary paper which detailed the assurance and decisions being asked of the Governing Body for this meeting.	

	The Governing Body noted the contents of this report.	
6	**Chairs Report** PJ did not propose to add anything further to the report, but took the opportunity to formally welcome Jane Milligan, Chief Executive of the Integrated Care System and NHS Devon CCG. PJ congratulated David Greenwell and Mat Fox for agreeing to continue in their roles as joint clinical lead representatives for the Southern Locality which will continue to April 2022 and he acknowledged the affirmation of members practice support for these roles. PJ referred to Roy Warnes and what an honour and a privilege it was to meet with him to celebrate his volunteer work and encouraged the Governing Body to read his inspiring story. **The Governing Body received and noted the contents of the Chair's report.**	
7	**Accountable Officer's Report** JM thanked everyone for such a warm welcome and looked forward to continuing with working closely with ST and colleagues in going forward. JM referred to the focus on staff wellbeing ensuring mechanisms are in place for collecting experiences from staff and the Black, Asian, Minority Ethnic (BAME) health inequalities report and recommendations that will be presented to a future meeting. JM noted that at the next Governing Body there will be an overview plan on delivering integrated care services (ICS) and what that means in relation to the CCG. JM informed the members that she is taking up offers and invitations to meet with Primary Care Networks (PCNs) and Local Care Partnerships (LCP) and that she was pleased to be in post and to continue supporting the fantastic work Devon has been doing. **The Governing Body received and noted the contents of the AOs Report.**	
8	**Performance and Quality Report** JC noted that this report reflected the period of February to March 2021 validated data during this period. She highlighted that over this period there had been high numbers of patients flowing through hospitals and it was important to note that whilst we are starting a period of recovery staff have been given time to take leave to recover their own wellbeing which is an ongoing priority. JC highlighted the following areas of performance: • Cancer services - 62-day target has seen an improvement to 75% all trusts and the recovery journey continues • 2ww has been challenging over recent months but has now improved to 82%, subsequently breast symptomatic has also improved despite challenges with demand and capacity and mutual aid support. Reassurance was given to the members that the delivery of the 28-day standard diagnosis is being maintained • Elective care – arrangements with the independent sector has now moved back to normal contractual arrangements and we are ensuring we are treating long waiters and achieving the equity use of capacity	

- Waiting lists – long waiters has increased, showing an underlying trend within context of the pandemic. There is a major focus to improve the position against 52 weeks which has seen an increase of 1800 patients
- Harm review - all trusts have undertaken risk assessments on a regular basis
- Diagnostics - an improvement has been but there is more to do to recover along with the use of the Nightingale Exeter and additional capacity which is already operational in that facility with a potential expand further
- Urgent care – this remains a challenge to ensure we have the system capacity balance to respond to urgent and emergency care (UEC)demand and also ensure the capacity to recover our planned care activity. We have seen an increase in urgent care activity since lockdown has eased. An additional challenge is that providers have to maintain separate COVID pathways and operate within infection prevention and control requirements which adds to constraints in terms of capacity
- Challenges are being seen regionally with UEC demand and the level ambulance handovers for University Hospitals Plymouth (UHP). There have been some changes in UHP made last month around arrangements for handovers which has led to improvement
- 4-hour performance - this remains an area of focus for the system. The Royal Devon and Exeter (RDE) remains challenged and improvement plans are in place to address and reflect demands and flow. UHP are not measured against the 4-hour target as they are a national pilot site for new metrics.
- We are continuing to build on the discharge to assess model for the management of complex discharges and each LCP have put in place flow improvement plans

DA highlighted the following areas of quality:

- We are continuing to work on the risk profile, risk stratification and harm, and acknowledge that clinicians are working to reduce backlogs. We are also being proactive to understand psychological as well as physical harm as part of early warning
- Improvements have been seen at UHP regarding lost ambulance time and we are doing more to identify the wider community quality impact
- Infection prevention and control since the lifting of some restrictions we have started to open visiting in hospitals which has impacted on flows and facilities and we have started seeing a prevalence of outbreaks in some areas. We have put on place a heightened level of surveillance to understand the next challenges

JC referred to mental health and children's services and there are plans in place to deliver improvement that are being closely monitored by the commissioning team. This includes addressing targeted area of concern around the access to eating disorders assessment. Work is underway around the challenging long waiting times for access, diagnosis and assessment for autism and speech and language therapy.

JC was pleased to report that there has been positive improvement with regards to annual health checks for people with learning disabilities and this is progressing, and we are confident there will be good outcomes for our quarter 4 position.

JC drew attention that the phase 3 activity recovery plan trajectories will be replaced with new trajectories from April onwards being finalised as part of the operating plan. The system performance improvement framework is being operationalised, with local care partnerships (LCPs) establishing the forums to review the integrated performance report and make improvement and exception report and raised issues for escalation to the

system performance group and ensure line of sight through to the Governing Body nd Integrated Care System (ICS) Partnership Board.

DSL asked whether clinicians have considered the BAME identity and social deprivation and is there a balance of acuity done the same way across the system. GS replied to confirm there has been lots of work regionally and nationally including the identification of good practice. NK added that a paper had been presented to the clinical cabinet and suggested this could be taken to the ethics committee to support the impact of clinical decision making.

SL raised concern around the unacceptable waiting times for children's autism assessment services and asked that we model the trajectory recovery carefully and monitor closely to understand the expected reductions in waits.

GA asked about breast symptomatic performance and was there support to woman waiting for assessment beyond the waiting time and was the harm factor registered. SMC provided clinical reassurance and JC confirmed that for the 28- diagnosis standard was being met. Further work is being undertaken around mutual aid and available capacity in response as part of recovery. NK assured the members that senior clinicians on the mutual aid group meet weekly to discuss all issues and that this was an exceptional cohesive meeting that works well and links into the cancer network.

GT drew the members attention to previous finance and performance reports and felt it would be useful for a performance position statement to be developed showing performance pre-COVID, currently and trajectory for elective recovery.

ACTION 4
Comparison report to be developed against pre-COVID performance and to be presented to a future Governing Body.

SMC referred to page 39 of the report and requested for primary care flows in the system to be reviewed as a system approach. SMC, as mental health clinical lead, also noted that she had not had sight of the issues relating to access to eating disorders and asked for this to be included in this work programme.

AD highlighted the figure of 139 weeks which was the longest wait for Autism assessment, and it was confirmed that the Quality Assurance Committee (QAC) review the waiting times to understand the impact on families. It was requested that when figures are presented to QAC in future they do not just show average waiting times but also the number of children waiting 26 weeks, 52 weeks etc to present a clear picture of the situation.

It was noted that we have seen unprecedent referrals for adult safeguarding reviews for this quarter. DA added that it was too early to identify variances and themes directly related to the impact of the pandemic and the correlation of concern that has come to fruition coming out of lock down, but will report back to the Governing Body in moving forward.

JWo asked about UHP and not reporting A&E waiting times due to the national pilot they are part of and where are problems addressed. JC reassured the Governing Body that there is significant scrutiny of UHP and emergency care performance and that the CCG see the reporting system that is in place along with regional daily triggers for breaches.

	She noted that last week there was a high level of walk in activity pressures and we are working to understand what is driving this and what interventions can be made. SK asked to see more evidence in the performance report around strategic intelligence for LCPs to enable them to make the right decisions to improve capability and capacity, as primary care has seen an increase in demand. JC was supportive of developing the information support to LCPs through the performance improvement framework. DG asked about the proactive management of long waiters and making the most of estates and JF described recovery plans in place for both areas. It was raised that people on the Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) are waiting a long time to be seen due to the availability of choice for their full pathway and not just diagnosis. JT acknowledged that this was a concern in general practice and that this issue will be brought to the commissioning committee for consideration and decision to put in place a policy in line with the NHS constitution that allows for the CCG to commission a pathway approach. PJ thanked everyone for their contributions to these discussions which reflects the importance of the performance and quality challenges and responsibility we feel for the services we commission. On behalf of the Governing Body, PJ gave thanks to JC for the exceptional work that she has undertaken in her role as interim Chief Operating Officer. He wished her well in her new role and next challenge in moving to support the integrated acute and community services in West Devon. **The Governing Body received and noted the contents of the Quality and Performance Report.**	
9	**CCG Objectives progress update** AM presented this report which captured the essence of the objectives which had been collectively agreed and presented in an easy way to read as to how they are progressing. He did not propose to go through the report in detail but highlighted the following: • First time objectives co-designed with staff • First report on progress against 5 main objectives with some actions sitting below and will include specific measurables to assess • Worked closely with directors and nominated leads and noted the CCG annual assessment report produced was now included in the objectives report and this will continue in moving forward • Progress of objectives process will be kept simple including a Red, Amber Green (RAG) rating allowing for adjustments as we move forward that will give a sense where the main objectives for the year ahead are as well as progress and mitigations • Feedback welcomed and adjustments to be made if required to improve and/or clarify points Although NB was hesitant for more detail to be added he did request the narrative to be strengthened to action 2. JWo also added that to make the NHS even better early involvement of people in designing services in the system should be more specific in objective 2.	

	SMC offered her congratulations to AM and a focus of attention in supporting and working with staff and wondered how this would be translated and carried forward into the ICS. AM replied that staff will remain front and centre and ST added that there is an intention of developing a staff engagement workstream for the ICS development work. PJ queried action 6 and the RAG rating for LCP Western and AM agreed to take an action to review. **ACTION 5** **AM to make some minor amendments to the corporate objectives:** • **By add more detail to action 2 and strengthen the wording** • **Be more specific re object 2 early involvement and engagement of local people in designing services** • **Check the RAG rating against action 6 for Western and link with Derek Blackford to ensure that progress is reflected accurately** **The Governing Body received and noted the contents of the monitoring and reporting of the CCG objectives report.**	
10	**Local Care Partnership (LCP) Updates** *Derek Blackford joined the meeting. Locality director Southern and West Devon.* The LCP updates were for information, but for this meeting there was a specific focus on Southern and West Devon area. Southern and West Devon DB referred to the latest draft document which had evolved took the LCP update taken as read. He noted that he had been working closely with JH and DG in relation to the Southern update and would be doing the same with SMC, Anna Coles, and NB for West Devon. He did not propose to go into detail but drew attention to the following: • Time has been spent making sure the LCP architecture is right including making the right connections and relationships are being managed. He was pleased to report that he had managed to get partnership organisation representatives attending meeting. • He acknowledged there were anxieties in moving forwards with LCPs working together for Plymouth and Southern and understood there was plenty more work to do. • He recognised that for West Devon the benefits need to be articulate • A joint session is being developed including executive delivery groups both setting the work with engagement leads and was on the verge of identifying best placed support for the West. • Work is continuing around the oversight of performance and there has been useful time spent on conversations to extend mental health social and primary care • Clinician to clinician conversations are also underway • There is a focus on improvement plans and flows through the system and a draft has been shared with NHS England where positive feedback has been received. • More work is required around ownership and engagement and key deliverables and short term impact arrangements have been put in place	

	• Development work is ongoing in making sure the right connections for programmes of work with localities are in place • Specific issues and challenges for Torbay and South Devon include ambulance handovers and ED and there is a focused effort including system partners committed to address these issues • Making sure the implications are clear for the Long-Term Plan (LTP) road map and operational delivery in the short-term until the team is resourced to full capacity JH complimented DB and the way he has got to grips with the issues in the South and asked how the South and West LCPs are focusing on workforce issues. DB responded that people have been linked together in the system and acknowledged that there was LCP workforce challenges in each area of service, and this is being taken forward. SK asked in developing part of the delivery group how would you get the right clinicians involved in conversations. DB confirmed that they were exploring ways of bringing people together including clinicians and primary care attendance through existing or through a different delivery mechanism. DSL acknowledged the importance of co-creation and asked what the system can do to support and evaluate the learning to spread across other LCPs. ST referred to the commissioning cycle and expert support for localities to evaluate share and adopt into other areas and that we cannot evaluate until we have a good baseline and targets in place first. DSL wondered what was happening in the system regarding long COVID and are we building services to include peer to peer support. JT described the service set up and how clinicians are working together and that when the evaluation of the pathway was at the right time there would be an evaluation for effectiveness along with linking with localities and voluntary sector peer support. **ACTION 6** **Long COVID evaluation report to be brought back to a future Governing Body. Action lead JT.** **The Governing Body received and noted the contents of the LCP update reports.**	
11	**Assurance Committee Updates** <u>Finance and Performance</u> GT referred to page 3 of the report and the recommendation to the Governing Body to approve the financial budget for H1 (for the first six months of year) which was detailed in Appendix 1 table 3. JD emphasised the recommendation for Governing Body approval and gave context to the paper which was a system allocation to the Devon system of which Devon CCG forms part of it. He noted that the financial envelope funding meets our Long-Term Plan commitments and re-emphasised that Governing Body approval was for the first half of the year April 2021 to September 2021. JD added that we are awaiting further confirmation as H2 our further allocation for the second part of the year and this was dependent on national level discussions with the NHS and treasury and the outcome would be passed to the Governing Body as soon as it was known. **The Governing Body:**	

	• **Approved the CCG H1 Budgets as set out in Table 3 in Appendix 1 (section 7), in order that the CCG officers may make authorised expenditure in line with its scheme of delegation. The proposal demonstrates that a balanced plan is being set for H1.** • **Governing Body noted that a development session is to be organised for the Governing Body regarding the proposed changes to procurement legislation – post meeting date this has been added to the Governing Body development forward planner** <u>Quality Assurance Committee</u> There was nothing further to add to this report. <u>Primary Care Commissioning Committee</u> There was nothing further to add to this report. <u>Commissioning Committee</u> There was nothing further to add to this report. **The Governing Body received and noted the contents of the Assurance Committee Chair's Reports.**	
12	**Any other business** PJ thanked everyone for their contribution, energy and focus and thanked the members of the public who joined this meeting.	
13	**The meeting closed at 11:43**	

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) [A]	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
James Wooldridge (JW) **	Associate Non-Executive Director, Devon CCG
Jayne Carroll (JC)**	Chief Operating Officer, 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 (in absence of DG)	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) **Chair** **	Clinical Chair, Devon CCG
Penny Harris – (PH) **	Director of Commissioning in hospital, Devon CCG
Ruth Harrell - Dr (RH) **	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
Sonja Manton – Dr (SMa) **	Executive Director and SRO for Integrated Care Partnership (Western Devon), 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
Dr Andrew Girdher (AG) **	Clinical Chair of Bath and North East Somerset, Swindon, and Wiltshire CCG
Derek Blackford (DB) ** **item 10**	Locality Director, South and West Devon, Devon CCG
Minutes approved | Date:	Signed by chair:

NHS Devon Clinical Commissioning Group

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	25/02/2021 25/03/2021	Briefing paper on MIUs and the current position of out of hospital urgent care to be developed for the Governing Body meeting to be held in March.	10-Jun-21	John Finn	02.03.2021 this agenda item has been added to the Governing Body forward planner for 25 March 2021. 25.03.2021 MIU's and future shape of community urgent care provision to be added to the Governing Body forward planner for June 2021. Post meeting update this action to add to the forward planner has been completed.					**IN PROGRESS**
2	29-Jan-21	AM to link with DH to discuss how we better recognise the role that volunteers play in services that are delivered.	27-May-21	Andrew Millward	20.05.2021 Darin Halifax is going to consider how best to do this, and is liaising with VCSE partners on the way forward.					**IN PROGRESS**
3	29/04/2021	New action to be opened feedback and learning from the patient experience/ story re volunteers for the vaccination programme.	27-May-21	Chair/all						**OPEN**
4	29/04/2021	JT to circulate briefing following further meeting with Debbie Francis re young people affected by mental health issues	27-May-21	Jo Turl	10.05.2021 briefing update circulated to Governing Body on 10 May 2021. Reccomendation for this action to be formally closed.					**FOR CLOSURE**
5	29/04/2021	Comparison report to be developed again pre-COVID performance and to be presented to a future Governing Body.	01-Jul-21	Jayne Carroll/ Sheila Roberts	20.05.2021 - When the 21/22 activity plans have been finalised as part of the operating plan the comparison report will be presented to the Governing Body and it is anticipated this will be at the meeting held on 01 July. A place marker has been added to the Governing Body forward planner					**IN PROGRESS**
6	29/04/2021	AM to make some minor amendments to the corporate objectives	27-May-21	Andrew Millward	20.05.2021 Nick Pearson and Andrew Millward will refine these and they will be featured in the next quarterly review of the CCG Objectives that come to Governing Body.					**IN PROGRESS**
7	29/04/2021	Long COVID evaluation report to be brought back to a future Governing Body. Action lead JT.	28-Oct-21	Jo Turl	20.05.21 An evaluation of Long COVID will be undertaken when the pathway has been in place for 6 months. This will be taken through Commissioning Committee and reported through to Governing Body. A place marker has been added to the Governing Body forward planner for October 2021.					**IN PROGRESS**

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Schedule of what the Governing Body is to achieve at this meeting				
Date of committee: 27 May 2021 **Date report produced: 19 May 2021**				
Author (s) Name and Title: **Dr Paul Johnson, Clinical Chair** **Contact Details:** **Paul.johnson4@nhs.net**		**Supporting Executive: N/A** **Name and Title:** **N/A** **Contact Details: N/A** **Report Approved by:** **Name and Title:** **Dr Paul Johnson, Clinical Chair** **Date:** 19 May 2021		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

The Governing Body is asked to:

- **Receive and note** the contents of the Chair's Report
- **Receive and note** the contents of the Accountable Officer's Report
- Integrated Care Partnership (Western Devon) – Contract Award Recommendation Report:
    - **Reflect on the:**
        - The strategic risks that have been considered and mitigated through this process, particularly in relation to capacity and capability to deliver the contract, contingencies for provider landscape change and partnership working arrangements,
        - The transformation benefits and delivery plans,
        - The contractual terms and governance arrangements to support this

  Subject to approval by Plymouth City Council's Executive as the associated commissioner with statutory responsibility for adult social care, it is recommended by the ICP Executive Group that NHS Devon CCG Governing Body **approve:-**
    - The award of contract for delivery of the Integrated Care Partnership services for the Western Locality of Devon to University Hospitals Plymouth NHS Trust as lead provider.
    - That the contract commences on 1st July 2021 for a period of 10 years with the option to extend for a further 5 years.

- **Consider** the understanding the experiences of health and care in Devon for BAME communities and staff final report and recommendations
    - **Approve** the allocation of the recommendations
    - **Discuss and identify** resourcing for delivery of the recommendations
- **Receive and note** the contents of the Local Care Partnership (LCP) Reports and **participate** in the discussions with regards to the deep dive of the Plymouth locality
- **Receive and note** the contents of the Assurance Committee Chair's Reports and **consider and approve** recommendations made to the Governing Body

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.

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:

None

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

GOVERNING BODY

Report title: Chair's Report				
Date of committee: 27 May 2021 **Date report produced: 19 May 2021**				
Author (s) Name and Title: **Dr Paul Johnson, Clinical Chair** **Contact Details:** **Paul.johnson4@nhs.net**		**Supporting Executive: N/A** **Name and Title:** **N/A** **Contact Details: N/A** **Report Approved by:** **Name and Title:** **Dr Paul Johnson, Clinical Chair** **Date:**		
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 contains updates on:

- Introduction
- Primary Care Collaborative Boards
- ICS Governance Task and Finish Group
- Local Government Elections
- Clinical and Professional Leadership

Management of Conflict of interests:
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Committees that have previously discussed/agreed the report and outcomes:

N/A

Key recommendations and actions requested:
This report is for information and the Governing Body are asked to note the contents.
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:
None
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

GOVERNING BODY – CHAIRS REPORT

1. Introduction

The weather is warmer, although unfortunately wetter, days are longer and social restrictions are slowly lifting. There is a sense of optimism in our county, cities, towns and neighbourhoods. And this is reflected in the number of people receiving their Covid vaccination (over 700,000 first doses given) and the number of people in our hospitals with Covid the lowest they've been since last summer. There is still need for ongoing caution and we will continue to be very clear around the need for regular self testing, hand washing, use of masks and sensible approach to the relaxation of the rules. My thanks as always to everyone involved in the vaccination program, everyone who has supported and cared for people in the community and in hospital with Covid and the population of Devon who, by following the advice they've been given, have helped keep our levels of infection and serious illness amongst the lowest in the country.

2. Primary Care Collaborative Boards

I have now had the opportunity to meet with all four Primary Care Collaborative Boards. I am encouraged by the consistent desire from our PCN Clinical Directors to be involved in working more closely with other system partners, to understand their population better and help tackle some of the wider determinants of health we know will make the biggest difference to long term morbidity. All are keen to utilise Population Health Management and to be actively engaged with their Local Care Partnerships. There is a need for ongoing support and development particularly as we further embed our General Practice providers in the Devon Integrated Care System and we are working closely with the AHSN on this.

3. ICS Governance Task and Finish Group

The ICS Task and Finish Group chaired by Suzi Leather (Independent Chair of the ICS) continues to meet with the aim of ensuring the governance of the ICS fulfils its functions as a system enabler of integrated working, its ability to adopt the functions that sit within the CCG from April 2022, and to fulfil its statutory responsibilities. There is still much to do with an initial focus on agreeing the principles that should underpin the governance structure.

4. Local Government Elections

Local Government Elections took place across the country on the 6th May 2021. In our area elections took place for Plymouth City Council, Devon County Council and Exeter City Council.

I would like to congratulate all of the Councilors that secured seats and in particular Councillor John Hart, who won his seat and continues to lead Devon County Council, and Councillor Phil Bialyk who has retained control in Exeter.

In Plymouth no single party has an overall majority, but a minority conservative administration will be in place from 21 May 2021. I would like to congratulate Cllr Nick Kelly as the new leader of Plymouth City Council, but also put on record our thanks to his predecessor Councillor Tudor Evans MBE who led the council through the extraordinarily difficult times of the last few months.

5. Clinical and Professional Leadership

Clinical and Professional Leadership continue to be central to us as a CCG and the wider system. Over the last month, the Clinical and Professional Cabinet has met, bringing together senior clinical leaders with a focus this month on a whole system approach to medicines optimization, health inequalities and our 2021/2022 Operating Plan. The Clinical and Professional Reference Group for our Long Term Plan also met ensuring that the plan aligns to clinical priorities. My thanks to Dr David Greenwell for convening and chairing this group which will be a vital part of our longer term plans.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Accountable officer report				
Date of committee: 27 May 2021 **Date report produced:** 17 May 2021				
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: 19 May 2021**		
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. Meeting staff and partners
2. Accelerator programme
3. System approach to the operating plan
4. Vaccination and COVID-19 update
5. Equality and diversity research with staff
6. Researching patient decision making
7. ICS development
8. Devon having a say
9. Sir Simon Stevens

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 public)		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. Meeting staff and partners

I have been in Devon now for less than two months, and as well as getting up to speed with the role, I am getting through a long list of introductory meetings.

These are really helping me to understand more fully the challenges we face as a system as well helping me to build relationships with people.

I attended my first staff partnership forum this month and met the team that represents staff. I've led a couple of staff briefings and have started to attend as many staff team meetings as I can.

I've now had 1-1s with all executive team members, met our non-executive directors, local system leaders, including our local authority colleagues.

I'm also popping into the various LCP meetings to hear about developments there, meeting each of the regional directors and of course, am now in regular conversation with our providers, hospices and others.

2. Funding for accelerator programme

We received good news earlier this month when it was announced that we would receive additional funding to support our work to tackle long waiting lists for eye and joint surgery caused by the Covid-19 pandemic.

Health and care partners in the county are set to receive £11.3million from the new national Accelerator Systems Programme (ASP) to spend on three initiatives aimed at further reducing waiting times for certain types of operation in Devon, Somerset, Cornwall and Dorset.

This includes:

1) **Increasing the number of planned orthopaedic operations at the former Nightingale Hospital in Exeter**

- This will involve leasing two modular (ready-made) operating theatres for use at the site
- Surgical teams will follow national best practice methods to maximise use of the facility, offering as many procedures to as many people as possible in a day, while maintaining strict safety and infection control measures
- As the site is separate to local acute hospitals, it will be better protected from the disruption often caused by the need to divert clinical teams to deal with emergency cases
- The facility will also offer some additional diagnostic and outpatient services, such as CT and MRI, further supporting our acute hospitals and the wider Devon system

2) **Increasing the number of eye operations in Plymouth**
   - This involves creating a purpose-built modular ophthalmology unit at Derriford Hospital to increase capacity for eye operations, such as cataract removal, and cut waiting lists
   - The new unit will free up extra ward and theatre capacity at the hospital for use by other services
   - Technology will allow follow-up outpatient appointments to take place by phone or video

3) **Eye operations in the community**
   - Details of this scheme are currently being confirmed, but the ambition is to allow more eye operations to take place by potentially converting existing community facilities to allow more patients to be seen in line with best practice and cut waiting lists.

As you know, some aspects of normal NHS work, such as emergency care and urgent cancer care continued throughout the pandemic. However, despite the best efforts of NHS clinicians and staff, the pressure on beds and equipment, combined with the enhanced infection prevention and control measures necessary to keep people safe, disrupted non-urgent care and meant that many people have had to wait longer for treatment than they usually would.

We are currently planning for the above and I will, of course, report progress as the new initiatives begin.

3. System approach to the operational plan

Colleagues have been very busy over the last couple of months finalising the system's operational plan for 2021/22.

The operational plan is the plan by which all partners in the NHS system will work to this year – and next.

It has been a huge task this year due to additional demands of COVID.

Everyone involved, our providers and staff and clinicians at the CCG, has done a really thorough job and earlier in the month we were invited to present the main aspects of the plan to Elizabeth O'Mahony's team.

The meeting itself went very well with region being impressed with our ambitions.

Some minor tweaks and additions are being made this month and we will be submitting the final plan early June.

My thanks to Jayne Carroll for leading this work and to everyone involved. It was a good example of system working.

The operational plan was Jayne's last substantive piece of work with the CCG. I am pleased to say that Jayne will be retained in the system, taking up a new role at United Hospitals Plymouth NHS Trust at the end of the month.

4. Vaccination and COVID-19 update

It gives me enormous pleasure to report that a real milestone has now been reached in Devon with more than one million vaccines now administered.

This is an amazing achievement and owes everything to the hard work, dedication and partnership working across health, social care and the voluntary sector.

It is incredible to think that in just a few months we have reached this point and although we have not yet completed all age groups, we are now vaccinating the under 40s and expect to reach all adults by July 31 – within the deadline set by the Government.

To reach the million-dose milestone the local vaccination programme has been working with diverse communities across Devon, ably assisted by our communications team, to increase take-up and address any concerns. Work included:

- Enlisting the support of vaccine ambassadors to provide reassurance and support to local ethnic minority communities
- A pop-up vaccination clinic at Exeter Mosque and Cultural centre
- Translating vaccine information into other languages so people have access to reliable information
- Using a mobile vaccination unit to reach workplaces with high numbers of migrant workers and rural communities
- Developing a film in partnership with service users to help people with learning difficulties access the vaccination
- Working with Gypsy, Roma and Traveller communities to understand perceptions of the vaccine

In terms of some of the local logistics, it is important to note that the large COVID vaccination centre in Exeter moved in early May from Westpoint to nearby Greendale Business Park. All appointments have now been transferred from Westpoint.

Newton Abbot Racecourse is also now being used by a group of local GP practices as a COVID-19 vaccination centre.

My thanks to Darryn Allcorn, who is leading the vaccination planning work.

I've seen for myself what it takes to run a centre and as well as the doctors and nurses helping to administer the vaccine, there is a whole host of people, whether they are volunteers or staff, behind the effort. Thank you all.

I'm pleased to report that the numbers of patients in hospital with COVID continue to be small. But with the further lifting of restrictions in recent weeks, we are keeping an eye on whether and how this affects the NHS. But for the moment, it appears reasonably stable with low numbers.

5. Equality and diversity research with staff

I am pleased to report some important work we are undertaking to understand staff perceptions around sexual orientation and gender identity.

We are working with locally-based LGTBQ+ charity Intercom on this.

It follows recent staff survey results which showed that people did not always feel able to disclose their sexual orientation.

The survey to inform this work closed last week and we expect a full report in June.

6. Researching patient decision-making

There is currently a significant amount of pressure in the system, particularly across both primary and secondary care.

We are still trying to understand what is contributing to pressures in certain parts of the system, why there are increases in activity in certain parts of the system and which factors are creating demand in certain services.

We are working with system partners and our Virtual Voices Citizen's Panel to identify some of the rationale for patient decision-making and behavior, and exactly where this pressure is coming from and what is creating the demand.

- We are also working on a local communications approach that:
- Promotes self-care options and access to healthcare services
- Increases awareness of available healthcare services – and alternatives,
- including community pharmacy
- Reinforces the benefits of using 111 for urgent advice (as part of the ongoing Think 111 First programme) - we have developed a system-wide plan for reaching residents and visitors this summer with 111 being a key part of the message.
- Manage patient expectations for both primary and secondary care services
- Build trust in the role of triage in primary care and the multi-disciplinary – not just GP and manage expectations.
-

7. ICS development

Planning for the transition to ICS continues. We are working very closely with our providers and social care colleagues.

A governance task and finish group has been established across bot health and local authorities and we are making plans with partners shortly to discuss the principles underpinning our ICS development work.

Next month our director of communications Andrew Millward will be leading an ICS development session across the region, focusng on citizen involvement – an area close to all of our hearts I know.

8. Devon having a say

We continue to feedback where requested to give views on fledging ICS guidance and/or policy. We have offered a system view on five of six pieces of guidance now.

Our feedback goes straight into the heart of NHSE, at region or national level, for consideration.

9. Sir Simon Stevens

You may have seen coverage in the media that Sir Simon is to leave his role as chief executive at the end of July. He will then take a seat in the Lords.

Sir Simon has led the NHS for 7 years – and through one of the most difficult periods in its history; the pandemic. He has been instrumental in the forthcoming reforms and we will miss his leadership immensely.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY (PUBLIC)

Report title: Integrated Care Partnership (Western Devon) – Draft Contract Award Recommendation Report				
Date of committee: 27th May 2021 **Date report produced: 20th May 2021**				
Author (s) Name and Title: **Emma Cane, Programme Office Manager - NHS South, Central & West Commissioning Support Unit** **Dr Sonja Manton, SRO, Integrated Care Partnership**		**Supporting Executive:** **Name and Title: Jo Turl, Director of Commissioning (Out of Hospital)** **Contact Details: jo.turl@nhs.net** **Report Approved by:** **Name and Title: as above** **Date 20th May 2021**		
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 Governing Body are asked to make a decision on the contract award for the Integrated Care Partnership for the Western Locality of NHS Devon CCG. The attached paper is the contract award recommendation report and associated appendices.

The key objectives and proposed benefits of the procurement were to implement the vision for a model of integrated care and improve the outcomes, services and experiences for the local population.

The total value of the contract for the Integrated Care Partnership for the Western Locality of NHS Devon CCG is £1,621,126,000 (figure includes extension period). The contract will be for an initial term of 10 years, with a possible extension of any period up to a further 5 years, as defined and at the discretion of the Commissioner. Services will commence from 1st July 2021.

The recommendation in May 2021 will be to award the service to University Hospitals Plymouth, led by University Hospitals Plymouth and in association with Livewell Southwest as the material sub-contractor.

The contract is an outcomes-based contract with a 10 years term plus 5 years extension option; the standard 12-month termination clause is included for all services.

Legal advice has been sought and feedback was shared with GB members in the April Governing Body

meeting in private under legal privilege.

Due consideration has been given by the ICP Executive to the risks and benefits of this revised contract and the emphasis this puts on system and partnership working to deliver transformation.

These are presented in the report and associated appendices.

The Governing Body is asked to reflect on:

- The strategic risks that have been considered and mitigated through this process, particularly in relation to: capacity and capability to deliver the contract, contingencies for provider landscape change and partnership working arrangements,
- The transformation benefits and delivery plans,
- The contractual terms and governance arrangements to support this.

Subject to approval by Plymouth City Council's Executive as the associated commissioner with statutory responsibility for adult social care, it is recommended by the ICP Executive Group that NHS Devon CCG Governing Body approve–

- The award of contract for delivery of the Integrated Care Partnership services for the Western Locality of Devon to University Hospitals Plymouth NHS Trust as lead provider.

- That the contract commences on 1st July 2021 for a period of 10 years with the option to extend for a further 5 years.

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:

ICP Executive

Key recommendations and actions requested:

The Governing Body is asked to reflect on:

- The strategic risks that have been considered and mitigated through this process, particularly in relation to: capacity and capability to deliver the contract, contingencies for provider landscape change and partnership working arrangements,
- The transformation benefits and delivery plans,
- The contractual terms and governance arrangements to support this.

Subject to approval by Plymouth City Council's Executive as the associated commissioner with statutory responsibility for adult social care, it is recommended by the ICP Executive Group that NHS Devon CCG Governing Body approve–

- The award of contract for delivery of the Integrated Care Partnership services for the Western Locality of Devon to University Hospitals Plymouth NHS Trust as lead provider.
- That the contract commences on 1st July 2021 for a period of 10 years with the option to extend for a further 5 years.

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:

Appendix A - C

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.

Contract Award Recommendation Report for the Commissioning of an Integrated Care Partnership for the Western Locality of Devon

Project Ref: PR002829

Detail Description	Summary Detail
Contract Title	Integrated Care Partnership for the Western Locality of Devon (Lot 1)
Contract Reference	PR002829
Contracting Authority	NHS Devon Clinical Commissioning Group (Co-ordinating) Plymouth City Council (PCC) NHS Kernow CCG
Project Lead	Garry Mitchell
Contract Start	1st July 2021
Primary Contract End	30th June 2031
Contract Period (plus any potential extension)	10 years with a possible extension of any period up to a further 5 years
Date of this Report	20 May 2021
Date ITT Issued	19th December 2019
Date ITT Returned	31st January 2020
Total Contract Value (inc. extension)	£1,621,126,000

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1. Executive summary purpose

The purpose of this paper is to recommend the formal award of the Integrated Care Partnership ("the ICP") for the Western Locality of Devon for NHS Devon CCG, Plymouth City Council and NHS Kernow CCG ('the Commissioners'). It is a comprehensive end stage report which sets out the full procurement process undertaken together with any outstanding issues to inform the decision making process.

The key objectives and proposed benefits of the procurement were to implement the Commissioners' vision for a model of integrated care and improve the outcomes, services and experiences for the local population.

The total value of the contract for the ICP for the Western Locality of Devon is £1,621,126,000 (figure includes extension period). The contract will be for an initial term of 10 years, with a possible extension of any period up to a further 5 years, as defined and at the discretion of the Commissioners. Services will commence from 1st July 2021.

Subject to the approval of Plymouth City Council Executive who have statutory responsibility for Adult Social Care the recommendation is to award the service to University Hospitals Plymouth (UHP), led by University Hospitals Plymouth and in association with Livewell Southwest as their material sub-contractor.

2. Strategic Commissioners Intentions and the purpose of this procurement

Early in 2018 NEW Devon CCG (now Devon CCG) and Plymouth City Council published their strategic ambitions for delivering Integrated Care in the Plymouth System. These intentions set out a number of priorities, including commissioning an Integrated Care Partnership for Adults and Older People. A paper was drafted setting out the contracting approach for the procurement of an Integrated Care Partnership, to include Community Health, Adult Social Care, Acute, Local Mental Health Services and some Primary Care Services.

Since the original paper was produced the ambitions around an ICP have evolved, in line with developing an Integrated Care Model, Primary Care Networks and the Long-Term Plan, to focus on integration of non-acute care.

The case for change was built on a number of key drivers including the Commissioners' vision and blue print for integrated care, General Practice sustainability and NHS Long-term Plan ambitions.

Vision and blue print for the Integrated Care Model

The Commissioners' vision is that our population and system will benefit from integrated health, care and wellbeing services – integrated care. These integrated care services comprise, for adults primarily, physical health services for people with complex needs, mental health services, services for people with a learning disability

and social care services. These services are often described as 'community' services – they are usually, and should be, provided close to, or in, people's homes, outside of hospital.

We want services that are person centred with care being agreed, instigated and managed with the person using services as an equal partner with those providing services; with care that is provided holistically to the needs and values of the person.

We want integrated care services to coordinate and work in partnership with other services, notably those in primary care, secondary care (often based in hospitals) and care provided by the voluntary sector so that the person's experience is seamless, and information and data shared effectively and appropriately.

A population health management approach should not only result in care being better coordinated for the person and for the population but greater health and wellbeing promotion, prevention and early intervention, with opportunities for a non-medical approach (e.g. social prescribing, health coaching and prevention) being better identified and followed up – this requiring a shift of resources to where they are needed through effective partnerships with neighbourhoods and communities. This should reduce the need and demand on acute hospitals services and primary medical services where need would be better met elsewhere.

We want support based in neighbourhoods and communities as close to home as is safe and sustainable. We want support to be both innovative and evidence based making use of technology and digital communication opportunities

We want equity of access, experience and outcomes whatever the persons needs and wherever they live. People want no barriers to good experiences of high-quality care that enables them to lead their lives independently and in good health. Integration of services is the way we see this becoming the reality.

In response to this vision the Devon Sustainability and Transformation Partnership developed a Blueprint for an Integrated Care Model. The Integrated Care Model spans health, social care and wellbeing services for adults outside of hospital. The aims of the Integrated Care Model are to:

- Promote health through integration
- Empower communities to take active roles in their health and wellbeing
- Design and implement the locality-based care model
- Shift resources closer to home, or in people's homes
- Integrate health and social care.

What we are seeking to achieve

The Integrated Care Partnership (ICP) will provide a wide range of high quality, accessible and integrated services for adults in Western Devon. The catchment area of the service spans two local authority areas: Plymouth City Council in entirety and Devon County Council in part. Both local authorities are vital strategic partners from the perspective of statutory service provision for the population, the commissioning and provision of integrated services for the population and wider partnership working across the system. The area covers 260 square miles and stretches from Lifton to Salcombe, and Plymouth to mid Dartmoor. Approximately 360,000 people are registered with a GP Practice in the Western Locality. Devon County Council's adult social care services are not included in the ICP's scope of provision. The ICP's responsibilities also encompass the provision of stroke inpatient services and Early Supported Discharge (ESD) to residents of East Cornwall.

The outline scope of the ICP service provision is:

- Community physical health services for adults with complex needs (for people registered with a GP Practice in the Western locality of NHS Devon CCG)
- Mental health services (CCG funded) for adults (for people registered with a GP Practice in Plymouth) – noting that over the lifetime of this contract the national direction of travel is for services to be arranged for 0-25 year olds and 26 years and over, therefore this transition would need to be made between the ICP and respective mental health services for children and young people; and, for the Place of Safety this is available for the Devon population
- Learning disability and autism services (CCG funded) for adults including transition from children's services to adult services (for people registered with a GP Practice in Plymouth)
- Adult social care (PCC funded) (for people resident in Plymouth) – specifically, the delivery of services that meet adult social care statutory functions that have been delegated under the Care Act 2014

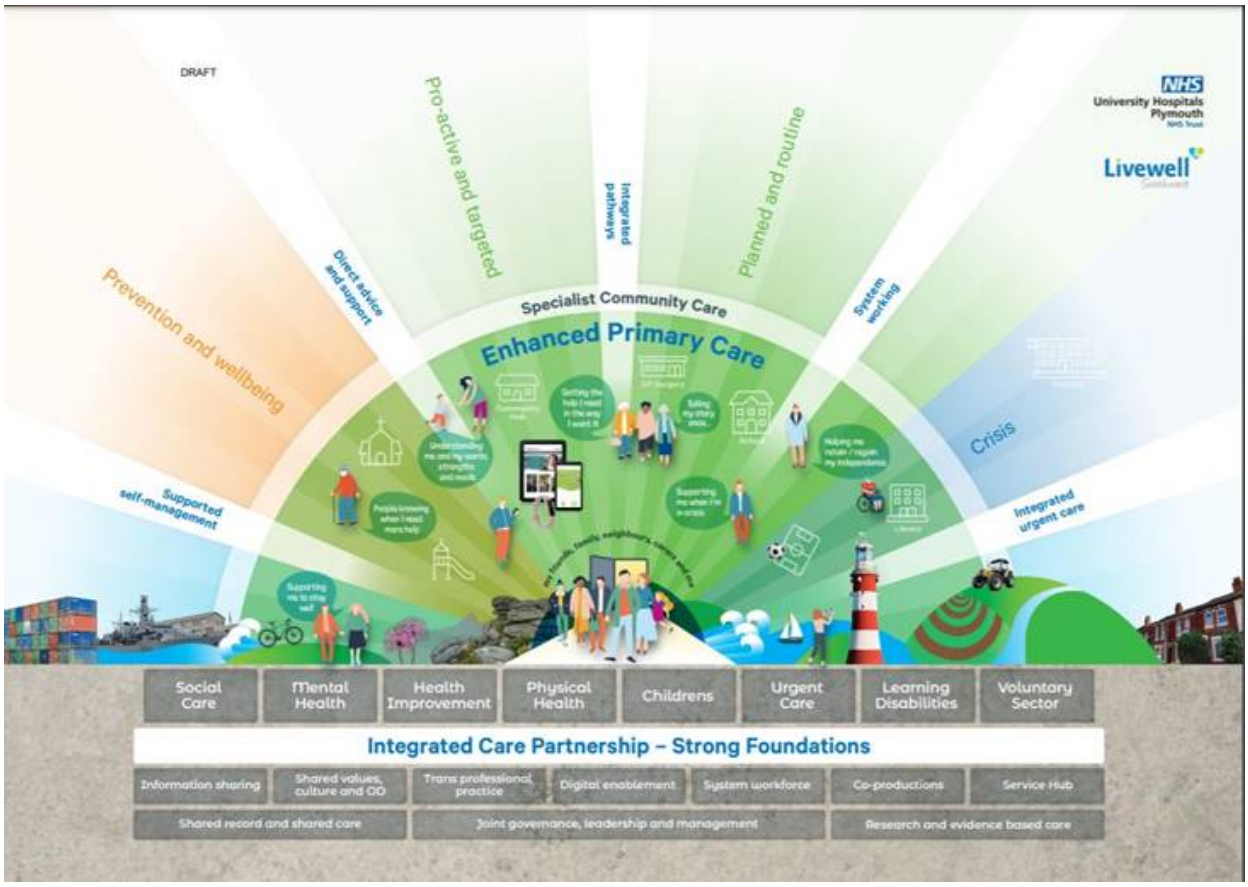
The Outcomes Framework

Commissioners have adopted an outcomes framework approach to this procurement and have sought an organisation to provide services for the system to ensure that they take a leadership role in linking services.

The eight key outcomes are as follows:

1. More people will be living independently in resilient communities
2. More people will be choosing to live healthy lifestyles and less people will be becoming unwell

3. People who do have health conditions will have the knowledge, skills and confidence to manage them
4. The healthcare system will be equipped to intervene early and rapidly avert deterioration and escalation of health problems
5. More care will be available in communities and less people will need to visit or be admitted to hospital
6. People will have far greater control over health & social care services and will be equal partners in decisions about their care
7. People who need treatment will be treated effectively and will be equal partners in decisions about their care
8. People will go into hospital and will be discharged efficiently and safely with the right support in the community



What will look different a year into the contract – our early priorities for making a difference

Priority	Position by Year 1
1. Single Point of Access	• Establishing the Service Hub as the single front door for all services in year 1
2. Enhanced Primary Care	• All 9 Primary Care Networks using the integrating Aging Well Multi-Disciplinary Teams (MDT), clear escalation and de-escalation routes being used routinely • Embedded Care Home Liaison Service prioritising Care Home support and MDTs
3. Integrated Frailty/Health care for the Elderly (HCE) Pathway	• Integrated Frailty offer that provides services for patients at home and across the provider interface (PCNs; Community Hospitals; Acute) under a single accountable and integrated Health Care of the Elderly Service in conjunction with Frailty network support. • Implementation of electronic advance care plans for end of life
4. Delivery of the Community Mental Health Framework (CMHF) to the agreed delivery plan	• CMHF model rolled out to first cohort PCNs using Population Health Management data • Implementation of a rehabilitation/recovery specialist and dedicated team • Implementation of a personality disorder specialist dedicated team • An all-age mental health home treatment offer in place
5. Development of end to end pathway for prioritised services: Respiratory, Cardiology, Stroke/Neurology	<u>Respiratory</u> • Place based respiratory pathway co-designed and co-delivered implemented <u>Cardiology</u> • Senior clinical oversight for whole pathway and caseloads established across pathway • Cardiac rehab – phase 1, phase 2 and phase 3 delivery established • Review implementation of new medicines and treatments <u>Stroke/Neurology</u> • Integrated delivery of stroke pathway; reduction in length of stay
6. Further develop and embed a system based Infection Prevention and Control delivery assurance model	• System based Infection Prevention Control delivery model embedded and functioning consistently across locations

7. Mental Health Provision. Emergency department	• Currently under review but establishment of a fit for purpose and inclusive Mental Health model for emergency care

3. Background

The Services procured through this tender process are healthcare services falling within Schedule 3 to the Public Contracts Regulations 2015 ('the Regulations').

The NHS South, Central and West Commissioning Support Unit (SCW) procurement team managed the procurement process on behalf of the Commissioners.

Integrated Care and Partnership working is a key foundation of both our existing and future models of care – it has been evidenced nationally and locally that it can improve outcomes, efficiency and experience of care.

The procurement of the ICP is a further step towards joining up local services for the population of Plymouth, South Hams and West Devon and the transformed model that will be delivered through this promises to address many of the existing and ongoing challenges the local system has faced.

Built on a long history of partnership working, this procurement has operated under extended timescales due to:

- the high level of detailed work that Commissioners and providers undertook in dialogue phase in 2019 to discuss and evolve the planned service transformations to support the initial bid and support the selection of a preferred bidder in March 2020
- the response to the global pandemic, and the opportunity of rapid transformation, partnership working, learning and revision of specification that this presented
- the detailed due diligence, with enhanced support from regulatory processes that has been undertaken by all parties in Autumn 2020/Spring 2021

The following Critical Success Factors were established and approved by the Governing Body and have remained the golden thread throughout the process forming the basis of evaluation and assurance:

- A comprehensive offer for prevention and self-care for the whole population
- Services which are wrapped around primary care networks to support our most vulnerable people through Population Health Management (PHM)
- People are kept safe and well and are able to participate as active members of their communities
- Integrated physical and mental health and care services in the community
- Seamless pathways for people with long term conditions between community and acute services
- Integrated pathways for people with serious mental illness

- Collaboration with system partners to effectively manage demand and support the delivery of services within current budgets
- Partnership working with the wider health and care system to ensure that service delivery is achieved without any financial consequences for partner organisations. It is imperative that any actions that impact upon another system partner are discussed and agreed in full ahead of any change being implemented.

It is recognised that some of the above cannot be achieved by what is in the scope of the ICP alone, but the expectation that the ICP's role in promoting and achieving their contribution in these has been clear.

In its role as Co-ordinating Commissioner for this contract, the Governing Body has had the opportunity to gain understanding and assurance about the proposed arrangements that expect to deliver long term transformational change to meet the current and future needs of the population.

This report sets out the procurement process and detailed arrangements to support recommendation of the contract award.

It is important to reflect this important decision in the context of our integrated care system and both the population and provider landscape that we face in the next 15 years. The proposed contract seeks to hold the tension between robust delivery, partnership working and flexibility to respond to changing context.

4. Project Governance

Approval was granted from the NHS Devon CCG Governing Body for this procurement to be advertised on 5th July 2019 for the Commissioning of an ICP for the Western Locality of Devon in line with the NHS Devon CCG Standing Financial Instructions. The procurement consisted of two lots. This award paper relates to Lot 1 – Integrated Care Partnership only. No award decision was made in relation to Lot 2 and the procurement for this Lot was closed in 2019.

The following table identifies where the ICP procurement has been discussed at Governing Body.

Date	Description of content
23 May 2019 (Private)	Report presented set out the vision for integrated community health, care and mental health services in Western Devon and Plymouth and the preferred contracting approach. GB noted the vision, timescales and extension to existing contracts and acknowledged the proposal to launch single procurement.
27 June 2019 (Private)	Paper presented to proceed to procurement. GB agreed that in the public session of the Governing Body they would be asked to approve the recommendation to proceed to procurement.
26 September 2019 (Private)	Update paper presented the GB noted the delegation of responsibility for agreeing the procurement documentation.

19 December 2019 (Private)	Update on progress to date and the procurement approach. GB approved the decision to proceed to the final stage of the procurement. Invitation to submit detailed solution (ISDS) for Lot 1.
27 February 2020 (Private)	Update on progress to date and the procurement approach. Due to conflicting timescales the Governing Body delegated the ICP Executive to approve the preferred bidder recommendation report and this would be done through a virtual approval route.
26 March 2020 (Private)	Presented paper to recommend postponement of the contract start date from 1 July 2020 to 1 April 2021 due to the CCGs response to COVID-19. GB ratified the recommendation to postpone the new contract start date until 1 April 2021 and extend contracts with Livewell Southwest.
24 September 2020 (Private)	Paper presented outlined the due diligence process had been restarted and revised specification. GB endorsed the revised timescale.
17 December 2020 (Private)	GB noted the progress within the report and that subject to satisfactory completion of all necessary procurement and regulatory processes, the service commencement date to be 1st April 2021. Noted that this posed a high degree of risk, which has not yet been mitigated through the due diligence process.
28 January 2021 (Public)	Presented assessment against progress and remaining work and asked that the final steps in the due diligence phase. GB endorsed the approach and pace of the remaining due diligence, commissioning and regulatory processes.
25 February 2021(Private)	Presentation provided following due diligence.
29 April 2021 (Private)	Draft CARR presented to GB which was supported and confirmed for presentation to GB in public on 27th May.

5. Key Officers

The authorised officer for this programme is:

Jo Turl
Director of Commissioning – Out of hospital, NHS Devon CCG

The lead officers for this programme are:

Sonja Manton
SRO for Integrated Care Partnership, NHS Devon CCG

Anna Coles
Locality Director Plymouth, NHS Devon CCG /Service Director Integrated Commissioning, Plymouth City Council

The procurement lead for this programme is:

Garry Mitchell
Deputy Director of Procurement, NHS South, Central and West Commissioning Support Unit

6. Procurement Timetable

The timetable for the procurement is set out below:

No	Stage	Dates
1	Invitation to Submit an Outline Solution stage (ISOS) issued to Bidders	5th July 2019
2	ISOS submission closing date	16th August 2019
3	Dialogue Stage	24th September 2019 – 27th November 2019
4	Invitation to Submit Detailed Solution stage (ISDS) released to Shortlisted Bidders	19th December 2019
5	ISDS submission closing date	31st January 2020
6	Commissioner Governing Body ratification of Preferred Bidder	26th March 2020
7	Preferred Bidder Stage to finalise terms with the Preferred Bidder	27th March 2020 – 31st March 2021
8	Final Approval/ Contract Award in Public at GB (subject to PCC executive approval)	27th May 2021
9	Contract Go Live	1st July 2021

7. Procurement Process

Since approval was given on the 5 July 2019 to commence this procurement the Governing Body have been sighted on progress and agreed to proceed at various key stages of the process.

Commissioners decided on a Competitive Dialogue approach to the procurement process. This route was used to enable in-depth dialogue to determine what the market can offer in terms of technical and financial solutions.

Bids were assessed and evaluated on the basis of most economically advantageous tender.

A summary report of each stage of the procurement is attached at Appendix A.

8. Conflicts of Interest

The SCW procurement team supported the project in the management of conflicts throughout the process. In line with national guidance *Managing conflicts of interest: revised statutory guidance for CCGs 2017* conflicts of interest were given a high priority within the procurement, with 'conflicts of interest' a standing item at project group meetings.

Project members were required to complete Conflict of Interest and Confidentiality forms prior to receiving any sensitive documentation. A version of the conflict register is available to members on request, including all measures that were taken. All conflicts were appropriately managed within the project, and there are no latent risks associated with the aforementioned conflicts.

Bidders were required to complete Conflict of Interest, Confidentiality, Canvassing and Collusion forms as part of their bid. They are also under an ongoing obligation to update the Commissioners should any declarations change in the future.

9. The Contract

The contract will be the NHS Standard Contract 2021/2022 edition, inclusive of all standard performance frameworks, payment mechanisms and terms. The service specification will be a core part of the contract document. The contract has been subject to extensive review by the CCG's lawyers and agreement between both parties. The Governing Body are asked to note the following:

- NHS Devon CCG are the co-ordinating commissioner with NHS Kernow CCG and Plymouth City Council both being associated commissioners to the contract.
- The contract is an outcomes-based contract with a 10 years term plus 5 years extension option, the standard 12-month termination clause is included for all services.
- Previously the termination clause was 18 months, with the earliest termination being 6 years into the contract. This position has now changed and the contract reflects the standard 12 month termination clause for all services. This change is to reflect the changing landscape in Health and Social Care, and allow the contract to able to be more flexible to accommodate any future changes, an example being the development of provider collaboratives.
- The contract is with University Hospitals Plymouth NHS Trust (UHP) and Livewell Southwest (LWSW) is the material sub-contractor, the sub contract is

based on the standard NHS 21/22 subcontract and mirrors all key terms set in the head contract.

- Agreed outcomes framework, Year 1 baseline and development work to agree expectations from Year 2 onwards, if agreement is not met by the end of year 1 schedule 4E notes Commissioners will determine the measures.
- The Commissioners appointed legal advisors in June 2019. They have provided extensive advice pre-procurement and at various stages during the procurement. They have fully reviewed the proposed contract and provided a legal position statement which has been reviewed by the Executive Programme Board. Outstanding contracting issues are detailed in Appendix A

10. Financial position of the contract

The contract is a block contract agreement with a total value of the contract for the 10+5 term totalling £1,621,126,000. The financial envelope has been agreed as a flat cash contribution from PCC as associate commissioners, with one payment flow from NHS Devon CCG to UHP as the Prime provider. NHS Kernow CCG will also make a single monthly contract payment.

Key elements relating to what makes up the financial envelope for Governing Body to be aware of:

- Financial envelope is based on the contract for services currently provided in 2020/21, based on previous years activities and agreed changes in year which include; £1,398k for 15 additional recovery beds, £561k for ADHD/Autism service, fully funding the First Response Services £831k, £499k transformation fund, £250k contract management resource, Dietetic and speech and language provision £105k, and a reduction of £789k to commission PICU outside of the ICP.
- Risk share agreements in the total Financial envelope include; Licence to use £401k and Spirometry service £120k.
- From Year 2 of the contract 1.5% of the contract value is an incentive payment which will be based on performance against the outcome measures in the contract, exact allocations and based line to be determined with the commissioner in year one of the contract.

11. Provider failure contingency plans

LWSW are the current service provider for community services across the Plymouth and West Devon footprint and for Adult Social Care services for Plymouth and will be a material sub-contract to UHP. The due diligence work done to date as part of the ICP procurement does not indicate that there is significant risk of provider viability concerns.

Nevertheless, Commissioners have completed further analysis in conjunction with regulators in order to assure themselves that adequate contingency plans are developed and in place to maintain service delivery should the provider landscape change.

12. System Transformation

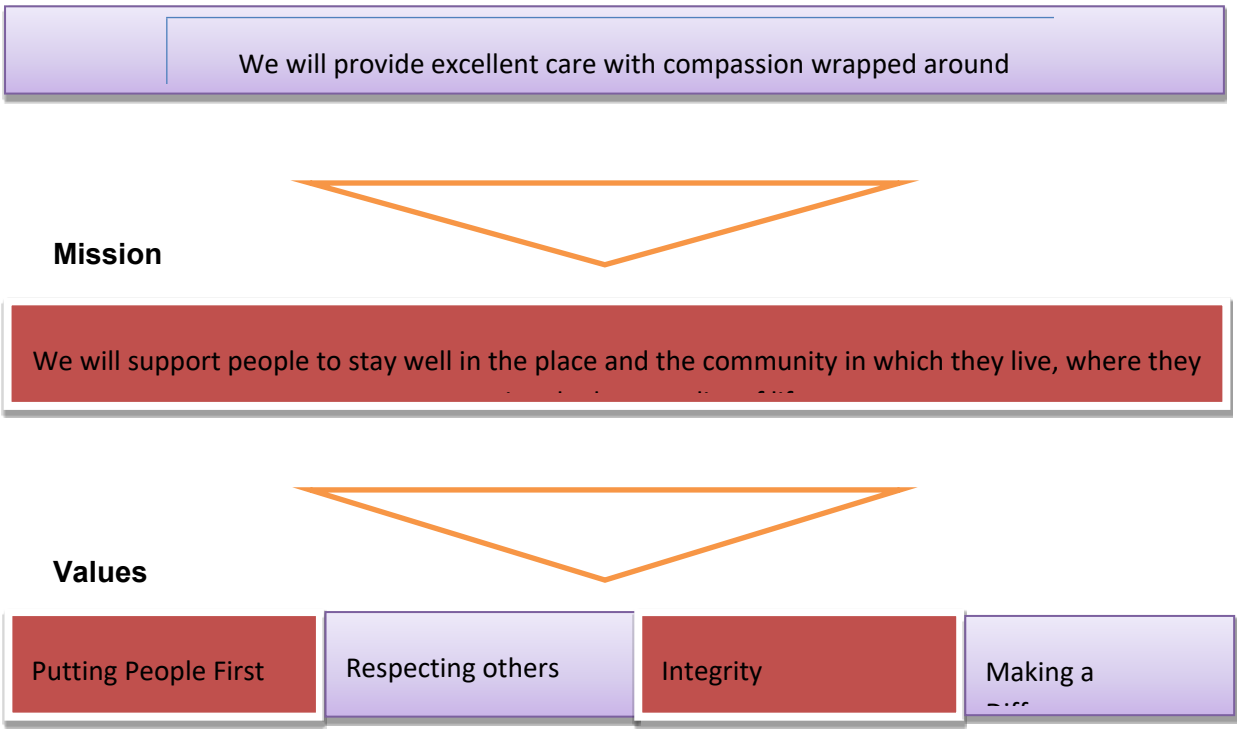
The ICP will bring together under a single governance framework many of Plymouth's Adult Health and Social Care Services and the partnership will continue to collaborate and align services with Devon County Council and Devon Partnership Trust in relation to the provision of mental health and social care in South Hams and West Devon.

In this way, UHP and LWSW will work in close partnership, with a common vision under a single governance framework.

The ICP will be structured with the transfer of some services (community rehabilitation and stroke inpatient beds) from the direct management of LWSW to UHP, with the remainder of the services being provided by LWSW under a material sub-contract arrangement with UHP. The key outcome of the ICP is to improve outcomes for the people it serves.

The Provider vision is set out below:

Vision



Clearly the award of the ICP Contract creates the landscape for further transformational change across the Western Locality and the initial agreed priority areas for year 1 have been developed in partnership with the Prime Provider and their material sub-contractor.

1. Establishing the Service Hub as the single front door for all priority services
2. Implement the Enhanced Primary Care (EPC) model, continuing to prioritise the development of the care home service and Multi-Disciplinary Teams (MDTs) with Primary Care Networks (PCNs)
3. Further developing a system-wide approach and pathway to Frailty and End of Life, through the care home service, MDTs with PCNs, and acute frailty and the integration of health care of the elderly acute and rehab beds.
4. Delivery of the Community Mental Health Framework (CMHF) to the agreed delivery plan
5. Development of end-to-end pathways for specialist services, prioritising Respiratory, Cardiology and Stroke
6. Further develop and embed a system-based Infection Prevention and Control delivery and assurance model

As the Devon ICS develops further considerations have been given during this procurement to the relationships that will need to be in place in order to support the successful delivery of the outcomes detailed within the contract. Whilst contractual mechanisms are in place including “step in” and termination arrangements, all parties are committed to working together to ensure that the improvements are delivered for the resident population. Learning has been taken from the collaborative approach adopted during COVID where individuals worked cross- organisationally on key agreed priorities; this facilitated positive deployment of the skills and capabilities required to deliver change and will continue across the Locality to ensure transformation is supported.

On Contract Award an Executive group between Commissioners and UHP will be established, this arrangement will ensure sufficient oversight and the mitigation of any risks during mobilisation and delivery. In addition the local performance and improvement group will bring together Chief Operating Officers and Commissioners to oversee performance improvements and agree transformation priorities including the deployment of resources when required.

13 Risk Implications

As part of the Due diligence phase, a number of risks were identified. The remaining strategic risks together with the mitigation actions are detailed below:

- UHP Capacity and Capability to take on ICP alongside a range of material improvement programmes
- Contingency in the event of provider landscape changes
- System arrangements to deliver transformation

See Appendix B risk register, residual risks will be transferred on contract award to the relevant corporate risk register.

UHP Capacity and Capability to deliver the ICP plans alongside a range of material improvement programmes						
Risk	There is a risk that there is insufficient capacity and capability at executive and senior level to deliver the planned transformation as part of the ICP in partnership with LWSW alongside a range of material improvement programmes that UHP are already focused on and need to delivery alongside and with this change.					
Mitigation	UHP have invested in additional capacity at executive and senior level to respond to improvement requirements and shared this regularly. To supplement the already existing capability, UHP have planned a suite of actions and programmes to develop better knowledge and understanding of LWSW services. Additionally, an external peer Trust has been engaged to provide advisory support to UHP's ICP SRO and the wider Board in respect of its performance and quality management responsibilities with respect to community and mental health services.					
Initial Score (/5)	**Impact**	**4**	**Likelihood**	**4**	**Total**	**16**
Mitigated Score (/5)	**Impact**	**4**	**Likelihood**	**3**	**Total**	**12**
Contingency for provider landscape changes						
Risk	There is a risk that if LWSW as the material subcontractor becomes an unviable provider during the lifetime of the contract and ceases to provide the services in the ICP in partnership with UHP, that there are gaps in service provision for the local population.					
Mitigation	UHP have planned a suite of actions and programmes to develop better knowledge and understanding of LWSW services to be able to take on direct provision if needed Contingency approach and principles agreed to ensure continuity of service provision and access for the population should there be provider landscape changes.					
Initial Score (/5)	**Impact**	**4**	**Likelihood**	**3**	**Total**	**12**
Mitigated Score (/5)	**Impact**	**4**	**Likelihood**	**2**	**Total**	**8**
System arrangements to deliver transformation						
Risk	There is a risk that the system arrangements locally between all partners are not sufficiently developed to deliver the transformation.					
Mitigation	Agreed ICS performance improvement framework. LCP performance arrangements agreed. Bespoke executive escalation and oversight of ICP from contract award. Agreement to sharing intelligence and capability across the system to address risks early and prevent escalation. Commitment to effective system and partnership working to collectively address issues and risks.					
Initial Score (/5)	**Impact**	**4**	**Likelihood**	**4**	**Total**	**16**
Mitigated Score (/5)	**Impact**	**4**	**Likelihood**	**3**	**Total**	**12**

14 Implications for Health Inequalities

The service specification set out the clear expectations on the new provider to play a role in ensuring a sustainable and safe health system that will keep a strong recovery focus and play its part in reducing health inequalities.

Quality Equalities Impact Assessment (QEIA) was conducted during pre-procurement.

The panel approved the updated QEIA on the 19th May 2021, with specific recommendations to ensure that more detailed impact assessments are reviewed and considered as service changes are implemented over the lifetime of the contract.

15 Recommendations

Subject to approval by Plymouth City Council's Executive as the associated commissioner with statutory responsibility for adult social care, it is recommended by the ICP Executive Group that NHS Devon CCG Governing Body approve–

- The award of contract for delivery of the Integrated Care Partnership services for the Western Locality of Devon to University Hospitals Plymouth NHS Trust as lead provider.
- That the contract commences on 1st July 2021 for a period of 10 years with the option to extend for a further 5 years.

Prepared by Emma Cane, Programme Office Manager - NHS South, Central & West Commissioning Support Unit

On behalf of

Jo Turl, SRO for Integrated Care Partnership, NHS Devon CCG

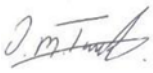
20th May 2021

APPENDIX A	**Procurement and Contracting Approach**
APPENDIX B	**ICP Executive Group Risk Register**
APPENDIX C	**Regulation 84(1) Report – Contents Checklist**

SCW Procurement Sign Off

Recommended by		Recommended by	
Name (Print)	Garry Mitchell	Name (Print)	Faye Robinson
Title	Deputy Director of Procurement NHS South, Central and West	Title	Director of Specialist Services (Procurement Director) NHS South, Central and West
Date	20 May 2021	Date	20 May 2021

NHS Devon CCG Sign Off

Award Approved by Director	
Name (Print)	Jo Turl
Signature	
Title	SRO for Integrated Care Partnership, NHS Devon CCG
Date	20 May 2021

NHS South, Central and West Commissioning Support

Appendix A_WA002829_Procurement Approach_v3

APPENDIX A Procurement Summary - Project WA002829

5/13/2021

Contents

Procurement Approach

This paper provides a summary of the procurement process. Further information relating to the Competitive Dialogue Process was previously reported to the Governing Body on 26th March 2020.

As agreed by the Governing Body in June 2019 the procurement followed a 3 stage approach:

- Stage 1: Invitation to Submit Outline Solutions (ISOS)
- Stage 2: Dialogue
- Stage 3: Invitation to Submit Detailed Solutions (ISDS)

This was followed by the stages detailed below:

- Preferred Bidder Stage
- Detailed Due Diligence
- Integrated Support and Assurance Process (ISAP) undertaken in conjunction with NHS England and Improvement

Stage 1 – Invitation to Submit Outline Solutions (ISOS)

The ISOS tender documentation was issued to bidders on 5th July 2019 with a deadline of 16th August 2019 which included the Selection Questionnaire (SQ) and the Invitation to Submit Outline Solutions (ISOS).

The following bidder submitted a tender response:

- University Hospitals Plymouth

University Hospitals Plymouth obtained a score of 57.8.

The Executive Group approved University Hospitals Plymouth be taken forward to the Dialogue Stage on 27th August 2019.

Stage 2 – Dialogue

Three dialogue sessions were initially scheduled between 24th and 26th September 2019 with University Hospitals Plymouth (UHP) regarding their outline solution.

These sessions focussed on the following three areas:

1. Session 1 - Service Model and Configuration
2. Session 2 - Mobilisation, Performance and Delivery
3. Session 3 – Finance

A further five dialogue sessions were undertaken to obtain a shared understanding of the outcomes requirement and give the commissioner's confidence in UHP's ability to deliver an acceptable detailed solution. These sessions were held between 10th October 2019 and 27th November 2019 on the following areas:

4. Session 4 – Outcomes Framework
5. Session 5 – Outcomes Framework
6. Session 6 – Contracting
7. Session 7 – Deliverability
8. Session 8 – Conclude Outstanding Issues

Stage 3 - Invitation to Submit Detailed Solutions (ISDS)

The ISDS tender documentation was issued to University Hospitals Plymouth on 19th December 2019 with a deadline of 31st January 2020.

The ISDS response was evaluated by an evaluation team constituting staff from NHS Devon CCG, NHS Kernow CCG, Devon County Council and Plymouth City Council including commissioning, finance, quality and patient safety, clinical experts and service user representatives.

Each member of the evaluation panel was required to complete, sign and return conflict of interest and confidentiality forms prior to the evaluation of bids. All evaluators received training from the Procurement Team in how to evaluate the bids prior to carrying out evaluation, including how to allocate scores and record appropriate comments.

Each member of the evaluation panel initially carried out an independent evaluation of their specific part of the bids according to the scoring criteria sent out to bidders. The scores were collated and then reviewed within moderation meetings with panel members that took place between 13th and 14th February 2020.

The following scoring criteria matrix was used for each stage of the tender process:

Scored Quality Questions

Score	Interpretation
5	Clear, relevant and well detailed response that addresses all of the question and provides the evaluator with confidence that the service will be provided to an excellent standard. Demonstrates in detail how all of the relevant requirements of the specification will be met.
4	Clear and relevant response that addresses all of the question and provides the evaluator with confidence that the service will be provided to a good standard. Demonstrates how all or most of the relevant requirements of the specification will be met. The information may lack relevant detail in areas but this does not cause the evaluator concern over the future delivery of services.
3	Response addresses all or most of the question and provides the evaluator with confidence that the service will be provided to an acceptable standard. Demonstrates how all or most of the relevant requirements of the specification will be met. However, the information lacks some relevant detail and/or raises issues which causes the evaluator minor concern over the future delivery of services.
2	Response addresses all or some of the question but does not provide the evaluator with confidence that the service will be provided to an acceptable standard. Demonstrates how all or most of the relevant requirements of the specification will be met. However, the information is lacking relevant detail and/ or raises issues which gives the evaluator more than minor concern over the future delivery of the services.
1	Response addresses all or some of the question but does not provide the evaluator with confidence that the service will be provided to an acceptable standard. Fails to demonstrate how most of the relevant requirements of the specification will be met.
0	Response does not address any of the question. Response fails to provide the evaluator with confidence that the service will be provided to an acceptable standard. Does not demonstrate how any of the relevant requirements of the specification will be met.

Scored Financial Questions

Score	Interpretation
5	Clear, relevant and well detailed response that addresses all of the question and provides the evaluator with excellent assurance concerning the value for money that the Commissioners will receive and/or excellent assurance regarding the level of financial risk that the Commissioners might be exposed to upon contracting with the Bidder.
4	Clear and relevant response that addresses all of the question and provides the evaluator with good assurance concerning the value for money that the Commissioners will receive and/or good assurance regarding the level of financial risk that the Commissioners might be exposed to upon contracting with the Bidder. The information may lack relevant detail in areas but this does not cause the evaluator concern over value for money and/or financial risk of the services.
3	Response addresses all or some of the question and provides the evaluator with acceptable assurance concerning the value for money that the Commissioners will receive and/or the level of financial risk that the Commissioners might be exposed to upon contracting with the Bidder is acceptable. The information lacks some relevant detail and/or raises issues which causes the evaluator minor concern over value for money and/or financial risk of the services.
2	Response addresses all or some of the question but provides the evaluator with limited assurance concerning the value for money that the Commissioners will receive and/or limited assurance regarding the level of financial risk that the Commissioners might be exposed to upon contracting with the Bidder. The information is lacking relevant detail and/or raises issues which gives the evaluator more than minor concern over value for money and/or financial risk of the services.
1	Response addresses all or some of the question but does not provide the evaluator with assurance concerning the value for money that the Commissioners will receive and/or no assurance regarding the level of financial risk that the Commissioners might be exposed to upon contracting with the Bidder.
0	Response does not address any of the question. Response fails to provide assurance concerning the value for money that the Commissioners will receive and/or the level of financial risk that the Commissioners might be exposed to upon contracting with the Bidder.

Moderation Meetings

The moderation meetings enabled the panel to review the scores awarded by each evaluator and agree a moderated score for each question. The meetings also ensured that scoring had been consistent and key points in each question had been accounted for. Each evaluator was asked to provide a documented rationale or comment for their original score for each question or sub-question. Average scoring was not used.

Final Scoring

Following moderation the following revised scores were set by the evaluation panel, forming the final outcome of the process

				University Hospitals Plymouth	
Section	**Section Weighting**	**Question no.**	**Question Weighting**	**Score**	**Weighted Score**
Service Delivery	55%	1	15	3	9
		2	15	3	9
		3	5	3	3
		4	10	3	6
		5	10	3	6
Strategic Partnerships	5%	6	5	3	3
Governance and Assurance	5%	7	5	3	3
Engagement and Communications	5%	8	3	3	1.8
		9	2	2	0.8
Contract and Contract Management	10%	10	5	3	3
		11	5	4	4
Finance	20%	12	5	3	3
		13	5	3	3
		14	4	3	2.4
		15	4	3	2.4
		16	2	2	0.8
Total				60.2	
Pass / Fail				Pass	

In accordance with the ISDS Bidder Guidance UHP obtained a score above the minimum 60% threshold.

The Governing Body ratified the recommendation to approve that University Hospitals Plymouth be nominated as Preferred Bidder to provide the Integrated Care Partnership for the Western Locality of Devon on 26th March 2020.

Preferred Bidder Stage

The purpose of the preferred bidder stage was to undertake due diligence, contract finalisation and conclude Checkpoint 2 of the Integrated Support and Assurance Process (ISAP) undertaken by NHS England and Improvement.

The postponement of the contract start date was requested and confirmed by the Governing Body on 26th March 2020 due to the COVID-19 (coronavirus) pandemic outbreak placing NHS systems and associated workforce under unprecedented pressure. This postponement enabled extra time for key personnel to support the due diligence work from both Provider and Commissioner organisations. The Governing Body ratified the recommendation from the Integrated Care Partnership Executive Group to postpone the new contract start date until the 1 April 2021. The Due Diligence process was delayed until July 2020.

The Preferred Bidder stage of this procurement was critical to ensure a clear understanding by both parties and finalise the terms of the contract. As part of the contract assurance process, University Hospitals Plymouth undertook an NHS England/ Improvement (NHSE/I) Transactional review process.

The COVID pandemic provided an opportunity for the CCG to take stock of the decisions made in March 2020 and consider whether the proposed service specification, outcomes framework and contract remain fit for purpose

A letter was sent to UHP on the 15 June 2020 informing the preferred bidder of the intention to restart due diligence process and followed up formally with correspondence on 14th July 2020 stating the intention to collectively review the specification and outcomes framework by the end of July to capture learning from COVID and bring forward the indicative contract start date to 1st December 2020.

The revision of the specification and outcomes framework with the preferred bidder (as part of the due diligence process) addresses local issues that have arisen during the pandemic that may not have been previously apparent, for example infection control capacity, patient flow into beds across the system, the strength of the identified partnership arrangements between the partners together with their associated governance, as well as taking into account recent changes in national policy. This will ensure any redesigned specification is achievable and fit for purpose. These have been overseen by the ICP executive group, who have delegated final sign off of the specification and outcomes framework to the Director of Commissioning and Locality Director (jointly with PCC).

Following a meeting on the 22nd July with UHP, the revised areas of the specification and outcomes framework were confirmed in writing on 10th August 2020 in a letter to UHP. The system has moved into restoration and recovery phase; work on the Due Diligence recommenced.

The Specification and Outcomes framework were reviewed and refreshed with preferred bidder to capture learning from COVID.

- Greater emphasis placed on the relationship the ICP will be required to establish with partners across the system including Plymouth City Council.
- The role of the Local Authority in co-ordinating voluntary sector support and market shaping to support the successful delivery of the ICP contract is further described.
- The multi-disciplinary team approach to support Primary Care is further articulated including the critical role this will play in reducing demands on both emergency care and statutory services across the wider health and care system
- The improvements delivered through COVID in relation to Mental Health service delivery are acknowledged as good foundations for improved provision
- The operating model for Caring for Plymouth is described and there is an expectation that this will form the foundation for single access to Care and support working in partnership with the Local Authority.
- The Care Home Liaison service is acknowledged as good practice and an expectation set that this will become a key service to support Care Homes and avoid admissions as we approach winter.
- Further emphasis has been placed on the importance of the utilisation of technology as a key enabler to deliver improved access to care and support in a timely way.
- The importance of patient flow across acute and community beds is noted with an expectation set that this will be improved as a result of this procurement and partnership arrangements between UHP and Livewell Southwest (LSW).

At the September Governing Body it was acknowledged that a service commencement date for the new contract of 1st December 2020 was not achievable and that a revised timeline for a service start date of 1st February 2021 was proposed. Agreed that this was used be used for planning assumptions until detailed project plans were provided by UHP, as it would have been difficult to assess the feasibility of revised timescales and a safe contract start date.

The CCG reviewed the business case and associated documents received from the preferred bidder against the seven key risks areas arising from the dialogue phase of procurement.

1. the Prime Provider model not achieving required improvements
2. transformation not being achievable within the existing financial envelope
3. the Preferred Bidder's commitment to the Outcomes Framework and improvement trajectories
4. arrangements and relationships with wider system providers
5. infection prevention and control capacity across partners
6. flow into beds across the system
7. the strength of the identified partnership arrangements

Integrated Support and Assurance Process (ISAP)

NHSE/I required the CCG and UHP to successfully undertake a regionally led process based on Integrated Support and Assurance Process (ISAP) principles. The CCG worked closely with the NHSE/I regional colleagues to ensure commissioning and regulatory processes were aligned with each other, and to the provider planning assumptions. Alignment with local authority processes also required careful consideration. Elected members were engaged throughout this process.

The CCG submitted an updated Repeated Assurance Model (RAM) in preparation for Checkpoint 2. This was undertaken using the key documentation received from the preferred bidder along with the procurement documentation which is used as evidence. The RAM was used to align evidence against a set of NHSE/I Key Lines of Enquiry (KLOE)s.

The ICP Executive approved the RAM at the Extraordinary Meeting on 18th February 2021 and submitted along with the appropriate evidence to NHSE/I on 19th February.

The Checkpoint 2 meeting was held on 15th April:

- To establish whether the final contract terms have been agreed and whether these meet the strategic objectives as described at Checkpoint 1;
- To determine whether the commissioner followed the established procurement process;
- To ensure that the commissioner and preferred provider have the capacity and capability to deliver the complex contract; and
- Consider whether the proposals represent a good solution for the system.

Following this meeting the CCG received feedback from NHSE/I which focussed on key themes and recommendations for the CCG which will enable the Governing Body to be able to make a more robust and informed decision on Contract Award.

The next step in the process is that NHSE/I will hold a touchpoint meeting with the CCG and the provider, pre-mobilisation, which will be set for mid-June to gain any additional assurance required.

The CCG continue to keep the assurance team appraised of progress and any emerging risks.

Legal and contracting

This table highlights the remaining outstanding contract areas as at the 20th May 2021 together with the associated RAG status, these will be resolved prior to contract signature.

Issue	Summary of outstanding contract areas	CCG Position/Mitigation
Termination period	The termination position has changed from an 18 month termination period, with earliest termination being 5 years from contract commencement; to a 12 month termination with earliest termination being 12 months from contract commencement. The compensation levels in the contract remain at the same levels as they were for the long term contract. The CCG to be aware a 'no fault' termination from either party would mean compensation is payable by them if they were to terminate with provider, and provider is liable to pay the CCG if they are to terminate the contract in line with Schedule 2i of the contact.	The change in termination period has been formally agreed between the provider and commissioners (letter confirming agreement from received 13th May 2021). The CCG are aware of compensation levels and are comfortable that these remain as the agreement is reciprocal between parties.
Payment Mechanism	Due to the update to 2021/22 contract there is a need for the contract to comply with the National Tariff Payment System (NTPS) and Aligned Payment and Incentive Rules (API). If the CCG wish to depart from the rules, then they will need to comply with rule 6 in the API schedule and complete the local departure agreement. Part of this process requires agreement from NHSE for the departure from the API rules, legal advice to seek approval from NHSE for this prior to contract signature.	Payment mechanisms and schedules agreed between provider and commissioners are included within the contract (final wording agreed between provider and commissioner finance teams 10th May 2021). NHSE have reviewed payment schedules as part of the ISAP process on 29th March 2021 which have been agreed, there have been no material changes to these schedules since this date.

Schedule 2G, inclusion of Adult Social Care service from PCC	Schedule 2G forms part of the specification in relation to Adult Social Care Services for PCC. Review of this schedule suggests there are some elements of the schedule which need to be moved to a collaborative commissioning agreement between PCC and the CCG as they are not an obligation on the provider. PCC to be aware that the general and service conditions would take precedence over schedule 2G in event of any conflict, therefore the need for a separate collaborative agreement to cover any specifics. Wording in the particulars has been suggested to show where schedule 2G would take priority of the particulars, for example in relation to pensions.	The contents and principles in Schedule 2G have been agreed between CCG, PCC and UHP (April 2021). The particulars of the contract have been updated to reflect the wording from legal in relation to schedule 2G, as per legal advice for pensions. CCG and PCC are working together on collaborative commissioning agreement which will be put in place prior to contract signature.
Local Quality Requirements	The local quality requirement headings do not appear to align with the framework set out in the NHS Standard Contract, and therefore CCG may forfeit its right to manage performance to traditional methods under GC 9. The CCG have confirmed this contract is commissioning for outcomes and would therefore be looking to manage performance under a Local Incentive Scheme (LIS). Wording has been provided to the CCG for the LIS (Schedule 4E) to ensure if mutual agreement is not reached prior to the 1st of March each year, in regard to the allocation of the LIS against the outcomes framework, the CCG will inform UHP on what these will be for the coming year.	Schedule 4A and 4B within the Particulars of the contract include all required national quality reporting requirements, which can be managed under GC9 Contract Management if required. The particulars of the contract include the wording from legal provided for schedule 4E (LIS), local performance will be measured under the outcomes framework. The CCG are content in the ability to manage this contract via outcomes and incentives, and this is accurately reflected in the contract.

ICP Risk Log

Date Identified:	Ref:	Description of Risk (Risk description should include cause/risk event/consequence and risk category)	Severity (1 - 5)	Likelihood (1 - 5)	RAG Rating	Specific Mitigating Actions	Expected RAG Rating	Target Resolution Date (or review date if target unknown)	Responsible Officer(s)	Comments
14/04/2021	**ICP_RISK_45**	There is a risk that there is insufficient capacity and capability at executive and senior level to deliver the planned transformation as part of the ICP in partnership with LSW alongside a range of material improvement programmes that UHP are already focused on and need to delivery alongside and with this change.	4	4	16	UHP have invested in additional capacity at executive and senior level to respond to improvement requirements and shared this regularly. To supplement the already existing capability, UHP have planned a suite of actions and programmes to develop better knowledge and understanding of LSW services. Additionally, an external peer Trust has been engaged to provide advisory support to UHP's ICP SRO and the wider Board in respect of its performance and quality management responsibilities with respect to community and mental health services	12	31/05/2021	Sonja Manton	These risks will be transferred on contract award to the relevant corporate risk register.
14/04/2021	**ICP_RISK_46**	There is a risk that if the CIC (Livewell Southwest) as the material subcontractor becomes an unviable provider during the lifetime of the contract and ceases to provide the services in the ICP in partnership with UHP, that there are gaps in service provision for the local population	4	3	12	UHP have planned a suite of actions and programmes to develop better knowledge and understanding of LSW services to be able to take on direct provision if needed Contingency approach and principles agreed to ensure continuity of service provision and access for the population should there be provider landscape changes Due diligence has been undertaken on the proposed partnership	8	31/05/2021	Sonja Manton	These risks will be transferred on contract award to the relevant corporate risk register.
14/04/2021	**ICP_RISK_47**	There is a risk that the system arrangements locally between all partners are not sufficiently developed to deliver the transformation	4	4	16	Agreed ICS performance improvement framework LCP performance arrangements agreed Bespoke executive escalation and oversight of ICP from contract award Agreement to sharing intelligence and capability across the system to address risks early and prevent escalation Commitment to effective system and partnership working to collectively address issues and risks	12	31/05/2021	Sonja Manton	These risks will be transferred on contract award to the relevant corporate risk register.
05/05/2021	**ICP_RISK_48**	There is a risk that decision making is not completed in time for the necessary transfer undertakings protection of employment (TUPE) to take place	4	2	8	CCG and PCC decision making processes now clarified and will happen 2nd June 2021 in time before TUPE.	4	31/05/2021	Sonja Manton	These risks will be transferred on contract award to the relevant corporate risk register.

Regulation 84(1) Report – Contents Checklist

This Appendix is to be completed to confirm compliance with section 84 of the Public Contracts Regulations 2015 and in the event that the Cabinet Office requests the information the information within this Appendix will be submitted as evidence of compliance.

Reg no	Data	Required?	If 'YES' please detail or indicate where this information can be located
84(1)(a)	Name and address of contracting authority	Y	Covering Page of CARR, OJEU advert and Contract Finder advert
84(1)(a)	Subject-matter and value of the contract	Y	Covering Page, OJEU advert, Contract Finder advert, ISOS and ISDS documentation
84(1)(b)	Names of candidates/tenderers passing any selection (SQ) stage and the reasons for their selection	Y	ISOS end stage report
84(1)(b)	Names of candidates deselected following any selection (SQ) stage and the reasons for their deselection	N	Not applicable
84(1)(b)	Names of bidders selected (following a "reduction of numbers" under Regulation 66), to continue to take part in a competitive with negotiation or competitive dialogue process, and the reasons for their selection	N	Not applicable
84(1)(b)	Names of bidders deselected (following a "reduction of numbers" under Regulation 66) from a competitive with negotiation or competitive dialogue process, and the reasons for their deselection	N	Not applicable
84(1)(c)	Reasons for rejection of any tender found to be abnormally low	N	Not applicable
84(1)(d)	Name(s) of successful bidder(s)	Y	CARR section 1
84(1)(d)	Reasons why successful bid(s) was/were selected	Y	CARR section 8
84(1)(d)	Share of the contract/framework agreement that the successful bidder intends to sub-contract	Y	Contract Award Notice

84(1)(d)	Names of the main sub-contractors	Y	CARR Section 1
84(1)(e)	Justification for use of competition with negotiation process or competitive dialogue process (see Regulation 26)	Y	Governing Body Minutes June 2019
84(1)(f)	Justification for use of negotiated procedure without a notice (see Regulation 32)	N	Not applicable
84(1)(g)	Reasons why the contracting authority decided not to award the contract/framework agreement	N	Not applicable
84(1)(h)	Reasons why non-electronic means was used for submission of tenders	N	Not applicable
84(1)(i)	Details of conflicts of interest detected and measures taken to nullify these	Y	Conflicts of Interest Register
76(4)(b)(iii)	In a Light Touch regime process, where the contracting authority has chosen to depart from the process as originally stated in the procurement documents (in accordance with the conditions permitting this at Regulation 76(4)), this decision and the reasons behind it must be documented in compliance with Regulations 84(7) and (8)	Y	Governing Body paper and minutes 26th March 2020

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Understanding the experiences of health and care in Devon for BAME communities and staff: Final report and proposed implementation plan					
Date of committee: 27 May 2021 **Date report produced: 13 May 2021**					
Author (s) Name and Title: **Andrew Millward** Director of Communications and Engagement, Integrated Care System Devon (ICSD); and Director of Communications, HR and IT, NHS Devon CCG **Nellie Guttmann** Senior Strategic Engagement Manager **Contact Details:** andrew.millward@nhs.net Nellieguttmann@nhs.net			**Supporting Executive: Andrew Millward** **Name and Title:** **Contact Details:** **Report Approved by: Andrew Millward** **Name and Title:** **Date13 May 2021**		
Public or Private (Governing Body only):			**Public**	**x**	**Private**
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):					
Purpose and scope of report:	**Consultation**	X	**Approval**	**x**	**Information** **x**
Does this report place individuals at the centre?			**Yes**	x	**No**

Executive Summary:

The COVID-19 pandemic placed a spotlight on health inequalities faced by ethnic minority communities, both nationally and within Devon.

During the development for an ethical framework for Devon in July 2020, negative experiences were shared by ethnic minority communities about access to healthcare. This prompted the ICSD to commission the Nous Group (Nous) to better understand health and care experience, access and outcomes among Black, Asian and Minority Ethnic communities and staff across Devon.

The work took place between September and December 2020 and the report and recommendations taken to the ICS Partnership Board in April 2021. All of the 23 recommendations were approved.

The recommendations have been reviewed and accountability and assurance for each allocated to the appropriate part of the system to ensure they are acted upon. The allocation of recommendations was supported by the System Health Inequalities Executive Leadership Group on 12 May 2021 and the Joint Executive Team meeting on 18 May 2021.

Whilst the recommendations have been approved in theory, it has not yet been established how the work to deliver them will be resourced. Successful delivery of the recommendations is dependent on investment, without which, there is a risk that this report becomes another well meaning, but ineffective report.

The Governing Body is asked to:

- **Consider the full report and recommendations**
- **Approve the allocation of the recommendations**
- **Discuss and identify resourcing for delivery of the recommendations**

Included in this pack are for review are:

- Full Nous report and recommendations for review
- Allocation of recommendations for approval
- Communications plan for the work for review

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:

ICSD Partnership Board, 7 April 2021

System Health Inequalities Executive Leadership Group, 13 May 2021

Joint Executive Team – 18 May 2021

Key recommendations and actions requested:

The Governing Body is asked to:

- **Consider the full report and recommendations**

- **Approve the allocation of the recommendations**
- **Discuss and identify resourcing for delivery of the recommendations**

Reference to other documents or accompanying papers:

Included in this pack are for review are:
- Full Nous report and recommendations for review
- Allocation of recommendations for approval
- Communications plan for the work for review

Have the legal implications been considered?

Yes

Equality Impact Assessment:

Who does the proposed piece of work affect?	**Patients**	✓	**Carers**	✓
	Staff	✓	**Public**	✓

	Yes	No
1. Will the proposal increase discrimination for people in protected groups?		x
2. Will the proposal reduce discrimination for people in protected groups?	X	
3. Is the proposal controversial in any way (including media, academic, voluntary or sector specific interest) about the proposed work?		X
4. Will there be a positive benefit to the patients or workforce as a result of the proposed	X	
5. Is there doubt about answers to any of the above questions (e.g. there is not enough information to draw a conclusion)?		X

If the answer to any of the above questions is yes (other than questions 2 and 4) or you are unsure of your answers to any of the above, you should provide further information using **Quality and Equality Impact Assessment**. If a quality and equality impact assessment is not thought to be required briefly explain why and provide evidence for the decision.

***Please add N/A if any of the sections are not relevant*

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.

Understanding the experiences of health and care in Devon for BAME communities and staff

Final report and proposed implementation plan

Background

The COVID-19 pandemic placed a spotlight on health inequalities faced by ethnic minority communities, both nationally and within Devon.

During the development for an ethical framework for Devon in July 2020, negative experiences were shared by ethnic minority communities about access to healthcare. This prompted the ICSD to commission the Nous Group (Nous) to better understand health and care experience, access and outcomes among Black, Asian and Minority Ethnic communities and staff across Devon.

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- Allocation of recommendations for approval
- Communications plan for the work for review

Recommendations

23 Recommendations in total

	ICS	LCP
Staff	**2**	**8**
Communities	**11**	**6**

Proposed Allocation of recommendations

- Over-all accountability – NHS ICS Board
- Over-all assurance – Health and Care Partnership Board

Recommendation	LCP / ICS	Sub-recommendation	Accountability	Assurance
Strengthen accountability	ICS	Appoint a non-Executive Director (NED) accountable for BAME inequalities	CCG Governing Body	CCG Governing Body
		Hold LCPs and partner organisations to account for progress.	Health Inequalities Executive Leadership Group / Quality Assurance Committee	CCG Governing Body
		Produce consolidated, clear external reports on performance.	Health Inequalities Working Group	Health Inequalities Executive Leadership Group
Improve governance Structures	ICS	Establish the system wide role of Health Inequalities Executive Leadership Group.	ICS Partnership Board	CCG Governing Body
		Redefine role of the Equalities Co operative	Health Inequalities Executive Leadership Group	CCG Executive
		Establish a Devon wide BAME Reference Group.	CCG Communications and Engagement	CCG Executive
		Establish a Devon wide BAME staff advisory group.	CCG HR	CCG Executive
Conduct activities at scale	ICS	Refine the Health Inequalities Workplan	Health Inequalities Executive Leadership Group	ICS Partnership Board
		Increase support for the Devon wide BAME staff network.	CCG HR	CCG Executive
		Commissioning and developing co designed training for engaging with BAME communities.	CCG Communications and Engagement / Population Health Management	CCG Governing Body
		Commissioning and developing co designed training for engaging with BAME staff.	CCG HR / Population Health Management	CCG Governing Body
		Developing good practice guidance for partner organisations on engaging with BAME communities.	CCG Communications and Engagement	CCG Governing Body
		Developing good practice guidance (e.g. toolkits) for BAME staff networks.	CCG HR	CCG Executive
		Taking the lead in developing relationships with Devon wide	CCG Communications and Engagement	CCG Body

		community organisations (e.g. Hikmat).	and ICS VCSE Lead	
Improve leadership and accountability	LCP	Improve data on BAME access, participation, experience and outcomes.	• Provider Governing Bodies • Health inequalities working group • Insight hub • Restoration	CCG Quality Assurance Committee Partnership Board
		Appoint accountable leaders for BAME inequalities	Provider Governing Body's	Health Inequalities Executive Leadership Group
Better engage local communities	LCP	Establish one or more BAME community reference groups with clear terms of reference around consultation, involvement and info	LCP communications and engagement group / Provider communication and Engagement teams	CCG / ICS Communications and Engagement team
		Conduct an immediate, short (e.g. 3 month) targeted qualitative consultation exercise to elicit views from local BAME communities	Provider communications teams	CCG Communications and Engagement and CCG Health Inequalities Executive Leadership Group
		Commission community engagement training for people in key roles	Provider HR / Communications / Population Health Management	CCG communications and HR and CCG Health Inequalities Leadership Executive.
		Tailor guidance for staff on engaging BAME communities, based on established good practice	Provider HR and Communications QEIA PHM	CCG communications and HR and Health Inequalities Leadership Executive.
		Review processes around EDS2 and Quality and Equality Impact Assessments Review processes around EDS2 and Quality and Equality Impact Assessments to ensure appropriate engagement is required and scrutinised	Provider Quality Assurance Committees	CCG Quality Assurance Committee
		Review relationships with relevant partner organisations (e.g. Healthwatch, Hikmat)	Provider communications and engagement teams	CCG communications and engagement teams
Co-design BAME community	LCP	Co design interpretation and translation services.	Provider EDI Leads	CCG EDI lead

Support		Co design and roll out training for engaging with BAME communities	Provider communications and engagement teams	CCG communications and engagement teams
		Co design response to impacts of isolation among BAME communities.	Provider communications and engagement teams Restoration programme Health Inequalities working group	Provider communications and engagement teams Health Inequalities Leadership Executive.
Improve Leadership and Accountability	LCP	Improve reporting of performance externally and internally.	Provider EDI, quality and BI teams Health Inequalities Working Group Restoration programme	Provider GB and Health Inequalities Leadership Executive.
		Collect and report more qualitative data.	Provider communications, BI and patient experience teams	Provider GB and CCG Quality Assurance Committee Health Inequalities Leadership Executive
		Appoint accountable leaders for BAME staff inequalities.	Provider HR	Provider GB
Improve staff experience	LCP	Create and support BAME staff networks.	Provider HR	Provider GB
		Implement robust complaints procedure for racial harassment.	Provider HR	Provider GB
		Co develop WRES reports and action plans.	Provider HR	Provider GB
Improve recruitment and progression	LCP	Implement good practice recruitment processes.	Provider HR	Provider GB
		Implement good practice in support for BAME progression	Provider HR	Provider GB

Experiences of health and care in Devon for BAME communities and staff

Final report

30 March 2021

Disclaimer:

*Nous Group (**Nous**) has prepared this report for the benefit of Together for Devon Partnership (the **Client**).*

The report should not be used or relied upon for any purpose other than as an expression of the conclusions and recommendations of Nous to the Client as to the matters within the scope of the report. Nous and its officers and employees expressly disclaim any liability to any person other than the Client who relies or purports to rely on the report for any other purpose.

Nous has prepared the report with care and diligence. The conclusions and recommendations given by Nous in the report are given in good faith and in the reasonable belief that they are correct and not misleading. The report has been prepared by Nous based on information provided by the Client and by other persons. Nous has relied on that information and has not independently verified or audited that information.

Contents

Executive summary

The COVID-19 pandemic has placed a spotlight on BAME health inequalities, both nationally and within Devon. Building on a wide range of pre-existing programmes and processes to tackle inequalities, Together for Devon has commissioned Nous Group (Nous) to better understand health and care experience, access and outcomes among Black, Asian and Minority Ethnic (BAME)[1] communities and staff across Devon; and to identify improvement opportunities.

This report presents findings and recommendations. It draws on interviews with representatives from each Together for Devon partner organisation; data provided by partner organisations[2]; public data; 9 group and individual interviews with BAME community members; and 11 group and individual interviews with BAME staff members, conducted from October-December 2020.

Devon has a range of processes in place to address BAME inequalities, but their effectiveness is limited

Devon CCG's system-wide Equality, Diversity and Inclusion (EDI) strategy was agreed in late 2019. Some elements of the strategy have potential application to BAME communities and staff, including developing a better understanding of communities and their needs through engagement; and strengthening governance and assurance, to provide system-wide accountability of addressing inequalities – including nominating the Devon-wide Equality Co-operative as the primary vehicle for pursuing the strategy. However, the strategy does not specifically identify BAME communities as an area of focus; and more broadly, **the strategy and the Co-operative appear to have little influence or recognition among partner organisations**.

Other prominent mechanisms, such as the Equality Delivery System (EDS2) and the Quality and Equality Impact Assessment (QEIA), have **limited impact in practice** – for example, QEIAs are typically completed, but not based on detailed data or community engagement. Similarly, EDS2 reporting is not based on substantive engagement with communities, as is intended. Partner organisations frequently note that there is **no effective system-wide accountability** for understanding and addressing BAME inequalities. More recently, the system-wide Health Inequalities Work Plan, developed in response to NHS England's Phase 3 COVID-19 Recovery response, provides a potential foundation for stronger, more coordinated action.

There is limited understanding of how BAME communities, patients and service users are faring

From the outset of this project, we anticipated building on provider organisations' understanding of current BAME communities' issues, and working through existing community relationships. However, conversations with nominated EDI representatives suggested that partner organisations have relatively **limited understanding of who their BAME communities are, what inequalities they may experience, and how to address this through their services**. Both qualitative and quantitative **data collection on these issues is mostly limited and unsystematic**. For example, we were unable to identify and quantify inequalities in outcomes and participation from existing data. Partner organisations note that while BAME issues have recently become a higher priority in the context of Covid-19 and Black Lives Matter, **resources and capabilities to address these issues are lacking** – in

1. The term "Black Asian and Minority Ethnic" shortened to "BAME" is commonly used in Equality, Diversity and Inclusion work. While it is not a definitive term or a singular identity, it provides a useful analytical framework to understand racial and ethnicity-based inequalities. In this report, BAME in the context of national and local data refers to all non-white ethnicities. However, some partner organisations include certain "white other" groups, such as Eastern European communities, in discussions relating to ethnicity based inequalities. Page 6 sets this out in further detail.
2. We issued data requests to 11 partner organisations, and have received substantive data from 7.

Executive summary

particular, capability to engage with BAME communities. This lack of understanding represents a substantial barrier to addressing BAME inequalities.

People from BAME backgrounds perceive barriers to access and appropriate care as a result of their ethnicity

Many people from BAME backgrounds report satisfaction and positive experiences with health services. However some report negative experiences linked to their ethnicity, highlighting potential inequalities. **Translation and interpretation services are sometimes inadequate**, creating barriers to effective access, and fears of being insufficiently understood and receiving inappropriate care as a result *("Our language line is rubbish – you never get the proper dialect").* Providers are often perceived to **lack the necessary skills to understand the cultural context** of people from BAME backgrounds, and to communicate with and provide responsive care appropriately. People feel they are disrespected or have their views dismissed due to their ethnic background. Certain segments of BAME communities are also perceived to be at **higher risk of social isolation and associated mental ill health** – especially older people and some women, who may have small networks, and face language or cultural barriers to broader community participation. Intersectionalities also influence BAME experiences, with BAME women noting that their gender often compounded perceived racial discrimination.

BAME staff experience substantial inequalities, with action to address this at an early stage of maturity

The **representation of BAME people across the workforce is mixed**, with overrepresentation in some organisations and workforce categories, and underrepresentation in others. For example, among the non-medical workforce at NHS Trusts, most Trusts have no people from BAME backgrounds at Very Senior Manager level. Many BAME staff cite such lack of senior representation as a cause of challenges they face.

In many organisations, BAME staff are less likely to believe there are equal opportunities for progression and promotion, and experience **lack of effective support to develop and progress**. BAME staff experience **more harassment, bullying abuse and discrimination** from colleagues and patients. Examples of these activities include racially insensitive comments (*"You're just a white person who tans a lot"*); managers siding with patients or making excuses for racist incidents; and having abilities and credentials questioned. Some staff are also unsure of how to report and raise these experiences; or **fear that complaints will be managed ineffectively**. Many staff reported that EDI more broadly was not a high priority for their organisations, representing **lip service rather than a genuine commitment to change**.

NHS organisations in Devon have a mix of measures in place to support BAME staff and address inequalities, including BAME staff networks, mentoring and reverse mentoring programmes, and tailored support for career development. However these activities are not consistent across the system; and many, particularly staff networks, have only recently been introduced.

Executive summary

There is also substantial variation across partner organisations. Reported rates of harassment, bullying and abuse among BAME staff are very different in different organisations; and in relation to BAME staff experience of discrimination from managers or other colleagues, some of Devon's NHS organisations have improved over the last year; while others have deteriorated. In some cases, deterioration may be explained by increased reporting – a positive sign. However, to the extent that it reflects genuine variation, this demonstrates that there are potential opportunities to drive improvement through sharing and applying existing good practice across the region.[1]

Devon must seize the twin opportunities of COVID-19 and the transition to ICS to embed accountabilities for BAME inequalities

This project identifies a range of recommendations for the Devon ICS, which apply at both the system-wide level, and at the local level (see page 7). Key areas for action include better data; stronger leadership and accountability for BAME inequalities; and more engagement with BAME communities.

More broadly, the COVID-19 pandemic has significantly raised the profile of BAME health inequalities both nationally and in Devon. This project has identified significant appetite for change, and many pockets of good practice and emerging bright spots – including Devon's roll-out of the vaccination programme, which has incorporated many of the principles of local community engagement and understanding discussed in this report. Devon has an opportunity to build on this momentum. At the same time, the transition to formal ICS arrangements presents an opportunity to lock in new structures, processes, cultures and ways of working to tackle inequalities – and draft ICS governance arrangements, which embed responsibilities for inequalities at both system-wide and local levels are promising. In the context of broader action to address health inequalities, meaningful improvement of BAME access, outcomes and experience is possible in the short to medium term.

Terminology and the use of "BAME"

The term "Black, Asian and Minority Ethnic" (shortened to "BAME") is commonly used within health and care to refer to people of non-White ethnicities, especially when making comparisons to the White population.

The term is imperfect, and often inappropriately used. There are concerns that it groups together diverse ethnicities: potentially masking instances of inequality and/or racism; or homogenising the experience of individuals and communities who experience racism in different ways. People are more likely to identify as a particular ethnic group or race, than as "BAME".

An alternative consensus on the terminology is yet to form and for the purposes of this report the term provides a useful analytical framework to understand racial and ethnicity-based inequalities. This report should be read fully cognisant of the limitations highlighted above, and experiences of racism set out in the report should not be assumed as applicable to all non-White individuals.

1 NHS Staff Survey, 2020

Executive summary

Recommendations are divided into system-level recommendations for Devon ICS; and local-level recommendations for individual partner organisations and future local care partnerships.

DEVON ICS

1. **Strengthen accountability**
   a. Appoint a non-Executive Director (NED) accountable for BAME inequalities
   b. Hold LCPs and partner organisations to account for progress
   c. Produce consolidated, clear external reports on performance
2. **Improve governance structures**
   a. Establish the system wide role of Health Inequalities Executive Leadership Group
   b. Redefine role of the Equalities Co-operative
   c. Establish a Devon-wide BAME Reference Group
   d. Establish a Devon-wide BAME staff advisory group
3. **Conduct activities at scale**
   a. Refine the Health Inequalities Workplan
   b. Increase support for the Devon-wide BAME staff network
   c. Establish mechanisms for system level activity

LOCAL CARE PARTNERSHIPS/PARTNER ORGANISATIONS

BAME communities and service users

4. **Improve leadership and accountability**
   a. Improve data on BAME access, participation, experience and outcomes
   b. Appoint accountable leaders for BAME inequalities
5. **Better engage local communities**
6. **Co-design BAME community support**
   a. Co-design interpretation and translation services
   b. Co-design and roll out training for engaging with BAME communities
   c. Co-design response to impacts of isolation among BAME communities

BAME staff

7. **Improve leadership and accountability**
   a. Improve reporting of performance externally and internally
   b. Collect and report more qualitative data
   c. Appoint accountable leaders for BAME staff inequalities
8. **Improve staff experience**
   a. Create and support BAME staff networks
   b. Implement robust complaints procedure for racial harassment
   c. Co-develop WRES reports and action plans
9. **Improve recruitment and progression**
   a. Implement good practice recruitment processes
   b. Implement good practice in support for BAME progression

Introduction

Context and purpose

People from BAME backgrounds experience substantial health and care inequalities

Inequalities in risk, access, experience and outcomes in health and care across the UK are well documented across a range of characteristics. Ethnicity is an important dimension of inequality, and BAME communities fare worse than White communities across many measures. Similarly, there is longstanding evidence that BAME staff members in NHS organisations face substantial barriers in recruitment and promotion, and experience racism and discrimination in their roles.

Devon's BAME population is relatively small. According to 2011 Census data, BAME communities make up roughly 3% of the Together for Devon geography, with the proportion higher in some areas (e.g. 7% in Exeter) – although these proportions are likely to have shifted since the last Census. As a result, there has historically been relatively limited emphasis on understanding and addressing BAME health inequalities in the region.

COVID-19 has placed a spotlight on BAME inequalities these issues, including in Devon

The impact of COVID-19 has highlighted the importance of BAME inequalities. People from BAME backgrounds are at higher risk of COVID-19 related deaths; and vaccination hesitancy is higher in BAME communities than White communities. The increased awareness of these issues has been accompanied by greater focus at the national level, including through Phase 3 of the NHS response, which set out a range of required actions including improving patient ethnicity data; and the NHS People Plan, which states that "*employers, in partnership with staff representatives, should overhaul recruitment and promotion practices to make sure that their staffing reflects the diversity of their community*".

Within Devon, work of the Devon Ethical Reference Group in mid-2020 highlighted worrying perceptions of health and care services among people from BAME backgrounds – including a reluctance to seek care, and a perception that they would be treated unfairly due to their ethnicity.

This project aims to improve understanding of inequalities and identify opportunities to improve

In response to these issues, the Chair of Together for Devon engaged Nous to better position the Devon health and care system to understand and respond to BAME inequalities. Specifically, this project aims to:

- Give Together for Devon a better understanding of the experiences of BAME communities and staff across Devon
- Give Together for Devon a better understanding of the related activity and initiatives currently underway across the system
- Identify specific actions to improve the system for BAME communities and staff.

This report presents the findings from our consultations and data analysis.

Approach

The project was conducted over 3 stages

DATA COLLECTION AND ENGAGEMENT

- **Partner organisations**. We engaged with nominated Equality and Diversity representatives from all the Together for Devon partner organisations
- **BAME communities and staff.** We engaged with BAME communities and staff through a mix of 1:1 interviews and group interviews. This included 11 consultations with BAME staff (29 people); and 9 consultations with people from BAME backgrounds (38 people).
- **Data**. We collected provider and public data to build a picture of Devon's current state in relation to BAME inequalities. Data included the Workforce Race Equality Standard, NHS Staff Survey, and the GP Patient Survey.

LIMITATIONS

There are a number of limitations to our approach which should be taken into consideration:

- **Number of people consulted.** 67 people from BAME backgrounds were consulted as part of this project. This is a small number compared with Devon's BAME population as a whole. More importantly, it did not reflect a representative mix of ethnic and geographic communities; or allow detailed exploration of the impact of intersectionalities of BAME experience. The findings should be interpreted as a starting point for further, sustained, more detailed engagement with communities and the local level to understand specific experiences.
- **Specific BAME communities engaged**. We engaged with people from a diverse range of BAME backgrounds; but this report does not give a breakdown by ethnic group. There are limitations with aggregating experiences into the term "BAME" as it may suggest a common experience between groups. Similarly, there will be experiences relating to specific ethnic communities which are not reflected here.
- **Partner organisation performance.** This report does not give an in-depth analysis of individual partner organisations either in terms of the experience and outcomes for their BAME service users or the experiences of BAME staff (apart from select data from the Workforce Race Equality Standard).
- **Social care**. The available project resources did not allow detailed engagement with representatives and staff from individual social care providers. This remains an important area for future work, in the context of an integrated health and care system.

Lines of enquiry

The lines of enquiry which guided our approach are outlined below. These set the scope for the project, and shaped engagement with BAME staff and communities, data analysis, and findings and recommendations.

BAME COMMUNITIES, PATIENTS AND SERVICE USERS

- How do access, participation and outcomes among BAME communities compare with white users across the Together for Devon footprint?
- What perceptions do BAME communities have of health and care provision in Devon? What is the cause of these perceptions?
- What is the experience of BAME individuals when they access health and care services in Devon?
- What are the system and service level barriers and enablers of access, participation and outcomes among BAME communities?
- What existing work is being done to improve the experience for BAME communities across health and care provision in Devon?
- What actions should Together for Devon prioritise and pursue in the short to medium term to improve access, participation, outcomes and experience among BAME communities?

BAME STAFF

- What proportion of staff across Devon ICS are BAME and how is that distributed across the geography and service provision of the ICS?
- What is the experience of BAME staff who deliver health and care services in Devon?
- What are the system level barriers and enablers of BAME staff recruitment, retention and promotion across health and care services?
- What existing work is being done to attract BAME staff to health and care services across Devon and to improve the experience of existing staff?
- What actions should Together for Devon prioritise and pursue to improve recruitment, retention and experience of BAME staff?

National overview of BAME health and workforce inequalities and policy responses

Inequalities in health outcomes exist for BAME communities

According to the 2011 census data, BAME communities make up **14%** of the UK population.[1] The proportion of BAME communities in the overall UK population is expected to rise with the 2021 census which is currently underway. People from BAME backgrounds experience substantial health inequalities.

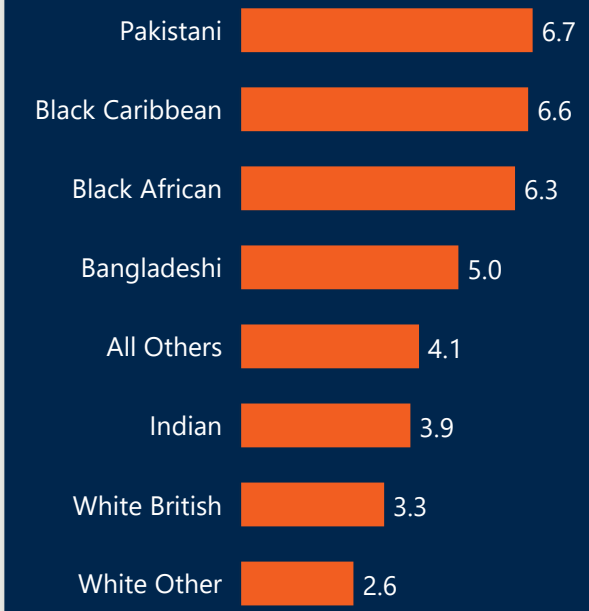
The landmark **Marmot Review: Fair Society, healthy Lives** published in February 2010 outlined the scale of health inequalities in England and the actions required to reduce them. Ethnicity was a key focus of the report, showing mixed outcomes in access and outcomes between and at times, within various ethnic groups. The report also highlighted the overlay of geographic disparities. For example, Black ethnic minority groups in London were 1.3 times more likely to be injured as pedestrians and car occupants on the city's roads than those in white ethnic groups.[2] **The Health Equity in England: Marmot Review 10 Years On** report found inequalities to be widening for BAME communities.[3]

Documented inequalities for BAME communities include:

- Higher infant mortality rates for some BAME communities[4] (Figure 1)
- Higher rates of diabetes among some BAME communities
- Higher rates of heart disease among people from a South Asian background
- Higher rates of hypertension and stroke among people from Caribbean and African backgrounds[5]

Some BAME communities fare better than White British people on specific health indicators, such as children's weight (4-5yrs), alcohol related hospital admissions, and suicide attempts.[6]

FIGURE 1. Infant mortality rates, by ethnicity in England and Wales, per 1,000 live births, 2013[4]



SOCIAL DETERMINANTS OF HEALTH AFFECT BAME HEALTH INEQUALITIES

There is a substantial body of evidence documenting the multidimensional social and economic factors, including racism, which contribute to ethnic inequalities in health. Examples of social determinants of health include: socio-economic deprivation and poverty, education qualification levels, health literacy and previous experiences of health and care.[7] People from BAME backgrounds experience inequalities in each of these factors. Genetic and biological factors have also been identified as a driver; however this has been deemed to have only a limited impact.[8] New evidence is emerging that the disproportionate impact Covid-19 is having on BAME communities, is driven by these social determinants.[9]

1 Census 2011, Office for National Statistics
2 Marmot, M et al. (2010). Fair Society, Healthy Lives: The Marmot Review. Institute of Health Equity
3 Marmot, M et al. (2020). Health Equity in England: Marmot Review 10 Years on. Institute of Health Equity and Health Foundation
4 ONS (2013), Pregnancy and ethnic factors influencing births and infant mortality
5 Byrne, B., Alexander, C., Khan, O., Nazroo, J. and Shankley, W., 2020. Ethnicity, Race And Inequality In The UK. Bristol: Policy Press.
6 Public Health England (2018) Local action on Health inequalities- understanding and reducing ethnic inequalities in health
7 Byrne, B., Alexander, C., Khan, O., Nazroo, J. and Shankley, W., 2020. Ethnicity, Race And Inequality In The UK. Bristol: Policy Press
8 Public Health England (2018) Local action on Health inequalities- understanding and reducing ethnic inequalities in health
9 ONS (2020) Coronavirus (COVID-19) related deaths by ethnic group, England and Wales

Many people from BAME backgrounds have worse experiences of health and care services

BAME communities have varied experiences when accessing health and care services across both primary and secondary care. Inequalities for BAME communities in their experience with health and care services include[1,2]:

- **Lower levels of access to preventative healthcare**, such as cancer screening or smoking cessation services
- **Lower rates of access to some primary services,** such as dental services and talking therapies for common mental health disorders, when compared with white populations.
- **Lack of access to high quality interpreting services,** creating barriers for some BAME communities accessing health and care services and compromising care.
- **Lower uptake of cardiac rehabilitation** among some ethnic groups
- **Higher rates of admission to psychiatric hospitals with a diagnosis of psychotic illness** among people from Caribbean and African backgrounds

Stereotyping, racism and lack of cultural competence have been identified as factors which contribute to these disparities in experience for BAME communities.[3]

BAME COMMUNITIES' EXPERIENCE WITH GP SERVICES VARIES

BAME communities face disparities in their access to GP services. In the 2020 GP Patient survey, 27-29% of respondents from Bangladeshi, Chinese, Pakistani background reported a 'very good' experience, far fewer than those from British White backgrounds where 46% reported a very good experience.[4] Ethnic minority people who had been diagnosed with a cancer saw their GP several more times than White British people before they were referred to a hospital.[5] Black people are less likely than all other ethnic groups to access online services from GP surgeries and Asian people are least likely to find it easy to get through to their GP by phone.[6] Research also shows that some 16% of Gypsies and Travellers were not registered with a GP; it is 37% for those who travel all year round.[7]

Only **27%** of Bangladeshi people have had a "very good" experience of their GP services, compared to **46%** of White British service users[4]

1 Public Health England (2018) Local action on Health inequalities- understanding and reducing ethnic inequalities in health
2 3 Byrne, B., Alexander, C., Khan, O., Nazroo, J. and Shankley, W., 2020. Ethnicity, Race And Inequality In The UK. Bristol: Policy Press
4 GP Patient Survey 2020, Q31. Overall, how would you described your experience of your GP Practice?, note: British White includes English/Welsh/Scottish and Northern Ireland
5 Byrne, B., Alexander, C., Khan, O., Nazroo, J. and Shankley, W., 2020. Ethnicity, Race And Inequality In The UK. Bristol: Policy Press
6 GP Patient Survey 2020
7 Public Health England (2018) Local action on Health inequalities- understanding and reducing ethnic inequalities in health

Covid-19 has brought sharper focus on inequalities for BAME communities

BAME COMMUNITIES ARE AT A HIGHER RISK FROM COVID-19

The COVID-19 pandemic has brought the issue of health inequalities for BAME communities to the fore; BAME communities are at greater risk from COVID-19 than white populations.[1]

In Public Health England's report published in August 2020, sets out disparities affecting BAME communities from the first COVID-19 wave. 36% of those admitted to critical care were from BAME communities, well above their representation in society. People of Chinese, Indian, Pakistani, Other Asian, Black Caribbean and Other Black ethnicities had between a 10% and 50% higher risk of death when compared to White British people.[2] Data published by the Office of National Statistics (ONS) shows that Black males are 4.2 times more likely to die from COVID-19 than White males, while Black females are 4.3 times more likely to die from COVID-19 than White females.[3]

Social determinants of health play a role in increasing the risk to BAME communities. The Public Health England report highlights that BAME people are more likely to live in urban areas, in overcrowded households, in deprived areas, and have jobs that expose them to higher risk. The report also suggested that some co-morbidities which increase risk from the virus are more prevalent in some BAME communities.[4] Adjusting for factors such as area deprivation, socio-economic position and heath or disability substantially reduces the odds of a death involving COVID-19 relative to white groups but the likelihood of death is still higher.[5]

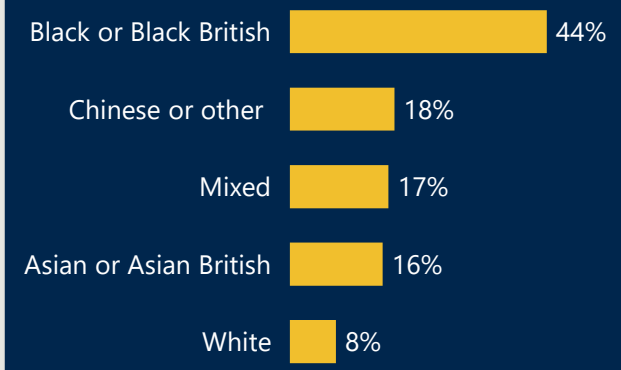
LACK OF TRUST FUELS VACCINE HESITANCY IN BAME COMMUNITIES

A lack of trust in government and health services is fuelling vaccine hesitancy in BAME communities. Since the COVID-19 vaccination programme began, research has highlighted that vaccine hesitancy is greater in BAME communities than in white populations. Vaccine hesitancy is highest in Black communities (44%), and in Chinese and other ethnic groups (18%), Both are in stark contrast to hesitancy in white populations which stands at 8%.[6]

Factors for vaccine hesitancy are well documented. Common reasons include, concerns about side-effects, and individual and collective previous negative experiences with health and care but mistrust in government and public services is consistently highlighted as a major factor.[7,8]. Several approaches have been taken to combat hesitancy in BAME communities and increase uptake of the vaccination. This has included opening vaccination centres in areas regularly frequented by certain BAME communities (e.g. local mosques), direct phone calls to patients who have not yet come forward, enlisting community and faith leaders to encourage their respective communities to take the vaccine, and creating networks of vaccine ambassadors to fight disinformation.[9,10,11]

Black people are over 4 times more likely to die from a COVID-19 related death than white populations[3]

FIGURE 2. Vaccine hesitancy by ethnicity[6]



1-2 Public Health England (2020), Beyond the data: Understanding the impact of COVID-19 on BAME groups
3 ONS (2020) Coronavirus (COVID-19) related deaths by ethnic group, England and Wales
4 Public Health England (2020), Beyond the data: Understanding the impact of COVID-19 on BAME groups
5 ONS (2020) Coronavirus (COVID-19) related deaths by ethnic group, England and Wales
6-7 ONS (2021) Coronavirus and vaccine hesitancy, Great Britain: 13 January to 7 February 2021
8 Scientific Advisory Group for Emergencies (SAGE) (2020) Minutes from 73rd meeting on Covid-19
9 BBC News (2021) Coronavirus doctor's diary: Why are some of Bradford's elderly refusing the vaccine?
10 The Guardian (2021) , Hundreds get Covid vaccine at East London mosque's pop-up clinic
11 NHS News (2021) GP determined to put in personal call to every at-risk patient yet to take up COVID-19 jab offer\

BAME staff experience numerous inequalities in health and care

BAME staff are overrepresented in the workforce but underrepresented at senior levels.

Within NHS Trusts and clinical commissioning groups (CCGs) in England, BAME staff make up 21% of the workforce compared to 14% in the population as a whole. As shown in Figure 3, the number of BAME staff in the NHS has been increasing over time. Progress has been made to increase BAME representation in mid-ranking and senior positions, however it is still not reflective of BAME staff in the workforce as a whole, in particular at the Very Senior Manager level (see Figure 4). Further, according to the latest WRES data, white applicants were 1.61 times more likely to be appointed from shortlisting compared to BAME applicants; this is worse than in 2019 (1.5) [3]. At the Board level, BAME people are also underrepresented. In 2020, only 10% of board members across all Trusts came from BAME backgrounds. Performance does vary across regions, with only 3.9% of board members being BMR in the South West, compared to 19.6% in London.[4]

In the adult social care workforce in 2019/20 nearly 21% of the 1.54 million jobs in the sector are filled by people from BAME backgrounds[5](Figure 5). This does not include those working in the NHS. Similar to the NHS, BAME staff are less represented in senior management positions. In 2019/20, 17% of senior management positions roles were filled by people from BAME backgrounds (see Figure 6).

BAME staff have worse experiences

BAME staff have a worse experience within the NHS when compared with white colleagues. A lower percentage of BAME staff believe that their organisation acts fairly with regards to career progression and promotion[7]. BAME staff were also 1.2 times more likely to enter the formal disciplinary process compared to white staff[8]. Further, 15% of BAME staff report higher rates of experiencing discrimination at work from a manager/team leader or other colleague, compared to 6% of white staff[9].

COVID -19 has brought sharper focus on experience of BAME NHS staff

Evidence of BAME communities' higher risk of death from COVID-19 has brought sharper focus on the experience of BAME NHS staff. By April 2020, 53% of healthcare workers and 95% of doctors who had died were from BAME backgrounds.[10] It was also reported that BAME doctors were more likely to be pressured into working with inadequate levels of PPE.[11] NHS Employers published guidance on risk assessments for BAME staff and encouraged NHS organisations to engage with their BAME staff and BAME staff networks.[12] Vaccine hesitancy among BAME staff is also well documented; Guys' and St Thomas' Foundation Trust has found that whilst over 80% of staff had been vaccinated only ¼ of black staff and even fewer Filipino staff had been.[13]

FIGURE 3. Staff in NHS Trusts and CCGs by ethnicity: 2016-2020[1]

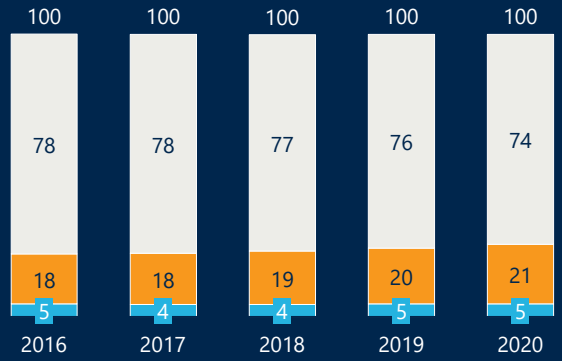


FIGURE 4. Ethnicity of Very Senior Managers in NHS trusts and CCGs in England, 2020[2]

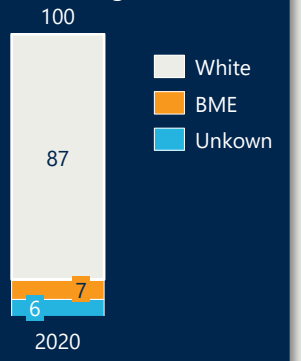


FIGURE 5. Ethnicity within adult social care workforce, 2019/2020[7]

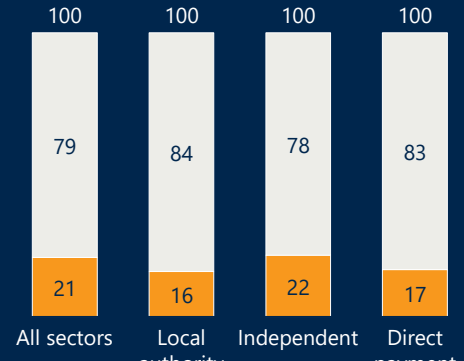
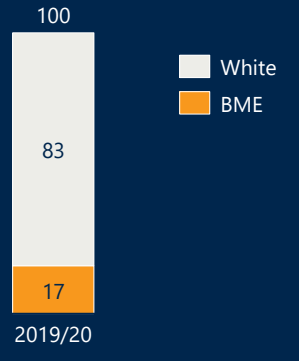


FIGURE 6. Ethnicity of adult social care workforce in senior management roles, 2019/2020[6]



1,2,3,4,7,8,9. NHS, *Workforce Race Equality Standard 2020 report*
5,6. Adult Social Care Sector and Workforce (ASC-WDS) 2019/20 Dataset, See Workforce demographics, 5.5. Ethnicity,
10 Health Service Journal (2020) Exclusive: deaths of NHS staff from covid-19 analysed
11. BMA (2020) BAME doctors hit worse by lack of PPE
12 NHS, Addressing impact of COVID-19 on BAME staff in the NHS
13 Health Service Journal (2021) Exclusive: Fewer black and Filipino NHS staff vaccinated amid 'hesitancy' concern

National requirements, strategies and resources have implications for Devon

At a national level, effort has been made to better understand the scale and causes of BAME inequalities and to put in place policies and initiatives to address them. This includes both BAME-specific activity, and activity to address broader inequalities.

Reporting and regulatory requirements

The **Equality Act 2010** requires public bodies to publish equality information and their objectives every four years. The Act includes the equality duty, which includes an aim to advancing equality of opportunity between people who share protected characteristics and those who do not.

Equality Delivery System (EDS2) is a system of structured information gathering and reporting to help local NHS organisations to review and improve their performance for people with characteristics protected by the Equality Act 2010, including staff, patients and communities.

The **Workforce Race Equality Standard (WRES)** is a process for reporting and addressing inequalities between BAME and white staff, and has been implemented at a local organisational level, at system level (e.g. STP/ICS), regional level and at a national level with arm's length bodies. It allows organisations to compare performance and provides a national overview of the current performance against the workforce race quality agenda.

Strategies and Plans

The NHS People Plan 2020-21 focuses on creating a culture of including and belonging. In 2020-21 is an updated plan which highlights the impact of COVID-19 on its staff, in particular those from BAME backgrounds. This plan requires providers to publish progress against **A Model Employer goals,** which aims to accelerate recruitment of BAME staff at senior levels.

The **NHS Long Term Plan**, the overall strategy for the NHS for the next decade, includes aspirations to improve BAME representation at senior levels in NHS, with each NHS organisation setting its own targets for 2021-22.

NHS Equality Objectives 2016-20 sets out six equality objectives; Objective 6 includes improving recruitment, retention, progression, development and experience for BAME staff.

The Department of Health & Social care recently published a consultative white paper, **Integration and Innovation: working together to improve health and social care for all,** builds on extensive work to develop integrated care systems with regional scale. Health and care partnerships envisaged under the reforms will enable a more integrated approach to addressing inequalities and the social determinants of health.

Resources and capacity building

NHS Equality and Diversity Council provides leadership on equality issues across and beyond the health sector, in particular to improve access, experiences, health outcomes and quality of care.

The new **NHS Race and Health Observatory** established in 2020 investigates the impact of race and ethnicity on people's health, in particular those from BAME backgrounds. The Observatory offers analysis and policy recommendations to improve health outcomes for NHS patients and staff.

Health and Wellbeing Alliance has been established by the Department of Health and Social Care to improve dialogue on health and social care policy.

A number of other bodies produce a range of resources to support individual systems and trusts to reduce the gap in health inequalities. For example, Public Health England has recently published a resource to tackle local health inequalities, Skills For Care, produces the Adult Social Care Workforce Data Set to help providers make informs decisions around organisational change and quality of care. The NHS Confederation runs a BME leadership network and some of the trusts in Devon have accessed their 'Diversity and Inclusion Partners' Programme

IMPLICATIONS FOR DEVON ICS

The examples above highlight that there are already imperatives for Devon to act to tackle BAME inequalities as well as resources to support that work. The reporting requirements under the Equality Act 2010 and EDS2 are obligatory for NHS organisations and the WRES can be helpful in identifying gaps and opportunities for improvement at the system level. It is important that activities undertaken by the Devon ICS partner organisations align to the high-level strategies of the NHS People Plan 2020/21, the NHS Long Term Plan, and the NHS Equality Objectives. These national level strategies should mutually reinforce the work in Devon. Importantly, the evidence and perspectives afforded through bodies such as the NHS Equality and Diversity Council and others can help ground the work of the partner organisations in best practice from across the UK. These materials can be further leveraged by the Devon ICS partner organisations when developing programmes and policies.

Devon's ICS can learn from other regions' system-level approaches to improve health and care outcomes for BAME communities.

Other ICSs engage BAME communities in the highest level of formal governance structures.

In the wake of COVID-19, NHS England and Improvement in the South East developed the Turning the Tide strategy to better respond to the health and wider inequalities experienced by BAME communities. The strategy includes the formation of a **BAME Disparity Advisory Panel,** comprising five working groups and with direct accountability to the system leadership. The working groups include addressing population disparity, addressing workforce disparity, corporate NHS England / NHS Improvement BAME workforce, communications and engagement, and implementation and dissemination. From 2021, the BAME Disparity Advisory Panel will evolve into a wider Health Inequality Advisory Panel and be co-chaired by a senior leader of the NHS England and Improvement in the South East leadership team (with the other co-chair to be a rotating member representing different inequalities).

Surrey Heartlands ICS have established a BAME and wider health inequalities Steering Group to embed the voice of BAME communities within system level governance structures. The group brings together numerous third sector organisations representing BAME communities with commissioning leads, provider leaders and Surrey County Council. This group feeds into the Health Inequalities Board which includes senior leaders from all the partner organisations.

Within the South Yorkshire and Bassetlaw ICS, BAME communities form the **Citizens' Panel** which provides an "independent view and critical friendship on matters relating to tackling inequalities"

Dedicated funds can encourage innovation in programmes and care approaches for BAME communities.

The West Yorkshire and Harrogate Health and Care Partnership have made £450,000 funds available through a **Health Inequalities Grant Fund** to tackle the impact on various communities affected by COVID-19. Seven of 13 groups focused on supporting BAME communities, through interventions such as diabetes prevention and continuity of care for maternity services. Providers and local community organisations identified needs within their localities and drew on resources from the system as needed.

Other health and care systems have publicly demonstrate their commitment and willingness to improve the health and care outcomes of its BAME communities

Through its Better Health and Wellbeing for Everyone five-year plan, the West Yorkshire and Harrogate Health and Care Partnership has also articulated a series of **Ten ambitions** for the system. Among these ambitions includes a commitment to increase the number of women who receive continuity of care for maternity services to 75% from BAME communities.

The Sandwell and Birmingham NHS Trust have also developed an **Inclusion and Diversity Pledge**, which contains specific commitments to BAME communities (i.e. develop an action plan in response to patient complaints)

3 Experiences of health and care in Devon for BAME communities and staff final report (004).pdf

Devon's ICS can also learn from other regions' system-level strategies to reduce inequalities within the BAME workforce

Devon ICS can publicly report on its progress to address BAME workforce inequalities, enabling shared ownership of issues across the system.

At its March 2020 meting, the West Yorkshire and Harrogate Health and Care partnership **committed to publishing data in relation to BAME staff**, including against the following indicators: percentage of BAME staff to all staff in each of the AFC Bands 1-9 or Local Authority Grade 4 and VSM; relative likelihood of staff being appointed from shortlisting across all posts; percentage of staff experiencing harassment, bullying or abuse from patients, relatives or public in the last 12 months, among other measures of equality.

The Sandwell and Birmingham NHS Trust have committed to an **Inclusion and Diversity Pledge** for its workforce, including a series of detailed actions to ensure a safe and inclusive working environment for BAME staff. This pledge includes conducting an annual review of access to training for BME staff, support BME staff network group to have a visible presence in the organisation, develop BAME panellists on interview panels, among others.

Devon ICS can create opportunities for all staff to learn about and take action on BAME inequalities in the workforce.

The **Race Equality Change Agents Programme** facilitated through the Greater Manchester Health and Social Care Partnership focuses on training staff who are wanting to make "small changes" within their organisation or scope of influence. Aimed specifically at staff who don't hold a formal equality and diversity position, this programme develops strategies around reducing bias within recruitment processes in local contexts through to identifying ways for BAME staff to bring their whole selves to work.

Devon ICS can develop targeted leadership and mentoring programmes to build the capacity and capability of BAME staff at senior levels.

West Yorkshire and Harrogate Health and Care partnership have introduced a **BAME Fellowship programme,** to increase the capacity of senior-level BAME leaders. Over 12 months, the programme builds practical leadership development skills and provides participants with system level exposure, and the opportunity to engage with the partnership Board. Participants undertake two placement rounds, working on a system-level project, followed by shadowing or taking on the full responsibilities of a senior position for six months. Participants are also engaged in skills modules on topics such as collaboration and political acumen.

The **BME Staff Reciprocal Mentorship Programme** within the Northern Care Alliance (comprising the Salford Royal NHS Foundation Trust and the Pennine Acute Hospitals NHS Trust) mobilises the expertise and skills of senior leaders at executive and board level to engage in reverse mentoring. Emerging BAME leaders have the opportunity to shadow and trial senior level positions, while the executive leads provide them with advice and guidance.

Devon ICS can implement a coordinated approach underpinned by common principles to reduce BAME workforce inequalities

Organisations and trusts across the North west London ICS came together to establish common principles, develop best practice approaches and training resources, and adopt a **unified approach to conducting risk assessments** so that they could better identify BAME staff who may be at-higher risk of contracting COVID-19.

3 Experiences of health and care in Devon for BAME communities and staff final report (004).pdf

Devon's approach to BAME inequalities in health and care

Devon's BAME population is spread across the region and made up of many different ethnic communities

At the time of the last census in 2011, Devon's overall population, including Plymouth UA and Torbay UA, was **1,133,742**[1], with **3%** of BAME ethnicity[2] - or 5% if people of 'White – Other' ethnicity are included. Across Devon, Plymouth and Torbay the density of BAME populations varies. As shown in Figure 7, in 2011 Exeter, Plymouth and Torbay had the highest BAME populations, ranging between 2.5-6.9%, compared with Torridge which has 1.3%.

However these proportions are likely to be higher now. Devon County Council estimates that BAME communities today make up 8-10% in some parts of the County.[3]

The largest BAME ethnicity groups are Mixed/multiple ethnic groups and Asian/Asian British. Figure 8 illustrates the different ethnic groups and their overall proportion within BAME communities across Devon. At a sub-county level there is variation in where particular BAME communities are located. For example the biggest portion of those with Asian/British background live in Exeter (56%) and mixed/multiple ethnic groups are the largest group in Torridge (52%), West Devon (49%) and South Hams (48%)[4]. Plymouth has the largest proportion of Black/African/Caribbean/Black British (17%) in the region. Stakeholders also identified a significant Polish community in many parts of the county – although quantifying this is complicated by the breadth of the 'White – Other' category in Census data.

Figure 7. BAME population demographics by local authority in Devon, 2011 Census[5]

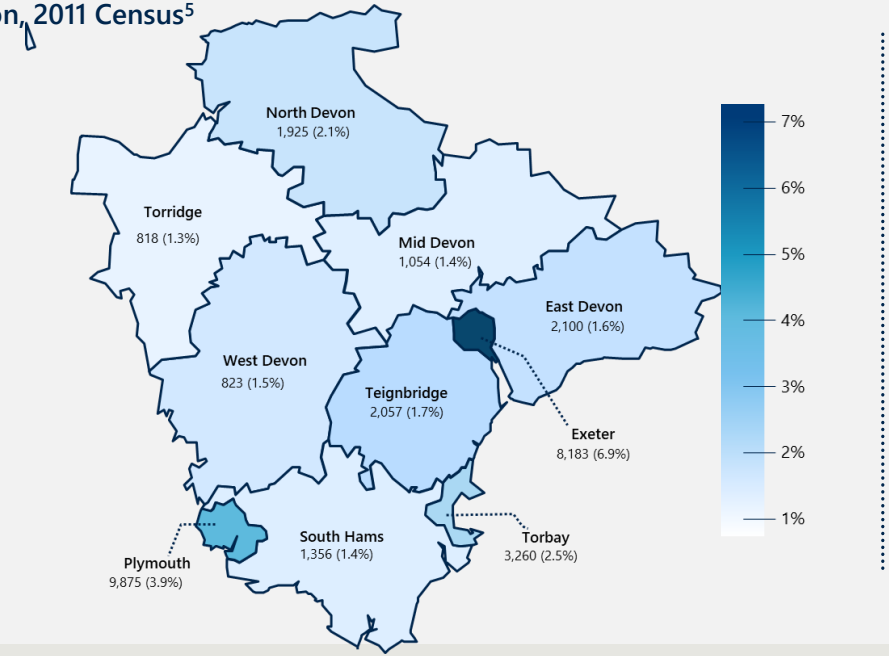
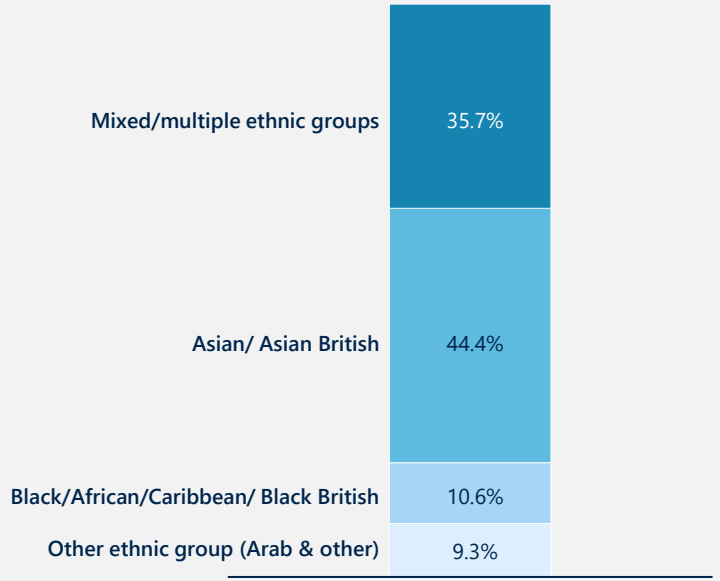


Figure 8. BAME Ethnic minority groups in Devon, 2011 Census[6]



1. 2011 Census: Key statistics for local authorities in England and Wales, 11 December 2012, Table KS201EW, refer to KS201EW_Numbers
3. Devon County Council, Race – ethnicity, national origins, race or colour, accessed 21 October 2020
4-6. 2011 Census: Key statistics for local authorities in England and Wales, 11 December 2012, Table KS201EW, refer to KS201EW_Numbers

There are existing system-level structures to tackle health inequalities

The ICS has a number of system level governance arrangements in place to address inequalities in health and social care and to respond to national level frameworks such as the Equality Delivery System (EDS2) and the Workforce Race Equality System (WRES). The following table the key components of governance across the ICS.

SYSTEM LEVEL GOVERNANCE	DETAILS
ICS PARTNERSHIP BOARD	Addressing health inequalities is one of the five overall priorities for the ICS[1] and under proposed future governance arrangements, the Partnership Board and Locality Care Partnerships (LCPs) will share responsibility for reducing health inequalities.[2]
HEALTH INEQUALITIES EXECUTIVE LEADERSHIP GROUP & HEALTH INEQUALITIES WORKPLAN	The Health Inequalities Executive Leadership Group was established to co-ordinate the system's response to the NHS 8 urgent actions to address inequalities, which were set out in NHS England's Phase 3 recovery response to Covid-19, in July 2020 (see page 23 for further detail). The urgent actions include accelerating preventive programmes, strengthening leadership and accountability and improving data.[3] The Health Inequalities Executive Leadership group put together a workplan which sets out how the Together for Devon partner organisations can respond to the urgent actions.
NHS DEVON CCG	The CCG has a system-wide role in addressing inequalities. CCG staff provide support to the Health Inequalities Executive Leadership group and are involved in the development and monitoring of the Health Inequalities workplan. The CCG also engage directly with BAME communities for consultations and some health campaigns (i.e. Covid-19 vaccination drive for BAME communities).[4]
NHS DEVON CCG REMUNERATION AND WORKFORCE COMMITTEE	The committee has delegated authority from the CCG Governing body on EDI matters and seeks assurance from EDI lead through two annual reports. The committee also has oversight of the Quality and Equality Impact Assessment (QEIA).[5] The tool is used to examine the extent to which a policy or strategy may impact any particular groups, and where necessary, recommends mitigation measures to ensure access to services and opportunities is maintained.
DEVON-WIDE EQUALITY CO-OPERATIVE	The group has representation from all partnership organisations and acts as a mechanism to undertake EDI work between them. The group is amongst other things, responsible for ensuring all members are compliant with statutory obligations relating to EDI including the WRES, EDS reporting and grading, sharing knowledge and good practice and developing shared resources for training[6]
DEVON-WIDE BAME STAFF NETWORK	The network is open for BAME staff to share experiences in the workplace in a safe space and helps shape the inclusion agenda across Devon health and care services.8 It was founded in mid 2020 by the Equality Co-operative and is convened by a Chair.[7]

1 https://www.togetherfordevon.uk/priorities/
2 NHS Devon CCG Governing Body papers, 24 September 2020
3 NHS England and NHS Improvement, Urgent actions for the NHS response to Covid-19 Phase 3
4 NHS Devon CCG,NHS is Devon working with local Black, Asian and Minority Ethnic communities to increase vaccine up-take
5 NHS Devon CCG, Quality and Equality Impact Assessments (QEIA)
6 Equality Co-operative Terms of Reference
7 Devon BAME staff network Terms of reference

System-level arrangements currently have limited impact

National level equality exercises are not fully effective in Devon

National level EDI equality exercises appear to not be fully effective in Devon. For example in relation to EDS2, the EDI inclusion report in March 2020 found that 4 out of 9 NHS Trusts were not compliant, and none had an action plan.[1] Stakeholders and staff involved in these exercises did not have a positive view of EDS2, referring to the process as bureaucratic and burdensome. The intensive community engagement envisaged under EDS2 does not consistently take place.

There is insufficient accountability for EDI across the system

While a range of mechanisms are in place for pursuing EDI and BAME-specific objectives, the lack of clear accountability for these appears to inhibit substantial change and improvement. For example, the Devon-wide Equalities Co-operative does not currently have a clear line of accountability to senior decision-makers, and does not have the authority to direct resources. As a result, while stakeholders recognise the value of sharing good practice, many feel the Co-operative lacks the mechanisms to deliver the work required to tackle BAME inequalities across the system. Members were unclear where the committee was reporting to and who was being held to account for what was discussed.

Public accountability is restricted by lack of public reporting of performance and outcomes. For example, there is substantial inconsistency in what information is published on partner's websites in relation to EDS2 and WRES performance.

The new Health Inequalities Executive Leadership group, explored on the previous slide, does seek to hold senior partner organisation leaders to account through the Health Inequalities workplan. However, the Health Inequalities Executive Leadership Group is still relatively new and is not fully established across the system as the main driver for tackling BAME inequalities.

The Devon wide BAME staff network is under-resourced

The Chair of the Devon-wide BAME staff network has minimal resource to carry out the role. The Chair's current duties include convening network meetings, maintaining a network database, liaising with various partner organisations, engaging with the Equalities Co-operative and engaging with BAME staff networks nationally. The Chair is not allocated additional time to carry out these duties on top of their existing NHS role. Concerns were raised about attendance which was starting to decline, despite a strong start in 2020.

STAKEHOLDER QUOTES

> *"There are a lot of tick box exercises but [tackling equality] is not really a priority at all"*

> *"The co-operative is not being held to account by anybody…it doesn't sit anywhere"*

> *"We need to establish data sharing agreements…some organisations are happy to share [their data], others don't"*

> *"Leaders say the right thing in the right places…but they don't follow up"*

3 Experiences of health and care in Devon for BAME communities and staff final report (004).pdf

1 Devon CCG EDI Report 2019/20

The Health Inequalities workplan has emerged as a potential system-wide driver for tackling BAME inequalities

The Health Inequalities workplan emerged from the CCG's response to Covid-19 Phase 3 recovery

In July 2020, NHS England set out the Phase 3 recovery response to Covid-19, setting out what ICSs, CCGs and NHS Trusts should do to respond to that stage of the pandemic. This was followed up by an implementation document in August which included 8 urgent actions that health systems and organisations should take to address health inequalities (listed on the right). In response to this, Together for Devon established the Health Inequalities Executive Leadership Group, and set out the actions and tasks required for the system to respond to the 8 urgent actions in the Health Inequalities workplan. Members of the Leadership Group are nominated executive leads for health inequalities within the partner organisations and the group is chaired by the independent chair of Together for Devon (although this is being reviewed). The workplan currently only applies to the NHS Trusts within the ICS.

There are actions related to improving tackling BAME inequalities within the existing plan

The 8 urgent actions refer to health inequalities in general, but the existing health inequalities workplan contains key tasks which relate to tackling BAME inequalities specifically. These tasks set out Devon's health inequalities workplan include accelerating preventative programmes for BAME communities, reviewing the progress of WRES action plans and workforce analysis, establishing a system-wide equality data collection protocol and engaging with BAME communities to better understand attitudes to sharing data on ethnicity. CCG staff work with partner organisations to monitor progress and agree on a RAG rating for each provider against different elements of the plan. However, there is room for improvement to make the existing workplan more effective in tackling BAME inequalities. Currently, the timeframes don't give a clear indication of when actions will be completed, and the plan doesn't capture the scale of the change and resource required to meet its objectives.

There are aspirations for the workplan to drive further action to tackle BAME inequalities at a system level

Currently the plan is focused on the CCG's response to the 8 urgent actions but there are aspirations for the workplan and the Leadership Group to coordinate the system-wide response to health inequalities in the longer term. It is expected that the broader evolution of the ICS structure will shape the governance and accountabilities for the group, and plans are underway to begin formal reporting to the ICS Partnership Board. The expectation is that all partner organisations will eventually be included within the workplan.

NHS 8 urgent actions to address inequalities

1. Protect the most vulnerable from COVID-19
2. Restore NHS services inclusively
3. Develop digitally enabled care pathways in ways which increase inclusion
4. Accelerate preventative programmes which proactively engage those at risk of poor health outcomes
5. Particularly support those who suffer mental ill-health
6. Strengthen leadership and accountability
7. Ensure datasets are complete and timely
8. Collaborate locally in planning and delivering action

3 Experiences of health and care in Devon for BAME communities and staff final report (004).pdf

Lack of data, resources and priorities means organisations have a limited understanding of the experiences of their BAME communities

Most of the organisations that were consulted were unable to talk confidently about their BAME communities, including their level of access, experience and outcomes, and how services respond to their needs.

There was acknowledgement that this gap in their organisation's knowledge exists and needs to be addressed. Many organisations identified a lack of resources and competing priorities as reasons why there is limited intelligence of BAME communities' experience in their regions. For example, one individual noted that even though they engage with some BAME communities, others exist about whom they have little to no knowledge. A lack of resources makes it difficult to find the time to find and build these relationships.

There is also a lack of capability within partner organisations to engage with BAME communities. Individuals working for partner organisations felt that they did not have the skills or knowledge to engage effectively with BAME communities – how to work with with community members, through techniques such as consultation, engagement and survey. This was significantly affecting their ability to collect the relevant data to understand BAME communities' experience.

There is some administrative data that provides some high-level insight into BAME inequalities. For example, the 2018 NHS North, East, and West Devon CCG Equality and Health Inequalities Report highlighted that hospitalisation rates were far higher for BAME communities in the region compared to the rest of England. The CCG reported a rate of 23 per 1,000 population compared to 15.9 for the rest of the country.

STAKHOLDER QUOTES

> *"As a whole, we don't know as much as we should know"*

> *"A lot of BAME communities don't come to us with issues"*

> *"I'm not sure we have gathered evidence or feedback from our communities"*

> *"Really disappointed we aren't making inroads with our community; we need to work as a system to understand our populations"*

3 *Experiences of health and care in Devon for BAME communities and staff final report (004).pdf*

BAME communities, patients and service users

BAME communities, patients and service users highlight a number of challenges with health and care services

We engaged BAME community members through community organisations. Some had had very positive experiences with health and care. However, a number of challenges emerged. Three themes are highlighted below and are expanded in more detail on the following slides.

KEY THEMES

INTERPRETATION AND TRANSLATION

Inadequate interpretation and translation support is a major barrier for BAME communities accessing health services. BAME communities experience challenges when booking appointments, accessing interpretation services during care and whilst receiving treatment. BAME communities experienced further challenges understanding changing public health guidance during Covid-19.

CULTURAL COMPETENCE

BAME communities experience a lack of cultural competence when engaging with health services. Some individuals feel that their health concerns are not taken seriously and experience cultural insensitivities during the provision of care. The fear of a lack of understanding from services is also a challenge for BAME communities, presenting an additional barrier to BAME communities' access to health and care services.

MENTAL HEALTH AND ISOLATION

Mental health and isolation were challenges for BAME communities, exacerbated by Covid-19. Some members of BAME communities are more vulnerable to being isolated in some cases as a result of language barriers and small ethnic communities: both present risk factors for mental health. The pandemic has also created barriers in accessing support services and primary care for BAME communities.

ENGAGING WITH COMMUNITY ORGANISATIONS

Nous engaged with both Hikmat and the Plymouth and Devon Race Equality Council to set up consultations with BAME communities. Through them we were able to engage with individuals from a wide range of BAME communities, including East Asian, South Asian and African communities, as well as refugees and asylum seekers.

Community organisations themselves had faced challenges engaging with health and care services, and were initially sceptical about the effectiveness of Nous' engagement. They cited previous consultation processes which had resulted in little action, and offers for support rebuffed. One community organisation member relayed that they had offered GP services free training on refugees and asylum seekers but that this was turned down.

Inadequate interpretation and translation support are a major access barrier

Many of the BAME community members we consulted do not have English as a first language and identified several challenges with current interpretation and translation services.

Booking appointments

BAME communities who don't have English as their first language face issues with interpretation when booking appointments. During Covid-19, when more bookings and consultations are online or over the phone, individuals who do not have English as a first language struggle. This is a particular challenge for individuals who have just arrived in the country and require medical support, including refugees and asylum seekers. In some cases appointments were missed as bookings and confirmations were misunderstood without an interpreter present. In other cases, there are challenges co-ordinating an interpreter on the call in order to book an appointment.

Accessing interpretation services during care and whilst receiving treatment

People face challenges relating to availability and quality of interpreters. In some cases, the interpreter is able to speak the right language, but doesn't have the right dialect for the individual who requires the service. In one case, a child was asked to interpret for a parent. This goes against established good practice, demonstrating a lack of basic understanding among some healthcare professionals.

Bilingual individuals from BAME communities are called upon to translate for other members of their community. This can create an uncomfortable dynamic for the person requiring interpretation support; they may not feel comfortable disclosing personal health issues to someone whom they know from their local community.

Understanding changing public health guidance during Covid-19

Some individuals from BAME communities struggle to understand the public health guidance relating to Covid-19, because it is rarely translated into their own languages. When the guidance is translated, it still requires individuals to be able to read in their first language, creating an additional barrier. Much of the information is distributed online, which means that individuals are not always informed on guidance on shielding and social distancing. Some individuals from BAME communities are not following the latest guidance and advice as they are not aware of recent changes.

QUOTES

> *Booking appointments is a constant battle*

> *When you have a pregnant women in labour on the phone [with an interpreter] it just doesn't work*

> *In the hospital, nurses never give them language line, they just call me*

> *Our language line is rubbish; you never get the proper dialect*

BAME communities perceive a lack of cultural competence among providers

Health concerns are not taken seriously by health professionals

The health concerns of people from BAME communities are not taken seriously by health professionals. BAME communities attribute these experiences to a lack of understanding about their cultural background. In three separate cases, consultees who were also healthcare professionals themselves, had had their or their family members' health concerns minimised; only after they persisted did healthcare professionals realise that the condition of the individual was much more serious that initially assessed. In each of those cases consultees felt that their concerns were not taken seriously because of their cultural background.

Cultural insensitivities during the provision of care

People from BAME communities encounter incidents where they are treated in a culturally insensitive way. Examples include having religious dietary requirements overridden by diets instructed by doctors, and being treated unkindly by front-desk staff. In the latter example, staff are known to speak deliberately loudly and slowly which many people from BAME communities find patronising. Individual negative incidents can risk whole BAME communities forming negative perceptions; in Torbay, it was anecdotally noted that Turkish communities may not be attending GPs due to one negative experience of an influential individual in the community.

Little understanding of gender preferences

Some service users from BAME communities feel more comfortable speaking to and being treated by a person from the same gender for particular health issues. While this is not necessarily appropriate or desirable, the perceived impact of this issue on the responsiveness and adequacy of care demonstrates that this potential sensitivity isn't acknowledged or communicated effectively.

Fear of a lack of understanding from health services

Individuals from BAME communities are discouraged from engaging with health and care services because they fear that they will be misunderstood. Research from Hikmat highlights that some GPs are known for being more culturally aware than others, and BAME service users struggle when they are not able to see their preferred GP.

QUOTES

> *They [doctors] are dealing with you as if you are stupid and they can feel your pain better than you*

> *If they had listened to me, this [condition worsening] would have been avoidable*

> *Given my culture, I would have preferred a male member of staff*

BAME communities have challenges with mental health and isolation, exacerbated by Covid-19

Women and the elderly were highlighted as particular groups who were isolated and had mental health challenges

BAME communities face isolation and loneliness, a particular concern for elderly members of the community and women from some ethnic and religious backgrounds. In parts of Devon, some individuals from BAME communities are close to only a few people from their own ethnic community, limiting individuals' social circles and increasing the likelihood of isolation, particularly for those with low levels of English. In addition, isolation is a particular challenge for women from some communities, especially when the woman is out of work and/or has childcare responsibilities. Individuals in these situations have limited opportunities to socialise and in some cases do not leave their house for days on end.

These experiences are problematic as being isolated with limited social interaction is a risk factor for mental health problems. Many of the levers to address social isolation sit outside of health services. This highlights the need for integrated health and wellbeing approaches across service providers and systems to take preventative action to address mental health challenges within BAME communities.

Covid-19 has created barriers in accessing support services and primary care for BAME communities

Covid-19 has exacerbated existing issues as access to support services has become more challenging. Processes and procedures have changed due to the pandemic and the move away from face-to-face support has made accessing support services challenging for BAME communities. Inability to use and/or lack of access to technology, particularly for elderly BAME community members has created additional barriers for service users.

Accessing GP surgeries during COVID-19 is also a particular challenge. Where previously some BAME service users would have been accompanied by an enabler or interpreter, they now have to articulate their symptoms themselves, often over the phone. Some individuals have given up trying to access the services, seeing their conditions deteriorate as a result.

QUOTES

> *We don't live in a big city so the BAME community is very isolated*

> *People are isolated with few friends or family to communicate or go out with; especially for older people*

> *Some people get into depression and haven't been outside for weeks*

Consultees identified opportunities for improving the experience of BAME communities across health and care

The consultations and feedback from community organisations highlighted that there is more that health and care providers can do to best serve BAME communities. Consultees highlighted key opportunities for improvement.

IMPROVEMENT OPPORTUNITIES IDENTIFIED

INCREASING COMMUNITY OUTREACH

Consultees are keen for services to do more to reach out to their communities. They were unclear if there were existing ways to engage with local services, i.e. through community groups. Outreach and engagements should happen in a culturally sensitive way (e.g. In some BAME communities, women might feel more comfortable opening up about their experiences in a women only group).

IMPROVING INTERPRETATION AND TRANSLATION SERVICES

Consultees stress the importance of improving interpretation and translation services. Interpretation services should be easily accessible, interpreters should be from outside their local community (to protect confidentiality), while also speaking the appropriate dialect.

INCREASING THE CULTURAL COMPETENCE OF STAFF

Consultees identified increasing the cultural competency of staff as a key priority. This is necessary so that practitioners can better understand the experiences of BAME communities accessing services. They suggest doing this in a number of ways, including through training. Some community organisations suggest that they are well placed to support health and care services with this.

INCREASING THE DIVERSITY OF STAFF

Increasing the diversity of staff across health and care services was highlighted as an important area for further improvement. This would give BAME service users more confidence accessing these services and will increase the organisation's understanding of the needs of BAME communities.

QUOTES

> *Most importantly: work closely with BAME groups, regular diversity training and better communication*

> *We need to listen to health practitioners about what issues they don't understand – a two-way dialogue. We need more sharing*

> *There needs to be population health outreach activity, as a way to build communication and trust*

Examples of good practice from other regions/sectors on improving experience for BAME communities

CASE STUDY: SHAPE UP FOR ARABIC WOMEN IN BRIGHTON AND HOVE

This health improvement programme provides nutritional advice and exercise to aid weight loss. This programme was tailored to be more accessible and provided opportunities for this group to have access to information they may not have been able to get elsewhere in the community.

CASE STUDY: SIKH ELDERS SERVICE SUPPORTING FRAIL AND ELDERLY

A dedicated Punjabi speaking team support Sikh Elders to live independently. Through group and social activities, individual home visits and telephone contact, and "volunteer friends," this service aims to reduce loneliness and isolation among this community.

Relevance for Devon ICS

These programmes underscore the importance of developing tailored approaches for engaging distinct ethnic groups, and that responds to the unique challenges faced by those communities.

CASE STUDY: ROMBELONG PROGRAMME

Kings College London have developed the RomBelong programme to support Gypsy, Roma and Traveller students to succeed at university. Through scholarships, mentoring and structured activities, RomBelong works with a range of organisations to support students as they leave school through to graduation

Relevance for Devon ICS

Supporting BAME communities involves a whole-of-community approach, comprising multiple organisations, individuals and resources.

CASE STUDY: DIABETES AWARENESS AND PREVENTION IN SLOUGH

NHS East Berkshire CCG recruited six community champions to increase the awareness, prevention and self-management of diabetes; all champions are from BAME backgrounds. 8.9% of people living in Slough have diabetes and a large proportion of those are from BAME backgrounds. Some BAME. Certain BAME communities, such as South Asian, and African and Caribbean communities are more likely to develop Type 2 diabetes than White British populations. The Champions were recruited to better connect with BAME communities through organising local events, delivering presentations and talks.

CASE STUDY: DORSET BME AMBASSADORS

Dorset CCG worked with the Dorset Race Equality Council to set up a Health Ambassadors Network for BAME communities. The BME ambassadors network is comprised of community leaders who are consulted on service changes and developments and provide feedback from their respective communities to health providers.

Relevance for Devon ICS

This approach highlights the value of actively involving members of BAME communities in outreach work as champions or ambassadors to better engage with BAME communities to address health inequalities.

BAME staff

BAME staff face challenges at different stages of the staff journey

Nous engaged with BAME staff primarily through BAME staff networks. BAME staff have challenges which are summarised with the 2 main themes highlighted below. These themes are expanded in more detail on the following slides alongside the relevant data from the Workforce Race Equality Standard (WRES) reports.

KEY THEMES

RECRUITMENT, REPRESENTATION AND PROGRESSION	BAME staff have concerns relating to recruitment, representation and progression within their organisations. There is a lack of ethnic diversity within their organisations, and BAME staff are particularly underrepresented at senior levels.
STAFF EXPERIENCE	BAME staff have challenging experiences working in health and care in Devon. Incidents of overt racism are rare, but when they occur they are not dealt with effectively by their organisations. BAME staff experience microaggressions and cultural insensitivity on a regular basis. There are some examples of positive experiences from working with an inclusive team, but BAME staff feel that Equality and Diversity is not a priority for their organisations. Many BAME staff value their BAME staff networks, but have concerns about their sustainability.

ENGAGING WITH BAME STAFF NETWORKS

Nous engaged with BAME staff primarily through existing BAME staff networks in partner organisations. Many of these networks are relatively new, launched in response to increased focus on the BAME staff experience following the Black Lives Matter protests and the COVID-19 pandemic.

In some instances, staff felt reluctant to engage in the consultation process. Some BAME staff were sceptical about whether this exercise would lead to real change within their organisations.

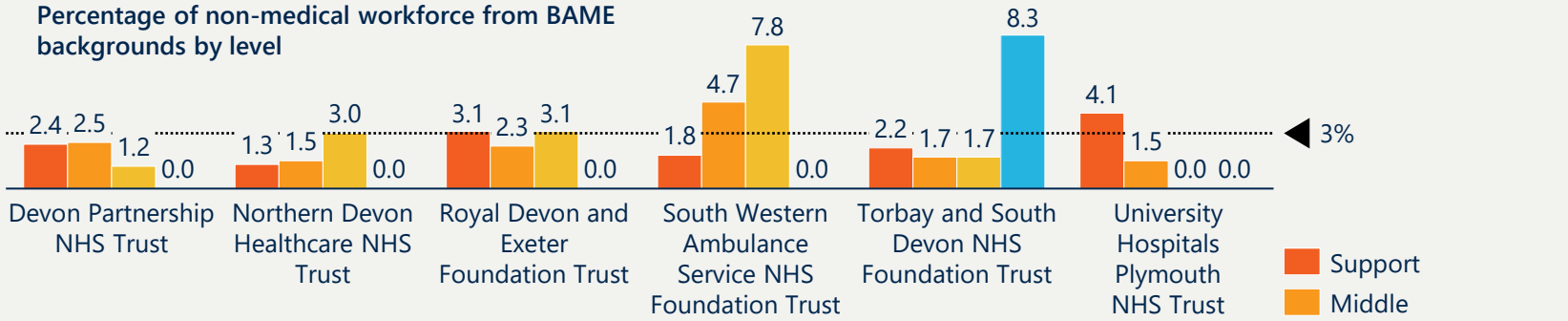
Representation of BAME staff varies between organisations, role type and level

BAME representation varies across roles within partner organisations. BAME staff noted that cohorts of doctors are reasonably diverse, but nurses and administrative staff are notably less so. This is attributed in part to the fact that the latter were more likely to be recruited locally. BAME staff also perceived a lack of diversity at more senior levels of their organisations, attributing to this many of the challenges BAME staff face more broadly

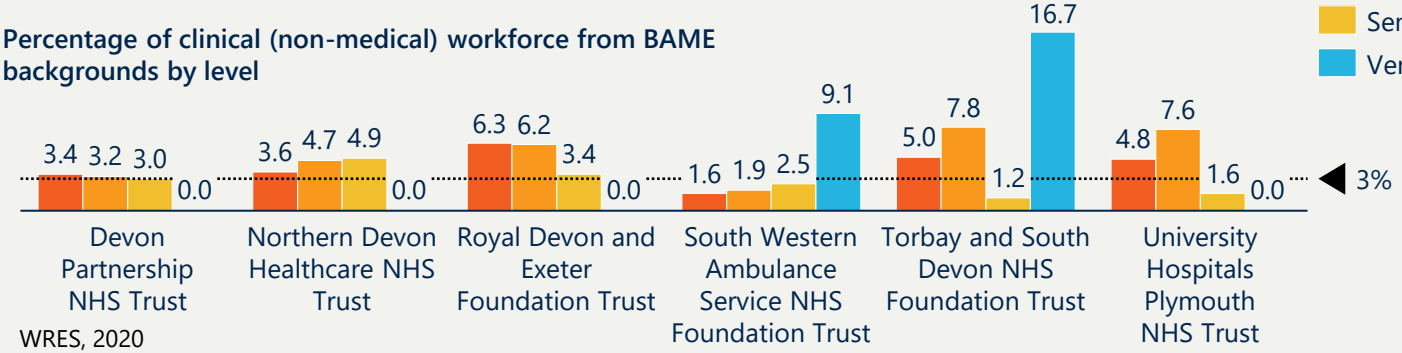
The charts below show the percentage of BAME staff at different levels of the workforce across Devon's NHS Trusts; the first chart shows the non-medical workforce and the second chart shows the clinical (non-medical) workforce.

- BAME staff are underrepresented in many categories relative to the Devon BAME population of 3% at the time of the 2011 Census (and likely now higher). This contrasts with the NHS nationally, where BAME staff are typically overrepresented.
- There is some variation in BAME representation at different levels. At some Trusts, BAME representation declines at higher levels; but at others it increase or remains stable.

Percentage of non-medical workforce from BAME backgrounds by level



Percentage of clinical (non-medical) workforce from BAME backgrounds by level



WRES, 2020

QUOTES

"We're not represented at all"

"If you look at the pictures on the senior corridor, there isn't a lot of diversity there"

"It's a very white local team – most of them are British"

"There's big diversity in medicine but hardly any on the admin side- nursing and admin staff are recruited locally"

BAME representation is also limited at Board level. Across all six Trusts combined, people identifying as from BAME backgrounds people make up just 2% of Board members. This compares unfavourably with Devon's 2011 BAME population of 3%, likely now higher, and is broadly consistent with Board underrepresentation at the national level. However, caution needs to be given in considering proportions at individual Board level, given the small numbers involved and people reporting as of 'other' ethnicity.

BAME staff perceive limited progression opportunities

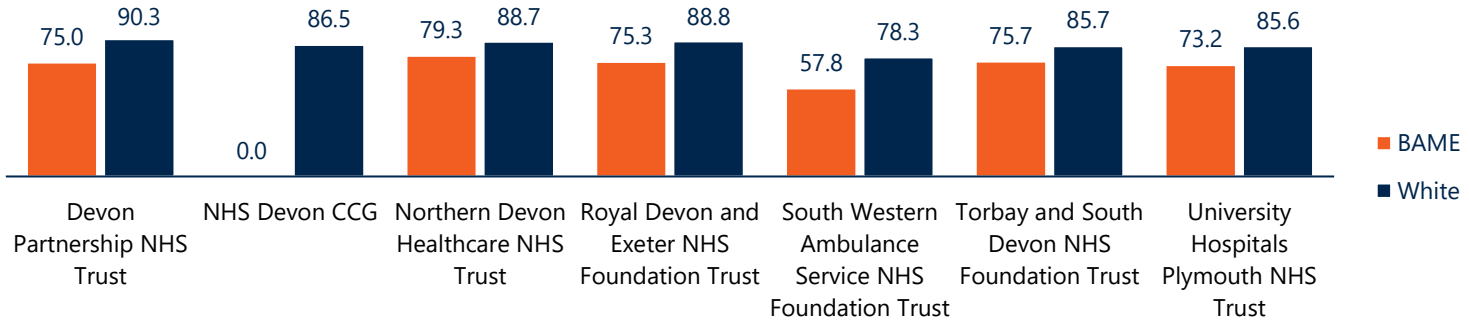
BAME staff feel that they have fewer opportunities to progress compared to their white counterparts. They are regularly overlooked for promotions, and observe that white staff with less experience are being "tapped on the shoulder" and promoted ahead of them.

A good manager is seen as critical to progression, but BAME staff often do not have managers who support their career progression. Access to mentoring opportunities is a challenge; one member of staff was unable to get onto a national training programme because mentoring opportunities weren't available in the organisation.

When BAME staff are promoted, they were not effectively supported in their new roles. During one consultee's brief time in a senior role, more junior staff were disrespectful and they were not supported to deal with it. The consultee ended up stepping down from the role. Another consultee referenced another senior BAME member of staff who left after a short period of time because they had been bullied out of the role. Some consultees highlighted their experience with the NHS Stepping Up programme (for BAME leadership development), but found the experience uncomfortable because facilitators could be culturally insensitive during the sessions. For other BAME staff opportunities for development are available, but the high workload prevents them from being able to take advantage of them.

In most Trusts, BAME staff are less likely to believe there are equal opportunities for progression and promotion

Percentage of staff believing that trust provides equal opportunities for career progression or promotion.



3 *Experiences of health and care in Devon for BAME communities and staff final report (004).pdf*
NHS Staff Survey, 2020

QUOTES

"I always had to "prove, prove, prove" myself"

"I'm demoralised; I have 30 years of experience but I'm not on a top band"

"To progress, you need a mentor and encouragement- I've had neither"

"Unless your face fits you won't progress that far"

Instances of overt racism, though rare, are traumatic for BAME staff and often not handled well by their employer

On the whole, overt racism is not a day-to-day occurrence for BAME staff, but many have experienced it throughout their career and feel that these incidents are poorly handled. Examples include overtly insensitive comments from managers and colleagues, patients refusing to be treated by them, and in one case a member of staff being ostracised by the team for calling out racism. Some staff feel confident to raise issues of racism and report it, but others do not feel able to and are unsure where to go. BAME staff face challenges with the process of raising complaints about racism. They have concerns that grievances relating to racism would likely be put to a panel of white managers who would not know how to handle the situation.

In instances where patients had been the instigators of racial abuse, some BAME staff said that other staff had taken the side of the patient, or tried to make excuses for the patient's behaviour. In one case, a member of staff who was racially abused by a patient was told to "calm down" and the patient's background and age was used to explain their behaviour. In another, the member of staff was explicitly told not to make a complaint about a service user who had racially abused them. The person was later prosecuted for the incident. In a different incident, a consultee received racist abuse from a patient; the patient was asked to apologise but no further action as taken.

QUOTES FROM STAFF

> "For the first time in my life I feel as though I don't fit into England, even though I was born here."

> "When I was racially abused by a patient, I raised it immediately. But I have colleagues who just go to the corner and start crying. You need to speak up."

> "I've had a few patients who've said they don't want me looking after them."

> "I was told that "you're just a white person who tans a lot" by my manager."

> "Managers will take the patients' side [after facing racism from patients] and say 'it was your tone of voice'."

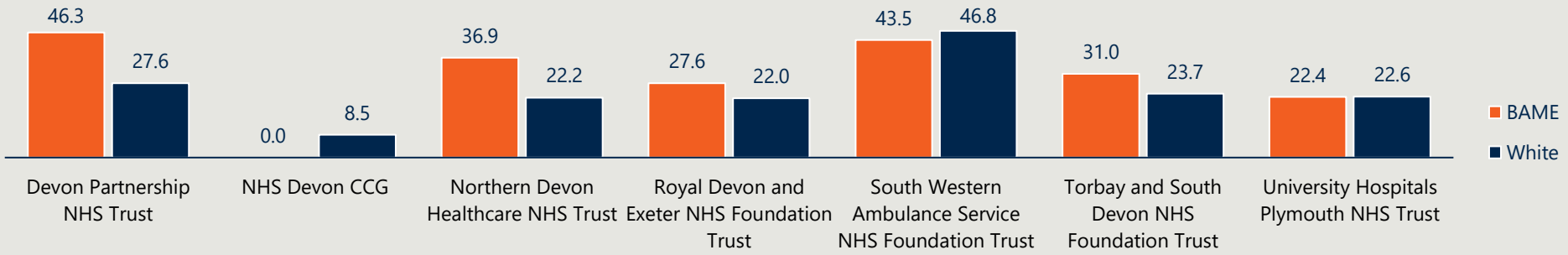
> "I was the butt end of the joke."

BAME staff at some of Devon's NHS organisations experience greater harassment, bullying and abuse

Consultations highlighted that there have been documented incidences of racism against BAME communities. The data suggests that this continues to play out within health contexts, with BAME staff experiencing harassment from patients, the public and other staff.

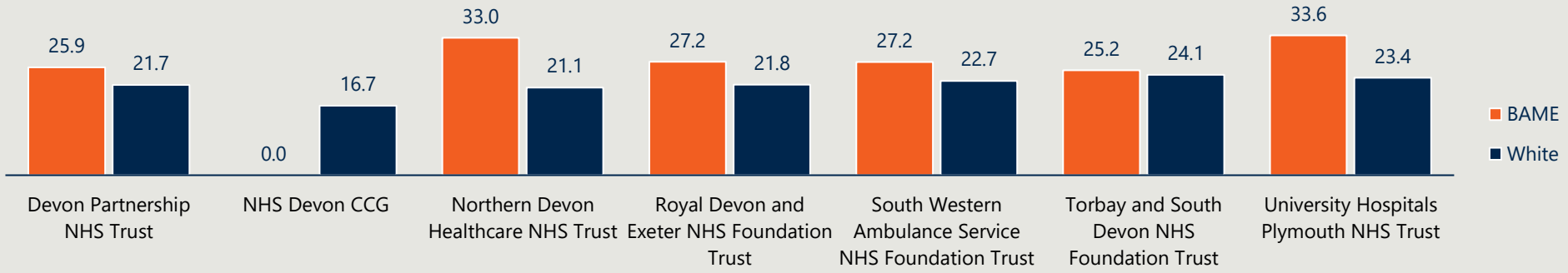
BAME staff report greater experiences of harassment, bullying and abuse from patients, relatives and the public in some Trusts

Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months.



BAME staff report greater experiences of harassment, bullying and abuse from other staff in most Trusts

Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.



NHS Staff Survey, 2020

Many BAME staff experience discrimination, microaggressions and cultural insensitivity on a regular basis

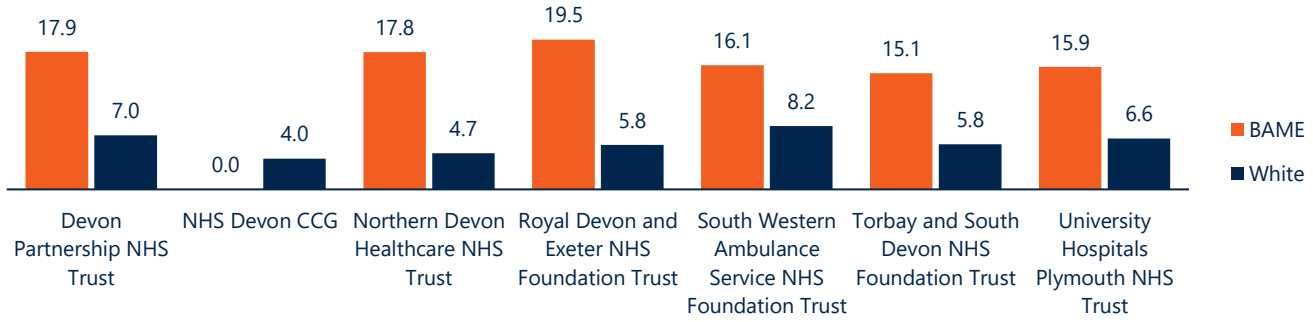
BAME staff experience microaggressions[1] and more subtle forms of racism of various forms on a regular basis whilst at work. Examples include being treated with suspicion, particularly when new to their organisations. Their abilities and credentials are often subtly questioned and they are often made to feel as though they don't belong in the organisation. Some consultees heard their colleagues making culturally insensitive jokes.

In some cases, BAME staff feel treated differently to White colleagues. In one instance, a staff member was not given permission to pick up her children from school when childcare arrangements fell through, but a white staff member whose dog was ill was given time off. In another case, a BAME staff member had their leave cancelled by their manager, but this never happened to their white colleagues. Some women consultees highlighted the intersectional nature of the discrimination, saying their gender compounded the subtle racial discrimination. A few consultees felt that they would be identified as 'trouble makers' if they raised their concerns. Many BAME staff feel as though they can't bring their whole self to work as a result of this discrimination. In one case, a BAME staff member left their organisation because of this.

WRES data illustrates these sentiments, with substantial proportions of BAME staff experiencing discrimination from managers or colleagues (below).

BAME staff experience discrimination at higher levels than white staff

In the last 12 months have you personally experienced discrimination at work from any of the following? – Manager / team leader or other colleagues.



NHS Staff Survey, 2020

[1] A microaggression a subtle but offensive comment or action directed at a member of a marginalised group, especially a racial minority, that is often unintentionally offensive or unconsciously reinforces a stereotype.

QUOTES

"They target you- gaslighting- I almost had a mental depression because of this."

"When I speak they say "oh you're aggressive- you should be gentle". We use our hands when we speak, that is our culture."

"There are a lot of tick boxes. [Equality and Diversity] is not really a priority at all."

"They had let a [white] social worker go home to look after her sick dog, but I wasn't allowed to go and pick up my own children."

"I have mature people on my team who are very [culturally] sensitive. Our manager was very good at embracing different cultures."

Many BAME staff have positive experiences with inclusive teams, but don't feel that equality and diversity is a priority at their organisation

Where BAME staff have positive experiences, they usually relate to their immediate team, which they find supportive. Some staff feel very welcomed by their team and that the team goes out of their way to make them feel included. In one case, a BAME staff member who was new to the UK found their team very supportive, particularly when there were challenges back in their home country. The team was respectfully curious about the situation and sought to support them as best they could.

Despite those positive experiences, many BAME staff feel that equality and diversity is not a priority for their organisation as a whole. While encouraging statements and commitments to equality and diversity have been made, they are seen by BAME staff as "tick box exercises" with little substance behind them. Covid-19 and Black Lives Matter have raised awareness about the experiences of the BAME workforce and some BAME staff have noticed changes as a result. Conversations about race and ethnicity have surface through the Covid-19 risk assessment process, which was formed in response to the health inequalities highlighted by the pandemic. However, improving BAME staff experiences is still not seen as an organisational priority.

QUOTES FROM STAFF

> "I have mature people on my team who are very [culturally] sensitive. Our manager was very good at embracing different cultures"

> "There are a lot of tick boxes. [Equality and Diversity] is not really a priority at all"

> "You see the posters and the policies; are they doing it? No."

> "I don't feel other colleagues treat me differently; this is something positive"

> "They [senior management] say all the right things in the right places- but they don't follow it up; they don't meet the basics"

> "A senior management was pushed out due to her eagerness to make sure that those from different backgrounds were given opportunities"

BAME staff networks have been partly effective, but are at risk due to a lack of resources

Many partnership organisations have recently established their own BAME staff networks. Where they exist, these networks are at different levels of maturity. Networks which are most mature (i.e. Plymouth NHS Trust and Devon Partnership NHS Trust) have network Chairs who have regular catch-ups with senior managers on behalf of their networks to relay BAME staff experiences. This is in addition to the Devon-wide BAME staff network which all BAME staff in health and care across Devon are invited to join.

BAME staff networks are a safe space for BAME staff to share their experiences and to support each other. For many, these forums present a new opportunity to connect with other BAME staff who are facing similar challenges and provides them with a source of support. In some partner organisations, the BAME network also has a sponsor at an Executive level, meeting regularly with the Chairs in order to take the concerns raised by the networks to more senior levels.

However, the networks face a number of challenges which have led, in some cases, to attendance waning. Few networks have been given additional support, which has put the Chairs of the networks under pressure. Many Chairs convene the groups on top of their day-to-day jobs, with their managers giving them little to no time to carry out their extra duties. Whilst some have had promising conversations with senior leaders, others say that there is little follow through from the commitments made to change. Some BAME staff fed back to the Chairs that fatigue of sharing their stories and failure to see progress is driving this drop in attendance.

QUOTES FROM STAFF

> "This forum has been a lifeline for me personally; it has enabled us to speak out"

> "As a forum we have made some strides recently; she [the Chair] has to take a lot of credit"

> "People are starting to drop off because they aren't seeing progress"

> "There are so few people who are coming to our BAME network- we are struggling to get through to them"

There is existing work underway and growing momentum to improve the experiences for BAME staff

Black Lives Matter and Covid-19 are leading to greater focus on supporting BAME staff

Partner organisations highlighted that the Covid-19 pandemic and Black Lives Matter movement have increased their organisations' focus on the issues facing BAME staff. As national level data highlighted the increased risk of death from Covid-19, many organisations have begun to have more conversations with BAME staff, in some cases through the process of Covid-19 risk assessments.

Growing visibility of significant cultural events and traditions

Some individual organisations are acknowledging and celebrating various culturally significant events. One trust has a consolidated calendar of major cultural events, which informs their internal communication and social activities. Creating space for these activities makes staff members feel welcomed.

Emerging examples of co-design and exchanging perspectives

In some cases, participants highlighted that there has been a shift in culture, to embrace a greater level of openness and honesty in discussing BAME staff experiences. Staff identified there are many opportunities to meaningfully engage BAME staff (e.g., co-designing a leadership programme).

Other initiatives underway include:

- **Reverse mentoring** process for staff from BAME groups with Trust Executives and Senior Medical and Nursing Staff
- **Bespoke support** and development for BAME staff to prepare them for leadership opportunities
- **BAME representation on panels,** for leadership appointments
- **Dedicated resource**, to support EDI agenda
- **Freedom to Speak Up Guardians from BAME backgrounds** to provide BAME staff with avenue to raise issues which they feel unable to raise via other routes

QUOTES

> "Our relationship with BAME staff is growing in confidence and trust"

> "We are having more strengths-based and compassionate conversations"

> "The organisation has stepped up since COVID and Black Lives Matter"

Consultees identified opportunities for improving experiences of BAME staff

BAME staff highlighted that there is more that health and care providers can do to improve the experiences of BAME staff. Consultees highlighted key opportunities for improvement.

IMPROVEMENT OPPORTUNITIES IDENTIFIED

DIVERSIFY RECRUITMENT, RETENTION AND PROGRESSION	Consultees said that more steps should be taken to diversify recruitment, particularly at Board and senior management levels. They suggested that more work should be done on staff retention and to consider acting on evidence from BAME staff exit interviews. More could be done to support BAME staff progression through shadowing opportunities and mentoring schemes.
INCREASE CULTURAL COMPETENCE AND AWARENESS	The need to increase cultural competence and awareness throughout their organisations was highlighted as a particular area of improvement. BAME staff felt that there should be meaningful cultural competency training to generate real conversations about race and ethnicity providing BAME staff with more opportunities to share their stories in a safe way. They also suggested more opportunities to celebrate cultural festivals and more proactive campaigns around inclusion.
SUPPORT BAME NETWORKS	More could be done to support and build capacity for BAME staff networks. BAME network Chairs should have the role factored into their workplans and provided with administrative support to carry out their roles. Consultees suggested that senior people should sponsor the networks and there should be additional opportunities for allies throughout the organisation to support the groups.
INCREASE ACCOUNTABILITY FOR ACTIONS	There needs to be clearer and more stringent accountability to improve the experiences of BAME staff. BAME staff felt that more was required to make sure that senior staff follow through on commitments and are held to account for progress.

Recommendations

Recommendations to tackle BAME inequalities in Devon

The following slides outline recommendations that Together for Devon should take to better address BAME inequalities. The recommendations are divided into system-level recommendations for Devon ICS; and local-level recommendations for individual partner organisations and future local care partnerships. The recommendations are summarised below.

DEVON ICS

1. **Strengthen accountability**
   a. Appoint a non-Executive Director (NED) accountable for BAME inequalities
   b. Hold LCPs and partner organisations to account for progress
   c. Produce consolidated, clear external reports on performance
2. **Improve governance structures**
   a. Establish the system wide role of Health Inequalities Executive Leadership Group
   b. Redefine role of the Equalities Co-operative
   c. Establish a Devon-wide BAME Reference Group
   d. Establish a Devon-wide BAME staff advisory group
3. **Conduct activities at scale**
   a. Refine the Health Inequalities Workplan
   b. Increase support for the Devon-wide BAME staff network
   c. Establish mechanisms for system level activity

LOCAL CARE PARTNERSHIPS/PARTNER ORGANISATIONS

BAME communities and service users

4. **Improve leadership and accountability**
   a. Improve data on BAME access, participation, experience and outcomes
   b. Appoint accountable leaders for BAME inequalities
5. **Better engage local communities**
6. **Co-design BAME community support**
   a. Co-design interpretation and translation services
   b. Co-design and roll out training for engaging with BAME communities
   c. Co-design response to impacts of isolation among BAME communities

BAME staff

7. **Improve leadership and accountability**
   a. Improve reporting of performance externally and internally
   b. Collect and report more qualitative data
   c. Appoint accountable leaders for BAME staff inequalities
8. **Improve staff experience**
   a. Create and support BAME staff networks
   b. Implement robust complaints procedure for racial harassment
   c. Co-develop WRES reports and action plans
9. **Improve recruitment and progression**
   a. Implement good practice recruitment processes
   b. Implement good practice in support for BAME progression

Devon ICS

Devon ICS should implement a number of changes at the system level to better address BAME inequalities. Key areas for action at this level are those that relate to ICS-wide governance and accountability; areas where there are economies or advantages of scale; or where ICS-wide consistency is desirable.

RECOMMENDATION 1: STRENGTHEN ACCOUNTABILITY

a. **Appoint a non-Executive Director (NED) accountable for BAME inequalities.** This NED, on the Partnership Board, would meet regularly with BAME staff and BAME communities to understand the key issues to be tackled at a system level. The NED would update the Board and the wider system on progress to address inequalities, and be involved in system-wide groups established to tackle BAME inequalities (i.e. Health Inequalities Executive Leadership Group). This appointment would signal that tackling BAME inequalities is a priority for the system, and help ensure it receives due priority across the ICS.

b. **Hold LCPs and partner organisations to account for progress.** Tackling inequalities at a system level will require LCPs and partner organisations to make progress. A formal mechanism for internal reporting and accountability is required to assure this. The mechanism should provide the Partnership Board with progress against action plans and regular, comprehensible reporting of LCP and individual partner organisation performance against agreed BAME metrics. The process recently established to implement the Health Inequalities workplan provides a good foundation for such a mechanism. The ICS should expand and convert this into a permanent structure for driving and monitoring action on BAME inequalities.

c. **Produce consolidated, clear external reports on performance.** Currently, public reporting on BAME inequalities is incomplete and fragmented. To establish stronger accountability, the ICS should publicly report against a simple set of measures of BAME experience, outcomes and employment, at a provider, LCP and ICS level, comparing BAME to White British or whole population results. This will allow stakeholders to clearly understand BAME inequalities, and sharpen incentives to improve performance. The table below highlights areas of data that the ICS could report against, comparing BAME data to White.

Suggested areas for BAME inequalities reporting

BAME COMMUNITIES	BAME STAFF	
• Perceptions of health and care services • Service access and participation • Complaints • Patient experience • Patient outcomes • Population level health outcomes	• BAME staff representation in the workforce, including at different grades • % of BAME staff entering the formal disciplinary process • Ratio of white to BAME staff accessing non-mandatory training and continuous professional development	• % of BAME staff experiencing racism, harassment, bullying or abuse from patients, relatives and other staff • % of BAME staff believing that they are provided with equal opportunities for career progression or promotion • The retention rates of BAME staff compared to white staff

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Devon ICS

Devon ICS should implement a number of changes at the system level to better address BAME inequalities. Key areas for action at this level are those that relate to ICS-wide governance and accountability; areas where there are economies or advantages of scale; or where ICS-wide consistency is desirable.

RECOMMENDATION 2: IMPROVE GOVERNANCE STRUCTURES

a. **Establish the system wide role of Health Inequalities Executive Leadership Group.** The Health Inequalities Executive Leadership Group is a key driver for tackling health inequalities at a system level. It was established as part of Devon's Phase 3 Covid-19 response, and is supported by a central project team within the CCG. It brings together senior executives from partner organisations, as well as the Chair of the Partnership Board to track progress against a health inequalities workplan. This body should be formally established as the primary body for addressing BAME inequalities at a system-level, reporting to the Partnership Board. By convening senior leaders, along with the Partnership Board Chair, this will help drive the required prioritisation and resourcing within partner organisations. *(This is linked to Recommendation 1b, which sets out the importance of holding senior leaders accountable).*

b. **Redefine role of the Equalities Co-operative.** The Equalities Co-operative brings together staff from a wide range of partner organisations who work on inequalities. The group is responsible for ensuring partners are compliant with statutory obligations relating to EDI, including the WRES, EDS reporting and grading, sharing knowledge and good practice and developing shared resources for training. However, the current role of the co-operative within the system is unclear; it lacks accountability and is not an effective body for delivering on system-wide equality related strategies. As part of improving system-wide governance arrangements, the Equalities Co-operative should formally become aligned to the Health Inequalities Executive Leadership Group, which should set its agenda and hold it accountable.

c. **Establish a Devon-wide BAME Reference Group.** This group would consist of BAME community members from across Devon and be representative of the diversity of BAME communities in the region. The group would meet quarterly with the appointed BAME-accountable NED. They would be involved, consulted and invited to collaborate on ongoing work at a system level to tackle inequalities for BAME communities. This will provide BAME communities with the opportunity to influence system-level strategies and provide the system with valuable insights into BAME communities' perspectives on ongoing progress

d. **Establish a Devon-wide BAME staff advisory group**. This group would consist of all the BAME Staff Network Chairs from each partner organisation. The group would meet quarterly with the appointed BAME-accountable NED. They would be involved, consulted and invited to collaborate on the ongoing work at a system-level to tackle inequalities for BAME staff. This will provide staff, through their BAME staff network chairs, an opportunity to influence progress at a system-level and provide the system with valuable ongoing insights into the BAME staff experience within the partner organisations.

Devon ICS

Devon ICS should implement a number of changes at the system level to better address BAME inequalities. Key areas for action at this level are those that relate to ICS-wide governance and accountability; areas where there are economies or advantages of scale; or where ICS-wide consistency is desirable.

RECOMMENDATION 3: CONDUCT ACTIVITIES AT SCALE

a. **Refine the Health Inequalities Workplan**. The Health Inequalities workplan, recently developed as part of Devon's Phase 3 Covid-19 response, should be refined to become a more effective lever for change. The plan is the most comprehensive Devon-wide instrument to drive change at a system-level and should be leveraged in the long term to tackle BAME inequalities across the system on an ongoing basis. While current actions are ambitious and fairly comprehensive, some do not have the right level of detail to capture the resources and capabilities required to deliver. Key recommended changes include:

   - Action 8b1: *"engage with communities suffering health inequalities to improve understanding of what is preventing uptake or access to service, using the insight gained to ensure pathways are tailored to the needs of specific groups"*. Currently, some partner organisations lack the capability and culture to interpret and deliver this action effectively. This action should be expanded to include more detailed requirements, including training and resources in community development; volume and type of activity and outputs; and engagement with expert external organisations.

   The plan should also be rationalised. It currently includes nearly 100 specific sub-tasks, many of which entail significant activity in their own right. To ensure visibility and accountability for delivery, the Health Inequalities Leaders Group should identify a small number of high-impact priority actions (e.g. 10-15) as the focus for detailed scoping, reporting and sharing good practice.

b. **Increase support for the Devon-wide BAME staff network.** The Devon-wide BAME staff network should receive additional resources to support BAME staff at a Devon-wide level. The Network has provided a valuable forum; but is currently struggling and losing engagement due to lack of resources. The ICS should provide additional support including: in-kind administrative support; part-time backfill to enable the Chair allocated dedicated time to the role; and a mentor for the Chair.

Devon ICS

Devon ICS should implement a number of changes at system level to better address BAME inequalities. Key areas for action at this level are those that relate to ICS-wide governance and accountability; and areas where there are economies or advantages of scale, or where ICS-wide consistency is desirable.

RECOMMENDATION 3: CONDUCT ACTIVITIES AT SCALE

c. **Establish mechanisms for system-level activity**. Where there is a need for consistent approaches to improving inequalities for BAME communities and staff on a system-wide basis, the ICS should lead. This includes:

i. **Commissioning and developing co-designed training for engaging with BAME communities.** Lack of staff cultural competency and related skills is a major challenge. Many organisations having reduced relevant training in recent years. New system-wide training should be designed to support staff to understand BAME communities; and give them the tools to engage. Programmes should combine cultural competency basics with community-specific elements. It should involve elements of experiential delivery, such as roleplay. It should be tailored for specific roles (e.g. clinicians, managers and other community-facing staff). Organisations should co-design and deliver the training with BAME community members and organisations, for example through engaging them to identify relevant topics and involving them in delivery.

ii. **Commissioning and developing co-designed training for engaging with BAME staff.** Organisations should also consider cultural competency training for staff when engaging with their BAME colleagues. BAME staff experience culturally insensitive comments and microaggressions on a regular basis. Many white staff are fearful of "saying the wrong thing", unsure of the appropriate terminology to use around race and ethnicity. This cultural competency training will address these challenges to give staff the tools to engage with BAME colleagues in a culturally sensitive way. Given the similarities, this training could be combined with the cultural competency training for BAME communities.

iii. **Developing good practice guidance for partner organisations on engaging with BAME communities.** There is significant variation in partner organisations' resourcing, capability and practice in engaging BAME communities. The ICS should develop guidance on organisational approaches – for example on methods, frequency, and expectations; resources, such as survey questionnaire templates and interview guides; and individual guidance on language, behaviour etc.

iv. **Developing good practice guidance (e.g. toolkits) for BAME staff networks.** This should include expectations for support and resources provided to BAME networks and Chairs; and practical guidance on roles, responsibilities and activities. It should build on good practice from partner organisations with well-established networks.

v. **Taking the lead in developing relationships with Devon-wide community organisations** (e.g. Hikmat). It is expected that each of the partner organisations will engage with Devon-wide community organisations at various points, but to ensure a consistent approach, the system should take the lead in developing these relationships. This will prevent duplication and ensure that the community organisations do not have separate and inconsistent agreements.

Local Care Partnerships / partner organisations – BAME communities and service users

Local Care Partnerships (LCPs) and constituent individual Trusts and other partner organisations should take specific actions to improve access, participation and outcomes for BAME communities and service users. The major theme of these recommendations is to improve capability and capacity to genuinely engage with and understand BAME communities and incorporate these perspectives into the design and delivery of services.

RECOMMENDATION 4: IMPROVE LEADERSHIP AND ACCOUNTABILITY

a. **Improve data on BAME access, participation, experience and outcomes.** Improving collection and use of data has already been identified in various strategies and plans as an area where progress is needed; it is restated here as a matter of foundational importance. In addition to improving systems and processes for collecting ethnicity data, organisations should make stronger use of collecting qualitative data to generate insights on improvement opportunities. Lack of data or data limitations must not be used as an excuse for inaction.

b. **Appoint accountable leaders for BAME inequalities**. Organisations should appoint a senior executive and a NED to sponsor and be accountable for performance against selected metrics and targets in relation to BAME staff and service user access and outcomes. This will help maintain appropriate focus on performance at senior levels. This extends an action in the Health Inequalities workplan to appoint executive leads for inequalities (Action 6a1).

Local Care Partnerships / partner organisations – BAME communities and service users

Local Care Partnerships (LCPs) and constituent individual Trusts and other partner organisations should take specific actions to improve access, participation and outcomes for BAME communities and service users. The major theme of these recommendations is to improve capability and capacity to genuinely engage with and understand BAME communities and incorporate these perspectives into the design and delivery of services.

RECOMMENDATION 5: BETTER ENGAGE LOCAL COMMUNITIES

Organisations should act to improve engagement with their BAME communities through a number of ways. Better engagement will provide better insights into patients' experiences of health and care services to understand performance, identify improvement opportunities, and design change. This will ultimately lead to better health outcomes and greater trust between communities and service providers. NICE principles of good practice in community engagement provide a good framework and organisations should look to align strategies to those recommendations. We recommend that LCPs and partner organisations:

a) Establish one or more BAME community reference groups with clear terms of reference around consultation, involvement and information-sharing. Post-Covid staff should meet the community in their own contexts (i.e. community centres, religious venues)

b) Conduct an immediate, short (e.g. 3 month) targeted qualitative consultation exercise to elicit views from local BAME communities on current issues and improvement opportunities

c) Commission community engagement training for people in key roles

d) Tailor guidance for staff on engaging BAME communities, based on established good practice (i.e. how and when to engage and what resources are required) and make accessible for all staff

e) Review processes around EDS2 and Quality and Equality Impact Assessments to ensure appropriate engagement is required and scrutinised

f) Review relationships with relevant partner organisations (e.g. Healthwatch, Hikmat) to ensure principles and processes are mutually beneficial

Local Care Partnerships / partner organisations – BAME communities and service users

Local Care Partnerships (LCPs) and constituent individual Trusts and other partner organisations should take specific actions to improve access, participation and outcomes for BAME communities and service users. The major theme of these recommendations is to improve capability and capacity to genuinely engage with and understand BAME communities and incorporate these perspectives into the design and delivery of services.

RECOMMENDATION 6: CO-DESIGN BAME COMMUNITY SUPPORT

a. **Co-design interpretation and translation services.** Interpretation and translation services are major barriers for BAME communities when accessing health and care. As a priority, organisations should commence targeted work with community groups and organisations to identify specific challenges and improvement opportunities and co-design solutions to interpretation and translation challenges.

b. **Co-design and roll out training for engaging with BAME communities**. Health and care staff's lack of cultural competency was highlighted as a major challenge for BAME communities when accessing services. This is not helped by some organisations reducing relevant training in recent years. Organisations should plan and deliver cultural competency training in line with the new training developed by the ICS (see Recommendation 3ci).

c. **Co-design response to impacts of isolation among BAME communities.** This work has identified that isolation and associated mental health risks are particular challenges among BAME communities. Primary and community health services and local authorities should work alongside BAME community organisations to identify people and communities at risk of isolation and co-design activities or initiatives to address these challenges. A co-design approach is important to ensure that the solutions are effective, particularly given that these individuals are likely to be the hardest to engage.

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Local Care Partnerships / partner organisations – BAME staff

The following recommendations are aimed at the future Local Care Partnerships (LCPs) as well as constituent individual Trusts and other partner organisations. Some Trusts have many of these actions already in place (i.e. through WRES action plans) and we suggest that all future LPCs look to build on existing progress and implement all recommendations.

RECOMMENDATION 7: IMPROVE LEADERSHIP AND ACCOUNTABILITY

a. **Improve reporting of performance externally and internally.** Currently, information on performance in relation to BAME staff is fragmented and incomplete. Partner organisations and eventually LCPs should publish annual data on their BAME staff outcomes, experience and actions in clear, easy-to-understand formats. The findings should be distributed through BAME community networks and organisations. This will sharpen incentives to improve performance and make progress against commitments. It will also help to build relationships and goodwill with BAME communities. Currently, many BAME staff members are mistrustful of senior managers' commitment to delivering on BAME inequality targets. In addition to public reporting, organisations should establish clear feedback loops (e.g. "you said/we did") communicating actions to BAME staff.

b. **Collect and report more qualitative data.** Organisations should collect and report on more qualitative data to better understand staff experience. This could include regular focus groups with BAME staff or specific, targeted programmes aimed at understanding issues and improvement opportunities in particular target areas or segments of the workforce.

c. **Appoint accountable leaders for BAME staff inequalities.** Organisations should appoint a senior executive and a NED to sponsor and be accountable for performance against selected metrics and targets. This will help maintain appropriate focus on performance at senior levels.

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Local Care Partnerships / partner organisations – BAME staff

Local Care Partnerships (LCPs) and constituent individual Trusts and other partner organisations should take specific actions to improve access, participation and outcomes for BAME communities and service users. Partner organisations already have WRES action plans in place, and are redeveloping them under the ICS Health Inequalities work plans. A key focus of our recommendations is to ensure accountability for progress.

RECOMMENDATION 8: IMPROVE STAFF EXPERIENCE

a. **Create and support BAME staff networks.** Where effective, BAME staff networks are a safe space for BAME staff to network, share their experiences and seek support. They also provide a useful channel for the organisation to hear the experiences of BAME staff on an ongoing basis. Organisations should put structures in places to best support their BAME staff networks and initiate networks for those who don't have them. Where numbers of BAME staff are small, LCPs should form cross-Trust networks, for example, at the LCP level. Organisations should appoint an executive sponsor of the network to allow issues to be escalated quickly. They should also provide the BAME network chair with a mentor to provide ongoing support. Networks should be resourced effectively and the Chair should agree in conjunction with the executive sponsor and their line manager the hours they will give to the role, backfill requirements, and any additional administrative support necessary.

b. **Implement robust complaints procedure for racial harassment.** Many staff do not know where to go within their organisation if they experience racial harassment and even if they did report it they were not confident that it would be dealt with appropriately. All staff from BAME backgrounds should be able to access a complaints process for racial harassment without fear of consequences for their safety or career. Diverse panels should review complaints at each stage.

c. **Co-develop WRES reports and action plans.** The WRES provides a valuable framework to further understand the experiences of BAME staff. The WRES reports and action plans should be co-designed with BAME staff (e.g. through the BAME staff network), to ensure that actions taken fully address the concerns raised and are endorsed by BAME staff.

Local Care Partnerships / partner organisations – BAME staff

Local Care Partnerships (LCPs) and constituent individual Trusts and other partner organisations should take specific actions to improve access, participation and outcomes for BAME communities and service users. Partner organisations already have WRES action plans in place, and are redeveloping them under the ICS Health Inequalities work plans. A key focus of our recommendations is to ensure accountability for progress.

RECOMMENDATION 9: IMPROVE RECRUITMENT AND PROGRESSION

a. Implement good practice recruitment processes.

Many organisations lack BAME staff diversity, particularly at senior levels. While organisations are addressing this, including through WRES action plans, they should ensure key elements of standard good practice are in place including:

- Reviewing job adverts and specifications to ensure they aren't inadvertently discriminating against BAME staff
- Rejecting non-diverse shortlists
- Advertising jobs in a wider range of places to attract greater diversity in applications
- Ensuring that the application process is as transparent and accessible as possible
- Diversifying recruitment panels

b. Implement good practice in support for BAME progression

Organisations should consider a range of options to support BAME staff to progress their careers within the organisation. Currently, BAME staff feel that they have fewer opportunities than their white counterparts to progress, contributing to the lack of diversity in senior positions.

Organisations should ensure key elements of standard good practice for BAME staff progression are in place, including:

- Arranging mentoring opportunities for BAME staff
- Supporting staff to access local and national career development schemes and initiatives
- Reviewing their progression pathways to ensure that they are as transparent and as accessible as possible

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Nous Group is an international management consultancy operating in 10 locations across the UK, Australia and Canada.

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Understanding the experiences of health and care in Devon for BAME communities and staff – Recommendations

Implementation and accountability plan

Recommendation	LCP / ICS	Sub-recommendation	Ownership	Assurance
Strengthen accountability	ICS	Appoint a non-Executive Director (NED) accountable for BAME inequalities	CCG Governing Body	CCG Governing Body
		Hold LCPs and partner organisations to account for progress.	Health Inequalities Executive Leadership Group / Quality Assurance Committee	CCG Governing Body
		Produce consolidated, clear external reports on performance.	Health Inequalities Working Group	Health Inequalities Executive Leadership Group
Improve governance Structures	ICS	Establish the system wide role of Health Inequalities Executive Leadership Group.	ICS Partnership Board	CCG Governing Body
		Redefine role of the Equalities Co operative	Health Inequalities Executive Leadership Group	CCG Executive
		Establish a Devon wide BAME Reference Group.	CCG Communications and Engagement	CCG Executive
		Establish a Devon wide BAME staff advisory group.	CCG HR	CCG Executive

Conduct activities at scale	ICS	Refine the Health Inequalities Workplan	Health Inequalities Executive Leadership Group	ICS Partnership Board
		Increase support for the Devon wide BAME staff network.	CCG HR	CCG Executive
		Commissioning and developing co designed training for engaging with BAME communities.	CCG Communications and Engagement / Population Health Management	CCG Governing Body
		Commissioning and developing co designed training for engaging with BAME staff.	CCG HR / Population Health Management	CCG Governing Body
		Developing good practice guidance for partner organisations on engaging with BAME communities.	CCG Communications and Engagement	CCG Governing Body
		Developing good practice guidance (e.g. toolkits) for BAME staff networks.	CCG HR	CCG Executive
		Taking the lead in developing relationships with Devon wide community organisations (e.g. Hikmat).	CCG Communications and Engagement and ICS VCSE Lead	CCG Body
Improve leadership and accountability	LCP	Improve data on BAME access, participation, experience and outcomes.	• Provider Governing Bodies • Health inequalities working group • Insight hub • Restoration	CCG Quality Assurance Committee Partnership Board
		Appoint accountable leaders for BAME inequalities	Provider Governing Body's	Health Inequalities Executive Leadership Group

Better engage local communities	LCP	Establish one or more BAME community reference groups with clear terms of reference around consultation, involvement and info	LCP communications and engagement group / Provider communication and Engagement teams	CCG / ICS Communications and Engagement team
		Conduct an immediate, short (e.g. 3 month) targeted qualitative consultation exercise to elicit views from local BAME communities	Provider communications teams	CCG Communications and Engagement and CCG Health Inequalities Executive Leadership Group
		Commission community engagement training for people in key roles	Provider HR / Communications / Population Health Management	CCG communications and HR and CCG Health Inequalities Leadership Executive.
		Tailor guidance for staff on engaging BAME communities, based on established good practice	Provider HR and Communications QEIA PHM	CCG communications and HR and Health Inequalities Leadership Executive.
		Review processes around EDS2 and Quality and Equality Impact Assessments Review processes around EDS2 and Quality and Equality Impact Assessments to ensure appropriate engagement is required and scrutinised	Provider Quality Assurance Committees	CCG Quality Assurance Committee

		Review relationships with relevant partner organisations (e.g. Healthwatch, Hikmat)	Provider communications and engagement teams	CCG communications and engagement teams
Co-design BAME community Support	LCP	Co design interpretation and translation services.	Provider EDI Leads	CCG EDI lead
		Co design and roll out training for engaging with BAME communities	Provider communications and engagement teams	CCG communications and engagement teams
		Co design response to impacts of isolation among BAME communities.	Provider communications and engagement teams Restoration programme Health Inequalities working group	Provider communications and engagement teams Health Inequalities Leadership Executive.
Improve Leadership and Accountability	LCP	Improve reporting of performance externally and internally.	Provider EDI, quality and BI teams Health Inequalities Working Group Restoration programme	Provider GB and Health Inequalities Leadership Executive.
		Collect and report more qualitative data.	Provider communications, BI and patient experience teams	Provider GB and CCG Quality Assurance Committee

				Health Inequalities Leadership Executive
		Appoint accountable leaders for BAME staff inequalities.	Provider HR	Provider GB
Improve staff experience	LCP	Create and support BAME staff networks.	Provider HR	Provider GB
		Implement robust complaints procedure for racial harassment.	Provider HR	Provider GB
		Co develop WRES reports and action plans.	Provider HR	Provider GB
Improve recruitment and progression	LCP	Implement good practice recruitment processes.	Provider HR	Provider GB
		Implement good practice in support for BAME progression	Provider HR	Provider GB

“Experiences of health and care in Devon for BAME communities and staff”

Final report communications plan

In September 2020, the ICS for Devon (ICSD) commissioned the Nous Group (Nous) to better understand health and care experience, access and outcomes among Black, Asian and Minority Ethnic communities and staff across Devon; and to identify improvement opportunities.

The report is now complete, and the recommendations approved by the ICSD Partnership Board.

Effectively communicating these findings will be essential in demonstrating the ICSD’s commitment to addressing the concerns laid out in this report and health inequalities more broadly.

The information below summarises the communications that are planned to share the report findings and communicate the next steps.

Timeline

Week beginning 10 May 2021 (NHS Confed’s Equality, Diversity and Inclusion week)

- Share report findings with participants with a cover letter from Dame Suzi Leather and Jane Milligan
- Confirm action plan for implementation of recommendations

27th May

- Full report and action plan to CCG Governing Body

28th May

- Publish report and action plan

Communicating the report

In addition to the report itself, several materials will be developed to ensure the report is accessible to a broad range of audiences, these include:

- The full report available in alternative languages
- Cover letter to key stakeholders
- Press release
- Quotes from spokespeople
    - Jane Milligan – ICSD and Devon CCG Chief Executive

    - Lincoln Sargeant – Chair of the Health Inequalities Executive Leadership Group
- Short film featuring Nous representatives and participants to the project to highlight the findings and the outline the actions being taken to deliver the recommendations

Disseminating the report

The report will be disseminated in two phases:

Phase	What	How	Stakeholders	When
Phase 1	Disseminate findings and next steps	Cover letter and full report shared directly with key groups	Report participants – communities Report participants – staff ICSD Leadership ICSD HR Directors for information and consideration NHS Devon CCG Governing Body ICSD inequalities group Political stakeholders (MPs / local councillors) VCSE, including Healthwatch and Living Options	10 May 2021
Phase 2	Publicise the report with media and wider public and align to activity that demonstrates ICSD is acting on the findings	Press release, short film, social media	Media outlets NHS Staff across Devon Local Authority (LA) (Devon, Plymouth, Torbay) Providers Public	28 May 2021

Key stakeholders

- Report participants – communities
- Report participants – staff
- ICSD Leadership
- ICSD HR Directors
- NHS Devon CCG Governing Body

- ICSD inequalities group
- Political stakeholders (MPs / local councillors)
- VCSE, including Healthwatch and Living Options
- Media outlets
- NHS Staff across Devon
    - CCG
    - Primary Care
    - Acute, Community and Mental Health providers
    - SWAST
- Local Authority (LA) (Devon, Plymouth, Torbay) Providers (e.g. care homes)
    - LA staff
- Local Authority (LA) (Devon, Plymouth, Torbay)
- Public

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Locality Update Report

Locality:	Northern Devon
Period covered by update:	April – May 2021
Localiy Clinical representative	Dr John Womersley
Locality Executive Lead	Andrew Millward
Locality Non-executive representative	Charlotte Burrows

Key achievements/progress

1. LCP Developments

- The weekly Northern COVID-19 Cell team meetings set up to deal with COVID-19 has now developed into the Northern System Operational Meeting. This weekly 1-hour meeting enables system partners (NDHT/PCNs/DTP/CCG etc.) to bring issues requiring swift partner-supported resolution, and for updates on fast-moving areas of work in the locality. In addition, this weekly Ops meeting can provide a timely and agile response to any actions and immediate priorities that emerge from the monthly IDG.
- The relaunched Northern Integrated Delivery Group (IDG) met on 4th May with a focus on a locality 'partnership' review of identified activity and performance issues and priorities, and the subsequent agreement on necessary actions to be taken to deliver improvements to the local health and care system in the northern locality.
- In April, the Northern LCP Executive meeting welcomed the attendance of a GP representative from the Northern Primary Care Networks, which now completes the Executive group's membership structure.

2. Our Future Hospital Programme

- The Our Future Hospital programme is continuing to develop the strategic outline case working closely with commissioners and system partners with sign off scheduled for end July 2021.
- A case for change has been approved by the Trust Programme Board; it sets out:
  - A summary of the condition of the current estate using the 6 facets survey methodology
  - A detailed model of future healthcare demand using ONS population and non-demographic growth assumptions.
  - Our ambition for a digitally enabled care experience.
- The new hospital programmes across Devon (TSDFT, UHP and NDHT) are working collaboratively to align our contribution to the delivery of the Devon Health and Wellbeing strategy.
- Stakeholder engagement includes briefing DCC/NDDC/TDC along with assessing wider public and staff aspirations for future healthcare through engagement events and surveys.

3. Elective Care & Planned Care Restoration

Referrals are now returning to pre- COVID-19 levels; elective and day case activity is also recovering. Links between the central Elective Care Restoration Programme team and the LCP are being strengthened to understand the operational plans and responsibilities to address the backlog of patients waiting for treatment.

4. One Northern Devon (OND)

- OND Partnership working with the "Our Future Hospital" team are planning local engagement event(s) on the future models of care to meet the needs of a growing older population living longer with multiple long-term conditions (LTC). The plan is to bring together patients, carers, statutory and non-statutory health and care providers. The aim is to come up with a system-wide model of care and support for LTC Management with clear proposals for implementation.

- OND is supporting mental health and wellbeing work through the One Communities network by:
  - Mapping current services & support currently available in each community.
  - Engaging with Community Mental Health teams and different organisations across North Devon i.e. the Alzheimer's society, MIND, Wings and Recovery Devon, to share information and identify gaps.
  - Scoping and developing befriending projects.
  - Developing Mental Health sub-groups in each One Community
  - Liaising with Link Centre staff with the intention to develop community café.
  - Delivering yoga, mindfulness, walking groups for those worried about getting out again and gym sessions for young people through Community Developers.
  - Supporting men's mental health projects e.g. men's sheds in Braunton & Barnstaple.

5. Population Health Management (PHM)

One Northern Devon, Northern PCNs and the CCG primary care team are working together to explore opportunities under the additional Roles Reimbursement Scheme (ARRS) and PCN development activity to enable the further piloting of the flow project using the PHM approach.

6. COVID-19 Vaccination Programme Update

Primary care concentrating on identifying patients requiring their second dose and no longer providing first dose vaccines. Going forward first and second doses will be administrated at the Leisure centre and pharmacies with patients being advised to make contact via the national centre.

7. Mental Health update

- Activity remains high for unplanned and planned care with bed occupancy reported as 97% across DPT, and community services recording around 120-180 community contacts per day, Home Treatment supporting 17 patients per day at risk of admission to hospital, with significant activity in other Community Teams and Psychiatric Liaison teams. Moorland View (adult acute ward) and Meadow view (older adult functional) reports very low number of delayed discharges.

- Early work with OND and DPT continues in North Devon with use of discharge facilitation funding to support early and safe discharge using VCSE collaboration – this collaboration is essential to improve care over time.

- Community Mental Health Services Framework developments are continuing - confirmation has been received of the successful bid application. The core principles of the new system wide approach are:
  - Co-production and co-design with people who have lived experience
  - Consistent services based around people's whole-life needs – not just their mental health needs
  - A good quality assessment wherever and whenever people access support
  - Care that can be stepped-up and stepped-down in line with a person's needs
  - Services as close-to-home as possible and more closely shaped to meet the needs of local communities
  - A one-team approach - removing organisational boundaries to ensure joined-up care
  - Support in navigating the system.

- The core features of the new approach are:
  - Targeted neighbourhood support aligned with Devon's PCNs and provided by **Multi Agency Teams (MATs)** – rolled-out over the next three years.
  - Recovery Navigators to walk alongside people, so they get help when & where they need it.
  - A specific focus on:
    - the transition of young people to adult services
    - the needs of younger adults (18-25-year olds)
    - the needs of older adults
    - the physical health of people with mental health needs

- In addition, three clinical areas will be the focus of more targeted support, rolled-out over the next two years:
  - Eating disorders
  - Personality disorders and complex lives
  - Mental health recovery and rehabilitation

- Appropriate independent and high-quality supported housing care provision remain challenging.

Key priorities for the next three months

- Continue to shape and influence the development of the LCP infrastructure and work programmes.
- Develop the governance arrangements and programme structure to take forward the community service contract work.
- Embed the learning from the Population Health Management into to other areas of Northern LCP work.
  Maintain focus on the recovery and restoration of elective care services.

Issues of concern or risk

- The need for on-going resource to support the LCP developments, and the post COVID-19 recovery of business as usual work.

- The need for system Data Protection Officers to resolve information governance issues in relation to the application of Population Health Management across Devon.

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Locality Update Report

Locality:	Eastern Devon
Period covered by update:	April-May 2021
Locality Director:	Tim Golby

Key achievements/progress

- Teams at the Royal Devon & Exeter NHS Foundation Trust (RDEFT) have implemented an 8 week rapid improvement programme for urgent and emergency care. High numbers of patients are attending the Emergency Department and waiting times for patients have become significant. The programme implements a Gold Command operational structure, with senior input and additional staffing in place. 4-hour performance has already risen, and some joint working has begun between RDEFT and local primary care looking at presenting conditions and devising specific ambulatory care solutions.

- The Eastern Flow Programme Board will be leading 4 workstreams that will pick up and embed learning from the Gold Command process, seek to improve flow into and through Pathways 1-3 so that patients get the right care at the right time and ensure that community care capacity is sufficient to meet the needs of our local population.

- An Eastern Locality Delivery Group session, led by Suzanne Tracey, is planned for 13th May to review and agree the Local Care Partnership workplans for the 5 focus areas for this year:
  1. Recovery & Restoration
  2. Community Urgent Care
  3. Community Care
  4. Prevention
  5. Community Mental Health

  The Eastern Collaborative Board have agreed to provide primary care leads in each thematic to provide general practice leadership and perspectives to these programmes of work alongside other system partners. It will also be important to identify how these map across to specific work areas, such as the service transformation required within the community contract, the developing Community Mental Health Framework work and the outputs from the Population Health Management pilots so that local system working is joined up.

- Primary Care in the Eastern locality has been experiencing increased patient demand, with reflections that some conditions have become more severe as

patients have stayed away until now. Telephone contacts are significantly increased and there is significant pressure for immediate contact with the GP teams. General Practice Access Data (GPAD) is improving data quality to more accurately capture the full scale of scale of activity that general practice is providing for patients.

- The Eastern Prevention workstream is focusing on Population Health Management (PHM) as a tool, a lens through which we can design services and interventions to support people. The needs analysis for Eastern Devon highlights 3 key areas of focus:
    1. Self-harm and alcohol use in young people
    2. Unpaid carers and social isolation in working age adults
    3. Loneliness in older people

  The analytical and project support to facilitate this workstream is being identified.

- Work is ongoing to understand the future potential for the community hospital sites in the locality, with a detailed review received on the Hub in Budleigh Salterton, now known as Seachange. Local teams are in discussion to understand the benefits identified there and the role the Hub can play within the Woodbury, Exmouth and Budleigh area. This is in conjunction with the piece of work being undertaken to review service delivery in the Crediton area following the opportunity to utilise a purpose-built building on the new Crediton surgery site.

- The next Eastern Locality Forum (ELF) is planned for Monday 17th May and will be continuing to showcase the work and impact of local heath and wellbeing groups, with a presentation from Wellmoor, a community initiative from North Dartmoor. This aims to build connections across place and identify potential areas of best practice that might be replicated. The group will also be looking at proposals for the sub-place level arrangements to support and enable engagement between people and organisations working across Eastern Devon and the ICS.

- The workplan for the Community service workstream is defined by three key themes:
    1. Strength and resilience in the community
       Long Covid pathways, first contact practitioner models, Support to Eastern Locality Forum to invigorate community conversations and provide support to local leaders
    2. Supporting people to remain/ return safely home (including flow)
       Urgent Community Response 2 hour and 24 hour standards, right-sizing the care home and domiciliary care markets and enhanced integrated ambulatory care
    3. Education and support across provider organisations to coordinate and share skills
       Supporting care homes with RESTORE2, sharing skills and resources, Multi-disciplinary support to care homes aligning with other system partners across health and social care.

- There has been universal agreement from Primary Care Networks (PCNs) in Eastern Locality to work closely with Devon Partnership Trust (DPT) to embed Mental Health Link Workers in PCNs. This process will involve the movement of a current member of DPT into a Primary Care setting. The details of the evolution of this role and the job description are going to be co-designed by Eastern Collaborative Board Members and DPT. This will ensure that all communities across Eastern Locality will benefit from this enhanced access to mental health services.

- We are pleased to official announce the newly elected Eastern Collaborative Board Leadership:
    - Chair - Dr Barry Coakley
    - Vice Chair - Dr Frank O'Kelly
    - Sub-locality Leads: Eastern Devon - Dr Barry Coakley, Exeter - Dr Emma Green, Mid-Devon - Dr Jo Harris.

Key priorities for the next three months

- The recovery and restoration of services, learning lessons from the Covid-19 response and taking these forwards into new ways of working.

- To progress the overarching workplans of the Eastern LCP for the 5 thematic areas.

- Further development of engagement with community leaders and the development of proposals for an Eastern Locality Forum Conference in the Autumn.

- Understand what the ICS Strategic Outcomes Framework and the COVID-19 Framework mean across Place and at the neighbourhood level and how our work and priorities are impacted.

- Develop a case for change in collaboration with system partners and community engagement on the potential for a health and wellbeing hub in Crediton.

- Re-establish the diabetes transformation plan for the locality alongside the Diabetes Clinical lead.

Issues of concern or risk

- The need for system Data Protection Officers to resolve information governance issues in relation to the application of Population Health Management across Eastern, and Devon more widely.

- The need for an on-going resource to support and co-ordinate locality development and delivery.

4

Support required and/ or barriers to progress
The need for an on-going staffing capacity to support and co-ordinate locality development and delivery.

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Locality update report

Locality:	Southern Devon
Period covered by update:	April 2021
Person completing template:	Derek Blackford – Locality Director (S&W)

Key achievements/progress

Local Care Partnership (LCP) development:

An approach to communications and engagement is being further developed in conjunction with leadership from Jane Harris (T&SDFT) and respective partners which will help take us forward.

The agreed joint session pulling together members of the emerging Executive & Delivery architecture takes place on 20th May and will consider amongst other things, a refresh of the arrangements in respect of the infrastructure for the locality; the emerging themes and priorities which we will work together to deliver; visibility of how programmes of work are overseen and issues escalated and the way we want to collaborate and communicate as we progress. The core groups that would be in place to support in this area include the Executive, Delivery, Performance Improvement and Locality Forum.

The work done in relation to the emerging themes suggests a set of initial priorities that would include a focus on Discharge to Assess, Population Health Management and the Community Mental Health Framework. Specific areas for focus and inclusion include self-harm, suicide and alcohol to deliver against once the final priorities have been agreed.

System flow:
Hospital flow has been an area of focus by the NHS England/Improvement national teams, both in relation to acute and community settings. A series of mini review/'deep dive' sessions monitoring the data began in January. This has helped build upon the CCG Discharge Cell scrutiny approach maintained throughout this last year and has until last week been operating daily meetings and reporting. A specific focus remained on creating capacity to support hospital discharge appropriately. This now sits in the context of an end to end improvement plan which has been drafted but is now being further developed with enhanced action and agreed deliverables.

Vaccination Programme:
Links have been established between South Commissioning/Primary Care Teams and Torquay Public Health Vaccination Inequalities group. Specific sessions for homeless people are being provided at the Riviera Centre in Torquay by the Torquay Local Vaccination Service. All PCNs are signed up to continue to provide vaccinations to cohorts 10-12. Newton Abbot and Torbay hosted the Mobile Vaccination Unit between the 7th April to the 10th April. New Pharmacy-run site opened in Brixham.

Same Day Emergency Care (SDEC):
Torbay and South Devon NHSFT joined the Acute Frailty Network (AFN) in September 2020 (a 12-month national programme) and this has been a catalyst for driving forward with an emphasis on identification and same day emergency care. Work has been undertaken to ensure that workforce capacity and processes are in place to ensure that people over the age of 65 years presenting at the Emergency Department and Medical Receiving Unit would be assessed with the agreed clinical frailty tool (Rockwood).

Analysis has also been undertaken to understand the patient journey/pathway upon arrival at the Emergency Department, number of moves, length of stay, intervention, and outcomes etc. This gives clearer insight into potential improvements. Recruitment for a Frailty Nurse/Allied Health Professional, and a Consultant Geriatrician, following approval, to be based at the Front Door has concluded and will be in place shortly. This will result in greater speciality presence and the ability to identify frail patients, whilst working closely with the Joint Emergency Team.

A Same Day Emergency Care self-assessment tool has been completed which scopes current provision, gaps, and specific areas of focus. A task and finish group will be established in April to discuss further.

Community Urgent Care Response:
Discussions have taken place with Community Service Managers, Rapid Response co-designed with SWASFT, regarding the process for paramedics to access 2-hour urgent community response. The process is being applied to 111 with ageing well funding obtained for external support, data collection and processing, which will enable accurate reporting and review.

Frailty and Healthy Ageing Partnership (FraHAP):
Following discussions earlier in the year on reviewing the aims, objectives of this group a change of name has been adopted, Torbay and South Devon Frailty and Healthy Ageing Partnership Group. It is felt that this better reflects the preventive aspects, as well as keeping a focus on the long-term condition that is frailty. The group will re-convene in May to review the work plan and agreed subgroups (communication and education, identification, stratification and proactive management, acute frailty, falls and bone health, end of life and delirium, dementia and cognitive disorder).

A Frailty Awareness Launch week was scheduled to showcase the vision for those living with frailty supporting people to live longer and better. This was included within the Chief Executives weekly Vlog in addition to communication within the CCG Bulletin. Future information will include detail about the frailty pathway which is being developed, advising that information is available on the South Devon Joint Formulary, Icon frailty pages and the Hive etc, development of the Comprehensive Geriatric Assessment (to be shared electronically system wide) and Care of the Elderly Advice and Guidance service.

Proposed Leadership arrangements

The LCP leadership arrangements have been confirmed and are in place with review during the next 6 months, with Simon Tapley, CCG Accountable Officer taking the role of the Chair with Liz Davenport, Chief Executive, T&SDFT, being vice-chair.

Key priorities for the next three months

The key priorities for the next three months include:

1. The further development of the Local Care Partnership, finalising the engagement plan, establishing communications, and delivering against the priority ambitions.
2. Local performance oversight and improvement sub-group arrangements.
3. Supporting the arrangements in respect of the rollout of the vaccination programme in conjunction with primary care networks and system partners.
4. Maintain focused attention on discharges and the robustness of associated data reporting in line with national expectations.
5. Embedding the learning from the Population Health Management pilot to other network areas.
6. Contributing to and ensuring arrangements which seek to deliver against more short-term deliverables within the Operating Plan and Long-term plan roadmap.

Issues of concern or risk

The main areas to consider are:

- the capacity to manage respective priorities and pace, particularly whilst we look to shift our focus toward planning and restoration of services.
- maintaining focus on the development of the LCP priorities alongside those in relation to our response to COVID-19, vaccination programme & operational pressures will be key.
- Workforce pressures and capacity across local providers with particular challenges in relation to clinical staff and the necessity for recovery as a result of the impact felt from the period of the pandemic.

Support required and/ or barriers to progress

- None at present.

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Locality update report

Locality:	Plymouth
Period covered by update:	April 2021
Person completing template:	Anna Coles

Key achievements/progress

Delivery Highlights

- Completion of Regional Assurance process for Integrated Care Partnership Procurement. The Contract Award report is on the Governing Body agenda with similar arrangements underway at Plymouth City Council.
- Progressing the Cavell Centre- draft Model of Care developed following engagement with providers. Engagement and Consultation approach in development, additional resources being secured to assist with community based design work. Programme governance reviewed and additional workstreams developed to ensure interdependencies are managed.
- Embracing Devon-wide approach for Long COVID clinics with Livewell South West coordinating the triage Devon-wide. Focus to improve pulse oximetry take up across the locality
- Fortnightly huddle with PCN CD's continues to ensure strong engagement with Primary Care locally, attended by UHP/LWSW/St. Lukes/LPC/LMC/LA. Work completed with Collaborative Board Chair and Western Locality Clinical Chair to develop forward plan for these sessions to ensure clinical engagement maximised across primary and secondary care to support system improvement. Attendees reviewed to ensure clinical representation from AHP's, MH specialists and Social Care.
- Performance and Improvement Group established to provide locality oversight of delivery and improvement activity.
- UEC Locality Improvement Plan developed and Urgent Care forum reviewed to ensure appropriate oversight of delivery.

Local Care Partnership Delivery Group

- Board continues to meet and are overseeing a number of key developments:
  - Establishment of the Homelessness Prevention Board
  - Approval and roll out of the Community Empowerment Framework
  - A Bright Future- A new strategic plan for Children and Young Peoples Services
  - Recommissioning of Family Centres.
  - Further development and refinement of the Locality Profile
  - Leading a review of the LCP Priorities and workstreams

Proposed Leadership arrangements

Together For Plymouth Exec Group meeting monthly and Membership includes

- Devon CCG
- Livewell Southwest
- Plymouth City Council
- Primary Care Network Representation
- University Hospital Plymouth

The TFP Executive Group maintains effective and efficient governance links with other statutory boards. Specifically the Executive group reports to the Health and Wellbeing Board quarterly through a Chairs Report. LCP Delivery Group now established with wider participation including VCS and Healthwatch.

Primary Care Involvement: There has been ongoing engagement with the Chair of the Western Collaborative Board, with regular meetings in place. The existing Huddle fortnightly has been remodelled to create a forum for clinical input and oversight of local priorities. The collaborative board has identified a number of representatives to join programmes of work to ensure there is a strong primary care representation across the locality. The CCG has led engagement with Primary Care and have developed in partnership with the Collaborative Board, and PCN CD's support arrangements including assistance with administration, alignment of Clinical Advisors and support from the Head of Integrated Care.

Key priorities for the next three months

Priorities for the next three months:

1. Focussed delivery of UEC Improvement Plan
2. Refresh of the Health and Wellbeing Strategy
3. Establishment of programmes of work for LCP priorities
4. Development and roll out of Local Communication and Engagement approach
5. Refinement of the Performance group
6. Further development of local care model to inform estates priorities
7. Development of resourcing plan to support LCP progress

Issues of concern or risk

Maintaining a focus on developing the LCP at the same time as managing a recovery and restoration from COVID-19
Capacity for Primary Care Networks to play a full role in the LCP
Capacity for UHP and LWSW to play a full role in LCP with current significant operational pressures.

Support required and/ or barriers to progress

None

NHS Devon Clinical Commissioning Group

Locality update report

Locality:	Western Devon
Period covered by update:	May 2021
Locality clinical representative:	Dr Shelagh McCormick
Locality Director:	Anna Coles/Derek Blackford
Locality non-executive representative:	Nick Ball

Key achievements/progress

Plymouth:

- Care Hotels, evaluated and de-commissioned
- Health and Wellbeing Hub in West End of Plymouth - Model of Care project in place further to 3 stakeholder workshops and agreement of investment objectives. Initiation of workstreams including Communication and Engagement, Collaborative and Integrated Working and Benefits Realisation as part of the project. Updated draft of the Plymouth Locality Profile taken to the LCP Delivery Group for review ahead of finalisation.
- Appointment of Programme Director to support UEC Improvement agenda.

Plymouth & West Devon

- Finalisation of assurance activity with NHSE/I and Preferred Bidder for Integrated Care Partnership procurement
- COVID vaccination programme continues to demonstrate positive examples of integrated working between PCNs, community and acute providers and commissioners delivering strong rates of vaccination with further work to implement outreach for those cohorts with lower uptake rates and needing alternative offers
- Independent Sector (IS) providers came out of 'surge' status at the beginning of March meaning that the NHS no longer has access to 100% of the IS capacity. The IS providers will return to full 'Business as Usual' from the beginning of April and the CCG is working with all providers to restore full elective services and assess the requirements for recovery of performance.
- Planning started as a system for the 2021/22 operating plan and Phase 4 Recovery and Restoration.
- Updates and proposed investment areas taken through LCP Delivery Group for review.
- Development of an agreed system wide urgent and emergency care recovery plan addressing demand, flow and capacity throughout the urgent care process. This also encompasses Cornish solution.

Key priorities for the next three months

Plymouth:

- Conclude the Integrated Care Partnership procurement in line with assurance requirements
- Finalising the Model of Care project and engagement for the Health and Wellbeing Hub in West End of Plymouth to support development of Business Case
- Finalise the Plymouth Locality Profile

West Devon:

- Further development of the Local Care Partnership arrangements, next session planned for 19th May.
- Plans to extend the arrangements to an Executive and Delivery/Operational approach will be implemented.
- Development of the emerging themes and priorities and finalisation of a first draft locality profile.
- Leadership arrangements confirmed with Chair being covered by Acting Chief Executive Officer, Livewell Southwest for this interim period.

Plymouth/West Devon:

- Finalise Urgent Care Locality improvement plan to address key performance challenges including ambulance handover delays and ED improvement recommendations and commence delivery against priorities
- Further develop Performance and Improvement group for LCPs
- Review of the use of care home placements for 'Discharge to assess' to understand changes in utilisation and ongoing requirements to support market management work.
- Continued locality actions and planning in partnership with Public Health and Local Authority to ensure a sustainable COVID vaccine delivery programme which does not exacerbate health inequalities.
- Implementation of the local Lower Back and Radicular Pain pathway in line with the agreed specification.
- 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)
- Restore all planned care services as redeployed staff return to their substantive roles and gain a better understanding of demand, capacity and non-recurrent solutions required to address the backlog.
- Phase 4 operational planning

Issues of concern or risk

- Staffing capacity across the commissioning team to manage priorities and operational demand including increased reporting requirements, albeit with some new starters in the next few weeks filling some vacancies.
- Workforce capacity across all Providers including nursing, domiciliary care, pharmacy, voluntary sector
- Cornwall capacity across community specifically Care Home provision which impacts on UHP Length of delay performance.
- PCNs may not be able to recruit to additional roles effecting their ability to deliver the DES requirements
- PCNs ability to continue vaccination programme and business as usual; mapping of provision Cohorts 10-12 to ascertain ongoing capacity with 5 PCNs stepping back
- Recruitment to vacant positions within Localities

Support required from CCG/system or barriers to progress

- Continued deployment of additional capacity to support Integrated Care Partnership (ICP) procurement
- Locality capacity returned as we move back to recovery phase

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Plymouth Locality LCP GB Update

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Plymouth Local Care Partnership

SYSTEM PLAN 2021-2024

1) Introduction

In 2013 the Plymouth Health and Wellbeing Board set down in the strategic ambition to create a fully integrated system of population based health and wellbeing where people start well, live well and age well. At the heart was a focus on tackling health inequalities and meeting the needs of the whole person, ensuring they received "the right care, at the right time, in the right place". This ambition formed part of the ***Plymouth Plan***, which remains the City's overarching Strategic Plan setting the vision, ambition and our direction until 2034. Since this original ambition was set the Plymouth system has also been an active participant in the Sustainability and Transformation Partnership and now the Devon Integatred Care System. This plan is therefore two fold, to act as the "plan for" in relation to the Health and Wellbeing elements of the Plymouth Plan and Plymouth's contribution to the delivery of the prorities of the Integrated Care Partnership and the Long Term Plan.

2) Aims of the Partnership

Plymouth Local Partnership is one of five Local Care Partnerships across the Devon Integrated care system. "Together for Plymouth" reinforces the collective intent for collaborative working to solve some of the deep-rooted challenges we face and to create a step change in system transformation. The primary purpose of the Partnership is to provide leadership and oversight to our ambition of creating an integrated system, which puts the needs of our population ahead of that of any single organisation.

The overarching aims of the Partnership are:

- Improve health and wellbeing outcomes for the local population
- To reduce inequalities in health & wellbeing of the local population
- To improve people's experience of care
- To improve the sustainability of the health and wellbeing system

3) System Working

Recognising Plymouth's place in the wider Devon system and our relationship with neighbouring partners. Together for Plymouth is committed to:

- Playing an active place based role in the developing Devon Integrated Care System
- Ensuring Plymouth makes the best contributor it can to system performance
- Working in close partnership to align plans with our neighbouring systems in South East Cornwall and Western Devon
- Forging links to the Mental Health and Children's Partnership Boards and emerging Provider Collaboratives

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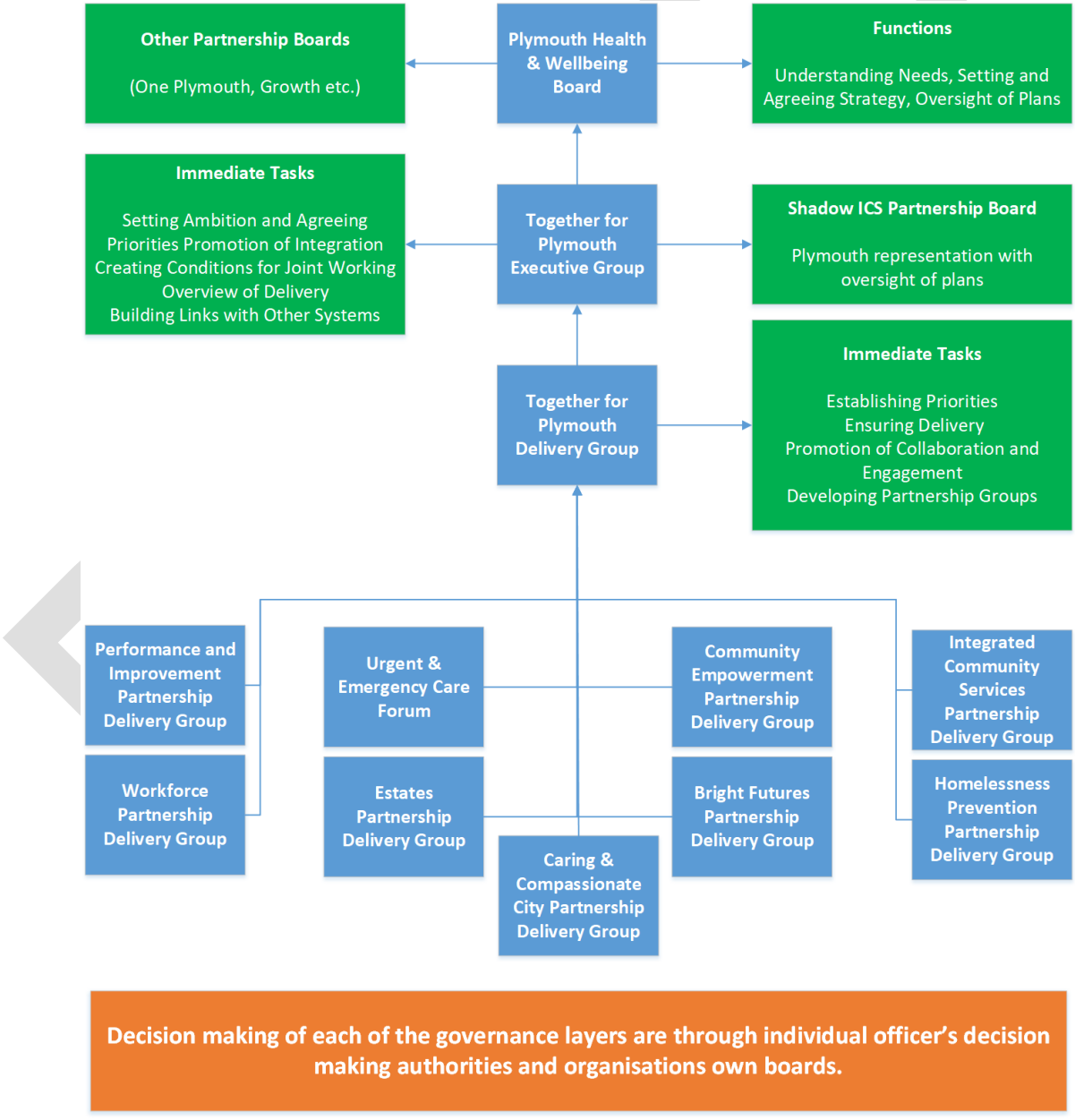
4) Governance of Plymouth LCP

The current LCP governance arrangements are set out below. The Together for Plymouth Executive Group meet on a monthly basis and membership includes Devon CCG, Plymouth City Council, Livewell SW, Primary Care representation and University Hospitals Plymouth. The Together for Plymouth Group maintains effective and efficient governance links with other statutory boards and now reports to the Health and Wellbeing Board (HWB) on a quarterly basis.

The Together for Plymouth delivery group was established in February 2021 with wider participation including VCS and Healthwatch representation. The delivery group will implement the shared vision and narrative for the health, wellbeing and care of the population, provide system leadership and coordination across the LCP and oversee the development of an integrated work programme.



Decision making of each of the governance layers are through individual officer's decision making authorities and organisations own boards.

Together for Plymouth
Health and care working in partnership with local communities in Plymouth and the rest of the Devon

5) Plymouth Locality Profile

Local Population Need

In Plymouth the JSNA is not one single document. Our JSNA process involves the production of a series of profiles and reports. It explores a variety of topic areas in depth. The closest thing we have to a single written JSNA is the '***Plymouth Report***', which provides an overview of a number of key issues which impact upon health and wellbeing in Plymouth, such as crime, education and employment.

Plymouth has a current population of 263,070 and this is estimated to grow to around 274,300 by 2034, a projected increase of 4.3 per cent. Due to approximately 26,000 students residing in the city, the percentage of 18-24 year olds (12.2 per cent) is higher than found in England as a whole (8.7 per cent). There will be a major shift in the population structure of Plymouth over the next 20 years as the proportion of the population aged 65 and over increases and the population aged 0-4 years decreases. ONS projects a rise in the percentage of the Plymouth 65+ population from 17.9 per cent in 2016 to 22.7 per cent by 2034. An ageing population suggests an increasing need for care and support services and also an increasing burden placed on the working age population. Residents appear to be enjoying a lifestyle above that of the average England resident.

Life expectancy in Plymouth has improved for both males and females in recent years however it remains below the England average. Healthy life expectancy in Plymouth (the average number of years a person can expect to live in good health) is significantly lower than the England average for both males and females. In terms of inequalities, the life expectancy gap between those living in the most deprived areas and those in the least deprived areas remains significant. Life expectancy in the most deprived group of neighbourhoods in Plymouth (at 78 years and 2 months) is 4 years and 9 months lower than the least deprived group of neighbourhoods.

Valuing mental health to the same degree as physical health enables NHS and local authority health and social care services to provide a holistic, 'whole-person' response to each individual in need of care and support. In 2017 there were over 26,500 people (aged 18-64) in Plymouth estimated to be suffering from common mental health problems including depression, anxiety, and obsessive compulsive disorder. Over 11,900 Plymouth residents aged 18-64 years in 2017 were estimated to have more than one mental health problem; a figure that is projected to remain fairly static over the next 10-15 years. There has been an increase in the number of referrals to the Child and Adolescent Mental Health Services (CAMHS) in Plymouth. Service providers also report an increase in the complexity of children and young people's needs and issues requiring attention. Hospital admissions of young people (aged 10-24 years) for self-harm in Plymouth are higher than the England average (706 per 100,000 population compared to 421 per 100,000 population).

Four lifestyle behaviours (poor diet, lack of exercise, tobacco use, and excess alcohol consumption) are risk factors for four diseases (coronary heart disease, stroke, cancers, and respiratory problems) which together account for 54 per cent of deaths in Plymouth. Alcohol and drug (illegal and prescribed) dependence are significant issues for Plymouth. These dependencies are commonly associated with mental health problems, homelessness, offending, and have negative impacts on families and children.

18.6 per cent of Plymouth children live in poverty (9,990 children), and the vast majority (76.9 per cent) are living in workless households. The proportion of children in poverty living in working households is rising and there are still some suggestions that data underestimates the volume of 'in work' poverty.

Service Provision

There are two main health providers delivering health services in and around Plymouth: University Hospital Plymouth NHS Trust who deliver acute services and children's services via the Child Development Centre, and Livewell Southwest (LSW) who deliver community, Mental Health, Learning Disability and Children's services. Livewell Southwest provide adult social care services for people resident in Plymouth, enabling a greater degree of integration. UHP and LSW currently have an MOU in place to enable integrated working through Acute Ambulatory Unit and a range of other services to enable improved patient flow from the acute hospital. LSW are also working to develop their approach to working with Primary Care Networks on the integration of services in line with the integrated care model.

A procurement is currently underway for an Integrated Care Partnership for Adult Community, Mental Health and Learning Disability Services and Adult Social Care. This will ensure further integration of service provision. UHP, and to a lesser extent LSW, also provide services to residents of East Cornwall, and both organisations provide services across South Hams and West Devon.

Financial Challenge

The Devon Long Term Plan sets out the underlying system deficit of £152m (before FRF) by 2020/21 reducing to a deficit of £10m (before FRF) by 23/24, assuming the existing savings plans in the Long term plan can be delivered (an annual saving of at least £96m each and every year). If these significant financial deficits are to be addressed, the service model and system of care in the whole of Devon will require radical transformation to deliver a solution that is affordable and sustainable. The Plymouth funding allocation is currently below target (excluding specialist commissioning and delegated primary care) a commitment of recurrent funding has been made to ensure equitable funding.

Devon's Long Term Plan and New Model of Integrated Care

The Devon Long Term Plan sets out a number of key ambitions to change the model of care radically in the next 5 years to enable the provision of high quality services to all our residents. Of key importance is the development of integrated health and care networks of community, primary care, mental health and hospital services to reduce the need for acute based care; reduce the pressure on emergency hospital services and help to address health and wellbeing inequalities. Providing coordinated care will mean that the system is better able to meet the long term demographic challenges affecting Devon by proactively responding to the growing demand for care through supporting people to manage their needs in their own communities.

At a summary level, the new model of care consists of three key elements as summarised below:

1. **Primary Care Networks (General Practice) working at scale & providing strong system leadership –** GP Practices working more collaboratively to improve practice resilience, deliver improved access to a broader range of services**,** and benefit from improved economies of scale. PCN working will provide a stronger platform on which to deliver a more integrated community services model as summarised below.

2. **Stronger, more integrated care model** - this will include delivery of the blueprint for a more integrated and multi-disciplinary community-based service model wrapped around PCNs providing integrated primary, community, social care, mental health and more integrated, networked model of acute service provision.

3. **A sustainable acute care service -** In line with the agreed service model being developed as part of the peninsula clinical services strategy, this will be delivered by working in closer collaboration with other Acute Trusts across Devon as part of a wider Acute Trust network.

It will be a health and care system with people and services working together to connect with and harness the power of communities to achieve greater emphasis on promoting wellbeing, independence and community resilience supported by proactive community services working seamlessly with transformed secondary care in-hospital and specialist services.

Whole System collaboration
All partners working together in a coordinated and systematic way will be a critical enabler of this new model of care as outlined in this document and within the Devon LTP.

Providers of acute, community, mental health, primary care, social care services and voluntary services are key partners in the drive and delivery of integrated care for the population. The procurement of an Integrated Care Partnership for community complex care, mental health, social care and learning disability services for adults will further strengthen these arrangements. Many of the critical success factors underpinning the procurement and delivery of the ICP are drawn from the Devon Integrated Care Model blueprint, public engagement and best practice.

Other models of integrated working are already in place, including the partnership underpinned by an MOU, between Plymouth City Council, Livewell and UHP to form Access, a multi-agency triage response to children with additional needs including SEND. Plans are underway to further develop innovative and collaborative approaches, with the intention of developing of an Innovative Partnership to drive the development of 0-19 Family Hubs; places and support for families to be able to access Early Help, to prevent escalation into statutory services and build on resilience in communities.

6) Impact of COVID

The impact on the communities that we support has already been significant and will continue to have a significant impact going forward:

- **Direct impacts –**
  - Significant impact on our care homes however relatively low cases, hospitalisations and deaths compared to national averages
  - As yet we don't know much about long covid and rehab

- **Indirect impacts –**
  - Mental health and wellbeing (all age)
  - Health behaviours (smoking, alcohol, diet and physical activity)
  - Lived experience (especially for vulnerable groups and potential increases in childhood trauma)

- **Impacts of changes to…**
  - Access to healthcare (reduced screening and diagnosis, delayed care)
  - Income (recession leading to unemployment, more unstable work and financial insecurity)
  - School and education (impact of learning from home)
  - Built and natural environment (this has been a positive, with green spaces throughout the city being used more to support wellbeing)
  - Care Markets, more voids, less demand for Residential Care, increased costs of providing care
  - Demand for Services, Increases in Children in Care, Homelessness, Domestic Abuse

In spite of these challenges, when services were already under strain, the approach to meeting the challenges of the Pandemic has seen an unprecedented City Wide Response with partners coming together in a collective endeavor, working at pace, focusing on delivery and maximizing technology. Partnership working across the City has never been stronger, with a clear focus on supporting our citizens. Joint initiatives in responding to the pandemic has therefore created an environment for further collaboration and cooperation. The response to COVI-19 has also created a renewed ambition, energy and drive to meet the needs of the most vulnerable, with the Plymouth LCP determined to "Build, Back, Better".

7) Tackling Inequalities

Thrive Plymouth**,** our 10-year plan to improve health and wellbeing and reduce health inequalities in the city, remains our strategic approach towards tackling health health inequalities and will have a focus on helping people to stay well and targeting interventions to those most in need. Tackling health and wellbeing inequalities is fundanmental to the aims of the Plymouth LCP and each part of this this plan will contribute to meeting that ambition. Therefore each

programme of work will be expected to identify the health and wellbeing gaps relevant for their programme, have plans for tackling them and understand the likely impact of COVID19 and the mitigations needed.

8) System Priorities and Programmes of Work.

Our Joint Strategic Needs Assessment, Plymouth Report and Locality Profile, as well as our experience and learning from COVID have shaped a small number of priorities of the Plymouth Local Care Partnership:

1) Building a ***Compassionate and Caring City***
2) Developing a sustainable system of ***Primary Care***
3) ***Empowering Communities*** to help themselves and each other
4) Ensuring the Best Start to Life through ***"A Bright Future"***
5) Relentless focussing on ***Homelessness Prevention***
6) ***Integrating Care*** to deliver "the right care, at the right time, in the right place" to address local urgent and emergency care challenges.

Elective Recovery and Restortation is of course a priority for the ICS and the people of Plymouth and Devon. The Plymouth system will play a full roll in elective recovery part but this will be coordinated and managed at a Devon wide level.

In addition to the above the intention is to make best use of our collective resources and take forward the following enabling programmes, Estates and Workforce and Digital. As such the intention is to work with partners including our Universities and Colleges to develop a ***Plymouth People Plan*** aligning to and complimenting the Devon People Plan and the local Skills Strategy. ***An Estates Framework*** that sets down to the estate requirements to deliver our health and wellbeing operating model will also be developed. This will build on the One Public Estate Programme approach and align to HIP2 and the Devon Integrated Care System Estates strategy. Working within the ICS Digital programme, the LCP will set down a ***Digital Position Statement***, setting down the current initiatives, links to the ICS and requirements to deliver further change.

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Work Programme		
Priority	**Programmes and Workstreams**	**Indicators**
Compassionate and Caring City	Trauma Informed Compassionate City Enhanced Carers Support Dementia Friendly City	Increase in Carers Assessments Increase in Number of Dementia Friends Expansion of Trauma Informed Network Increase in number of compassionate friends
Primary Care	Vaccinations Population Health Management Access to Primary care Early identification and treatment of conditions Targeted focus on vulnerable groups and treatment delayed	PHM roll out Improved access to the primary care offer. Backlogs reduced Reviews completed Sufficient workforce in system who are well
Community Empowerment	Leadership, Cultural change and Engagement Informal and Formal Volunteering Empowerment through the VCS Enabling Community Resilience	Increased number of people volunteering Increased number of people involved in community activity More people accessing advice on finances & employment Increased digital inclusion
A Bright Future	Healthy and Happy Safe Achieve and Aspire	Fewer Children requiring Tier 4 admission More children of a healthy weight Fewer children brought into care Fewer children placed out of area More YP in EET
Homelessness Prevention	Tackling Rough Sleeping Improving housing conditions for those in Private accommodation Delivering an increased range of accommodation solutions Delivering health and social care systems that support the prevention & relief of Homelessness Children and Young People's Homelessness Prevention	Reduction of numbers in temporary accommodation Reduction in numbers of Rough Sleepers Reduction in numbers of YP in B&B
Integrated Care	Urgent and Emergency Care recovery Integrated Care Partnership Transformation Plan Ageing Well Programme Community Mental Health Framework Caring for Plymouth	Reduction in number of ED attendances More people discharge to home first Redution in number of people entering long term care Increased utilisation of alternative to admission and crisis response More MH clients being supported in the community Improved outcomes for people living in care homes

9) Monitoring and Review

This plan sets down the priorities and programmes of work for the Plymouth Local Care Partnership for the next three years. The plan will be subject to ongoing monitoring and an annual review where plans may be refreshed or refined to reflect emerging needs or new strategic priorities.

"Together for Plymouth"
Plymouth (Shadow) Local Care Partnership

Together for Plymouth Executive Group
Terms of Reference

Shared Purpose

- Together for Plymouth reinforces our collective intent for collaborative working to solve some of the deep-rooted challenges we face and to create a step change in system transformation.
- The primary purpose of the Partnership is to provide leadership and oversight to our ambition of creating an integrated system, which puts the needs of our population ahead of that of any single organisation.
- The shadow Devon ICS Board has set down the following aims for each of the LCPs:
    - Deliver Devon system strategies at local level
    - Improve health and wellbeing outcomes for the local population
    - Reduce inequalities
    - Improve people's experience of care
    - Improve the sustainability of the health and care system
- In addition the Devon ICS has set down the following activities that each of Local Care Partnerships should focus on:
    - Coproduce plan with ICS Partnership Board which will deliver improved health and care services at population level
    - Develop integrated services
    - Create conditions for healthy living
    - Manage resources within available budget
    - Plan services through engagement with citizens
    - Develop community assets
    - Support local engagement including with PCNs

Objectives of the Plymouth LCP Executive Group

- Develop a shared vision and narrative for the health, wellbeing and care of the population
- Provide system leadership and coordination across the LCP
- Agreeing and supporting delivery of integrated priority programmes and enablers that deliver the greatest health outcomes, social benefit and financial value for our local population
- Improving our public engagement activities so co-creation and experience based design become the norm, with outcome measures based on what matters to our local population

- Maximising utilisation of and motivating the people working within the health and care community
- Integrating and making best use of our assets such as land, buildings and information technology
- Driving efficiency, working towards adopting a single system financial control total and applying our shared resources in the most effective and efficient way
- Disinvesting when appropriate and safe to do so to reinvest in new models of care
- Establishing fit- for- purpose system-wide programme leadership and delivery oversight arrangements underpinned by robust governance and accountability arrangements
- Aligning place–based plans and governance structures within Wider Devon ICS where in best interests of population to do so
- Ensuring that the outcomes from the wider ICS are implemented within the Plymouth Locality.
- Monitor and drive delivery of the system work programme at a strategic level

System Working

Recognising ours place in the wider Devon system and our relationship with neighbouring partners we will:

- ❑ Play an active place based role in the developing Devon Integrated Care System
- ❑ Recognising the ICS role in performance improvement we will work to ensure place makes the best contributor it can to system performance
- ❑ As leaders of place set down a clarity of purpose- make it simple and articulate why it matters
- ❑ Facilitate local mobilisation empowering others to act- and declutter if necessary
- ❑ Planning and delivery will be seamless and will utilise strengths across the system
- ❑ Be governance light and delivery heavy with rapid decision making (within Frameworks)
- ❑ Work in close partnership to align plans with our neighbouring systems in South East Cornwall and Western Devon

Work Programme

The LCP Executive will produce annually the LCP priorities and an associated system work programme. Monitoring of those priorities will be through the development of the outcomes/performance framework. (It is recommended that an Executive Lead Member be assigned to this)

Member Organisations

- Devon CCG
- Livewell Southwest
- Plymouth City Council
- Primary Care Network Representation
- University Hospital Plymouth

Chair/Vice Chair

Requirement to be able to deliver LCP Role Profile
Progress now being made and important to build momentum
Interim position as Legislation may alter role
Needs confirmation by Christmas
Approach should support distributed leadership model
Initially 12 months with ability for Chair/Vice Chair to rotate at 6 months
Exec members to be assigned Leadership Portfolios (See above)
System should support PCNs to take up Leadership Roles

Accountability

Each member of the Executive Group is accountable for the collective effort of achieving the agreed priorities and programmes of work.

Decision Making

Decisions taken are by virtue of individual officer powers and where appropriate must be ratified through sovereign organisations governance processes.

Wider Governance

The TFP Executive Group will maintain effective and efficient governance links with other statutory boards. Specifically the Executive group will report to the Health and Wellbeing Board quarterly through a Chairs Report

Tasks and work programmes may be delegated to sub groups or other boards in support of the overall LCP objectives. The LCP may receive and approve recommendations and/or business cases from the LCP Delivery Board in furtherance of LCP objectives

Meeting Frequency

Monthly

Administration

Provided by Plymouth City Council

Quoracy

Meetings will not be quorate if less than 50% of member organisations are able to attend.

Date Approved

The Terms of Reference for the LCP will be reviewed annually. Next review due January 2022.

Together for Plymouth
Health and care working in partnership with local communities in Plymouth and the rest of the Devon

"Together for Plymouth"
Plymouth Local Care Partnership

Together for Plymouth Delivery Group
Terms of Reference

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    - Develop integrated services
    - Create conditions for healthy living
    - Manage resources within available budget
    - Plan services through engagement with citizens
    - Develop community assets
    - Support local engagement including with PCNs

Objectives of the Plymouth LCP Delivery Group

- Implement the shared vision and narrative for the health, wellbeing and care of the population
- Provide system leadership and coordination across the LCP
- Oversee the development of an integrated work programme deliver the greatest health outcomes, social benefit and financial value for our local population
- Monitor and drive delivery of the system work programme.
- Establishing fit- for- purpose system-wide programme leadership and delivery oversight arrangements underpinned by robust governance and accountability arrangements

- Embed public engagement activities so co-creation and experience based design become the norm, with outcome measures based on what matters to our local population
- Work to integrate and make best use of our assets such as land, buildings and information technology
- Ensure that the outcomes from the wider ICS are implemented within the Plymouth Locality.

System Working

Recognising ours place in the wider Devon system and our relationship with neighbouring partners we will:

- ❑ Play an active place based role in the developing Devon Integrated Care System
- ❑ Recognising the ICS role in performance improvement we will work to ensure place makes the best contributor it can to system performance
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- ❑ Be governance light and delivery heavy with rapid decision making (within Frameworks)
- ❑ Work in close partnership to align plans with our neighbouring systems in South East Cornwall and Western Devon

Work Programme

The LCP Delivery Board will produce annually the LCP priorities and an associated system work programme. Monitoring of those priorities will be through the development of the outcomes/performance framework and reports to the LCP Executive Board.

Member Organisations

- See Appendix Two

Chair/Vice Chair

- To be confirmed

Accountability

Each member of the Delivery Group is accountable for the collective effort of achieving the agreed priorities and programmes of work.

Decision Making

Decisions taken are by virtue of individual officer powers and where appropriate must be ratified through sovereign organisations governance processes.

Wider Governance

The Plymouth LCP Delivery Group will report to the LCP Executive Group on the priorities and work programme and escalating issues as appropriate. The Delivery Group will also oversee and establish a number of programme groups.

Meeting Frequency

Monthly

Administration

Provided by Plymouth City Council

Quoracy

Meetings will not be quorate if less than 50% of member organisations are able to attend.

Date Approved

The Terms of Reference for the LCP Delivery Group will be reviewed annually. Next review due February 2022.

Together for Plymouth
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Appendix One

Local Priorities (2020)

The Plymouth Plan remains the City's overarching Strategic Plan setting the vision, ambition and our direction until 2034. These priorities align to this plan and represent the Local Care Partnerships first tranche of priorities emerging from our COVID-19 response phase towards reset and restoration. They will form the focus of our joint endeavor whilst we develop our wider framework for tackling inequalities.

1. Building on Caring for Plymouth develop a single front door for care and support
2. Develop enhanced support for care homes
3. Strengthening out of hospital care through the Integrated Care Model with a focus on:
    a. Admissions Avoidance- provision of additional multi-disciplinary community crisis response to provide wraparound support for individuals in crisis.
    b. Improved access to step down provision to support hospital discharge arrangements including provision of additional beds with on-site therapy offer
    c. Further development of placed based Mental Health Support aligned to community multi-disciplinary offer wrapped around individual PCN's and supported by the voluntary sector.
4. Ensuring homeless people are housed in appropriate accommodation, have their needs fully met and as few people return to the streets as possible.
5. Working with Primary Care to build on learning from "Hot Hub" approach to ensure sustainable multi-disciplinary provision for COVID and non COVID residents.
6. Collectively and pro-actively support the City's *Resurgam* Programme, with a specific focus on the Health and Care Sector Plan, Skills, Building Plymouth, Spend-4-Plymouth and City Centre Renaissance.
7. Locally support a number of enabling programmes such as digital, workforce and infrastructure and estates. An initial priority in relation to estates will be seeking to maximise the HIP2 and One Public Estate Programmes to facilitate service change and develop new opportunities.

Together for Plymouth

Health and care working in partnership with local communities in Plymouth and the rest of the Devon

Appendix Two

Delivery Group Members (2021)

Name	Organisation
Craig McArdle	Plymouth City Council
Anna Coles	Plymouth City Council/CCG
Ruth Harrell	Plymouth City Council
Sarah Lees	Plymouth City Council
Emma Crowther	Plymouth City Council
Rachel Silcock	Plymouth City Council
Simon Murphy	Age UK
Sarah Gooding	Plymouth City Council
Michelle Thomas	Livewell South West
Natalie Hagan	Livewell Southwest
Joanne Beer	University Hospitals Plymouth NHS Trust
Shelagh McCormick	NHS Devon CCG
Tony Gravett	Healthwatch Devon, Plymouth & Torbay
Stephen Statham	St Lukes
Matt Bell	Pop
Vicky Shipway	Colebrook (SW) Ltd
Awaiting Nominations	PCN's

Together for Plymouth

Health and care working in partnership with local communities in Plymouth and the rest of the Devon

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee

Date of Governing Body: Thursday 27th May 2021

Dates of Committees covered in this report: 20th May 2021

(Minutes of these committee meetings to be available as an addendum)

Chair's Name and Title: Graham Turner, Non-Executive Director

Contact Details: g.turner5@nhs.net

Reports discussed and assurances received

- **Risk Register Reports** – see Risk Register review below.
- **The Performance & Quality** report was discussed and noted by the committee.

Reports received and noted

- Devon CCG month 12 finance report was noted by the committee. This confirms that the CCG has achieved a break-even financial position of the year 2020/21
- ICS month 12 finance report was noted by the committee. This confirms that the Devon NHS system has contained total expenditure within the financial envelope provided for the year 2020/21
- ICS Devon Operational Financial Plan for the first half of 2021/22. The committee noted work in progress to resolve the remaining plan deficit of £12.8m for the first half of the new financial year.
- Contracting & procurement update was noted by the committee. The committee discussed some learning points and recommended strengthening of the single action waver process for contract awards.

Risk Register Review Updates

- There are no new risks to report to this committee and no risk score movement.
- Risk 124 was agreed for closure.

Committee Decisions

- **None**

Items of concern to be escalated to the Governing Body
• **None**
Recommendations for Governing Body
• **None**
Recommendations for other Committees
• **None**
Terms of Reference or other committee effectiveness issues
• **None**

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.

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 Committee (Public)

Date of Governing Body: 20th May 2021

Date of Committee covered in this report: 6th May 2021

Chair's Name and Title: Judy Hargadon

Contact Details: judy.hargadon@nhs.net

Recommendations brought to Committee for approval or agreement

1) Director of Out of Hospital Commissioning Jo Turl **requested delegated responsibility** for approving PMS premium funding allocation.
The Committee agreed to delegate the decision making for PMS premium funding allocation to CCG Executive, subject to comments made at an earlier meeting about how to prioritise.

Reports brought to Committee for information, review, discussion and to be noted

Finance Report

- The budget has been planned for the first half of the year only, as that is what has so far been allocated.
- The amount allocated to Devon is the amount expected as a return to the original 5-year plan**.**
- There are some new areas of allocation this year.
- There are some areas of discretionary budget setting e.g. for Additional Roles funding.
- Budgets have been allocated for: GP contract, Primary care Networks, Service Development fund, Enhanced services, GP IT and GP engagement, prescribing.

Deputy Director's Report – with updates on

- Special Allocation Scheme Contract update - all now in place.
- March LMC Negotiations meeting

Internal Audit finalised paper – inclusive of actions

- Action updates to be overseen by PCCC regularly.

Core contract changes update

There are minimal General Practice contractual changes for 2021/2022 in order to support and aid continued stability throughout the GP response to COVID-19

Primary Care Strategy update – slide presentation
Workforce strategy pillar focus – presentation and paper
The CCG has committed to develop and retain an agile and engaged workforce, with a focus on multidisciplinary teams.
The four identified workforce areas are:

1. Developing the Primary Care Workforce
2. Recruitment and Retention
3. Agile and Multidisciplinary Workforce
4. Engaged Primary Care Workforce

Areas of focus included:

- Devon CCG Primary Care Strategy
- Workforce Implementation Group (WIG)
- Funding
- Primary Care
- Networks and Additional Roles Reimbursement Scheme (ARRS)
- Next steps,
- Impact Measures for success,
- Opportunities,
- Gaps and risks

Primary Care/Secondary Care interface Paper

Unplanned work transference between secondary care and primary care is an issue that has been raised through CCG/LMC Negotiation meetings, by secondary care providers, and is an entry on the CCG's Risk Register.

Through system wide discussions a draft document has been developed to describe provider expectations of one another, with the intention of this being the basis for framing provider to provider agreement. PCCC were keen to see this implemented with pace.

Recommendations for Governing Body
None
Recommendations for other Committees
None
Terms of Reference or other committee effectiveness issues
None

Management of Conflict of interests:

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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 – Commissioning Committee

Date of Governing Body: Thursday 27th May 2021

Dates of Committees covered in this report: Thursday 13th May 2021 (Minutes of the committee meeting are to be available as an addendum)

Chair's Name and Title: Dr Claire Hooper, Strategic Lead for Planned Care

Presented by Dr Nick Kennedy, Independent Secondary Care Clinician

Contact Details: claire.hooper2@nhs.net / nick.kennedy3@nhs.net

Reports received and noted

Update on Operating Plan
The Committee were provided with a brief summary on the operating plan. The Committee were invited to share their thoughts on the operating plan. It was noted that the first draft submission is due at the beginning of June.

Update on Long Term Plan and roadmap of Strategic Commissioner
The Committee were provided with an update on the Long-Term Plan and roadmap for the Devon ICS. It was agreed that the Forward Plan for the Committee would be updated to reflect the work that needs to come to the committee for approval.

Risk Register Review Updates

The Committee endorsed the recommendations within the risk report to:

- Support the risk coordinators to ensure all risks are recorded, updated, and have all the assurances, controls and mitigating actions recorded with regular reviews undertaken by all the teams.
- Identify any risks reporting to the Commissioning Committee that need to be added to the risk register or amended.
- Consider the adequacy and effectiveness of the controls and assurances identified in the management of risk including measures to address gaps in controls and assurances and identify any further action that should be taken to manage the key risks.
- Are assured and approve those risks highlighted as having increased or reduced in
- score.
- Note the addition of risk 149, Eating Disorders Physical Health has been added to the risk register.

Committee Decisions

Special Educational Needs and Disability (SEND) Joint Commissioning Strategy

Decision: The Committee approved the recommendation within the SEND Joint Commissioning Strategy to review and approve the plan.

- The key areas of the plan were outlined as:
  - Engaging with education and local communities such as for short breaks.
  - To have early access to services.
  - Addressing the waiting times in Autism and Speech and Language Therapies.
  - An increase in uptake of health checks.
  - Implementation of the Community Mental Health for those aged 18-25, care leavers and early support to those who are at crisis.
  - To provide training opportunities for adults fulfilling an inclusive education.

Diabetes Lipids Service Transfer

Decision: The Committee agreed in principle on the proviso that the service offered at TSDHT is comparable with other services offered in the ICS to be supported by Devon wide clinical referral guidelines. The process for management of follow up backlog was also flagged as an issue due to the unnecessary step of involving primary care and will need to be reconsidered.

- Approve the transfer of the Diabetes Lipid Service from Royal Devon and Exeter NHS Foundation Trust (RD&E) and Torbay and South Devon NHS Foundation Trust.
- Approve the approach which has been agreed between Royal Devon and Exeter NHS Foundation Trust (RD&E) and Torbay and South Devon NHS Foundation Trust (T&SD) regarding the management of the backlog of Diabetes Lipids patients at RD&E.
- Approve the additional funding of £54,104 per annum for the service.

The committee considers there should be a process for the CCG/ICS to review whether individual pieces NICE guidance should be fully implemented. It was suggested that the Commissioning Committee is the body to determine this, but there was no final decision made.

Clinical Policy Recommendations

- **Decision:** The Committee accepted the recommendation made by CPC for Oral semaglutide (Rybelsus®) for the treatment of type 2 diabetes.
- **Decision:** The Committee accepted the recommendation made by CPC for Freestyle Libre device for interstitial glucose monitoring in diabetes for people living with a learning disability.
- **Decision:** The Committee accepted the recommendation made by CPC for Blepharoplasty (upper and lower lid) including brow lift.
- **Decision:** The Committee accepted the recommendation made by CPC for Radiofrequency denervation.
- **Decision:** The Committee accepted the recommendation made by CPC for Chronic rhinosinusitis.
- **Decision:** The Committee accepted the recommendation made by CPC for Removal of adenoids for the treatment of glue ear.

Items of concern to be escalated to the Governing Body

None.

Recommendations for Governing Body
None.
Recommendations for other Committees
None.
Terms of Reference or other committee effectiveness issues
None.

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.

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 – Quality Assurance Committee (QAC) Public Part 1

Date of Governing Body: 27 May 2021

Dates of Committees covered in this report: 20 May 2021

Chair's Name and Title: Glynis Atherton, Non-executive lay member (Chair of Quality Committee)

Contact Details: glynis.atherton@nhs.net

Reports discussed and assurances received

The Committee received updated reports as detailed below

Reports received and noted

Patient Story: the committee heard the story of a carer whose mother was admitted to acute care from a care home and who was not communicated with despite holding power of attorney for her mother. The QAC agreed to a number of actions to be undertaken with the provider and also considered how the story could be used for training purposes.

Quality and Safety Report
Highlights from the report are:-
Primary care - There are currently 11 open serious incidents that require practices to investigate, a newly emerging theme follows that of PITCH and SEA submissions around timely access to care and delayed admissions causing harm. Currently 8 of the 11 open cases relate to delayed access, diagnosis and treatment.

Livewell Southwest (LWSW) – Have reduced their overdue serious incidents status from sixteen last month to ten. The CCG safety systems team remain in regular contact with LWSW regarding their overdue serious incident status and are assured by their processes in place to help further reduce the backlog.

Patient Experience P4 Report – The Elective Care Programme aims to reduce the backlog and waiting list. Ultimately this reduces the risk to patients. A Devon specific simulation model has been developed and presented to the Planned Care Programme Board which models over the next three years demand and capacity at totality and the impact on the total waiting list size.

In March 2021, the CCG and Devon County Council (DCC) Health Equality Programme (HEP) began work to understand patient experience and finding ways of ensuring those in most deprived areas or black, Asian and minority ethnic (BAME) backgrounds are contacted/ supported further when waiting long periods.

The Elective Recovery Programme is managed at ICS level. The programme is clinically led, system wide project groups report up to the Planned Care Programme Board. The focus of the Planned Care Programme Board is to change the context of how we are working across the Devon system with a focus on maximising recovery in the short-term, but also to ensure equity of access for patients across Devon and minimising harm for patients.

Learning from Life and Death Reviews LeDeR

The updated LeDeR policy has now been released by NHSE. The report outlines delivering service improvements based on themes emerging from learning from LeDeR reviews, good quality care, and several exciting projects this year to help to make a significant difference for the lives of people with learning disabilities, ensuring actions are implemented to improve health and social care provision. The new policy responds to the Oliver McGowan review recommendations. Devon LeDeR steering group will incorporate delivery of actions they identify reporting to Devon's Integrated care system.

Mental Health risk draft – Eating Disorders/Physical Health checks

There is no commissioned service for the physical health checks for adults who are within the Specialist Eating Disorder Pathway across the Devon CCG footprint. The establishment of a task and finish group seeking to find an immediate (short-term) solution given one primary care services has served notice to stop undertaking testing and acting on results has necessitated a short-term support system from DPT to primary care.

Longer term a bespoke service is the likely outcome. However, getting agreement on its role, function and establishment will take time – coupled with the need to find workforce that is currently depleted and hard to find nationally. A paper is being prepared for commissioning committee that seeks to find both a short term and lasting solution to the need for physical health checks for the eating disorder groups.

The findings of the recent coroner's inquest places responsibility across both commissioners and providers to ensure systems and processes are appropriately in place.

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 4 May 2021 of which it informs the Committee of any changes since the last Quality Assurance Committee (QAC) on the 15 April 2021. **Seventeen** risks that report to QAC.

There is one new risk to report to the Committee:
Risk 148 Devon Doctors Service Provision – The Committee did **not** agree to the addition of **Risk 148** in its current form and requested it to be reworded.

Four risks were presented to the Committee for removal from the Corporate risk register:-
Risk 126 Access to NHS 111 Service and **Risk 105 Devon Doctors Call Stacking** - were recommended for closure as these had been superseded by **Risk 148** and due to the discussions around **Risk 148** they are to be left on the risk register until such time the risk has been reworded.

Risk 123 - **Fit Testing – PPE/COVID 19** the Committee did **not** approve for closure until exit strategy has been agreed.

Risk 138 COVID 19 Vaccination Programme – this risk was **agreed** for closure by the Committee and will be transferred to the Directorate Risk Register as part of the risk management process.

Committee Decisions

- **Serious Incident Policy –** The policy was **approved** by the Committee.

Items of concern to be escalated to the Governing Body

- None

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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