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

MS Teams - refer to formal invite for joining details

28 April 2022 10:30 - 28 April 2022 12:15

AGENDA

#	Description	Owner	Time
1	To note *Regular breaks will be taken during this meeting		
2	Public, stakeholder and service user experience Verbal	Lynda Price, Read Easy	10:30
3	Welcome and apologies and questions from members of the public Verbal	Chair	10:50
4	Register of Interests (ROI) Paper DOI NHS Devon CCG Governing Body @07 Apr 20... 5	Chair	
5	Minutes of the last meeting and action log Paper 2022 31 03 Governing Body (public). DRAFT.docx 9 Master Action Log - PUBLIC v3 nc.xlsx 17	Chair	
6	Clinical Chair's Report Verbal 1 cover sheet chair's report.docx 18 2 Chairs Report April 2022.docx 20	Clinical chair	11:00
7	Accountable Officer's Report Paper AO report final April 22.docx 21	Deputy Chief Executive	11:05
8	PROGRAMME OF WORKS - items for recommendation, decision and assurance		

#	Description	Owner	Time
8.10	Devon Integrated Performance and Quality Report Paper Cover sheet IQPR FP (004).pdf 33 Devon IQPR report FINAL April .pptx 36	Chief Nurse	11:10
8.20	Final Accounts Process Verbal	Chief Finance Officer	11:25
8.60	Governing Body Effectiveness Report Paper Governing Body effectiveness report 2021_22 V0.1.... 128	Chair	11:40
8.70	Integrated Care System for Devon update - April Paper ICS for Devon update for Boards - April 2022.pdf 136	Director of HR, communications, IT and governance	11:45
9	LOCAL CARE PARTNERSHIP (LCP) REPORTS Paper 9 Final West LCP ICS Report April 2022.docx 143 Governing Body Update - South LCP (March 2022)... 145 Locality Update - Eastern Mar-Apr 2022.docx 148 Locality Update - Northern March- April 2022.docx 151 Plymouth-West Devon Locality Report for APRIL G... 155	Locality Directors	11:50
10	ASSURANCE COMMITTEE CHAIRS' REPORTS including items of escalation	Assurance Committee Chairs'	
10.10	Finance Paper Finance Committee Chair Report April 2022 v1.doc... 159		12:05
10.20	Primary Care Commissioning Paper PCCC Public Chair report - April 2022.docx 162		12:10

#	Description	Owner	Time
10.30	Quality Paper [P] QAC Chair Report for Part 1 GB April 2022 FINAL.d... 165		12:15

Declaration of Interests Register - NHS Devon CCG Governing Body
Register updated and generated by the Governance Team - 07 April 2022

Register last updated 07 April 2022

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

	Finn	John	Interim Executive Director of in-hospital commissioning to 31 May 2021 Substantive post Associate Director of Commissioning, Northern, Planned Care and Cancer	Member of Governing Body Exec Meeting Commissioning Committee (CC DOI) Northern Integrated Delivery Meetings System Restoration and Transformation Group Planned Care Programme Board Senior Leadership Team (SLT) Member of Finance and Performance Committee	No interests declared		19/01/2017	23/03/2021	Personal	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Fox	Matthew	Governing Body Locality GP NHS Devon CCG	Member of Governing Body A & E Delivery Board (SD&T)	GP principle, Barton Surgery, Dawlish. Director, Dawlish Medical Group Associate Medical Director TSDFT from 1 April 2019 Barton Surgery have rented a room to Chime. University of Exeter Medical School, Academic tutor and student teacher GP Locality Clinical Director Primary Care Network - The Coastal Network F2 academic tutor through the Deanery	Spouse is a co-owner of Barton Surgery Pharmacy Building	22/09/2016	17/04/2021	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay and South Devon NHS Foundation Trust
Dr	Greenwell	David	Governing Body Locality GP	Member of Governing Body Member of Finance and Performance Committee Remuneration and Workforce Committee(Non exec rem) Member Devon Joint Clinical Effectiveness Group (JCEG)	GP partner at Southover medical practice Member of an independent cooperative that provides out of hours medical cover to Devon Prisons Shareholder in Devon Doctors on Call Member of Upton Vale Baptist Church (personal interest) Member of Clinical Cabinet Primary Care Network - Torquay	Spouse is freehold owner of Southover Pharmacy	20/08/2015	22/10/2020	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Hargadon	Judy	Non Executive Lay Member - Primary Care and Prevention Geographical remit - Southern	Member Governing Body Member Audit Committee Member of Primary Care Commissioning Committee (PCCC) (Chair) Member of Remuneration and Workforce Committee Equality, Diversity and Inclusion Group IUCS Procurement Oversight Group (Chair)	Member of Women's Equality Party New management board chair at PenARC, – the National Institute for Health Research (NIHR) Applied Research Collaborations (ARCs) South West Peninsula	Spouse is Chair of Dartington Hall Trust Brother is GP in Cornwall	01/05/2019	25/05/2021	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote. Will not be involved in decisions about the CCG funding academic research	NHS Devon CCG
Dr	Harrell	Ruth	Director of Public Health, Plymouth City Council	Devon STP Clinical & Professional cabinet NHS Devon CCG Governing Body Member Devon Joint Clinical Effectiveness Group (JCEG) Member of Strategic Commissioning Partnership Primary Care Commissioning Committee (PCCC)	Director of Public Health for Local Authority		26/10/2016	18/08/2020	General	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Plymouth City Council
	Harris	Penny	Strategic Advisor - Long Term Plan	Attendee of Governing Body CCG Execs and Clinical Chairs Senior Leadership Team (SLT) Strategic Commissioning Partnership Joint Executive Team Meeting Strategic Commissioning Programme Board Commissioning Committee (CC DOI) System Restoration and Transformation Group Devon Urgent Care Board	Director of KERR Darnley Ltd Providing commissioning advice to variety of CCGs and Coaching/contract training Director of Kerr Mediation ltd - working alongside LMC law taking on primary care mediations commissioned by the LMC.		23/07/2019	29/10/2020	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	KERR Darnley Ltd
Dr	Johnson	Paul	Clinical Chair NHS Devon CCG Interim Medical Director ICS Devon	Member of Governing Body (Chair) Member of Remuneration and Workforce Committee Attendee Primary Care Commissioning Committee (PCCC) non voting Commissioning Committee (CC DOI) Strategic Commissioning Partnership Attendee Devon Joint Clinical Effectiveness Group (JCEG) Planned Care Programme Board Attendee of Finance and Performance Committee	GP Partner, Cricketfield Surgery (ceased August 2019) Salaried GP, Cricketfield Surgery (ceased December 2019) Member of Templar Care PCN (ceased December 2019) Locality Clinical Director at Torbay and South Devon NHS Foundation Trust (Nov 2016 to 28 March 2017) Church Warden Holy Trinity Church (ceased 2018) Non executive director role on the board for the South West Academic Health Science Network (SW AHSN)	Spouse works in emergency department at RDE and for Exeter Medical School	21/08/2015	15/09/2021	Financial Interest	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Kennedy	Nick	NHS Devon CCG Governing Body Secondary Care Clinician	Member of Governing Body Member of Quality Assurance Committee Attendee Remuneration and Workforce Committee Member of Primary Care Commissioning Committee (PCCC) QEIA Panel Member of Audit Committee Member Devon Joint Clinical Effectiveness Group (JCEG) Member of Devon Clinical Cabinet System Restoration and Transformation Group	Governing Body Independent Clinician BNSSG CCG Member South West Clinical Senate Council Consultant Anaesthetist, Taunton and Somerset NHS Trust Member of national Independent Funding Request Panel NHS England Non-Executive Director GO-OP, GO-OP is a Multistakeholder Co-operative Society (Somerset Rules), registered under the Co-operative and Community Benefit Societies Acts. GO-OPGO-OP will be the UK's first co-operatively owned and run Training Operating Company Introduced PPE supplier (Orthofix International) to Devon CCG. Company part owned by my cousin Non-Executive Director of a start up limited company called LinkExec, an online business aimed at promoting start up businesses and investors. April 2020 working one day a week for Somerset CCG on their Clinical Strategy and the Taunton/Yeovil merger strategy (11 Feb 2021) Trustee of St Margaret's Hospice Somerset Non Executive Director Go-Op Learn. A Co-operative organisation providing training opportunities (May 2021) Member of Western Provident Association on Anaesthesia (May 2021)		26/09/2017	12/03/2021	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	Kerr	Simon	Governing Body Clinical Lead – Eastern.	Member of Governing Body Member of Quality Assurance Committee Attendee Remuneration and Workforce Committee Attendee of Audit Committee Member Strategic Commissioning Programme Board Commissioning Committee (CC DOI) Eastern Locality Delivery Group	Chair of East Devon , Exeter and Mid Devon GP Members Forums GP Exec. Partner Coleridge Medical Centre Shareholder in Devon Health GP member of East Devon Health Federation GP Partner in Honiton , Ottery , Sidmouth Primary Care Network	Spouse works for Exeter Social Services	14/02/2017	28/04/2020	Financial / Personal	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

	Masters	Susan	Deputy Chief Nursing officer	Quality Assurance Committee (QAC) Member of Audit Committee Member fo Governing Body (Deputy for CNO) Member of Primary Care Commissioning Committee (PCCC) Member Vacancy Control Panel Senior Leadership Team (SLT)	Trustee Director of HQIP (Health Quality Improvement Partnership)		01/03/2021	24/08/2021	General Interest	indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
Dr	McCormick	Shelagh	Lead Clinical Representative (Western) – CCG Governing Body Strategic Clinical lead - Maternity Clinical Lead - Western Locality Clinical lead - Mental Health	Member of Governing Body Member of Quality Assurance Committee Member of QEIA Panel Member of Remuneration and Workforce Committee Member of Primary Care Commissioning Committee (PCCC) Member of Individual Packages of Care Panel (IPOC) Member of Local Maternity System (LMS) Board and Operational Committee	Elected member (and Deputy Chair from September 2019), South West Regional Council of BMA GP Appraiser (NHS England) Shareholder GlaxoSmithKline Working at Church View Surgery as self-employed sessional GP Elected to the Medical managers Committee of the BMA from September 2019	Partner is: Medical Secretary and Board member of Devon LMC GP Partner, Church View Surgery, Plymstock Clinical Director of Mewstone Primary Care Network(PCN) Clinical Director of Mayflower Primary Care Network (PCN)	26/09/2017	04/01/2022	Financial, Professional & Personal Interests	Direct & Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Milligan	Jane	Chief Executive of the Integrated Care System for Devon (ISCD) and NHS Devon Clinical Commissioning Group (CCG)	Member of Governing Body Joint Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee	Non Executive Peabody Housing Association House of St Barnabas Charity member	Partner Trustee for Action for Stammering	31/12/2020	29/04/2021	Personal	indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Millward	Andrew	Devon System Director of Communications and Engagement. Chief Communications, IT and People Officer, NHS Devon CCG Senior Information Risk Owner (SIRO)	Member of Governing Body Joint Executive Team Meeting Staff Partnership Forum Senior Leadership Team (SLT) Attendee Audit Committee Member of Remuneration and Workforce Committee Member of Vacancy Control Panel Equality, Diversity and Inclusion Group	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University DELT Board Member, CCG Devon nominated director		19/06/2018	14/04/2021	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Pearson	Nick	Chief of staff Office of the accountable officer for the ISCD and CCG	Senior Leadership Team (SLT) Commissioning Committee (CC DOI) Patient Engagement Group Primary Care Operational Group (PCOG) Attendee of Governing Body Joint Executive Team Meeting	Member of Exeter City Football Club Advisory Board Director, Centre for Health Communication Research, Buckinghamshire New University	Spouse is owner of Pearson Creative	13/01/2017	29/03/2021	Non-Financial Personal Interest	Direct & Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote. Will not be commissioned by employee	NHS Devon CCG
	Sargeant	Lincoln	Co-opted member of Governing Body	Member of Governing Body Member of Strategic Commissioning Partnership Member of Primary Care Commissioning Committee (PCCC)	Director Public Health, Torbay Council		24/02/2021	24/02/2021			Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	Torbay Council
	Snaith	Ginny	Board Secretary	Attendee of Governing Body (non voting) Attendee of Quality Assurance Committee Attendee of Finance and Performance Committee Attendee of Audit Committee Attendee of Remuneration and Workforce Committee Attendee of Commissioning Committee (CC DOI) Attendee of Primary Care Commissioning Commitee (PCCC) Joint Executive Team Meeting Senior Leadership Team (SLT) Working with Industry and Sponsorship Group System Restoration and Transformation Group Member of Strategic Commissioning Partnership Attendee Devon Joint Clinical Effectiveness Group (JCEG)	No interests declared		22/03/2019	10/08/2020				NHS Devon CCG
	Tapley	Simon	Deputy CEO for ICS for Devon and NHS Devon CCG Strategic Lead Commissioner for NHS Devon CCG	Member of Governing Body Strategic Commissioning Partnership Joint Executive Team Meeting Senior Leadership Team (SLT) Attendee Audit Committee (Audit Committee) Commissioning Committee (CC DOI) West LCP Executive Group Member Vacancy Control Panel Attendee of Finance and Performance Committee		Spouse is employed by TSDFT (ICO) 31/03/2017 Brother in Law is employed as Strategic Engagement Manager, NHS Devon CCG Step-son has started working as a health-checker	01/11/2016	05/05/2021	Non-Financial Interest Professional	Direct	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Tetley	Piers	Associate Director of HR and Organisational Development	Attendee of Remuneration and Workforce Committee Staff Partnership Forum Senior Leadership Team (SLT) Attendee of Governing Body/Member Governing Body (Deputy for Director of Communications) Member of Vacancy Control Panel CCG R&T Project Team meeting	No interests declared		16/10/2018	19/10/2020				NHS Devon CCG
	Turl	Jo	Executive Director of Commissioning - Out-Of-Hospital	A & E Delivery Board Senior Leadership Team (SLT) Mental Health Team Meeting Member of Strategic Commissioning Partnership Member of Governing Body Attendee Audit Committee Member of Finance and Performance Committee (occassional attendee) Member of Primary Care Commissioning Committee (PCCC) Joint Executive Team Meeting Strategic Commissioning Programme Board Commissioning Committee (CC DOI) Quality Assurance Committee Crediton Hub Project Group	No interests declared		13/08/2015	19/10/2020	Indirect interest	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

	Turner	Graham	Non Executive Lay Member-Finance	Member of Governing Body Member of Finance and Performance Committee (Chair) Member of Audit Committee Member of Remuneration and Workforce Committee (Chair)		Son employed by Care Quality Commission as an Information Analyst	16/10/2019	04/05/2021	Indirect interest		Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG
	Walling	Alex	Director, Grant Thornton UK LLP – external auditor	Attendee of Audit Committee Attendee of Governing Body	No interests declared		08/11/2018	08/09/2021				Grant Thornton
Dr	Wollaston	Sarah	Chair Designate Integrated Care Board for Devon	Attendee Governing Body, NHS Devon CCG	Trustee of Landworks, a Dartington based charity that works with ex offenders and people at risk of going to prison to support them into employment and reduce the risk of reoffending GP who works occasional locum sessions including as part of the COVID vaccination response	Spouse is president of the Royal College of Psychiatrists and a consultant forensic psychiatrist employed by Devon Partnership Trust Relative is a registrar in Obstetrics and Gynaecology on the South West training scheme (currently on maternity leave) but will be returning to RD&E in late 2022. Relative is a registrar in Anaesthetics on the south West training scheme and currently based at RD&E	01/12/2021	13/12/2021	Non-Financial Personal Interests	Indirect	Where a piece of CCG/ICSD work or an item on a Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG/ICSD
Dr	Womersley	John	Governing Body Clinical Lead – Northern Locality	Member of Governing Body Attendee of Audit Committee Member of Finance and Performance Committee Member of Primary Care Commissioning Committee (PCCC) Remuneration and Workforce Committee (Non exec rem) Northern Integrated Delivery Group	Member of One Ilfracombe Board Chair of One Northern Devon Partnership Board Member of steering group for CHILLUK. Chill Therapy CIC is a non-profit CIC providing cold water swimming sessions to help people manage anxiety and depression		14/02/2017	22/02/2022	Personal	Indirect	Where a piece of CCG work or an item on a CCG Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon CCG

NHS Devon Clinical Commissioning Group

NHS Devon Governing Body Meeting
DRAFT minutes held in PUBLIC

Date: Thursday 31 March 2022 Time: 09.30 – 11.45 Location: Via Microsoft Teams

Item	Discussion	*Action*
	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	
1	**Patient Experience** The chair welcomed everyone to the meeting held in public and a warm welcome was given to the guest speakers Grahame Flynn, CEO, and Judy Pride of Devon in Sight and Tracey Harper the spouse of a service user. Grahame Flynn (GF) gave context of Devon in Sight, the region's leading sight loss charity established in 1925. GF shared that 6 million people are estimated to be living with a sight threatening condition in the UK today and more than two million are estimated to be living with a sight loss which is severe enough to significantly impact on their daily lives. The biggest determinant of the onset of sight loss is older age, and this is a particular issue for Devon due to our higher than average aging population. It is estimated that by 2030 the number of people with sight loss in Devon and Torbay will increase 43% to nearly 56,000 people. GF shared the many ways in which the charity supports people both with emotional support (nationally only 17% of people are offered any emotional support in relation to their deteriorating vision) and practical support including gadgets to make life easier and the independent living service. It was highlighted that the charity also supports children and young people and their families, particularly around special needs, education and transition into work and independent living. Judy Pride (JP) ran through some of the telephone-based offers for people with sight loss can access. GF provided a visual representative of macular degeneration by using a filter. It was highlighted that appointment letters from hospitals were difficult to read in 12-point font and requested the CCG to consider appointment letters and information be in 16-point font to be more accessible. It was shared that when being discharged from hospital patients are being left with no onward support Tracey Harper (TH) the spouse of a service user shared the experience that her husband had been through since his sudden sight loss and highlighted there had not been follow up support offered by the hospital following his diagnosis. PJ identified that it was an accident that Devon in Sight was signposted to the family and shared this will be taken back as a challenge to providers.	

	AW offered to meet with Grahame and colleagues to take forward some of the areas discussed. GF shared he had been contacted by someone working in the eye unit who expressed concerns over being trained to give bad news to patients and families. PJ confirmed that this would also be discussed with providers. DG asked if the charity would be able to become involved much earlier in the process around shared decision making before patients make their decisions around surgical intervention. GF and JP felt that would provide a great opportunity for people to meet others and find out what it is like to live with sight loss. TF felt terminology is important when dealing with patients who have had bad news especially around counselling. GApp asked who can refer into the service. GF confirmed it is a self-referral service as well as GP and hospital led referrals. PJ thanked GF and JP for their presentation into what the staff at Devon in Sight are doing and thanked TH for her insights which were helpful to understand the difficulties faced. PJ shared a question from a member of the public around services available for the deaf community and commented that a full response would be provided in writing. PJ felt it was right to acknowledge that experience for people with hearing impairment is not always as good as it should or could be. However, there are things in place. There is a contract with sign solutions and with Relay UK to help people make their appointments. Devon Partnership Trust, who provide a lot of our psychotherapy services, use signed solutions in order for people to pre book sign language video interpreters. There is access to national services for children and young people and for adults to receive mental health support if they also have hearing loss.	
2	**Welcome and apologies and questions from members of the public** PJ welcomed everyone to the business section of the meeting, and the following apologies were recorded: Nick Kennedy Sarah Wollaston	
3	**Register of Interests** There were no amendments or new declarations made. DG has expressed a private conflict of interest. PJ confirmed this does not conflict with any of the items on the agenda.	
4	**Minutes of last meeting and action log** PJ led a page-by-page review of the minutes of the last meeting held on 24 February 2022. JWo commented in section 14, the Northern report, if the wording needed to be changed slightly, where it says the LCP is being effective in moving beyond the wider determinant of health, it should say into the wider determinant of health. Actions:	

	1. DA provided an update on the action around conversion rates for other cancers given the breast cancer figures showed similar data as pre pandemic. Confirmed data will be brought back to the next meeting. 2. ST confirmed the fair shares report has not yet been shared, however this will be circulated following the meeting.	
5	**Clinical Chair's Report** PJ shared there are discussions happening with non-executives and clinicians around how a shadow board of the ICS will work in parallel to the CCG Governing Body. This will ensure a smooth transition while the CCG still has statutory responsibilities to Commission for the population of Devon.	
6	**Accountable Officer's Report** JM shared that transition plans are well on track. There are still some questions around the interface with region in terms of delegated commissioning and areas which will change and have impact on areas such as staffing, governance and architecture. The continued Covid challenges were acknowledged with particular highlight to the significant staff sickness impacts. JM thanked everyone for their continued hard work. It has been identified that there are urgent care pressures as well as throughout the whole pathway. It was shared that work will be starting with social care colleagues, domiciliary care colleagues and care home collaboratives in terms of looking at the models of care within reablement. There has been a meeting around the SOF4 update, related to the CCGs performance, finance and the Devon transformation plan. It was acknowledged there is more work to do on this. The transition of board members process has begun with capturing how the successes and achievements of the CCG have been driven forward. GA asked when the Children's services review report would likely to be shared and about mental health, learning disabilities and autism and reducing the waiting list. JT shared that there is a draft report which has been undertaken in collaboration with our providers, this will be presented in the next couple of months. GA requested the current Governing Body to see the report before transition. JT confirmed the analysis around the waiting times had been undertaken however due to the effects of Covid the CCG are now working with providers around what is needed to be done differently. There has been additional investment to bring the waiting list back down to 18 weeks. DG highlighted that for ADHD and Autism there seems to be no service between the age of 16 and 18 and that due to the waiting list length the referral will be returned to the GP. JT confirmed this is not commissioning policy and requested to understand the details of the specific case to look into this. **Action – DG to share information of returned patient referral with JT to look into further. JT to bring back an understanding of support for 16 – 18 year olds around ADHD and Autism to next meeting.** DG asked if the CCG are satisfied caring for people in ambulances outside of hospitals is a safe model of care and shared concerns of those patients sat waiting for an ambulance	

	without being assessed due to delays at the hospitals in offloading. DA confirmed the CCG are not satisfied it was a safe model of care however shared the risks are balanced across the whole system. DA shared the CCG are looking at models of care are also looked into support for SWAST. PJ concurred that the CCG does not accept this as an acceptable level of care. SK requested to understand discussions around moving forward as a collaborative partnership from the supported meetings with NHSE/I. JM confirmed the work around the transition workstream and the work with provider collaboratives is a work in progress. SK asked if there is a plan to deliver the spring booster programme to housebound and care home patients. DA confirmed the spring booster programme will be ran as a hub and spoke model utilizing the vaccination centres. The plan for housebound patients is close to being signed off as if the plan for care homes. **The Governing Body received and noted the contents of the Accountable Officers report.**	
7	**PROGRAMME OF WORKS – items for recommendation, decision and assurance**	
	Devon Integrated Performance and Quality Report DA presented the report, confirmed the report has been through various sub committees and been evolved. The report now covers the 'so what' element in terms of the actions and the impacts. Highlights from the report were shared • Long waits in planned care remain high, high and sustained Covid numbers in March will impact this • Long waits along urgent care pathways • Reduction in ambulance attendances to ED, however, walk in attendances have increased as has a high abandonment rate in 111. • 6000 hours of ambulance handover hours lost in February. • Planned care pathway is being looked at particularly around harm. • Bed capacity within the care home market has increased with discharges down to 8.9 days with ambition to go down to five days by the end of April. • Covid patients are at some of the highest throughout the pandemic which is having significant impacts on flow and pathways. • CAMHS referrals continue to increase, metrics are being looked at and the conversations around the referral acceptance rates and the appropriateness of referrals. • Access to eating disorders remains a challenge and has been added to the risk register • Staff sickness continues to increase, however turnover has stabilized • Good feedback around primary care access PJ thanked DA for a very comprehensive report. JWo discussed workforce and felt the vacancies in Northern Devon were particularly high and shared it is very hard to provide a service due to this. DA shared there is overseas recruitment coming soon and there will be a national level of attraction to the South West.	

	In Northern Devon the CCG are trying to understand the hard to recruit roles and how this can be designed differently. JWo requested to understand if the merger between NDHT and RDE will support with vacancies. DA felt this would improve eventually but not sure when. DG queried whether the work around conversation rates and appropriateness into children's mental health referrals is also happening in adult mental health. DA confirmed this was the case. JH congratulated the work that has gone into evolve the report, however expressed a concern that while the CCG is working in crisis mode whether there is someone in place who is looking at the full report and reviewing whether there will be problems a year down the line. DA confirmed There will be someone coming in to lead this very soon and will pick up the areas mentioned. SK highlighted that if patients are being transferred out of the area there is a process to bring them back. JF reassured the Governing Body that for each patient a package of transport, accommodation and visitors is overseen by Carl Trimble and the transfer does not happen until this is all in pace. SK commented that the Primary care digital locum pool may not be working for all and that this has increased some areas of work. JT provided some clarity of the Primary care digital locum pool and the positive successes this has brought whilst acknowledging there may have been issues in particular practices. *Anna Coles joined the meeting and was asked to present at 11.20am.* AD queried where the report is being presented. DA and PJ confirmed there is a Governing Body briefing scheduled on 7th April where the report will be presented Comfort Break 10.57am.	
	Month 11 Finance Report JD presented the report and focused on the year-end position which remains on target for a £5.3 million surplus and is confident that the month 12 report will show the same. JD highlighted that for the last 2 years there has been significant additional resource received into the system, specifically about £140 million to deal with the direct impact of COVID and about £39 million to support with the restoration of elective care and as the CCG moves into the next financial year, financial challenge starts to become an issue. There will be a report to the governing body in due course on the operational plan. However, the report does continue to show stability. PJ good to know there is a good position for the next challenging year as the CCG moves out of Covid funding. SK asked whether pay increases will be an issue for primary care in the coming years if funding agreements and arrangements will become difficult due to being funded at a different rate. JD confirms the constraints from national arrangements remain and that national policy will be followed on this. JT recognized the general practice strategy is being consulted on and the system will look to see how support can be provided and the funding will also be looked at.	

	The Governing Body received and noted the contents of the finance report.	
	Integrated Urgent Care Service JT presented the paper and explained that this had been through various routes and is now well understood. It was highlighted that the final decision around the procurement had been made in private due to the risks around needing to inform all bidders and the incumbent organisation. The recommendations highlighted in the report were: To acknowledge the completion of the process to support the appointment of Practice Plus group and in particular note the next steps There will be a senior oversight group led by a senior member of the commissioning team with executive oversight to take this forward A show of hands from the members of the Governing Body confirmed that the decision to appoint PPG was supported. Thanks, and appreciation were given for a well written report and mobilization during the contracting process.	
8	**LOCAL CARE PARTNERSHIP (LCP) REPORTS** Southern DB highlighted the significant challenges, particularly around Torbay and the LCP in terms of the workforce and local market challenges. The Southern LCP is working hard with system partners on where we are. There have been signs of recovery at the time of writing the report however over the over recent weeks that has worsened due to COVID numbers. There will be a refocus on the ambulance handover improvement arrangements and system flow arrangements and a refocus of the South Urgent Care Board and being clear about the membership. LS highlighted there were other priorities within the system that had not been reflected in the report. DB agreed that there is a balance to strike about the current pressures and priorities and the broader programs of work. Western DB highlighted the place development programme has started looking at the PHN module including mental health challenges and elderly frailty. Voluntary, Community and Social Enterprise (VCSE) discharge coordination in South Hams hospitals are working well. SM shared she was initially dubious but now having attended a session now feels this is in a good place and is now fully prepared to be involved in the process. *Ruth Harrell left the meeting 11.28* Plymouth AC highlighted a focus on the here and now, with the significant pressures across urgent care. Focus on ambulance handover, system flow and discharges. The Dementia assessment unit has now opened and is a good step-down facility with good partnership work. Covid has significantly impacted with 49 facilities affected currently. LCP development work is continuing. Northern/Eastern TG highlighted urgent emergency care projects being worked on, one around low acuity tendencies and one around frequent attendees, trying to mirror and build upon the high	

	flow work that's been done in North Devon. There has been some Exeter University civic funding support for that. VCSE relationships are developing well. This sees 3 sub locality settings with a sector expert attending the locality forum. It was highlighted that the balance between the business as usual (BAU) daily reporting and system flow is impacting service provision and highlighted that a development day has been stood down. There are two minor injuries units not operating due to staffing and building works, this will need to be reviewed ahead of the tourist influx. A further risk factor is Cornwall patients where there have been some significant issues with discharges that are now being more robustly managed. One Northern Devon has continued to develop and TG will share the report to go out with the minutes. SM queried whether conversations around discharges are also happening with the Devon / Somerset border. TG agreed these boundaries are equally important and will be looked at. JWo felt it a challenge with the PCN which stretches across the Cornwall / Devon border and having to deal with different teams and CCGs. GT highlighted all reports reflect workforce issues and asked where this is being discussed and reviewed. JM shared that there is a People Board being developed and work is happening around pulling together analysis from Health Education England (HEE) and other sources. The workforce strategy is being developed and this will set out the road map. Workforce is one of the biggest priorities and will be pulled out. **Action – JM to share slides with members**	
9	**ASSURANCE COMMITTEE'S – including items of escalation**	
	Finance SK queried the scoring of Risk 160. GT confirmed the risk scoring is being reviewed by the Finance team.	
	Primary Care Commissioning Report taken as read, nothing further to escalate	
	Quality Assurance Report taken as read, nothing further to escalate	
	Audit NB shared a challenging conversation which took place around the Section 256 payments and that Grant Thornton were not prepared to give advice to the CCG as to whether we have been able to satisfy the requirements. JD confirmed the Finance team are continuing to work with Grant Thornton to enable this to be completed.	
10	**Any other business** None	
	Close of meeting 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

Lincoln Sargent – (LS) **	Director of Public Health, Torbay Council
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) **	Non-Executive Director/ Lay Member – Allied Health Professional, Devon CCG
Glynnis Atherton (GAth) **	Non-Executive Director/ Lay Member – Quality Assurance of Services, Devon CCG
Graham Turner (GT)**	Non-Executive/ Lay Member – Finance and Remuneration, Devon CCG
Jane Milligan (JM) **	
John Dowell (JD) **	Chief Finance Officer, Devon CCG
John Womersley – Dr (Jwo) **	Clinical Lead Representative, Northern Locality Devon CCG
Jo Turl (JT) **	Director of Commissioning – West, Devon CCG
Judith Hargadon (JH) **	Non-Executive Director/ Lay Member – Primary Care
Matt Fox (MF)	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) A	Secondary Care Doctor, Devon CCG
Paul Johnson – Dr (PJ) **	Clinical Chair, Devon CCG
Ruth Harrell – Dr (RH)**	Director of Public Health, Plymouth City Council
Sarah Wollaston – (SW) A	Designate Clinical Chair, Devon ICB
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 (SM)	Executive Director and SRO for the Integrated Care Partnership in Western, Devon CCG
Steve Brown – (SB) **	Director of Public Health, Devon County Council
In Attendance	
Jodie Howland (Minute Taker)	Governance and Facilities Business Manager
Sam Cush	Internal Communications Manager
Darin Halifax	ICS Lead for the Voluntary, Community and Social Enterprise
Charlie Read	Delt IT Technician
Grahame Flynn	Devon in Sight
Judy Pride	Devon in Sight
Tracey Harper	Spouse of a service user
Anna Coles (item 9 only)	Service Director of Integrated Commissioning - Plymouth City Council
Derek Blackford (item 9 only)	Director of Adult Social Care – Torbay City Council
Tim Golby (item 9 only)	Director of Adult Social Care – Devon County Council

Minutes approved	Date:	Signed by chair:

GOVERNING BODY - PUBLIC ACTION LOG										
Action Number	**Date of Meeting**		**Target Date**	**Lead**	**Progress on action**	**Assurance required to close action**	**Date Closed**	**By whom**	**Reported to Committee**	**OPEN/CLOSED**
Actions should be listed in sequential order	State the date of the meeting	Set out the actions needed in order to deal with the issue identified by the group and be narrate so that if minutes are not available the action is very clear to the owner and the committee members	State the expected date for completing the action	Name of person responsible for completing the action	The most up to date information to be provided to the group on the actions undertaken Yes/No confirmation if all actions	The most up to date information to be provided for assurance that all elements of the action have been completed.	Date action formally closed	This will be the lead or person to whom the action was designated	Confirmation that committee that raised the action is content the action has been completed	Confirmation if action complete
1	24-Feb-22	DA to investigate the conversion figures for other cancers.	31-Mar-22	Darryn Allcorn	31.03.22 - Confirmed data will be brought to June Meeting					**OPEN**
2	31-Mar-22	DG to share information of returned patient referral with JT to look into further. JT to bring back an understanding of support for 16 – 18 year olds around AHDH and Autism to next meeting.	28-Apr-22	Jo Turl	This item is not on the agenda for the 28 April, but a separate update report will be circulated to the Governing Body outside of the business meeting					**IN PROGRESS**
3	31-Mar-22	JM to share People Board slides with members	28-Apr-22	Jane Milligan	21.04.2022 The people plan steering group papers for April have been circulated to the Governing Body members. Recommendation for this action to be formally closed.					**FOR CLOSURE**

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Clinical Chair's Report				
Date of committee: 28 April 2022 **Date report produced: 20 April 2022**				
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: N/A** **Name and Title:** **Dr Paul Johnson, Clinical Chair** **Date: 20 April 2022**		
Public or Private (Governing Body only):	**Public**	√	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This report contains updates on:

- Introduction
- Joint Working with the ICB shadow board

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 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
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Clinical Commissioning Group

GOVERNING BODY – Clinical Chair's Report

1. Introduction

Pending legislation, we are going to be handing on the reigns to the Integrated Care Board from 1 July, so over the next three chair's reports I would like to take the opportunity to recognize the good work and dedication that the CCG and its Governing Body has done over the last few years.

I would like to start by acknowledging the progress that has been made in establishing clinical leadership at the heart of the NHS system. Being a membership organisation has meant keeping close to General Practice and benefitting from the clinical experience and leadership many of our GPs have brought to commissioning – thank you to our board member GPs who not only have kept true to their local areas but have also brought clinical challenge and oversight to our strategic approach and decision making.

Clinical leadership has not been exclusively primary care – we have learnt how to gain the benefit of allied health professional and secondary care clinician GB membership; demonstrating the benefit of diversity of clinical leadership which I hope will be built on into the future. Our Director of Nursing completes our board level clinical membership and has been able to both fulfil his role as an executive team member and bring his clinical experience to our board.

So, thank you Gaynor, Nick, Darryn, Shelagh, John, Simon, David and Matt, and all your predecessors for your hard work, experience and expertise.

2. Joint working with ICB Shadow Board

In July we will almost certainly see the formal establishment of the Integrated Care Board (ICB) which, as well as leading the Integrated Care System in Devon will take on the functions and responsibilities that currently sit with the CCG.

In order to ensure this handover process is as smooth as possible and that the good work initiated by the CCG Governing Body continues to benefit our patients beyond July, we will be joined today by members of the ICS Shadow Board. I'm sure my colleagues on the Governing Body will join me in welcoming them and look forward to working collectively over the next couple of months.

NHS
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GOVERNING BODY

Report title: Accountable officer report				
Date of committee: 28 April, 2022 **Date report produced:** 14 April, 2022				
Author (s) Name and Title: Nick Pearson, Chief of Staff		**Supporting Executive:** **Name and Title:** Jane Milligan, CCG Accountable Officer and Chief Executive of the Integrated Care System in Devon **Contact Details:**		
		Report Approved by: **Name and Title:** Jane Milligan, chief executive **Date:** 22 March, 2022		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:

This report contains updates on:

1. **Integrated Care System development and transition programme**
2. **Integrated Care System resources and staffing**
3. **Accountable Emergency Officer**
4. **Covid and vaccination latest**
5. **Merger of trusts in North and East Devon**
6. **Mental health, learning disabilities and neurodiversity update**
7. **Nightingale converted to tackle region's waiting lists**
8. **Great work of hospices in Devon**

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 only.

Impact on our objectives

(Delete as applicable)

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

Reference to other documents or accompanying papers:

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

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

Risk		x

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

Accountable Officer's Report

1. Integrated Care System development and transition programme

Programme Development

During March the programme team focused on developing the next iteration of the System Development Plan (SDP) for Quarter 4.

Each workstream contributed with their workstream development plans and a summary of progress since the October submission.

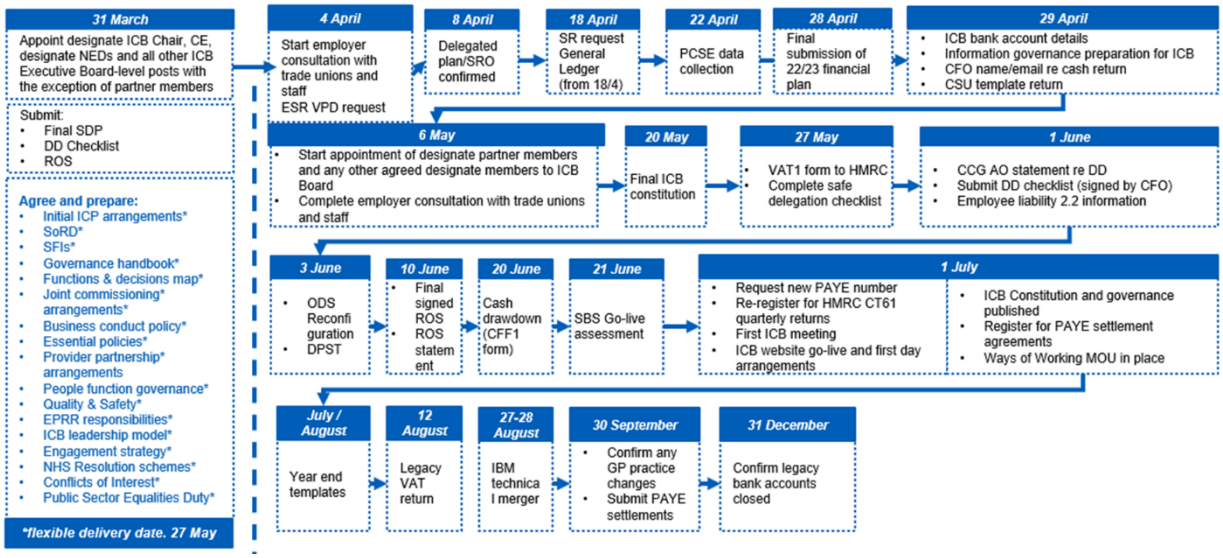
The SDP submission included the latest Due Diligence checklist which had received Strong Assurance from internal audit prior to submission.

The submission also included the Readiness to Operate Statement (ROS) checklist which tests level of confidence of each workstream's readiness to work across the system from 1st July.

The Due Diligence and ROS checklists are key documents for transition and will form part of the NHSEI sign-off process in June.

Informal feedback of our SDP submission was that it was comprehensive and more detailed than other SDPs from the region. NHSEI are now following up on any amber risks from the submissions to ensure there is a clear plan to address these prior to transition.

The next steps on overall programme development have been outlined by NHSEI in the following flow chart:



LCP and ICP Workshops

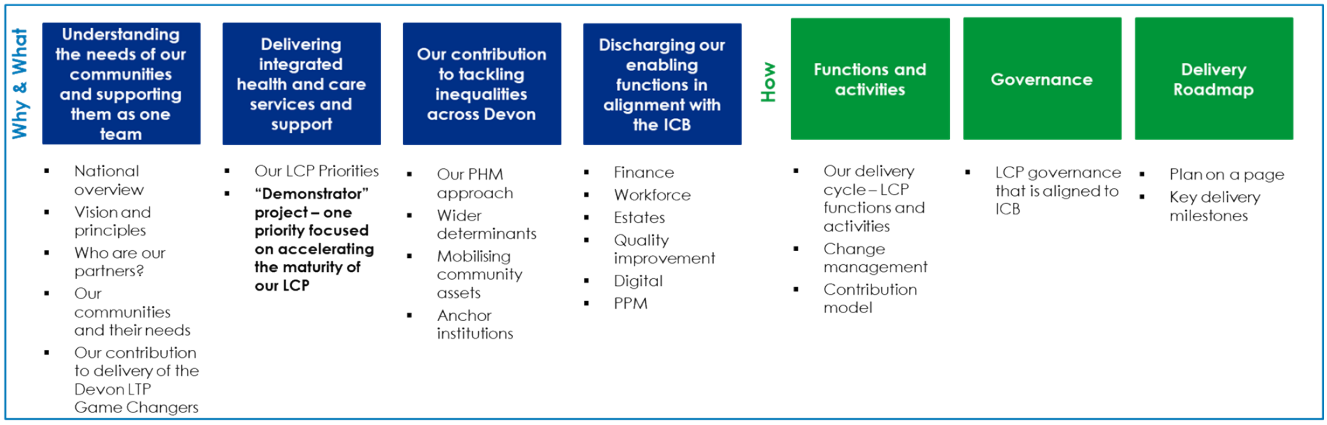
It is the ambition for each LCP to establish a development plan that is consistent in approach, but that emphasizes the uniqueness of each LCP and their communities. Plans will set out the ‘why’, ‘what’ and ‘how’ of place-based integration. A framework has been developed in alignment with the recently published Integration White Paper to support development of these plans (diagram below).

South, West and Plymouth LCPs have reviewed the framework and have agreed to use it to develop their plans. The framework is now being socialised with North and East LCPs to obtain their sign-up to this process.

Mobilisation of a ‘demonstrator project’ will form part of the delivery plan, designed to accelerate the maturity of each LCP. The demonstrator projects will test the principles of integrated working across the LCP through a ‘test and learn’ approach.

Work is now underway to review current activities in LCPs that can support content development for each plan. A gap analysis will be produced to identify where each LCP requires focused support and development.

LCP Development Plan Framework



Critical Path (Governance and People Transition)

- The deadline for our Constitution submission has been moved from the 31st March to the 21st April. A revised model constitution was issued by NHSEI on 31st March and we are reviewing this to incorporate key changes and ensure we are compliant with other supporting guidance that was issued.
- Terms of reference for committee structures are being drafted with support from key staff and Non-Exec members.
- All NED posts have been filled. Their engagement and induction is underway.
- Majority of Executive Director appointments have been made.
- The staff consultation was launched on 4th April

Other workstreams

Provider collaboratives – Allison Williams chaired the first meeting of the Acute Provider Collaborative. Jacquie Mowbray-Gold has begun work on the Mental Health, Learning Disability and Autism Provider Collaborative.

2. Integrated Care System resources and staffing

I am pleased to report that Dr Nigel Acheson has been appointed as our chief medical officer, where he will provide strategic and clinical leadership.

Nigel has held several high-profile national and regional clinical and leadership roles including deputy chief inspector of the CQC, regional medical director for NHS England, and medical director for the South West Peninsula Cancer Network.

Having originally trained in Birmingham, Nigel was appointed as a consultant gynaecological oncologist, before moving to a joint consultant role at the Royal Devon and Exeter and South Devon and Torbay Hospitals to help develop gynaecological cancer services.

In previous roles, Nigel has been a consistent champion for involving patients as partners in their care. He has a focus on improving the safety and quality of health services, and his research in ovarian cancer surgery led to the award of a Doctorate in Medicine.

The staff consultation on the Integrated Care Board (ICB) transition for CCG staff is now under way.

For staff below board level, there will be little or no change to their roles on 1 July.

The formation of the ICB will mark the start of the transition journey, with our system continuing to evolve post-July.

A consultation document was shared with staff at the beginning of April and consultation will last a month.

Other parts of the ICB are also coming together well.

I was pleased to co-host our first ICB Board and executive development day with Dr Sarah Wollaston a couple of weeks ago.

It was excellent to meet everyone and begin our journey as a team.

As well as getting to know each other a little better, we also began to look at our current position and how we can work together to improve care for our population now and in the future.

3. Accountable Emergency Officer

Darryn Allcorn, System Chief Nursing Officer has been delegated the responsibility as the Accountable Emergency Officer (AEO) responsible for Emergency Preparedness, Resilience and Response (EPRR). Darryn will be supported by Sam Wadham-Sharpe, Director of Performance and Assurance who commences in post mid-June 2022.

4. Covid and vaccination latest

There continues to be a high prevalence of COVID-19 with significant rises in infections in all age groups across England since February, when most remaining COVID-19 restrictions came to an end.

As I write, the latest data from Imperial College's React study, suggests approximately one in 16 people were infected with COVID-19 last month.

Seven of the top ten areas with the highest prevalence were in the South West, including Plymouth, Cornwall, South Hams, Torridge, Torbay, West Devon and Exeter.

Overall case rates are the highest recorded since the pandemic began, with the surge in infections being driven by people mixing more and the contagious Omicron BA.2 sub-variant, now dominant in the UK and responsible for around 90 per cent of cases.

Scientists say there are signs that the latest wave of COVID-19 infections may have peaked in children and younger adults and appears to be plateauing in adults aged between 18 to 54 years old, but rates in those older groups most vulnerable to severe disease are continuing to increase in England.

This is having a significant impact on our hospitals. We recently saw the largest number of people in hospital with COVID-19 since the pandemic began.

Even today, the number of people in hospital is more than the biggest peaks we experienced in 2020 and 2021. Staff absence due to COVID-19 is also high.

All this is a sobering reminder that the pandemic is not over.

How COVID-19 will develop over time remains uncertain, so we all still have a part to play in helping keep ourselves and each other safe and protected.

Please remember these five simple actions we can all take to help reduce the risk of catching the virus and passing it on to others:

- Get vaccinated
- Let fresh air in if meeting others indoors
- Remember the basics of good hygiene
- Wear a face covering
- Avoid contact with other people when you're unwell

All children aged 5 to 11 are now eligible for the COVID-19 vaccine. This age group will have two paediatric doses, 12 weeks apart.

Children who recently had COVID-19 will need to wait for their vaccine between 4-12 weeks depending on their risk level.

Clinics have already been vaccinating clinically extremely vulnerable children, who have a shorter interval between doses, and have been finding creative ways to put them at ease.

With Ramadan now underway leading Muslim NHS doctors are stressing that the COVID vaccine during the holy month does not break the daylight hours fast.

Resident TV doctor Dr Nighat Arif, a GP in Buckinghamshire, and Dr Farzana Hussain, a senior GP in East London and 2019 GP of the year, are among the doctors urging people to roll up their sleeves and have their jab.
If you have a Muslim friend or colleague, please urge them to take up the vaccine.

Finally, I'd once again like to thank our health and social care staff and clinicians, volunteers, managers and staff who continue to be part of the fight against the pandemic.

We are not out of the woods but our combined determination to lessen the impact of the pandemic and care for those who are ill, never dims.

5. Merger of trusts in North and East Devon

After many years of hard work, the Royal Devon and Exeter NHS Foundation Trust (RD&E) and Northern Devon Healthcare NHS Trust (NDHT) have formally merged to become the Royal Devon University Healthcare NHS Foundation Trust.

The new Trust has two acute and 20 community hospitals, and cares for a population of almost one million. It has nearly 17,000 staff, who work together to deliver core services to our local communities and specialist services across the whole of the peninsula.

The name of the overall Trust has changed, but North Devon District Hospital, the Royal Devon and Exeter Hospital (Wonford and Heavitree) and the Trust's community services – including community hospitals – will continue to be known by their existing names.

The merger is the culmination of incredibly hard work and is a fantastic achievement.

I would also like to take this opportunity to formally thank James Brent, their outgoing chairman for his excellent service to the trusts.

It is a great personal achievement to have chaired the RD&EFT and NDHT for ten and four years respectively, then bringing them together so successfully.

This would be difficult enough during normal times, but to do so while in the midst of an international pandemic, is very significant indeed and a lasting legacy.

I would also like to welcome Dame Shan Morgan to the trust, who replaces James. I have already had the pleasure of meeting Dame Shan and look forward to working with her, Suzanne Tracey and the wider team in this latest chapter of Devon's NHS.

6. Mental health, learning disabilities and neurodiversity (formally autism)

Last month I provided a significant update on work in this area. As a result, I would like to a few words about the provider collaborative.

Progress with shaping the provider collaborative for mental health, learning disability and neurodiversity continues well, building on existing care partnership arrangements and the strong history of joint working between NHS, local authorities, the voluntary sector and people with lived experience.

A programme director and clinical director are now in post to drive forward this important strategic development that will strengthen both the design and delivery of care and improved outcomes for the population and will form part of our overall ICS.

7. Nightingale converted to tackle region's waiting lists

The NHS Nightingale Exeter played a pivotal role in the national approach during the first stages of the pandemic, providing emergency in-patient care for patients with COVID-19 from across Devon, Somerset and Dorset.

As a result of a clinically led redesign programme, the Nightingale is now able to offer a range of orthopaedic, ophthalmology, diagnostic and rheumatology services to local people, helping to further reduce waiting times.

After being decommissioned as a COVID-19 hospital in March 2021, it was purchased by the Royal Devon & Exeter NHS Foundation Trust (now Royal Devon University Healthcare NHS Foundation Trust) on behalf of NHS organisations across Devon and the South West region.

The site has since been used to provide thousands of important diagnostic scans to local people and support the delivery of COVID-19 vaccine studies, as well as acting as a training centre to support new staff arriving from overseas.

In May 2021, it was announced that the Nightingale would receive a share of funding from the National Accelerator Systems Programme, which was awarded to Devon to support the reduction in waiting times.

The Nightingale site has now been transformed into a state-of-the-art facility, home to the following services:

- Southwest Ambulatory Orthopaedic Centre, which has two operating theatres for day case and short stay elective orthopaedic procedures

- Centre of Excellence for Eyes, which operates diagnostic screening services for ophthalmology patients and will run a high-volume cataract treatment hub

- Devon Diagnostic Centre, which is providing CT, MRI, X-ray, ultrasound, echocardiograms and fluoroscopy services

- The Royal Devon University Healthcare NHS Foundation Trust's Rheumatology department which provides outpatient care and day case infusions.

As we know, waiting times for NHS services have increased significantly since the start of the COVID-19 pandemic across Devon and the rest of the country.

The additional orthopaedic theatres, ophthalmology centre and diagnostic scans that the hospital now provides there will address the backlog of appointments caused by the pandemic.

It will take us some time to get to everyone on the waiting list but initiatives like this help us to make a real difference to the lives of people living across the South West.

Thanks to everyone involved.

8. Great work of hospices in Devon

One of the great pleasures of my role as CEO in the system is that I get to meet so many great people who care for others.

Last week I managed to get out of the office for a short time to meet the management and staff at Rowcroft Hospice in Torquay.

The Rowcroft Foundation offers community and inpatient hospice care for people affected by life-limiting illness and serves the communities of Torquay and South Devon. It has an inpatient unit with 12-beds providing respite care, symptom control and care for patients at the end of life.

The hospice also delivers end of life care in patients' homes and this service works closely with the hospice inpatient unit to support the care needs of patients.

I am grateful to Mark Hawkins, the hospice's CEO and Dr Gill Horne for showing me around in this its 40th year.

I was incredibly impressed with what they do there and am indebted to all hospice and their staff in our area for the sensitivity and care they offer to people.

I was also impressed by Rowcroft's plans for extending their care with a modernised inpatient unit with single rooms and en-suite facilities. It also includes family accommodation and a café.

Hospices do an incredible job and it is great to see them seeking to expand and update the services they offer to patients.

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Devon Integrated Quality & Performance Report (IQPR)				
Date of committee: 28 April 2022 **Date report produced: 14 April 2022**				
Author (s) Name and Title: **BI content: Karen Helliwell** **Performance summary: Lisa Heard** **Quality summary: Sara Wright**		**Supporting Executive: Darryn Allcorn** **Name and Title:** **Chief Nurse** **Contact Details:** **darryn.allcorn@nhs.net** **Report Approved by: Darryn Allcorn** **Name and Title:** **Chief Nurse** **Date: 14/04/22**		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

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

Outcomes
The outcomes report looks at indicators of the health of the population (the health status of the population and whether equitable outcomes are being achieved) and the health of the ICS (whether people are being appropriately and equitably supported by the ICS).
Whilst the ICS compares well to the national position for the majority of indicators there are a number where performance is lower or where there is significant variance across the system. These will be subject to quarterly exception reporting providing further context and detail around the headline indicator, key actions and timescales for improvement and any issues for escalation.

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

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

None

Key recommendations and actions requested:

Members of the F&P Committee are asked to:

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

Impact on our objectives

(Delete as applicable)

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

Reference to other documents or accompanying papers:

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

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

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

Together for Devon

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

Integrated Quality Performance & Finance Report

Date of issue: April 2022

#TogetherForDevon

Executive Summary

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

The Devon system has submitted its draft System 2022/23 Operating Plan which includes plans to work towards delivery of key elective care targets and address underlying issues that restrict ability to deliver elective activity. Operationally the ICS remains under extreme pressure with services competing for resources. This has resulted in a sustained position of increased risk, including delays in urgent care, discharges due to poor community capacity and COVID related staff absences. This has led to pressures in Emergency Departments (EDs) due to reduced patient flow resulting in a stepping down of some planned procedures.

System wide work is underway to understand the implications of harm in relation long waits in elective pathways. Multiple actions are in place to maximise efficiencies, capacity and ensure safe and high-quality care is delivered. One acute provider has successfully provided protected elective bed capacity to support elective recovery. Our principle remains that we ensure elective care is safely, sustainably and reliably provided as a system. Within the emergency pathways, ambulance response delays have shown to have a positive correlation with hospital handover delays and SWASFT are continuing to work on a system SI report for delayed attendances.

The system is developing a response into the full Ockenden Report and Devon providers have been implementing the 7 IEAs (Immediate and Essential Actions) identified in the interim Ockenden Report.

Children & Young Peoples eating disorder services continue to see increased acuity and referrals. Actions to address capacity and resilience should show improvements by October 2022.

Covid infections and admissions seem to have peaked in the current wave. Reported Covid case figures are now affected by significantly reduced levels of testing. Nosocomial (in-hospital) spread continues to account for a significant number of in hospital cases.

Financially the ICS is forecasting a year end £0.3m surplus which is £2.5m favourable against the £2.2m planned deficit.

Please note that on 01 April 2022 Northern Devon Healthcare NHS Trust (NDHT) and Royal Devon and Exeter Foundation Trust (RD&E) merged to form the Royal Devon University Healthcare NHS Foundation Trust (RDUH). In this report we have continued to report the sites separately under their previous names due to the period the report covers.

Key Risks & Priorities

Quality

- **Planned Care:** risk to patients, due to long waits. Initial GIRFT programme underway to review improvements in 4 months, in addition to increased capacity and communication with patient workstreams.
- **Urgent Care:** there is an ongoing issue of long-waits across whole pathway; 111, 999, ambulances through to EDs, system-side SI process agreed, as well as local analysis and improvement plans already in place.
- **Primary Care**: impact on PC workforce and capacity, due to long waits within planned and urgent care.
- **Community Care:** risk due to discharge delays and long waits for packages of care.
- **IPC:** On-going infection rates (COVID-19) impacting on both patients and staff in health and social care settings.

Workforce

- **Staffing** continues to be challenging across the whole healthcare sector with the following issues all impacting on each other.
- **Sickness:** Absence is currently at a high across Devon at 9.1% with Covid absence attributing 5.1%.
- **Turnover:** Turnover has remained static in recent months (11.8%), although it is higher than this time last year (9.3%).
- **Agency Spend:** Agency spend has reduced from last month and is now within normal control limits.
- **Vacancies:** Have reduced in all areas bar Allied Health Professionals.

Performance

- **Planned Care:** risk to RTT, diagnostic & cancer target delivery. Although improving position, 104ww trajectory gap of 860 at end June 2022.
- **Urgent & Emergency Care:** ED 4 hour under-performance (68%) and 60 minute handover delay breaches at all four acute hospitals (226.9 hours > 15 mins in March).
- **Discharge:** delays continue to impact on flow through the entire system & NCTR targets unmet. Although, a t otal of 91 additional beds have been mobilised.
- **IUCS**: 111 and Out of Hours service seeing continued capacity problems, although improvement actions progressing.
- **Childrens & Mental Health:** Reported improvement in Ockenden actions. Autism and Eating Disorder services continue to underperform.

Finance

- As at month 11 the Devon ICS had a surplus of £3.9m which is £6.8m favourable variance to plan. (M10 £7.7m)
- The forecast to the year end is £0.3m surplus (M10 £0.3m) which is £2.5m (M10 £2.5m) favourable against the £2.2m planned deficit.

Together for Devon

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Performance & Quality Context

2022/23 Operating Plan

All draft templates and narrative were submitted on 17 March 2022, in line with national requirements.

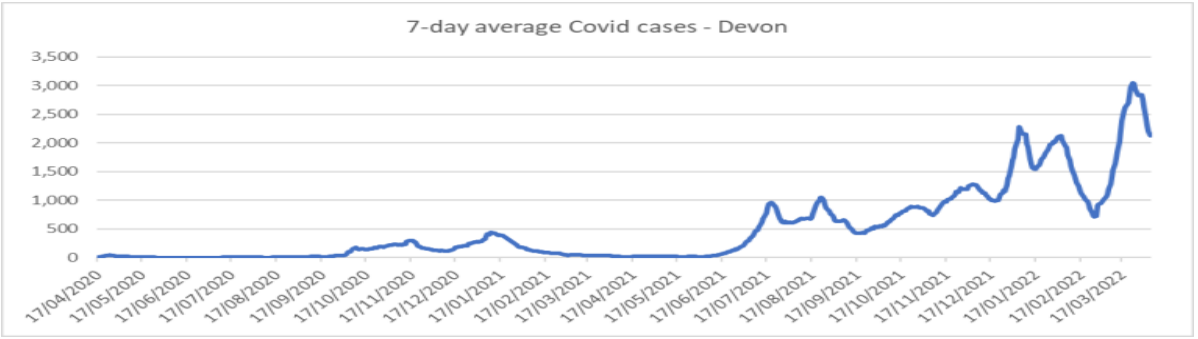
NHSE/I feedback was received 30 March 2022 and highlighted areas of good practice and also aspects of the plan that do not yet meet national requirements. Some of the key highlights and actions being undertaken are set out below:

- National outlier for 104 week waits (1317 at end of June 2022) – work is ongoing and has to date reduced this to 860 as at 30 June
- Deficit is second highest (proportionate to allocation) in the region, at 5.5% - work is continuing to improve the position and 12 April it has reduced by £27m to £104m. An expenditure review process is in place in early April to further impact.
- 50% of financial risk has no mitigation
- Working as separate organisations, rather than as a system
- Disparity between increase in workforce and in activity
- Not achieving non face to face outpatient and patient initiated follow-up targets (this has now been corrected and the system will meet these requirements)
- Not achieving required 120% for diagnostics – specifically endoscopies and ultrasound. Every plan has been reviewed and the improvement required to reach the 120% is understood. Whilst the position will improve, some of the initiatives rely on the Elective Recovery Fund (ERF) monies, so are at risk until this has been agreed.
- Areas of good practice set out in narrative, particularly in Health Inequalities section
- Needs more detail in narrative of timescales and trajectories, for example in relation to ambulance handover delays and 12 hour DTA breaches

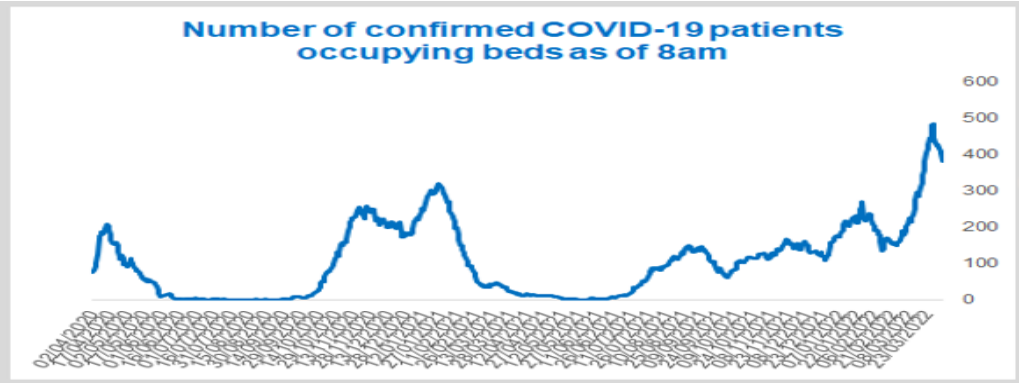
Work is underway to address errors and anomalies and to explain assumptions in more detail.
The final Operating Plan submission is due on 28 April 2022, following approval of the CCG Governing Body and the ICS Executive.

Covid Update

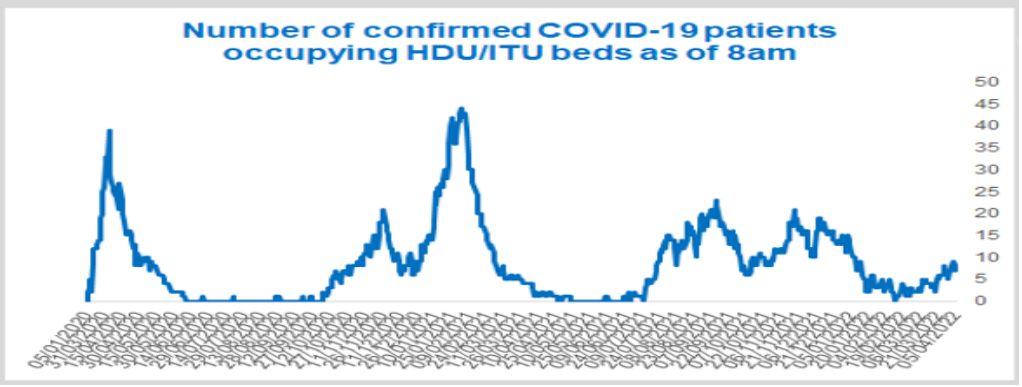
Covid infections rose significantly in March, reaching the highest level of the pandemic, but have started to reduce again. Reported numbers are now affected by significantly reduced levels of testing.



Admissions rose sharply in March but appear to have peaked.
An element of the increase was related to nosocomial (in-hospital) spread but admissions from the community were also high, reflecting increased prevalence.

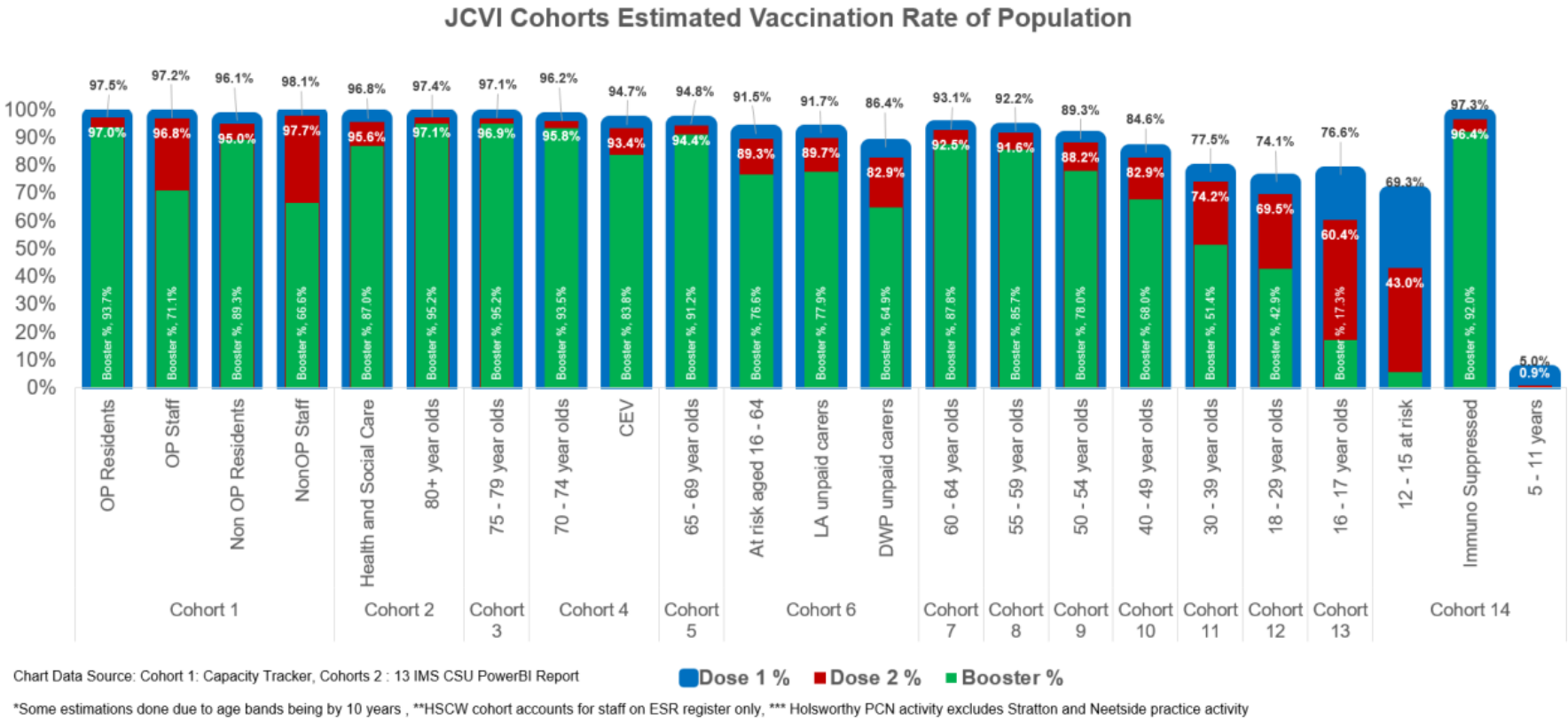


Covid patients in ICU have remained relatively low in 2022 even when general hospitalisation levels have increased. The daily level of Covid patients in ICU has remained incidental; under 10 since the end of January 2022.



Covid Update - vaccinations

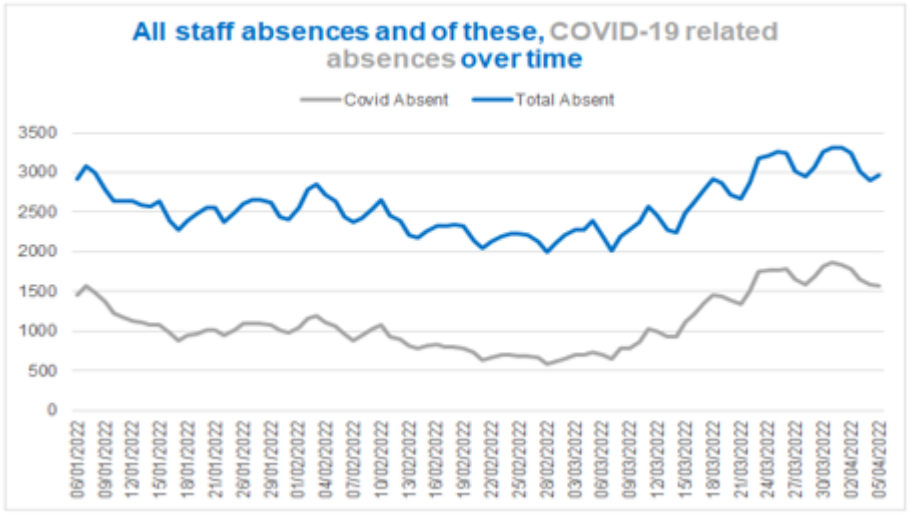
81% of the eligible Devon population have received one vaccination dose and 77% both doses. 69% of 12-15 year-olds have received at least one vaccination and 86% of eligible people have received a booster (all figures as of 30th March)

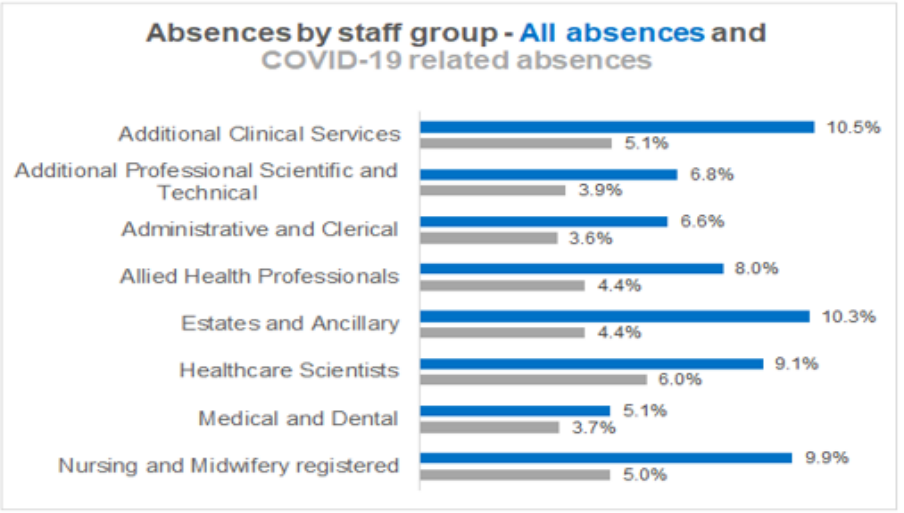


Covid Update - workforce absence

Covid-related absences peaked in late March but reduced in early April.

Latest figures from 4th April show 9.4% of staff were absent in total across Devon's providers, 4.9% of which were Covid-related. The level of Covid absences is fairly consistent between different staff groups, with clinical roles seeing slightly higher levels than non-clinical.





Primary Care: Mayflower Contract

Theme: Maintaining safe services during the successful transition of the Mayflower contract to the new provider
Underlying cause: Sustained staffing pressures impacting on patient access to services and known CQC issues. Owing to challenges with service delivery the current provider has handed back their contract and they will no longer deliver the service from the 31st March 2022. A short-term provider, Livewell Primary Care, will deliver the service from 1st April 2022 for 18 months to 30th September 2023, This is to allow for stabilisation of the service and a procurement for a long-term provider. A significant amount of work has taken place with regards to the safety and quality impacts through this due diligence. Work has focused on the outstanding CQC improvements and warning notices. Throughout this process all stakeholders have worked together to ensure that any safety and quality concerns have been addressed and mitigated. It should not be underestimated that there is a substantial amount of improvement work to be done by Livewell Southwest (LWSW) and this will require close monitoring. CQC are not intending to revisit in the immediate term. The most significant concerns continue to be related to high-risk medicines management, new Standard Operating Procedures (SOPs) being robust and embedded in practice. The ongoing backlog of reviews and administration tasks requires significant new processes to be in place if the risk to safety and quality is to be reduced.

Primary Care: Mayflower Contract

Actions undertaken in last month	Impact
CCG team supported by external resource continues to support the safe transition. CQC registration in place. Agreed core enhanced services. DDOC have shared their action plans and trackers, these have been thoroughly reviewed by the CCG team – LWSW have a known starting position with regards to these workstreams.	Robust / extensive team from both CCG and external support with subject matter experts supporting the new provider to mobilise. This external support will continue to provide subject manager experts to ensure the contract becomes stable and able to deliver robust services
Clinical review of all enhanced services undertaken to agree which will need to be provided from the beginning of the contract	Alleviation of patient safety concerns in relation to non -delivery of the full range of enhanced services

Actions for next month/s	Intended impact	Date impact will be realised
Maintain weekly meetings	The meetings will assure the CCG that the new temporary provider is providing resilient and safe core services.	1st April 2022 and onwards
Provision of full range of enhanced services, implementation to be monitored at weekly operation catch up meetings.	Provision of full range of services including all Enhanced Services	End of Q1

Primary Care: Clinical Activity

Theme: General Practice Clinical Activity Backlog	**Data:**
Underlying cause: Since the start of the pandemic a significant amount of General Practice activity has been deferred owing to both national directives (focusing on vaccination programme and those most in urgent need) and patients electing to postpone appointments in order to minimise attendance at clinical premises. This will inevitably have led to a backlog in clinical activity across primary care although the extent of this backlog is not readily quantifiable. Almost all Serious Incidents (SIs) from primary care are identified through PITCH and this remains a key process for primary care incident reporting. Delayed treatment continues to be theme across primary care SI's.	Primary Care team currently working with BI to look at what data is available to us that will support quantification. It will not be possible to quantify all areas of potential backlog from centrally held data. The primary care team has commissioned some work on this at collaborative board level

Actions undertaken in last month:	**Impact:**
Agreement with Collaborative Board Chairs on definition of backlog categorisation to support backlog quantification at practice, PCN and locality level, recognising that data available currently to CCG is limited.	Having definitions allows us to progress to quantification phase

Primary Care: Clinical Activity

Actions for next month/s:	Intended impact:	Date impact will be realised:
Access BI support and expertise to commence quantification of backlog	Will support a system-wide understanding of the impact of COVID on clinical backlog in partner organisations; important because of the interdependencies that exist and potential impact of plans in one part of the system on other partners.	Data set to be established by 30th April 2022
Launch Devon Spring Access Fund (DSAF). £1 million of funding made available to continue to support primary care access, skewed towards most challenged areas Mid Devon and East Devon Collaborative leads (with CCG support) will identify pilot sites to initiate the incident process development.	Additional capacity in general practice will help (a) avoid additional backlog build-up and (b) make inroads into backlog An initial focus will be on practices grouping multiple themes being identified and associated with work-load shift and submitting via a single PITCH.	Commences 1st April 2022, ceases 30th June 2022 (unless additional resource is made available to extend)

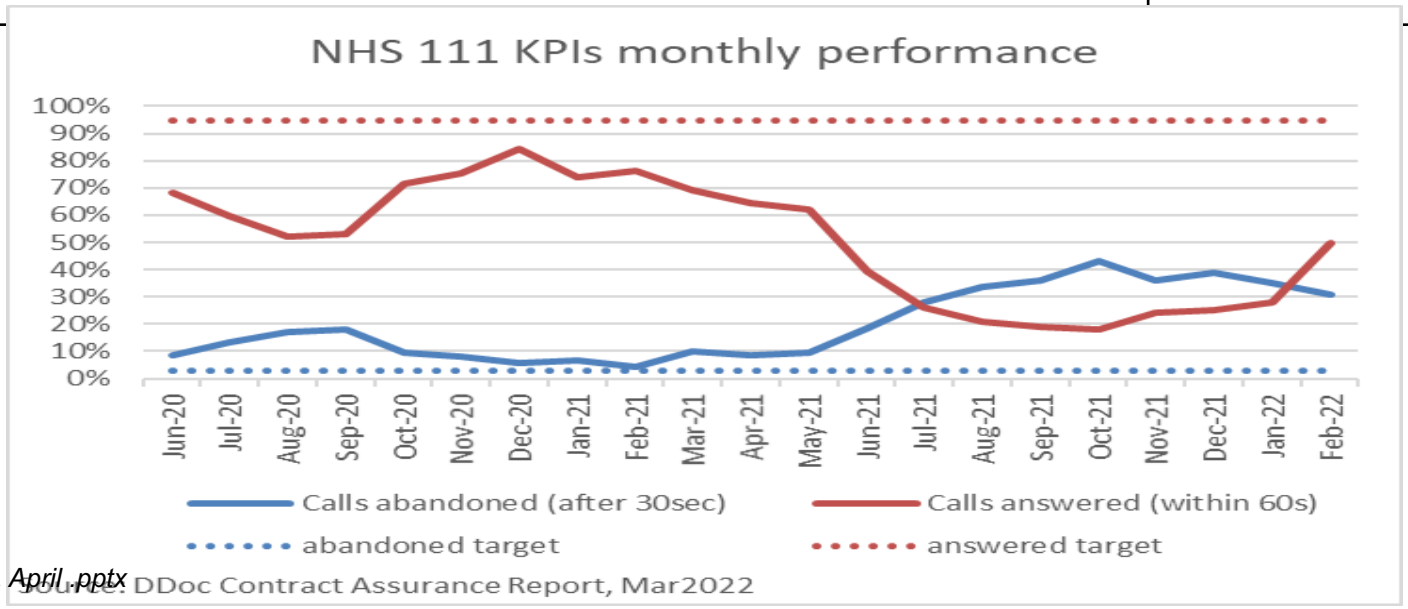
Integrated Urgent Care Service: NHS 111

Theme: Delivery of key NHS 111 service standards in relation to call handling and call abandonment.
A decline in call volumes In February (11% compared to January, has led to some improvement). However, call answering in 60 seconds is at 50% against a target of 95% and 30% of calls are abandoned. The target is for no more than 5%

Compared to national average, Devon Doctors remain one of the lowest performing providers for call abandonment.

As a result of long waits to speak to a call handler, many patients abandon calls. It is difficult to know the pathway they then take, but some will attend Emergency Departments or experience unresolved need at home. Therefore, this impacts on patient safety and experience, as well as the wider system, including use of EDs.

Underlying cause: Overall, poor performance due to low call answering capacity as a result of unplanned absence and insufficient establishment. However there has been a significant improvement in call answering performance, 22% from previous month, due to improved midweek rota fill and support from partnership arrangement with Herts Urgent Care (HUC).



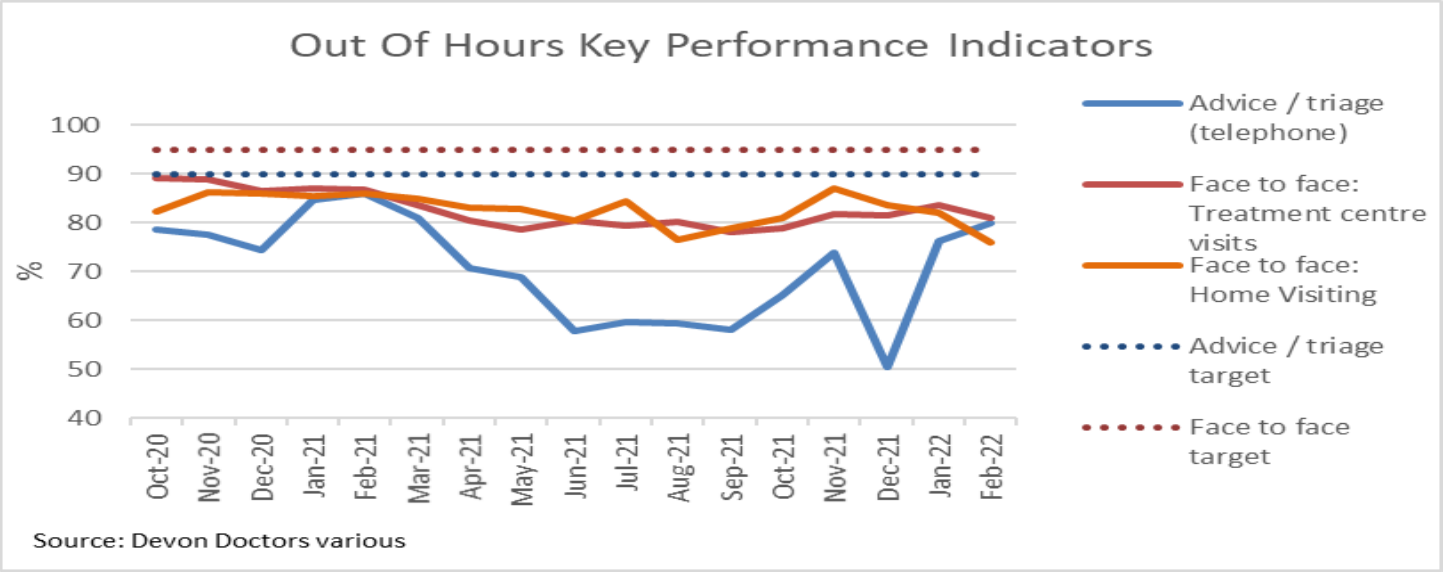
Integrated Urgent Care Service: NHS 111

Actions undertaken in last month	Impact
Increased recruitment for non-clinical call handlers continued in February.	Commissioners see the daily rota fill numbers twice a week which provide evidence that rota fill is starting to improve as staff complete the 6 week training programme.
CCG have continued to fund incentives to improve rota fill.	Incentives appear to have improved on the day sickness at weekends however, it is difficult to give increase of covid absence.

Actions for next month/s	Intended impact	Date impact will be realised
Devon Doctors are continuing to recruit to planned establishment. This is important to note as whilst Devon Doctors are the incumbent provider, IUCS will be delivered by a new provider, PPG, from 01 October 2022.	Continued improvement of non-clinical call handling rota fill will improve call answering metrics.	Expect planned establishment to be reached during April / May which, following training, would start to improve rota fill again from May.
Commencement of the Mobilisation Delivery Board chaired by the CCG and bringing together incumbent and incoming providers as part of the governance arrangements overseeing the IUCS service transition.	To oversee and support smooth transfer of IUCS to Practice Plus Group from Devon Doctors.	April.

Integrated Urgent Care Service: GP Out of Hours

Theme:	**Underlying cause:**
Delivery of a key GP Out Of Hours service standard for telephone advice / call triaged. The IUC KPI target is 90% of clinical call backs to be made within the timeframes determined by the disposition from NHS Pathways. Performance is currently around 80%. The OOH standard for 'face to face' service is measured from a combination of timeframes determined by the disposition from NHS Pathways. Overall the service remains below targets by between 10-15%. There are safety impacts as a result of delays with telephone and face to face. These include a delay in assessment and potential deterioration in the condition.	Fluctuating poor performance is due to low rota fill. Reduced fill / low pick up rates are due to a number of reasons including competing demand on limited workforce and taxation rules which led to changes in how shifts can be booked.



Devon IQPR report FINAL April .pptx *Graph shows the % achievement for the three different consultation types*

Integrated Urgent Care Service: GP Out of Hours

Actions undertaken in last month	Impact
CCG have continued to fund pay incentives to improve shift fill.	Commissioners see the daily rota fill numbers twice a week which provide evidence that rota fill is starting to improve
Guided by the CCG, Practice Plus Group have commenced meetings with clinical groups in Devon, including the Local Medical Committee, to build a strong relationship with in-hours primary care.	Part of a planned series of actions starting to build a strong relationship and dialogue with local clinicians with the aim to listen, understand and provide answers to ideas and concerns.

Actions for next month/s	Intended impact	Date impact will be realised
Use of the communications subgroup of the Mobilsation delivery board to provide assurance required from Devon Doctors on continuation of Doctors 'Clinical Resourcing Strategy' given the change of provider in 7 months.	Ensure continued rota improvement through mobilisation period.	Will continue until the contract ends in September 22
Review clinical communications to ensure clinicians are kept up to date during the transition period between providers.	Ensure continued rota improvement through mobilisation period.	May 22
Commencement of the Mobilisation Delivery Board chaired by the CCG and bringing together incumbent and incoming providers as part of the governance arrangements overseeing the IUCS service transition.	To oversee and support smooth transfer of IUCS to Practice Plus Group from Devon Doctors.	April. 22

Emergency Department 4 hour waits

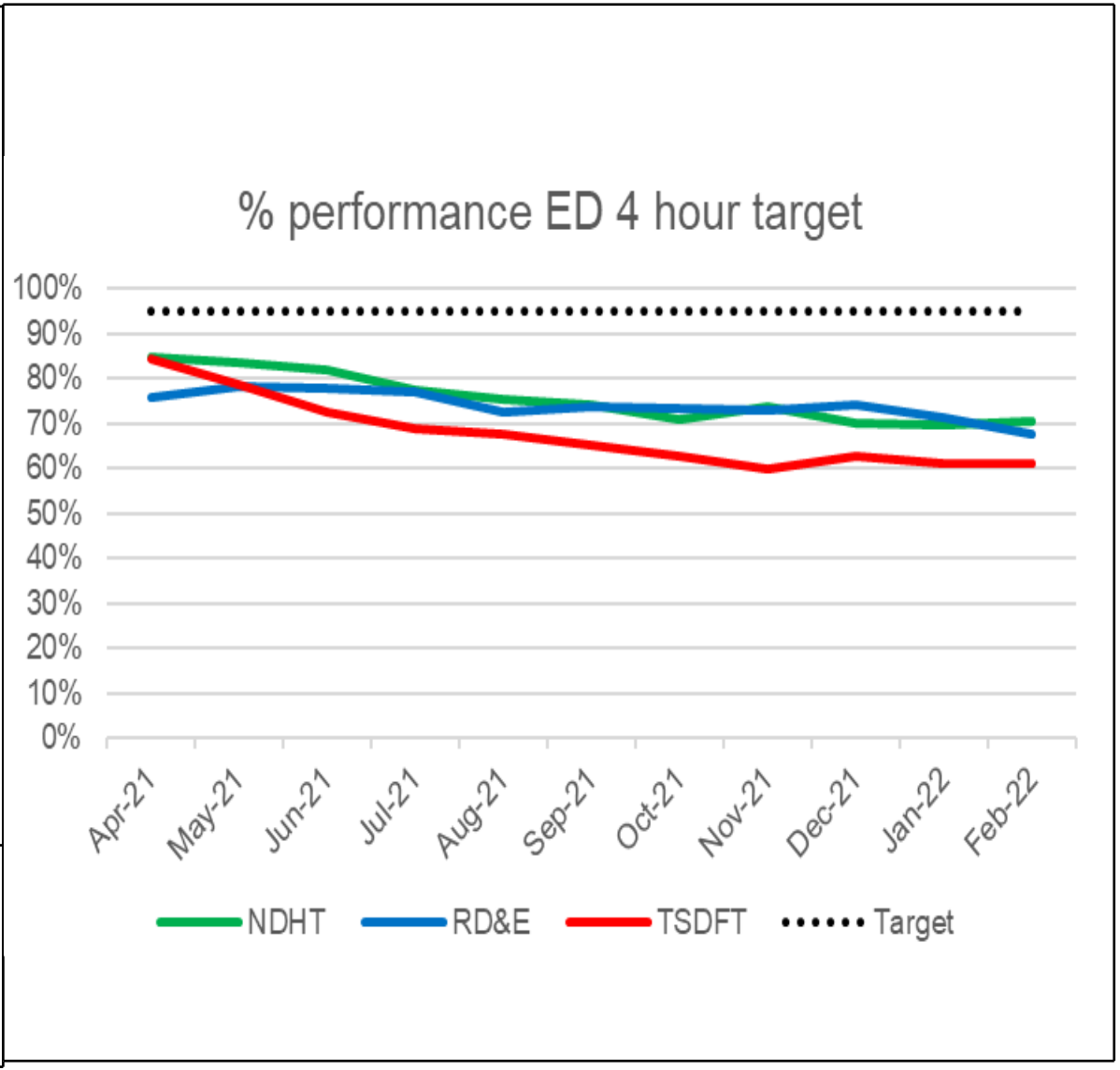
Theme: The operational standard is that at least 95% of patients attending ED should be admitted, transferred or discharged within four hours. No provider in Devon is meeting this target.
Latest Devon wide performance is 68% in March (Note: UHP does not report on 4 hour waits as it is part of a national pilot of new metrics where it reports on a range of metrics including time to assessment and time in department)

In addition to poor experience of the service, patient safety may be compromised, as a result of delayed assessment and intervention. This is a risk for all long waits, from 4 to 12 hours plus.

Some patients have also had a long wait for an ambulance.

To note: Currently reported to the CCG for February, Trusts have provided evidence of the following numbers of 12 hour breaches in ED: UHP 152, RD&E 68, T&SD 130, NDHT 22, giving a total of 372 reported so far.

Underlying cause: Delays caused by flow through the hospital being compromised due to delays to discharge. ED performance has also been impacted by winter, Covid and staffing challenges.



Emergency Department 4 hour waits

Actions undertaken in last month	Impact	
Cohorting and reverse queuing (holding patients in corridors after initial Emergency Medicine assessment) at UHP	Enables additional 8 patients to be cared for in the hospital rather than in an ambulance; supports resus capacity and category 1 “drop offs”	
Cumberland Centre improvement Plan	Early data indicates increase in ambulance conveyances - target 30 per month (six in February)	
Additional qualified private ambulance staff in place at T&SD	2x staff 12 hours a day increases capacity and allows flexible use of patient areas	
Ongoing role of winter room on scrutinising delays and looking for system solutions	Agreement of mutual aid on a number of occasions when there has been significant demand pressure	
Actions for next month/s	**Intended impact**	**Date impact will be realised**
New plan to be developed for urgent care in T&SD – focus on potential for redesign of ED to improve performance	Trajectories to be agreed as part of the plan	

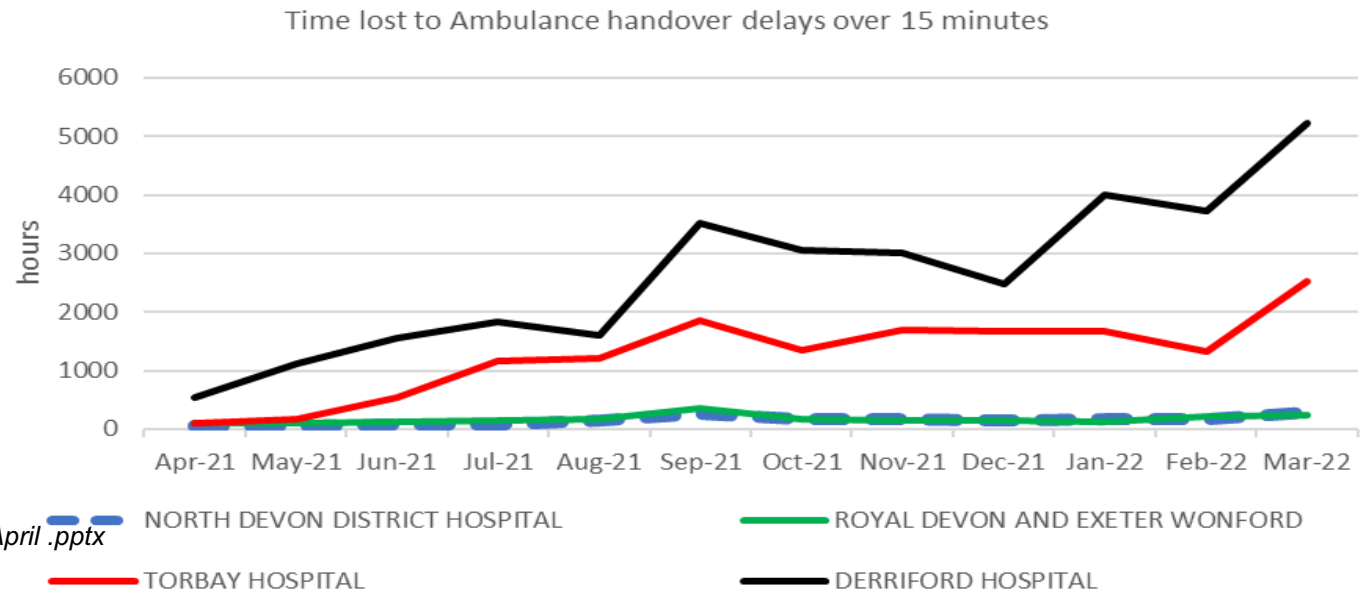
Ambulance Handover delays

Theme: Increasing ambulance handover delays
There is risk to patients waiting in ambulances for extended periods. Whilst care is provided in the vehicle, and ED clinicians often also attend, there may be delays in onward assessment, diagnostics, treatment and appropriate ward admission. Experience, including comfort and pressure care can also be affected.

With ambulances held outside EDs, there is a risk to those waiting for paramedics to attend at home. There is a risk to those waiting for an ambulance response particularly those with emergency conditions in category 2 such as stroke, sepsis and heart attack.

A number of Serious Incident (SI) investigations describe the urgent and emergency care environment 'Departmental overcrowding, extreme clinical workload for the senior decision makers in the Emergency Department'. The SWASFT system SI remains in progress and is due to be reported in April 2022.

Underlying cause: Delays caused by flow through the hospital being compromised due to delays to discharge. Performance has also been impacted by winter and covid pressures, staffing challenges and crowding in ED. Total hours lost to ambulance handover delays (of over 15 minutes) in March across Devon was 266.9 hours.



Ambulance Handover delays

Actions undertaken in last month	Impact
Cohorting and reverse queuing (holding patients in corridors after initial Emergency Medicine Assessment) at UHP	Enables additional 8 patients to be cared for in the hospital rather than in an ambulance; supports resus capacity and category 1 “drop offs”
Cumberland Centre improvement Plan	Early data indicates increase in ambulance conveyances - target 30 per month (six in February)
Additional qualified private ambulance staff in place at T&SD	2x staff 12 hours a day increases capacity and allows flexible use of patient areas
CCG funded SWASFT posts to support work in UHP and T&SD The CCG have discussed with SWASFT the incidents reported by SWASFT itself; previous barriers have been addressed and staff are now able to access incident reporting from the vehicle. Communications have been circulated to encourage and support staff to report incidents to drive learning & improvement.	Working flexibly to help improve relationships and patient flow

Actions for next months	Intended impact	Date impact will be realised
Increase capacity for Same Day Emergency Care (SDEC) at UHP including new pathways and investment case for acute medicine for longer hours	Increase SDEC capacity to reduce ED conditions seen in ED, increase ambulance conveyance direct to SDEC	June 2022
Implementation of “full capacity” protocol at T&SD	Reduced waiting in ED	May 2022
Increase in acute medical inpatient capacity at T&SD	25 additional beds available	May 2022

Ambulance Service Response

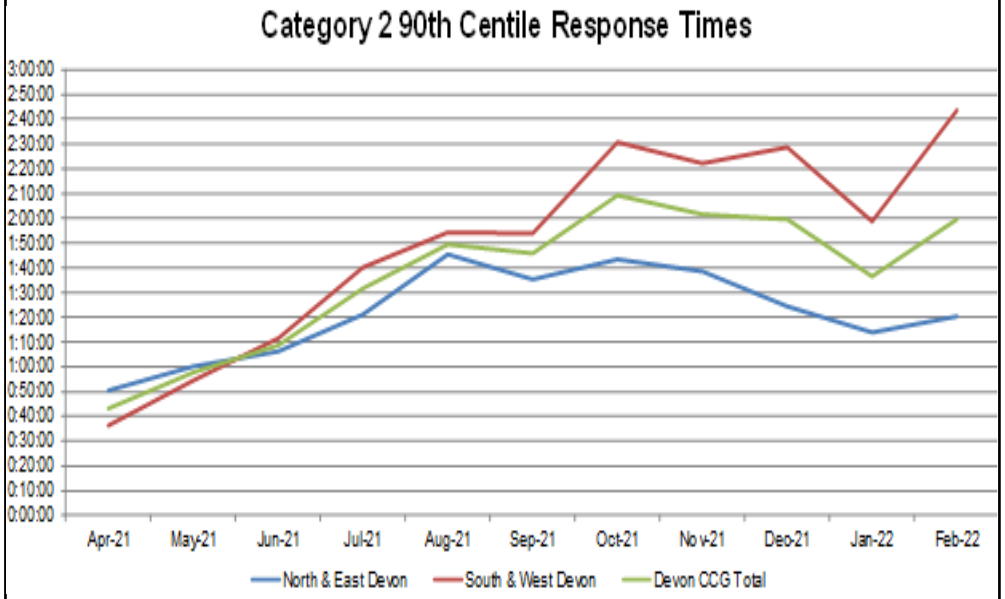
Theme: Delays to delivery of emergency care: 999 call answering, ambulance response (particularly category 2 which is an emergency response excluding immediately life threatening conditions) and hospital handover delays. SWASFT call response, ambulance response and resources lost to handover delays are the worst in England.

Ambulance response delays have a positive correlation with hospital handover delays, particularly in S&W Devon; category 2 performance aligns to other key metrics such as ambulance handover times and long waits in ED.

There has been a worsening position in March with over 7000 hours lost to handover delays at UHP compared to 3900 in February and over 2500 hours at T&SDFT compared to 1300 in February. In comparison, 212 were lost at RD&E and 270 at NDHT. March response time information is not available by locality, however in February S&W Devon response times for cat 2 90th centile were 240 minutes compared with 120 minutes in N&E Devon.

60% of SWASFT conveyances are category 2 and these will include some of the sickest patients hence the national priority to address this.

Underlying cause: Delays in call answering times relate to attrition and abstractions of emergency medical dispatchers (EMDs) and increases in calls answered. Through March, 38% of calls were answered in 60 seconds (target 95%) a reduction since February.



200 minutes 90th centile response in February across Devon (target is 40 minutes).
213 minutes 90th centile response in March across Devon.

Ambulance Service Response

Actions undertaken in last month	Impact
Recruitment and training of EMDs (+50 WTE by year end).	Increase in trained call takers and expected improvement in call answering times
Additional resourcing in hub to improve hear and treat rates, including dedicated mental health practitioners, and additional crew resources to improve response times.	Hear and treat rates of 31%. No response time impact seen as yet as handover delays worsen.
Handover improvement plans in place for Torbay and Derriford hospitals – see handover slide.	Handover delays continue to increase, impact of improvement actions have been affected by COVID – bed availability, occupancy and staffing issues.

Actions for next month/s	Intended impact	Date impact will be realised
Continued recruitment and training of Emergency Medical Dispatchers (EMDs)	182 WTE trained call takers in place. achieved. Improved compliance with calls answered in 5 seconds.	March 2022 – however this has not been achieved so a new trajectory will be required
Impact assessment of handover action plans and agreement of trajectories for improvement.	Reduction in average handover times at UHP and T&SD.	Impact expected July-September
Conclusion of SWASFT contract negotiation	Contract agreed which recognises resources lost to handover and resources required to improve response times	Impact expected July-September

Planned Care: 104 week waits

Theme:
The number of patients waiting over 104 weeks for elective procedures and number of patients on waiting lists for surgery.

Underlying cause:
Backlog in treatment of patients due to impact of pandemic and urgent and emergency care pressures on elective care capacity.

Provider	Total 104ww	P6s	104ww P6 Removed
Acutes	**1471**	**57**	**1414**
RDE	672	27	645
TSD	243	4	239
NDHT	7	0	7
UHP	549	26	523
ISP	**99**	**12**	**87**
Mount Stuart (Ramsay)	76	5	71
Exeter Medical (Ramsay)	1	1	0
PPG (Plymouth)	14	2	12
Nuffield (Plymouth)	8	4	4
Nuffield (Exeter)	0	0	0
Totals	**1570**	**69**	**1501**

Actions undertaken in last month

Capacity has been identified for complex orthopaedic surgery at the South West London Elective Orthopaedic Centre (SWLEOC) and each Trust had identified patients who have been waiting over 104 weeks, but SWLEOC revised the criteria, which meant some patients were no longer eligible.

A review of the end of March 2022 position for 104 week waiters and planning to reduce further patients waiting by the end of June 2022.

Updated plans for 104 ww position at the end of June 2022 have been produced by each acute trust at specialty level with a weekly trajectory to end of June 2022. The plans have been collated to provide a system view. As a Devon system, there is currently a gap of 860 which has been escalated to NHSE with a request for additional mutual support.

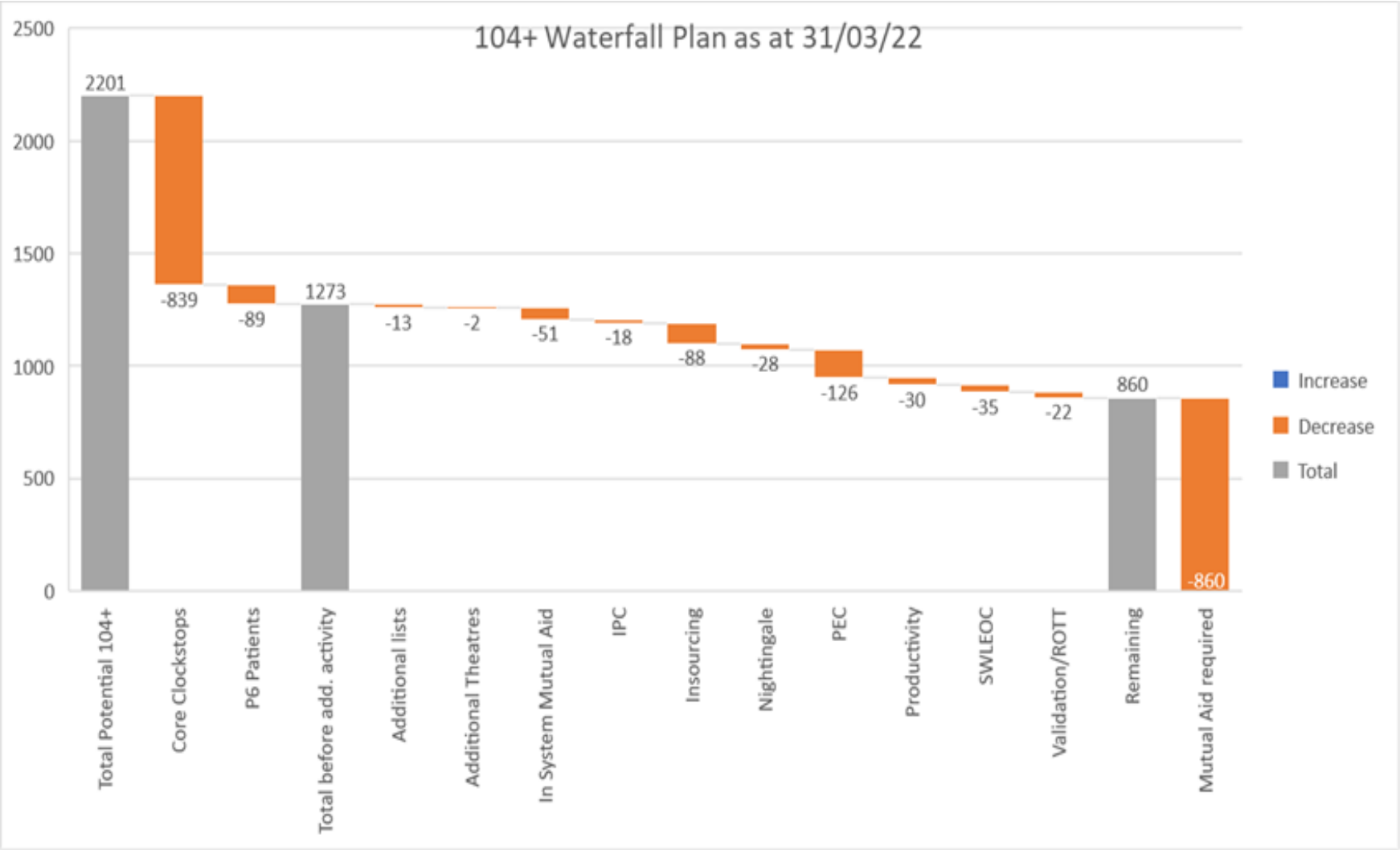
Impact

A reduction in number of patients waiting over 104 weeks by end of March but 43 more than planned, due to the impact of covid in the IS providers.

For all current, and planned actions:
An improved safety & quality position for patients; the System risk to patient safety and experience within commissioned acute trust services, due to long waiting times for elective care, including diagnostics, remains at 25.

An improved position will also positively impact on other services such as Primary Care, Urgent or Emergency Care and Mental Health services, as reduced numbers of patients switch to urgent care pathways as a result of their long wait.

Planned Care: 104 week waits



Planned Care: 104 week waits

Actions for next month/s	Intended impact	Date impact will be realised
Understand the amended offer from South West London Elective Orthopaedic Centre (SWLEOC) and follow up with national team who have escalated the issue.	Reduced 104 week waits, however requirement to understand the impact of the change in criteria will have on the patients waiting	This capacity will start to impact from April 2022
Trusts continue to focus on reducing 104 week waiters to delivery June targets and review/monitoring of plans at specialty levels	Reduction of patients waiting over 104 weeks for treatment	Impact each month
Review the opportunities identified through GIRFT/HVLC (High Volume Low Complexity) and Model hospital data to agree priorities for 22/23	Focus on opportunities for increased productivity in 22/23	Impact by end of March 2023
Work with regional/national teams to identify mutual aid from outside of Devon and review any further opportunities within Devon.	Reduction of patients waiting over 104 weeks for treatment	Impact each month

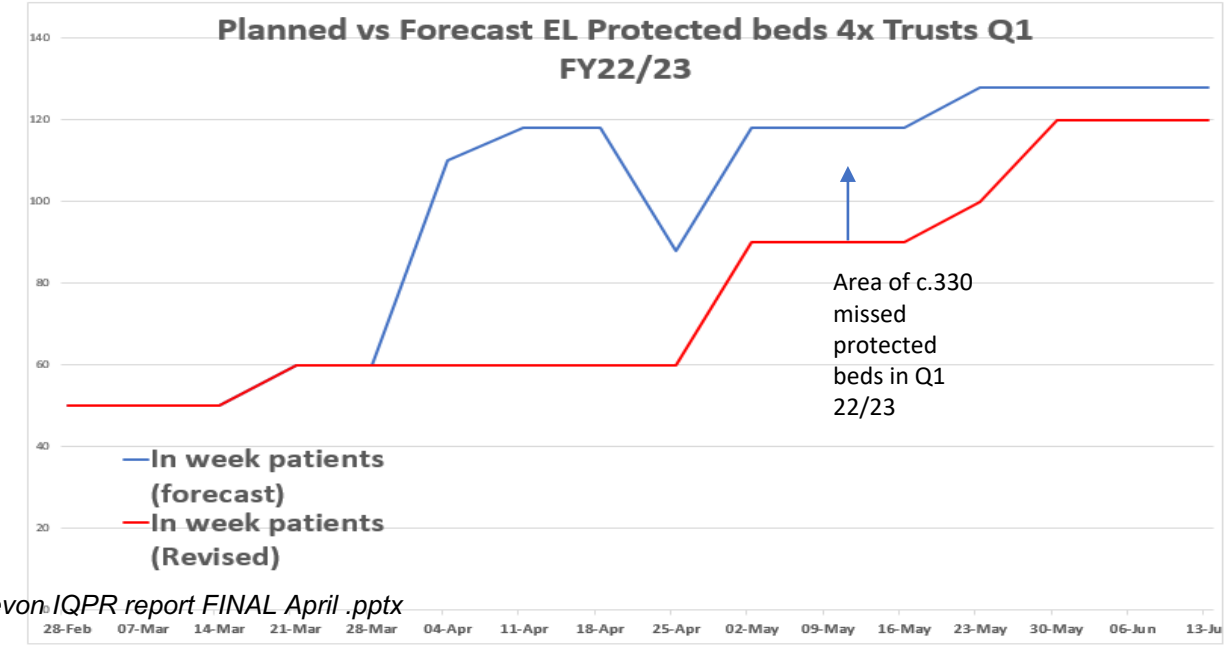
Planned Care: Protected Elective Capacity (PEC)

Theme: Lack of protected elective capacity (PEC) for complex orthopaedic surgery in acute trusts.

Underlying cause:
Pressure on all bed types and risk of protected beds being utilised for other specialty in-liers and non-ortho patients because of:

- Urgent and emergency non elective care pressures on elective (EL) care capacity.
- Backlog in treatment of patients due to impact of pandemic has led to an impact on hospital flow.
- Delayed transfer of care (DTOC) and social care constraints (plus pandemic) have impacted hospital flow

Impact: If elective capacity is not protected, an increase in waiting and subsequent poor patient experience will result. Also, seen and unseen physical harm. PEC will mitigate this risk.



104 Waiting Lists & Highest Priority elective care
RD&E and Nightingale Exeter (NHE) have successfully opened their protected capacity on time and to plan. c.48 beds in total, by repurposing a medical ward

Delayed openings. Between 31 Mar and mid-Jun c.330 procedures will be lost by the late opening of the protected beds in T&SD, NDHT and University Hospital Plymouth (UHP). With c.1240 procedures going through the remaining protected beds across all 4 providers plus NHE over the same period.

Planned Care: Protected Elective Capacity

Actions undertaken in last month	Impact
Meeting of clinically-led orthopaedic working group to confirm that plans are on track to deliver protected elective capacity at each site.	**Improved governance.** Agreement at Clinical Director/Specialty lead and CCG Director level that the Ortho group should oversee all ortho restoration activity in Devon, not just complex ortho.

Each Trust have developed plans to protect beds for complex elective surgery and RD&E site went live with their 26 protected beds on 28th February	• **Greater access to orthopaedic treatment for patients.**
	  • **104ww/highest priority elective care reduction**. EL Protected beds are currently delivering ortho work, to the plan, in RD&E and Nightingale Hospital Exeter (NHE)
	  • **Exec backing**. CEO/Exec level agreement on the importance of ringfencing
	  • **Clinical leadership**. Agreement across all clinical leads in the 4 major Trusts that EL protected beds must only be used for orthopaedic patients

Quality Impact Assessment completed and submitted to Devon clinical leads for ortho	**Clinical assurance** on the rigor of the operational plan.

Actions for next month/s	Intended impact	Date impact will be realised
Structure and governance. Establish Project Initiation Document, terms of reference & project delivery plan for orthopaedics workstream as a key workstream for the Planned Care Programme for 22/23	• Robust plans for delivery of protected elective capacity for complex orthopaedics across Devon. • Critical path and planning handrail for clinically led ortho recovery group to track performance	Complete by end of April
SOPs for ringfencing beds. Trusts to implement plans to open protected orthopaedic beds	Increased capacity for highest priority elective care and long waiting complex orthopaedic surgery – approximately 90 per week across Trusts by end of Sep 22	All Trusts expect to have rolled out some protected beds by end of April, but full impact over following months
104 list tracking. Modelling of the impact of the protected beds to be undertaken	Understanding of the impact of the protected beds to support planning	Complete by end of April

Planned Care:
Nightingale Hospital Exeter (NHE): An Update

The NHE site has now been transformed into a state-of-the-art facility and is home to the following services helping to reduce waiting times:

- Southwest Ambulatory Orthopaedic Centre, which has two operating theatres for day case and short stay elective orthopaedic procedures. Orthopaedic capacity is increasing from April 2022 with a minimum of 18 joint replacement procedures each week.

- Centre of Excellence for Eyes, which operates diagnostic screening services for ophthalmology patients and will run a high-volume cataract treatment hub. The surgicube for cataracts surgery will follow in the summer for cataracts surgery.

- Devon Diagnostic Centre, which is providing CT, MRI, X-ray, ultrasound, echocardiograms and fluoroscopy services.

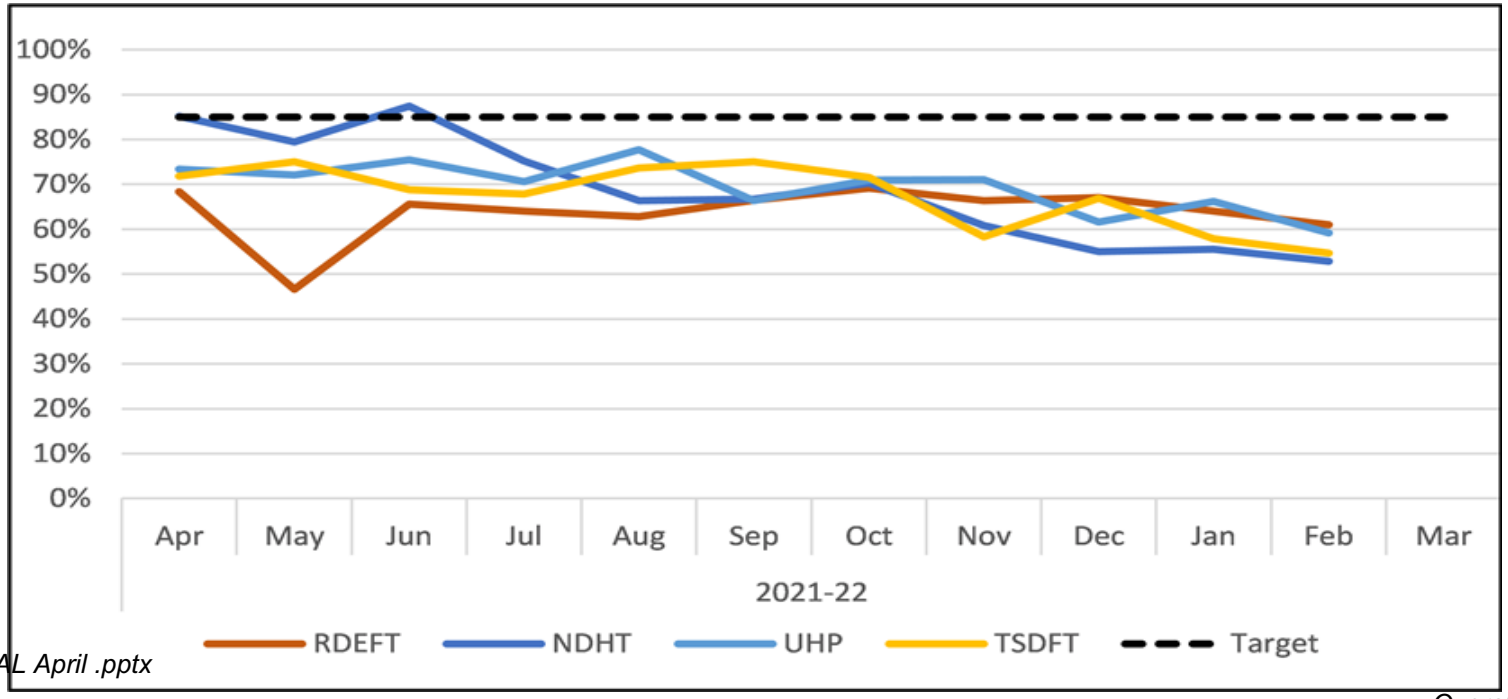
- The RD&E Rheumatology department which provides outpatient care and day case infusions.

Cancer Performance 62 Day Standard

Theme:
Failure to achieve statutory performance standard due to staff and physical space shortages, competing with urgent care pressures for general resources. Performance in January 22 was 63.4% against an 85% standard.

Underlying cause:
Existing problems alongside impacts of covid and current increase in prevalence on both staff and patients. Increased 2ww demand continues to increase due to public health awareness campaigns and restoration of screening services.

Impact: Numbers of patients are not receiving a confirmed diagnosis and starting treatment within 62 days.



Cancer Performance 62 Day Standard

Actions undertaken in last month	Impact
University Hospitals Plymouth breast mega clinics completed.	2ww standard achieved and 62 day standard improving.

Actions for next month/s	Intended impact	Date impact will be realised
Torbay and South Devon NHS Foundation Trust dermatology waiting list initiatives	Will bring 2ww performance back within target and reduce 62 day breaches	July 22
Further development of operational plans and trajectories for 22/23.	Clearly described and funded plans for recovery during 22/23	Across 22/23
Development of mutual aid support for urology services at Torbay and South Devon NHS Foundation Trust	Mitigating the effects of staff vacancies and move to Paignton Hospital to support opening of Day Surgery Unit.	April – June 22

Planned Care - Diagnostics

Theme:
Statutory performance target for Diagnostics not met. February 22 performance was 37% against a 1% target.

Underlying cause:
Impacts of covid increasing inpatient and urgent care activity. Infection prevention measures constraints reducing capacity.

April	May	June	July	August	September	October	November	December	January	February	
17434	17324	18712	22032	25006	24008	23810	22332	25090	26446	23468	
53840	57454	55758	61522	62756	62678	63202	62402	63752	62652	63350	
32.4%	30.2%	33.6%	35.8%	39.8%	38.3%	37.7%	35.8%	39.4%	42.2%	37.0%	*
1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	

* Acute providers only

Recovery trajectory in development as part of 2022/23 operational planning process. To be finalised June 2022.

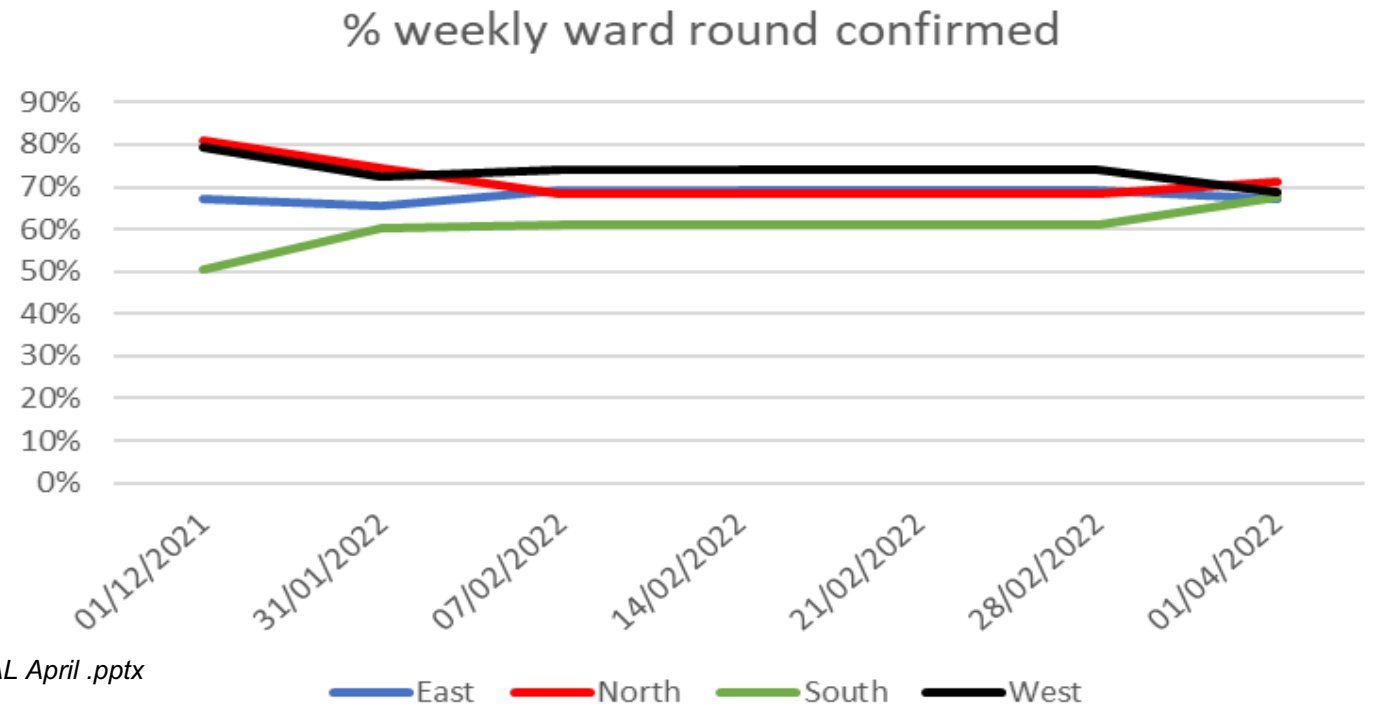
Planned Care - Diagnostics

Actions undertaken in last month	Impact
Targeted Investment Fund (TIF) Independent Sector (IS) mobile urology facility work completed at Torbay and South Devon NHS Foundation Trust in February 22.	60 procedures completed.
Insourcing waiting list initiatives at University Hospital Plymouth.	From 23/1/22 to 27/2/22 Diagnostic waiting list reduced by 754 CT procedures and 579 for MRI.

Actions for next month/s	Intended impact	Date impact will be realised
Targeted Investment Funding for independent sector mobile urology facility work scheduled for North Devon Healthcare Trust during March	Will reduce the waiting lists by approximately 130 and support cancer performance.	April 22
Allocation of scanning time at Exeter Community Diagnostic Centre across all four Trusts. (currently at 3)	Support reduction of waiting lists across the ICS	April 22.
Continued insourcing waiting list initiatives at University Hospital Plymouth.	Reduction of waiting lists	April 22.

Area: Community Services/Care Homes

Theme:	Underlying cause:
Within the Enhanced Health in Care Homes Framework there is a requirement for: • Residents to receive weekly clinical reviews & care homes to report completion of these within the national capacity tracker. • Early identification of deteriorating residents through the use of RESTORE2. implementation of training and use of RSTORE2 has been delayed as an impact of COVID There is a potential risk to safety for patients who are not receiving weekly clinical reviews. In addition, the staff will not benefit from learning from this process brings.	Care homes self report receiving weekly clinical reviews for residents using the national capacity tracker (CT) however, frequency of updating the information relies on care homes completing and this has been variable. There is no alternative data reporting method available.



Area: Community Services/Care Homes

Actions undertaken in last month	Impact
Review of capacity tracker reporting to: Identify which homes are not reporting weekly clinical reviews understand if these homes are receiving weekly clinical reviews for residents.	To understand variation in self reporting by care homes and identify those care homes that are not updating CT regularly. Enable targeting of those homes not reporting to establish whether weekly clinical reviews are in place.. Enable targeting of PCN's that have not undertaken weekly clinical reviews.
Reminder to care homes of importance of using the national capacity tracker during the 'Living with COVID' webinar 31/3/22	Increase the number of homes updating the tracker

Actions for next month/s	Intended impact	Date impact will be realised
Draft communication for PCN's to remind of requirement for weekly clinical review of residents.	Increase recognition by practices and care homes that weekly clinical visit to review each resident meets the requirement.	Q1 2022/23
RESTORE2 training dashboard development	Provide oversight of care homes & GP practices that have completed training	Q1 2022/23

Hospital Discharge

Theme:

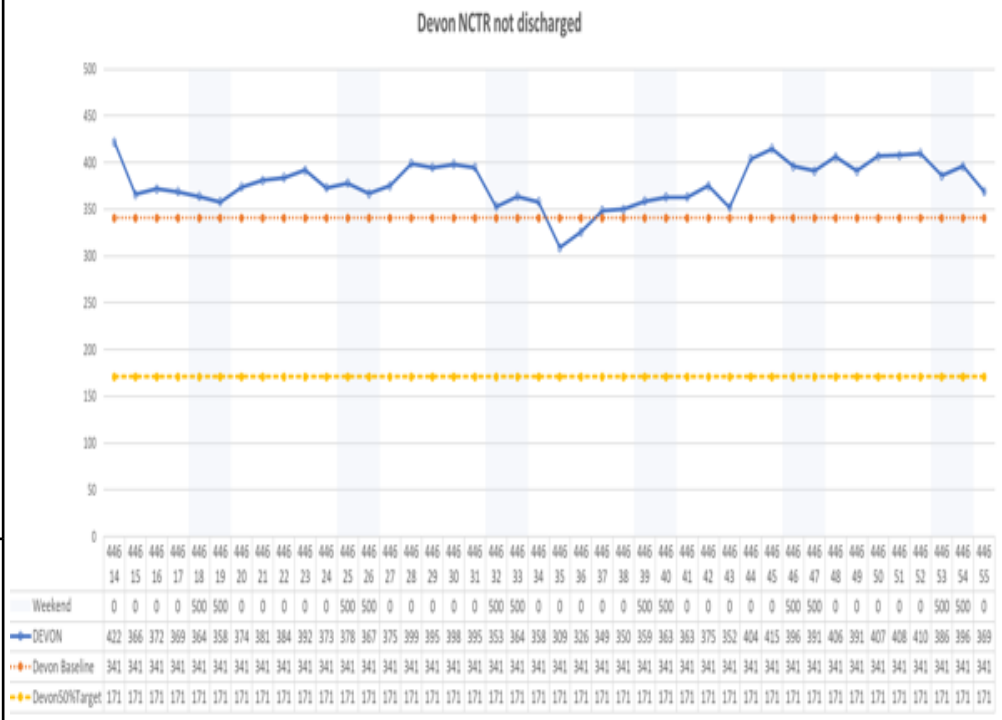
NHS England nationally set a requirement for all systems to reduce the number of individuals with No Clinical Criteria to Reside (NCTR) by 30% by 31/1/22 and by 50% by 31/3/22. The Devon System did not meet either target and remains above the baseline.

In addition to the risk of deconditioning and infection for the patients remaining in hospital when able to leave, there is impact on other areas of the system and pathways; patients in ED wait in excess of 4 and 12 hours when waiting for a ward bed to become available, whilst ambulances are unable to hand over their patients to ED staff. Patients waiting for these ambulances, often very sick at home, are left waiting extended periods and at risk of harm.

Underlying cause:

- Challenges in capacity to support individuals as a result of system pressures
- High numbers of Care Home outbreaks (w/c 28th March) this exceeded 50% of the Devon Care Home Market
- Market resilience and sufficient staffing resource due to high levels of covid related absences

Data:



Hospital Discharge

Actions undertaken in last month	Impact
Additional capacity has continued to mobilise (in line with existing plans).	Total of 91 additional beds have been mobilised along with peripatetic staffing teams focussed on enabling hospital discharges. Delivery of locality investment plans focused on increases in VCSE capacity/initiatives to support hospital discharge
Development of locality level action plans, owned at a trust level setting out capacity interventions and process improvements across pathways 1-3	Clear action plans have been developed, however, impact of significant increase in covid outbreaks and staffing pressures impacted on delivery. Activity to be rebaselined based on revised trajectories

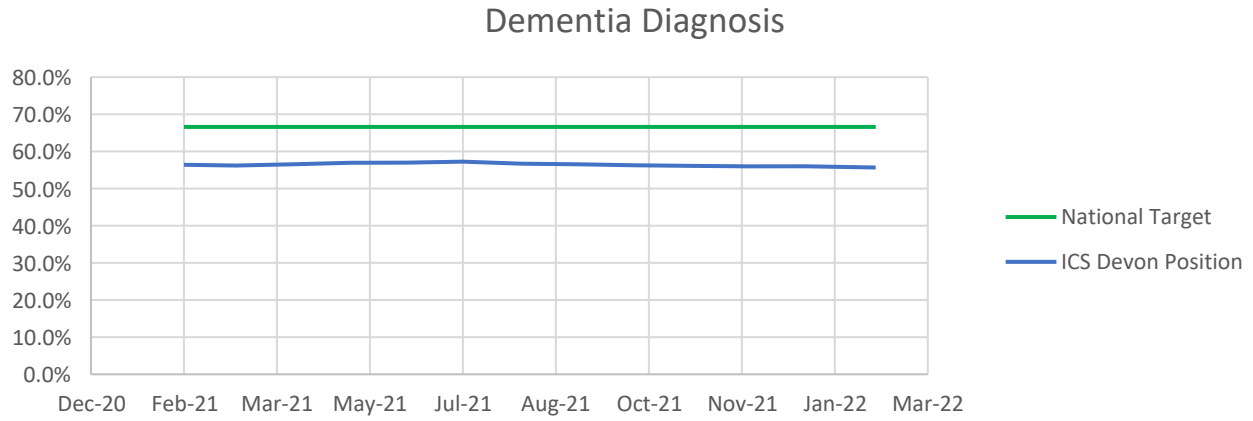
Actions for next month/s	Intended impact	Date impact will be realised
Development of improvement trajectories to meet system target of 50% reduction in NCTR	Maximising capacity will support reductions in NCTR improvements in time to transfer and support system recovery	Revised trajectories to be developed and agreed at System Flow meeting 12th April 2022
Review of additional capacity to ensure continued maximisation of utilisation (bedded capacity has been extended until 28th April 2022) and identify opportunities/need for extended provision beyond this	Maximising capacity will support reductions in NCTR improvements in time to transfer and support system recovery	Revised trajectories to be developed and agreed at System Flow meeting 12th April 2022
Continued system oversight of Local Action plans developed as part of data audits of individuals with NCTR and as part of 'perfect weekend' activity focused on 7 day discharges	Ensure delivery of local pathway improvement plans to reduce individuals with NCTR	Revised trajectories to be developed and agreed at System Flow meeting 12th April 2022

Mental Health – Dementia Diagnosis

Theme: Dementia Diagnosis Rate
The diagnosis rate for people aged 65 and over, as a percentage of the estimated prevalence based on GP registered populations is monitored nationally as a Long-Term Plan deliverable over the last 12 months..

Underlying cause: Diagnosis rate has been level for most of the last year. This is consistent with national experience. Devon's rate is at the lower end of what might be expected for our population, and so does not meet the national target, but is still within the expected range. We are taking action to understand in a more detailed way how dementia is related to other areas of health, which will help us target our actions for a better dementia rate to the local populations who are most at risk of dementia. We also know that the funding for general practice associated with dementia diagnosis may not be fully evident to all GP practices, so we are more consistently illustrating that. COVID-19 has had an impact, with relevant professionals in some parts of Devon diverted to support when people with dementia are in hospital, rather than focussing on new assessments.

Data: National Target: 66.6%. Current ICSD performance: 55.67%. Trend: Consistent performance maintained



Mental Health – Dementia Diagnosis

Impact:
For many people, obtaining a dementia diagnosis can help them and their families access relevant information, resources, support, care and treatment. It can empower people to make decisions about their future. If fewer people are accessing a dementia diagnosis then fewer people will get these benefits.

Actions undertaken in last month	**Impact**
During the last month, as part of the winter response, some teams have been diverted to support admission avoidance for older people with mental health problems, thus reducing diagnostic capacity.	This has had an adverse impact on the ability to increase diagnosis rates in some areas.

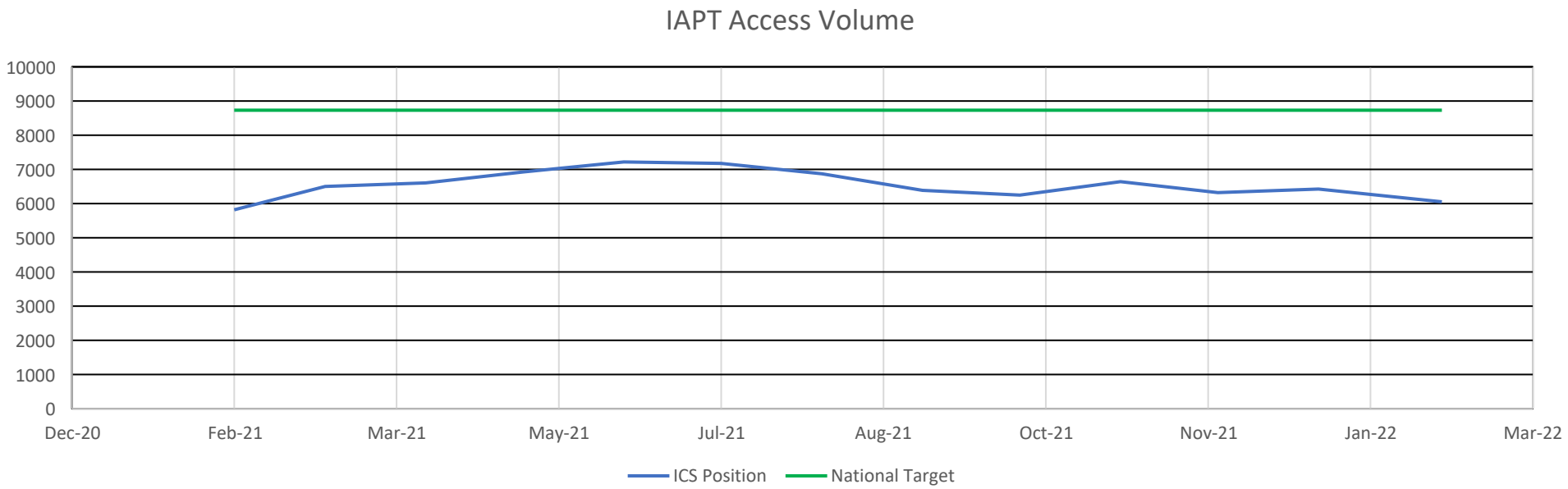
Actions for next month/s	**Intended impact**	**Date impact will be realised**
Following the Primary Care Operational Group on 15th March, improvement will involve the triangulation of dementia and cardiovascular data for practices; the development of additional diagnosis models for care homes; and clearer communication of primary care incentives for diagnosis.	i) Fuller understanding of relationship of practice population health to dementia prevalence. ii) Targeted interventions for remedial actions and sustainable change. iii) Earlier dementia identification with clear routes to dementia support.	30th March 2023.

Mental Health – IAPT Access Volumes

Theme: IAPT Access Volumes
This indicator tracks the national ambition to expand Improving Access to Psychological Therapies (IAPT) services and counts the number of people who receive IAPT in the quarter. This is compared to the ICS Devon requirements set by NHS England and Improvement.

Underlying cause: Access is lower than expected, due to decreased referrals (also observed regionally and nationally).

Data:
National Target for ICS Devon: 8,731 patients in Q3
Performance in ICS Devon: 6,052 patients in Q3



Mental Health – IAPT Access Volumes

Impact:
There is evidence to suggest that whilst demand for these services has decreased, need has increased. This means people are less likely to be accessing appropriate support, care and treatment early in the development of a need. Delayed access to treatment can increase the intensity of the response needed and, in some cases reduce the benefit.

Actions undertaken in last month	**Impact**
In ICS Devon we continue to: - Augment the national promotion of IAPT through additional local communications and marketing efforts - Maintain prioritised access for key workers - Target promotion of the service to job sectors impacted by COVID and other major incidents and events - Work with primary care and local care partnerships to promote referral - Offer support into long covid pathways	The impact of local and national promotion activities should be to increase access to the IAPT service.

Actions for next month/s	**Intended impact**	**Date impact will be realised**
Continued collaborative working across IAPT teams, understanding challenges and promoting effective access improvement approaches.	Fuller understanding of 'what works' to aide increased uptake of IAPT, enabling a move to more specific actions taking place.	Q2 2022/23

Mental Health – CYP Eating Disorders

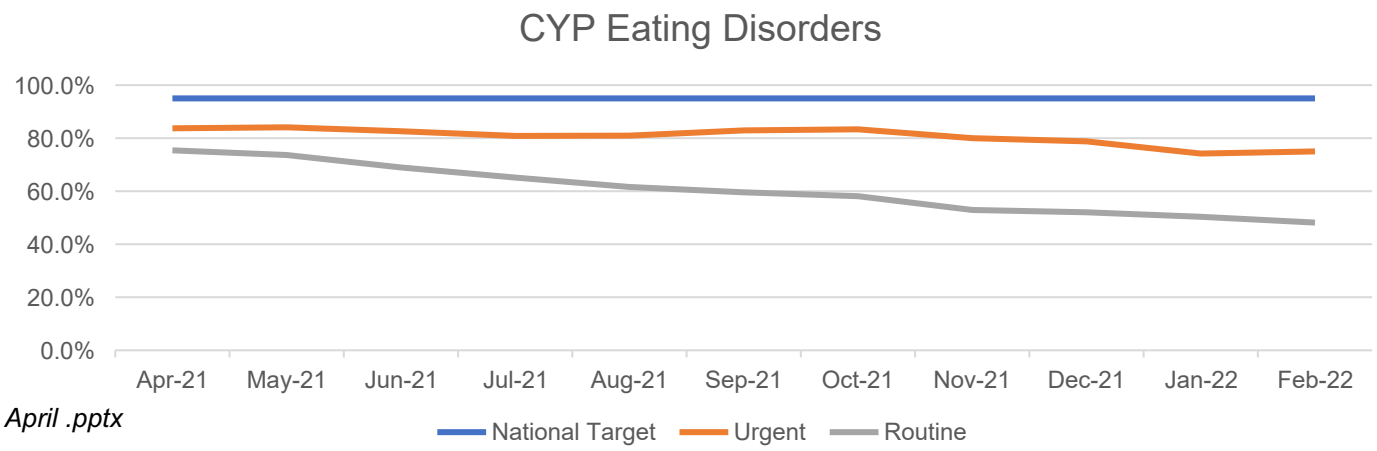
Theme: Urgent and Routine Referral to Treatment Waiting Times for CYP with an Eating Disorder

These indicators demonstrate performance against the national standards for these services which are part of the Long-Term Plan. The focus is on improved access and on effective treatment at the earliest opportunity in order to improve outcomes, reduce rates of relapse and need for admission.

Underlying cause: There has been increased longitudinal demand (prior to and due to COVID) and average acuity of need at the time of referral has increased. These are also nationally observed trends.

Data: Urgent Access RTT
National Target: 95%
Current Performance: 74.19%
Trend: Variable. Improvement against rolling 12 month national target will be gradual, current trajectory for achievement is October 22/23.

Data: Routine Access RTT
National Target: 95.0%
Current Performance: 50.35%
Trend: Deterioration, resource prioritised to respond to urgent referrals. Improvement against the rolling 12 month national target will be gradual, current trajectory for achievement is May 23/24.



Mental Health – CYP Eating Disorders

Impact:
Eating disorders are serious mental health problems which can have severe psychological, physical and social consequences; prompt access to evidence-based, high quality care and support can improve recovery rates, lead to fewer relapses and reduce the need for inpatient admissions.

Actions undertaken in last month	**Impact**
Additional capacity is being recruited and trained with some capacity now becoming operational.	To increase service capacity to enable achievement of the wait time standards.
Mutual support to maximise capacity across the system continues to be explored.	To increase the resilience of service capacity across the system.
Teams are working with families to ensuring that preparatory work is undertaken, and support is provided whilst people wait.	To ensure that CYP and their families are supported to be safe whilst waiting to access support and are ready to engage.

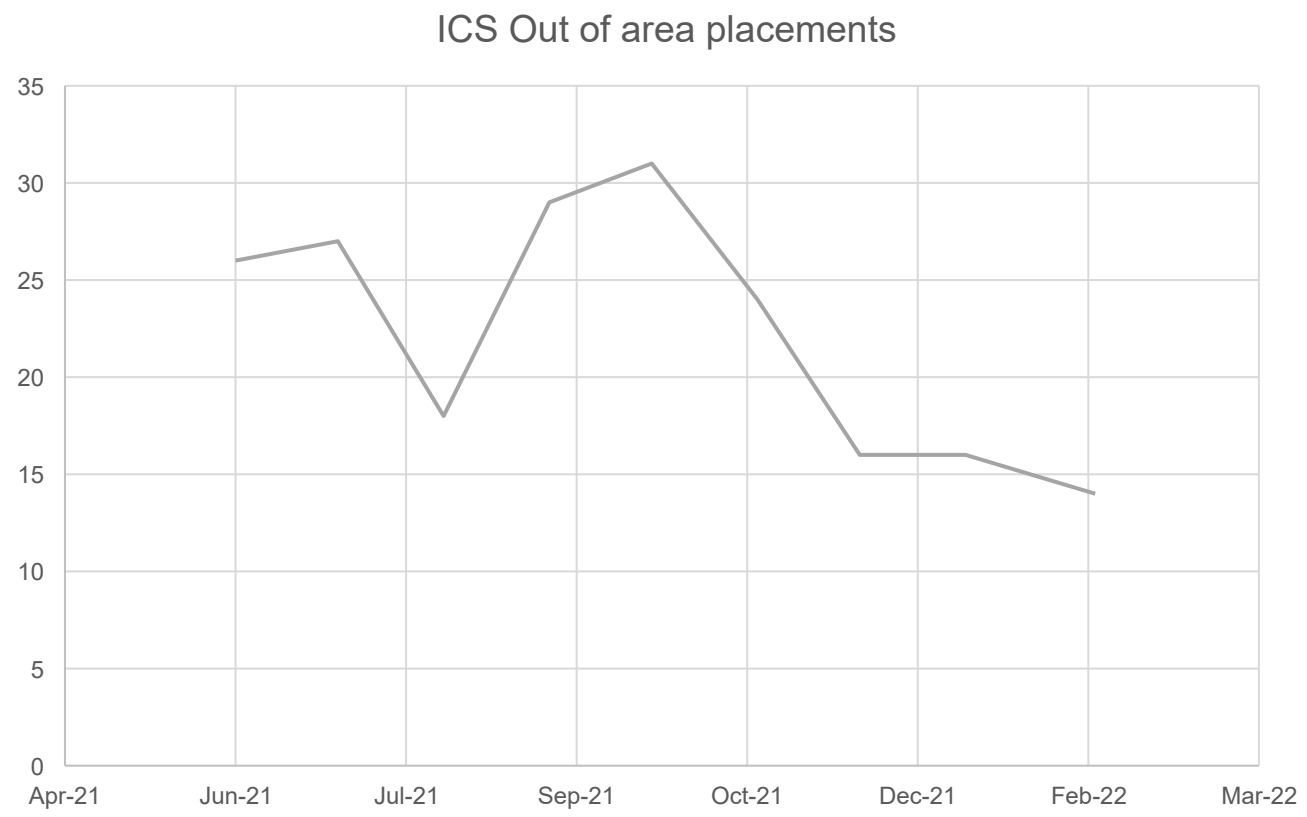
Actions for next month/s	**Intended impact**	**Date impact will be realised**
Continuation of the above actions.	Continuous increase in performance	Routine – October 2022-23 Urgent – May 2023-24

Mental Health – Out of Area Placements

Theme: Number of inappropriate out of area placements
The number of people placed out of area inappropriately for acute mental health inpatient care at the end of each month.

Underlying cause: ICSD has a historical challenge in relation to performance against this metric. This is in part because the volume of bed-based provision for acute mental health in Devon is below the national average. Occupancy rates for inpatient mental health care remain high.

Data:
National Target: 0



Mental Health – Out of Area Placements

Impact:
Inappropriate out of area placements are where patients are sent out of area because no bed is available for them locally. This type of placement dislocates them from their friends, families and community and the local health and social care support, care and treatment. Overall, this can delay their recovery, resulting in increased length of stay and reduced long-term outcomes.

Actions undertaken in last month	**Impact**
Maintaining utilisation of external provision (Elysium) to increase bed based capacity.	Continue planned reduction in inappropriate out of area placements.

Actions for next month/s	**Intended impact**	**Date impact will be realised**
Increased capacity becoming available: Salus Ward (16 beds) and Sycamore Ward (26 beds).	Reduce inappropriate out of area placements to ‘0’ in ICSD.	June 2022

Women, Children & Young People

Ockenden Report – System Update

Current Status:

- Following the initial Ockenden report return and CSU assessment, the Ockenden Report Part 2 was released last month.
- Working with the LMNS (Local Maternity and Neonatal System) all of the Devon providers have been implementing the 7 IEAs (Immediate and Essential Actions) identified in the interim Ockenden report.
- The Devon System is committed to using the report to further improve and ensure safe maternity care for women and families.
- The current position for each trust was reported through providers in March and the Board approved positions will now be confirmed to the Regional Team by 15th April. This will be published once it have been through the National Maternity Transformation Board in May.
- There have been improvements in the majority of IEAs across all providers, we await the CSU assessment to verify our returns.

Next steps for Devon:

- Chief Nurse to convene a system wide meeting with Trust Board Safety Champions and the Maternity System Leads to establish and ensure the ICS response to Ockenden.
- Appoint a lead midwife for Perinatal Quality and Safety to co-ordinate the ICS approach (funded through LMNS transformation funding).
- Prepare for regional insight visits to take place in each Trust in June 2022.
- Undertake a review of each Trust's plans for Midwifery Continuity of Carer, confirm status and operational response.

Women, Children & Young People

Section 1 1-7 Immediate and Essential Actions (IEA)	Ockenden Status following evidence submission June 2021. Devon LMNS (Local Maternity and Neonatal System)	Plymouth	North Devon	Exeter	Torbay
IEA1 Enhanced Safety	Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight				
IEA 2 Listening to Women and Families	Maternity services must ensure that women and their families are listened to with their voices heard				
IEA 3 Staff Training and Working Together	Staff who work together must train together				
IEA 4 Managing Complex Pregnancy	There must be robust pathways in place for managing women with complex pregnancies				
IEA 5 Risk Assessment Throughout Pregnancy	Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway				
IEA 6 Monitoring fetal Wellbeing	All maternity services must appoint a dedicated lead midwife and lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.				
IEA 7 Informed Consent	All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.				
Section 2 **Maternity Workforce**	Demonstrate an effective system of clinical workforce planning to the required standard.				
Midwifery Leadership	Director /Head of Midwifery accountable to an executive director –how does your organisation meet the maternity leadership requirements – Strengthening midwifery leadership :a manifesto for better maternity care.				
Nice Guidance	to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate.				

Women, Children & Young People

Section 1 1-7 Immediate and Essential Actions (IEA)	Ockenden 8th April 2022 status. (Perinatal Quality Safety Surveillance Group) Devon LMNS	Plymouth	North Devon	Exeter	Torbay
IEA1 Enhanced Safety	Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight				
IEA 2 Listening to Women and Families	Maternity services must ensure that women and their families are listened to with their voices heard				
IEA 3 Staff Training and Working Together	Staff who work together must train together				
IEA 4 Managing Complex Pregnancy	There must be robust pathways in place for managing women with complex pregnancies				
IEA 5 Risk Assessment Throughout Pregnancy	Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway				
IEA 6 Monitoring fetal Wellbeing	All maternity services must appoint a dedicated lead midwife and lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.				
IEA 7 Informed Consent	All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.				
Section 2 **Maternity Workforce**	Demonstrate an effective system of clinical workforce planning to the required standard.	Assessments due on 15th April 2022.			
Midwifery Leadership	Director /Head of Midwifery accountable to an executive director –how does your organisation meet the maternity leadership requirements – Strengthening midwifery leadership :a manifesto for better maternity care.				
Nice Guidance	to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate				

Women, Children & Young People

Torbay Special Educational Needs and Disabilities (SEND) Written Statement of Action (WSoA)

- Between 15 -19 November 2021, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of the local area of Torbay to judge the effectiveness in implementing the special educational needs and/or disabilities (SEND) reforms as set out in the Children and Families Act 2014.
- As a result of the findings of this inspection and in accordance with the Children Act 2004 (Joint Area Reviews) Regulations 2015, Her Majesty's Chief Inspector (HMCI) Ofsted determined that a Written Statement of Action (WSoA) was required because of significant areas of weakness in the area's practice. HMCI also determined that the local authority and the CCG are jointly responsible for submitting the written statement to Ofsted.
- The WSoA had been developed collaboratively, across education, health and care over the past 3 months. The voice of parents and carers, and children and young people has been reflected through every element of the WSoA.
- On the 14th April the submitted WSoA will be reviewed by the Department for Education and NHS England to ensure that it is robust and sufficient to address all of the 8 areas of weakness identified in the report.

Women, Children & Young People

Pillars of the SEND Improvement Programme

- 4 Pillars of improvement underpin the improvement plan
- 19 areas of focus have been identified to address the 8 areas of weakness
- Accountable Officers and Leads have been identified for each of the focus areas

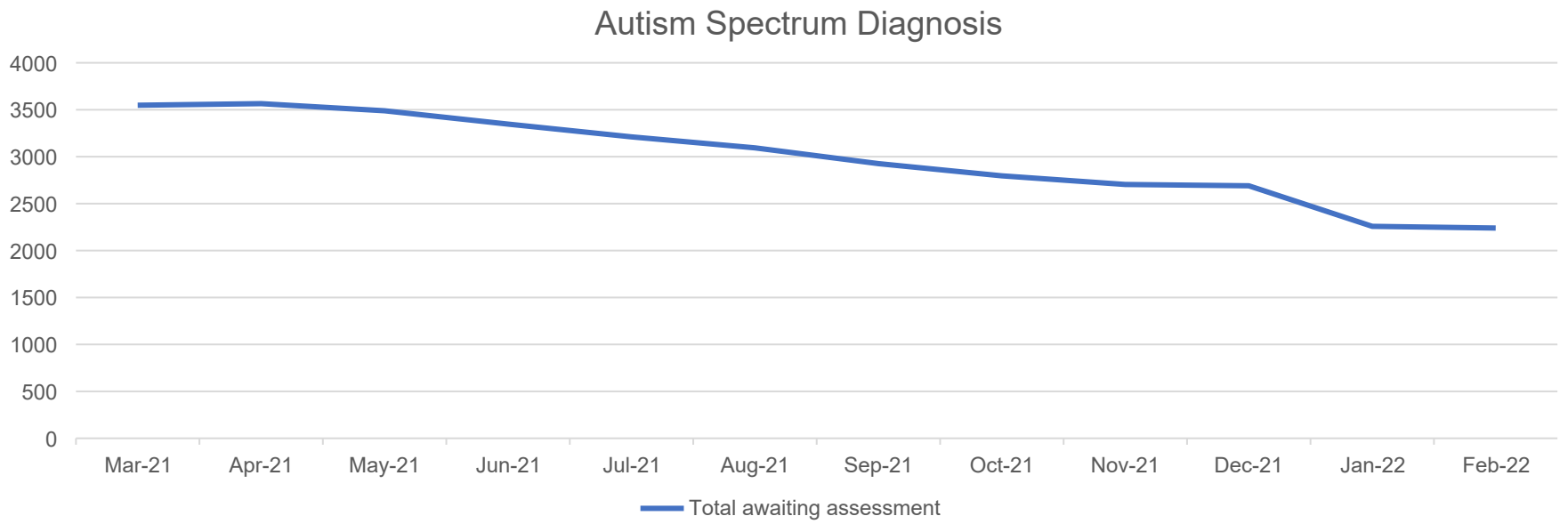
Women, Children & Young People

Responding to the Inspection Findings- Critical Success Factors

Children & Young People: Autism Diagnosis

Theme:
Children in Devon are having to wait longer than the 3 month NICE guidelines to receive an autism diagnosis.

Underlying cause:
The system has previously been unable to recruit and retain sufficient staff to reduce the waiting list. Impact of present high numbers of COVID cases in Devon has impacted on school observations- schools cancelling due to low staffing numbers Additionally, the wait list recovery plan will not achieve the target of clearing the waiting by April 2022.



Children & Young People Autism Diagnosis

Impact:
Whilst mitigation is in place, to support children and carers who are experiencing long waits, such as contact telephone numbers, impact in delays to assessment lead to delays to treatment and support, both within health and education. Levels of anxiety this may cause children, young people and their carers may not be easily quantifiable, but remain an impact.

Actions undertaken in last month	Impact
Contract with Babcock signed and in place for them to provide school observations contributing to the assessment. Recruitment processes to fill core staff vacancies as well as agency staff for the virtual team. Analysis of data referral confirms that self referrals remain high. Data Quality of process and assessments completed continues to be undertaken. Babcock continue to arrange meetings with school SEND staff to support the assessment process.	1799 children have been taken off the wait list since April 2021 (either assessment started, completed) as part of the Devon Autism waitlist recovery plan.

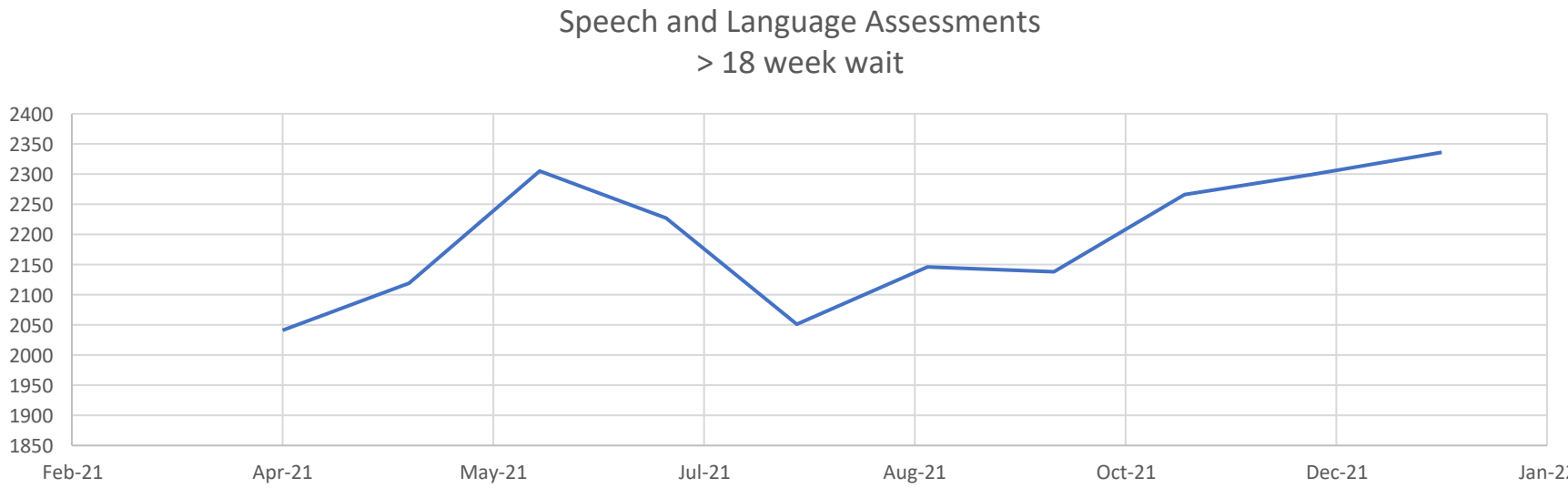
Actions for next month/s	Intended impact	Date impact will be realised
Meeting to deep dive into data and performance and to produce revised trajectory based on realistic experience of recruitment and retention and performance improvement	Provide guidance and direction to reduce waiting list times.	New proposed trajectory to be agreed by 31st May 2022
Progress next stage of neurodiversity Game Changer scheme- specifically review of care pathways for diagnosis and meeting need at the point of presentation – current stage engagement with key stakeholders	Reduction of referrals Reduction in waiting times Improved experience for CYP & Families	This is a medium to long term transformation programme that will be delivered across 2022/23

Children & Young People: Speech & Language

Theme: Speech and Language
Currently there are 2,336 children in Devon waiting for more than 18 weeks for a Speech and Language assessment.

Underlying cause:
High numbers of referrals are continuing to be received, whilst staffing vacancies have compounded the problem. Service was originally stood down at start of pandemic. Changes are needed to the environment and clinic space impacted, also moving to online and wearing of masks is not appropriate for SALT (Speech and Language Therapy).

Impact:
Delays to assessment lead to delays to treatment and support, both within health and education. This can impact on long term, as well as short term, outcomes.

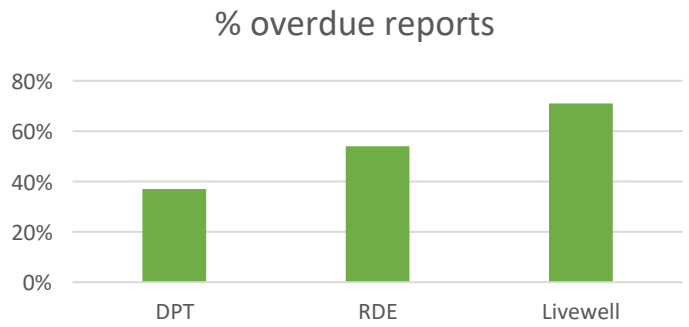


Children & Young People: Speech & Language

Actions undertaken since last report	Impact
CFHD (Children and Family Health Devon) service efficiency has been improved by reviewing caseloads, streamlining the referral and documentation process; and triaging cases.	WTE (Whole Time Equivalent) staff are completing on average 66 appointments per month, an increase from 37, thus assisting with the reduction of awaiting referrals.
LWSW have introduced a new process. That following assessment a 12 week intervention course will commence. Upon completion the child's case will be reviewed to determine if any further treatment is needed.	Following the 12 week intervention, it is assessed that this process will support the reduction of children on the wait list.

Actions for next month/s	Intended impact	Date impact will be realised
Staff efficiencies are expected to continue. Implementation of assessment and 12 week offer of intervention.	More appointments will be completed by the same amount of staff (compared with previous performance). Therefore reducing the amount of children awaiting an assessment.	March 2023 – waiting list to achieve a zero/acceptable level.

Serious Incidents

Issue:	**Data: Highest numbers of overdue Incident Reports 31.03.22**
• There has been an increase in overdue reports and a decrease of in date reports for several providers. This is due to operational pressures and lack of staff. This means that the learning is not captured promptly and improvements made.	
Underlying cause: • Workforce; several providers have had sickness in their safety team.	

Actions undertaken in last month	**Impact**
• Contact made with providers , support offered and meetings arranged.	• Focus on mitigating actions to alleviate the backlog, ensure completed on time for patients & families and learning takes place.

Actions for next month/s	**Intended impact**	**Date impact will be realised**
• A series of meetings have been planned to agree improvement plans.	• To support the providers moving forward with a plan to decrease their outstanding Incident reports.	• Initial meetings will be completed by 8th March with a plan to decrease outstanding reports.
• To continue weekly support meeting with the trusts to facilitate action and process.	• Further reduce the number of outstanding incident reports	• Decrease in the number of due and overdue reports over the next quarter.

Incident Reporting Improvement Plan

Issue:	**Data:**
• The current rate of PITCH submissions makes it difficult to create monthly thematic reporting. However, it is obvious the main themes relate to discharge summaries and workload shift. Without the view of the entirety of the system reporting there will be a lack of understanding around the themes and trends.	February PITCH submission - 32 March PITCH submissions - 71
Underlying cause: • The cause is that there is a lack of robust understanding from primary care and other community settings as the benefit of incident reporting and system wide understanding of the issues.	

Actions undertaken in last month:	**Impact:**
• Introduction of a trial process for Western PITCH submission. • Weekly meeting with Patient Safety Quality colleagues to review all locality submissions and deciding on best course of action. • Includes sending any submissions relating to University Hospitals Plymouth on the day of processing, as part of listening to our Western GP's concerns relating to PITCH.	• Increased collaboration with primary care in response to concerns raised through PITCH. • An increased awareness of the importance of reporting and a system-wide understanding of the themes and trends that are causing quality and safety issues.

Actions for next month/s:	**Intended impact:**	**Date impact will be realised:**
• Easy to use top tips: PITCH • Updates to our PITCH webpage • Presentation slides that can be used by the Nursing and Quality team to continue promoting the use of PITCH.	• Increase in the number of PITCH submissions. • Improved communication & information for primary care. • Ability to create and learn from themes.	August 2022 an increased awareness of the importance of reporting and a system-wide understanding of the themes and trends that are causing quality and safety issues.

Patient Experience (CCG): Patient Contacts

Issue: There has been an increase in contacts with the CCG Patient Experience Team over the last 3 months. Additionally, due to the increase in contacts, there is a corresponding increase in the number of open cases; both formal complaints and informal queries/concerns that are overdue. This of course may result in poor patient experience, as well as delayed system learning from the contact with users.	**Data:** **New contacts:** January 50 February 75 March (29 March 2022) 94. **Open Complaints (29 March 2022):** 7 open formal complaints 53 open informal queries/concerns.
Underlying cause: The cause is two-fold, due to increased number of contacts due to operational pressures in the system and a reduced workforce within the CCG.	

Actions undertaken in last month	Impact
• The Patient Experience telephone calls have been fully integrated into the DRSS' Helpdesk.	• Increased workforce and collaborative working to improve response times and reduce delays for patients.

Actions for next month/s	Intended impact	Date impact will be realised
• Approval to utilise our Helpdesk colleagues to triage, acknowledge, signpost and log on to Datix all emails received into the Patient Experience email box from week commencing 11 April 2022. • Requirement to ensure that the CCG team is able to meet the current demand once fully staffed.	• Further workforce capacity to improve performance, reduce delays for patients and subsequent improved patient experience.	• A reduction in time taken to close complaints- May 2022 onwards. NB: It is not possible currently to state when patient experience of services will improve.

Workforce

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

Vacancies

- All vacancies (other than AHP's) have reduced over the last month. Our system medical recruitment campaign planned in April 2022 will support attraction of medical colleagues from outside of the system to work in Devon. Marketing company 'White Space' have designed a 'We are Devon' identity and assets for all to use. The campaign will focus on 6 specialities: CAMHS, Psychiatry, Respiratory, Oncology, Emergency Medicine and Radiology.
- The international pipeline remains healthy, and on track to meet targets by end of March 2023 with 246 hires made as of end Feb 22). Planning for c800 NHS and c300 Social Care recruits in 22/23 is in progress along with a review of the delivery model.

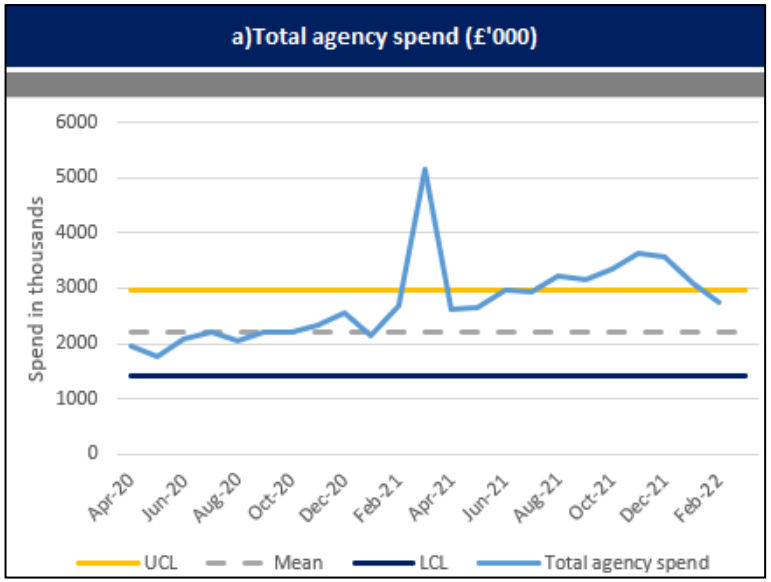
- Livewell /Social care recruitment pilot update: 150 applications of interest with 23 offers made and 18 in post. Pilot to run for a further 3 months and expanded thereafter. Applicants are being fed into the pilot where they did not meet the requirements of similar posts in health care settings.

- Highly successful Argyle job fair to add further 50 EOIs to the dashboard.
- Providers are currently attempting to over recruit into rapid response teams to aid discharge. 33 are in post with 52 offers from the target of 70WTE. The impact has been to support teams and maintain the status quo and stabilise their position against a challenging recruitment market.

Workforce

Bank and agency spend

- Agency spend is within normal control limits, and has reduced from last month. We are in the process of creating a system wide plan to reduce the proportion of our overall pay bill that is spent on agency staffing.
- Plans are being formulated to setup within 12 months a collaborative nursing bank across the system, adding to the already established medical collaborative bank.
- We will also be standardising agency rates and formalising the approach to the cascade process to agencies whilst adding the use of the NHSP National bank prior to shifts going out to agencies.
- Through the refreshed systemwide Temporary Staffing Group, we are also formulating plans to eradicate the use of non- framework agencies whilst ensuring we do not deteriorate staffing levels.



Workforce Strategy

- Work continues on the development of a ICSD Workforce Strategy. Extensive engagement was undertaken in the latter part of 2021 across the system with c100 leaders from clinical, professional and management roles across our system partners to support the development of the Workforce Strategy.
- Further engagement with HRDs, Medical Directors, CNOs, Workforce Leads and other senior stakeholders from across all system partners is currently being planned for April & May.
- The Workforce Strategy has been progressed through the People Plan Steering Group and the People Programme Board. Work is on track to meet the agreed deadline for final approval by the newly formed People & Culture Assurance Committee and the ICB in July.

Other

- Turnover has remained the same as the last report (11.8%) and is higher than this time last year (9.3%).
- At 30 March absence is at a high in Devon - 9.1% (COVID related 5.1%). By the end of April we plan to have completed reviews with Trusts and agreed an action plan – ensuring there is agreement on standardised best practice processes.

Workforce

		ICS	NDHT	RD&E	TSDFT	UHP	DPT
Consultant	Substantive Workforce	1281.1	110.8	388.3	240.6	460.1	81.4
	Vacancies	79.9	13.5	0.0	10.3	36.0	20.2
	Vacancy rate	6.02%	11.03%	0.00%	4.26%	7.71%	20.85%
	Trend						
Nursing	Substantive Workforce	7236.3	775.5	2176.0	1293.8	2198.9	792.2
	Vacancies	543.7	99.1	61.5	123.8	108.2	151.1
	Vacancy rate	7.41%	11.46%	2.91%	9.35%	5.11%	16.46%
	Trend						
HCA	Substantive Workforce	3748.273	310.05	1094.24	545.6901	1274.553	523.74
	Vacancies	322.7853	43.09	50.14543	102.6095	162.0103	-35.07
	Vacancy rate	7.93%	12%	4.38%	15.83%	11.28%	-7.18%
	Trend						
AHP	Substantive Workforce	2066.575	238.6	644.94	522.3353	450.3394	210.36
	Vacancies	149.7148	59.79	25.7048	38.4	23.27	2.55
	Vacancy rate	7.63%	20.09%	4.66%	7.82%	5.40%	1.33%
	Trend						

Note:
Percentages are calculated from the reported vacancies in the cells immediately above
Trendline data period runs from April 2021 – February 2022.

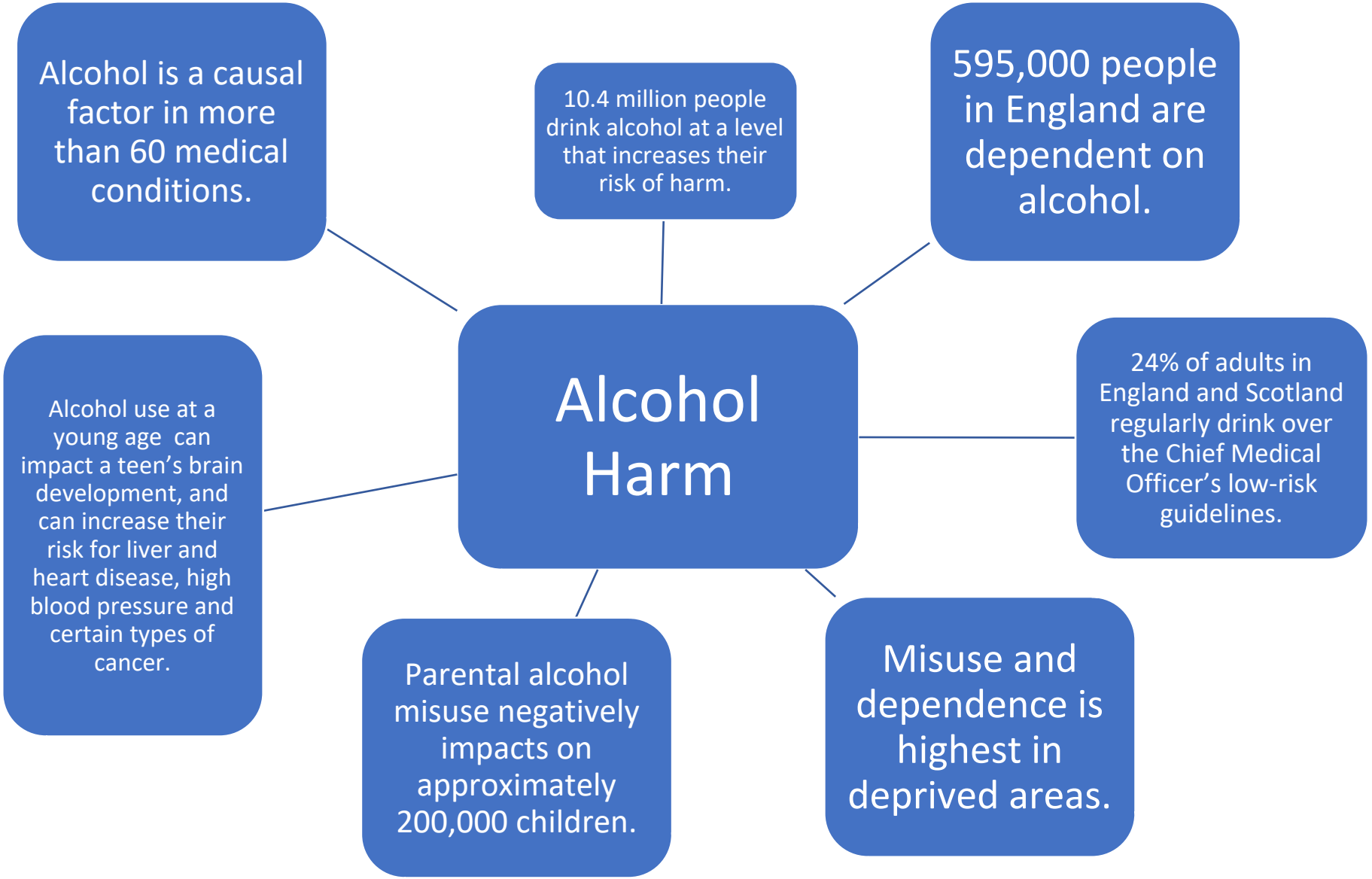
Together for Devon

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

Performance Deep Dive: Alcohol Admissions

#TogetherForDevon

Snapshot

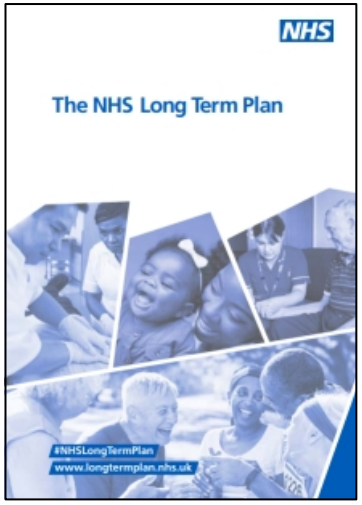


Sources: PHE – Alcohol Harm Reduction – Recovery Action Card
Help guide – Underage Drinking and Teen Alcohol Use

Relevant Policy/Guidance

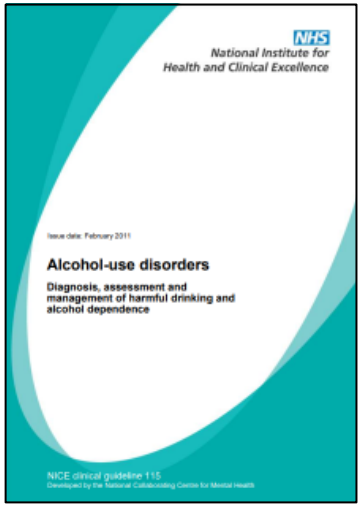
NHS Long Term Plan

Establish specialist Alcohol Care Teams – Reduce emergency admissions, bed days, readmission and ambulance call outs.



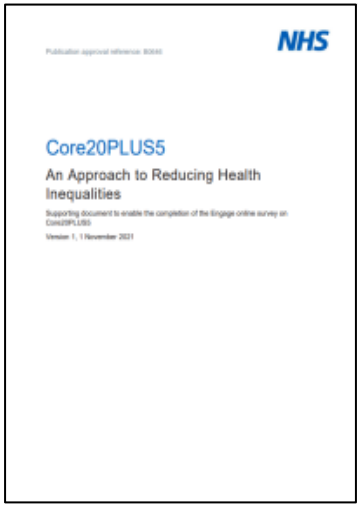
NICE Clinical Guidelines CG115

Diagnosis, assessment and management of harmful drinking and alcohol dependence.



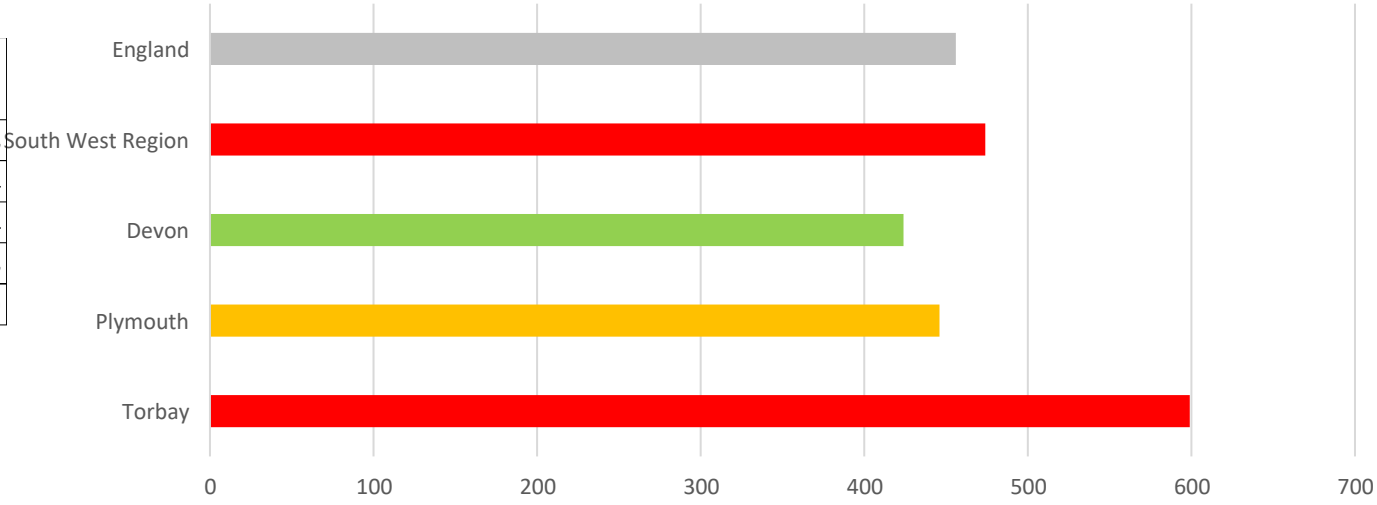
Core20PLUS5

Reduce health inequalities across the most deprived areas across the system



Current Position – Admission episodes for alcohol-related conditions (all ages) 2020/21

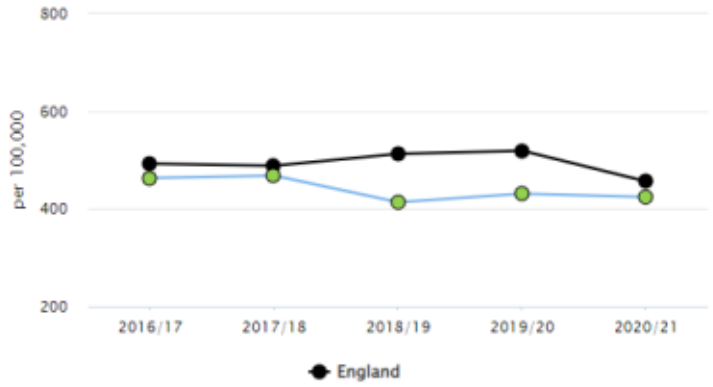
	Episodes	Rate per 100,000
England	247,972	456
South West Region	27,112	474
Devon	858	424
Plymouth	1,102	446
Torbay	3,644	599



These conditions are defined as admissions to hospital where the primary diagnosis is an alcohol-attributable code (condition) or a secondary diagnosis is an alcohol-attributable external cause code (condition).

Whilst Devon is lower than the England average and there is a slow downward trajectory, there are still over 3,500 admissions per year. Moreover, in later slides younger people are disproportionately represented.

Current Position – Alcohol Admissions all ages



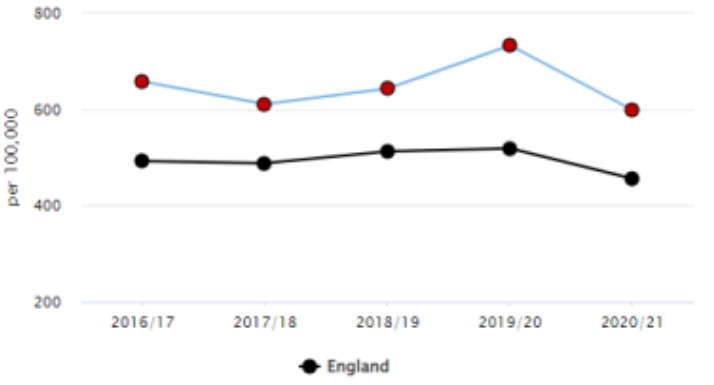
Recent trend: ⬇ Decreasing & getting better

Period		Devon Count	Devon Value	Devon 95% Lower CI	Devon 95% Upper CI	South West	England
2016/17	●	3,781	463	448	478	504	492
2017/18	●	3,888	468	453	483	503	488
2018/19	●	3,486	413	400	428	528	512
2019/20	●	3,660	431	417	446	528	519
2020/21	●	3,644	424	410	439	474	456

Source: Calculated by OHID: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

These charts show the number of episodes described as "count." The "value" is a standardised rate per 100,000 population, thus allowing comparative benchmarking.

Over the reporting periods Devon has maintained a position below the national average. However, Devon may not maintain this place should the national average reduce at the same rate again.

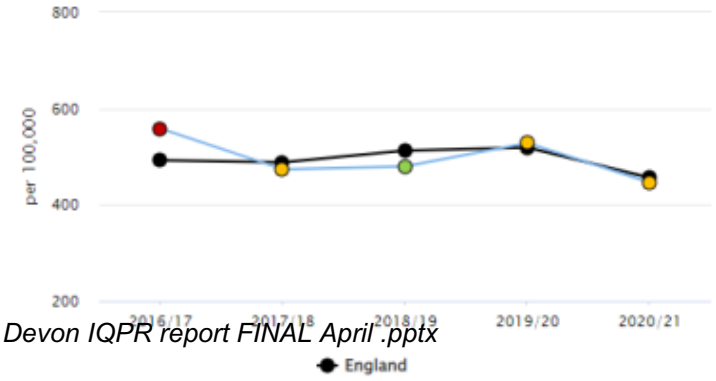


Recent trend: ➡ No significant change

Period		Torbay Count	Torbay Value	Torbay 95% Lower CI	Torbay 95% Upper CI	South West	England
2016/17	●	922	657	615	702	504	492
2017/18	●	866	611	570	654	503	488
2018/19	●	926	643	601	687	528	512
2019/20	●	1,054	732	688	779	528	519
2020/21	●	858	599	558	642	474	456

Source: Calculated by OHID: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

Torbay has continued to stay above the national average and in some years in excess by 50%. NHS and Public Health projects are underway to improve these figures.



Recent trend: ⬇ Decreasing & getting better

Period		Plymouth Count	Plymouth Value	Plymouth 95% Lower CI	Plymouth 95% Upper CI	South West	England
2016/17	●	1,370	558	529	589	504	492
2017/18	●	1,176	474	447	502	503	488
2018/19	●	1,189	480	453	508	528	512
2019/20	●	1,307	528	500	558	528	519
2020/21	●	1,102	446	420	473	474	456

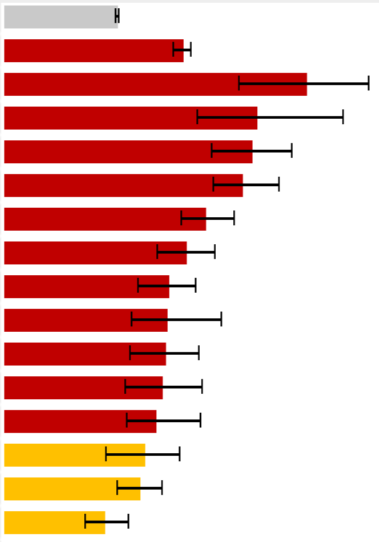
Source: Calculated by OHID: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

Plymouth has consistently maintained a position mapping closely to the national average. Continued investment in their services may see this trend being maintained.

Admission episodes for alcohol-specific conditions – Under 18s (persons) 2020/21

Areas: **All in South West region** | All in England Display: **Table** | Table and chart

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	10,569	29.3	28.7	29.9
South West region	–	1,530	46.0	43.8	48.5
Bath and North East Somerset	–	85	78.1	60.7	94.5
Torbay	–	50	65.4	49.7	87.7
Bournemouth, Christchurch and Poole	–	145	63.8	53.4	74.6
Somerset	–	205	61.5	54.0	71.2
Devon	–	230	52.2	45.9	59.6
Wiltshire	–	150	47.2	39.3	54.7
Bristol	–	120	42.5	34.6	50.0
North Somerset	–	55	42.0	33.0	56.4
Dorset	–	85	41.8	32.5	50.6
Plymouth	–	65	40.9	31.0	51.5
South Gloucestershire	–	70	39.3	31.6	50.9
Swindon	–	55	36.3	26.2	45.8
Gloucestershire	–	135	34.9	29.3	41.3
Cornwall	–	85	26.0*	21.1	32.5
Isles of Scilly	–	-	*	-	-



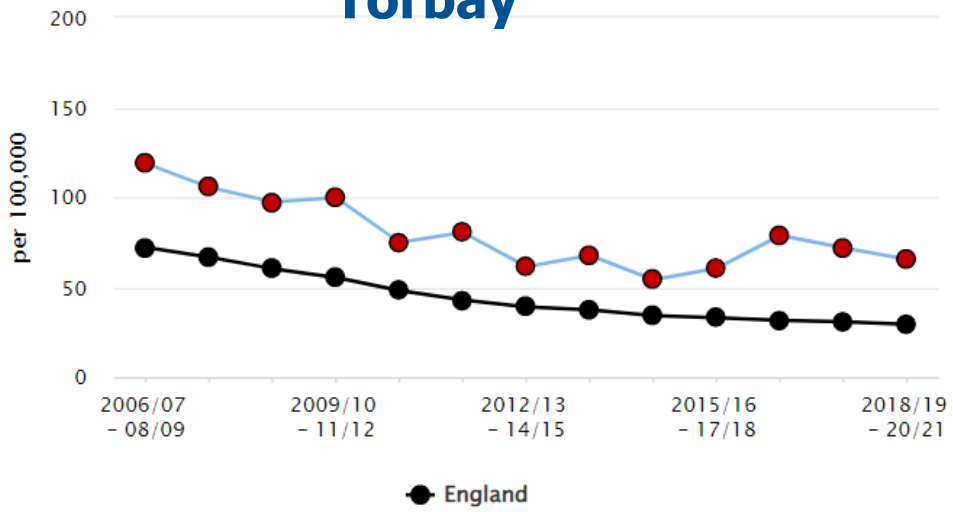
Source: Calculated by OHID: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

Under 18s alcohol admissions are all above the national average across the system. In particular, Torbay has a value twice that of the national average.

The following slides show trends for each council district across our system.

Admission episodes for alcohol-specific conditions – Under 18s

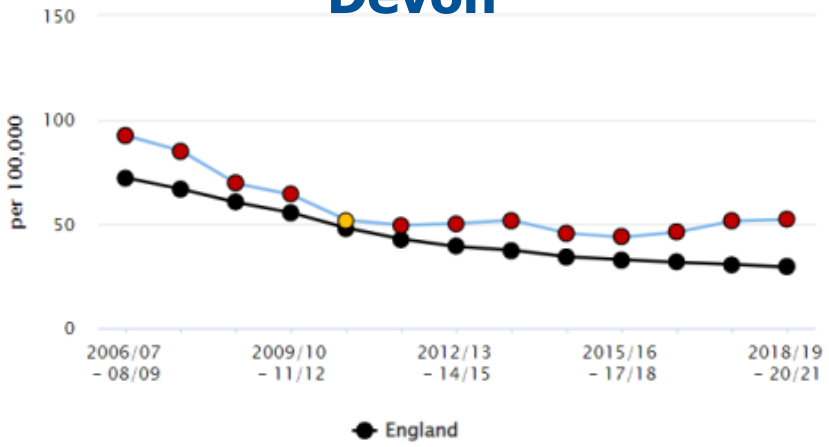
Torbay



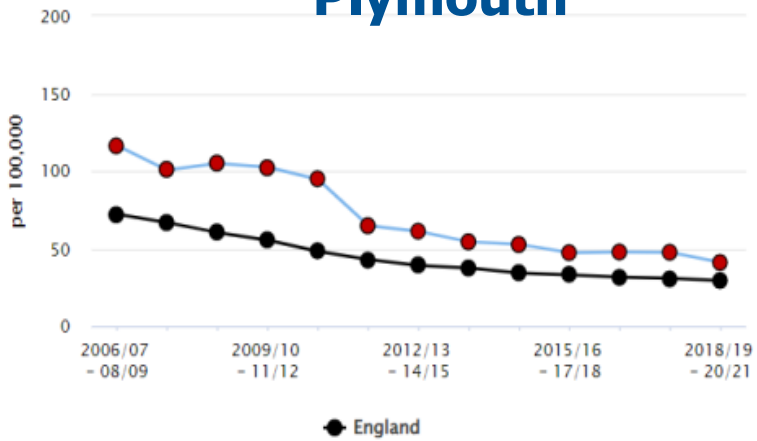
Torbay and Plymouth are maintaining a downward trajectory towards the England average.

However, Devon is now in a levelling off position suggesting that further invention is required to reduce admissions.

Devon



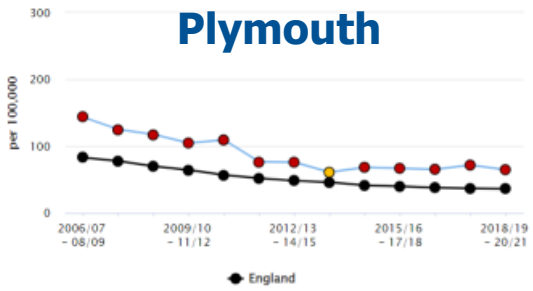
Plymouth



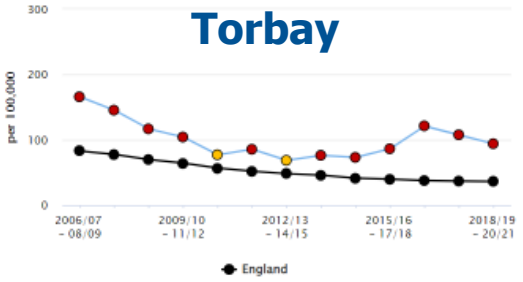
Admission episodes for alcohol-specific conditions – Under 18s / by gender

Female Admissions

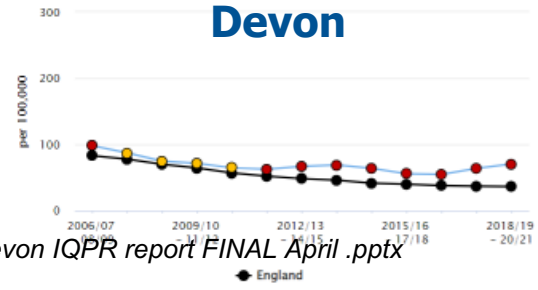
Plymouth



Torbay

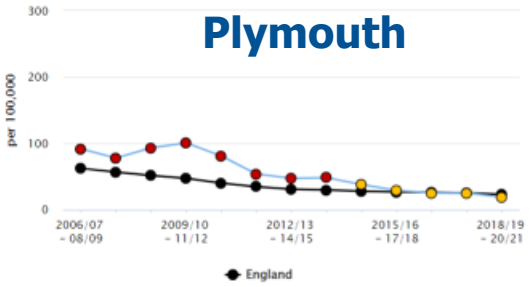


Devon

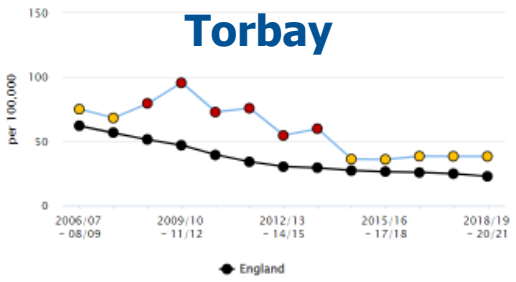


Male Admissions

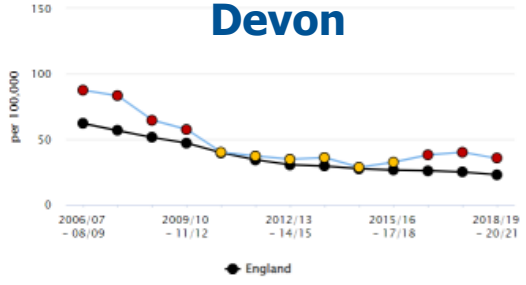
Plymouth



Torbay



Devon



	2018/19 - 20/21	
	Female	Male
England	36.1	22.8
Plymouth	64.6	18.4
Torbay	93.8	38.3
Devon	70.2	35.2

This information shows the “value” as a standardised rate per 100,000 population.

Female admissions are much higher than male admissions, with the most recent data showing between 2-3 times as many admissions compared to males.

More work is required to fully understand this situation and to reduce admissions.

Forthcoming projects are detailed on the following slide.

Alcohol Harm Reduction Projects/Posts

Torbay

- Torbay Council have commissioned a volunteer lead service for screening that was stood down due to Covid, the restart date is anticipated for this summer.
- Late 2021, NHS England funded a 3 year trial Alcohol Care Team service – 1 x B7, 1 x B6. Funding matched by T&SD. Although, Long term Plan recommendations suggest 4.2 WTE, whilst a seven day service is recommended by NCEPOD (National Confidential Enquiry into Patient Outcome and Death). Early indicators of effectiveness include better patient engagement, reduced admissions and reduced bed days

Plymouth

- Year long pilot establishing an alcohol assertive outreach team. Outcomes, significantly reduced bed days (143 > 43) and hepatology admissions (43 > 14). Two posts substantively funded through Fair Shares.
- Links to the Young Peoples Substances Misuse Service (SHARP) via the UHP Safeguarding Nurse.
- Currently, Derriford has two B6 Alcohol Liaison Nurses in post (Substantively funded).
- Additionally, a further alcohol complex needs pilot has been extended into 2022/23 and is sub-contracted to Devon Mind.

Devon

- DCC have a working group, bringing stakeholders together and is based on the PHE recovery framework to reduce alcohol harm.
- Y-SMART is funded by multiple stakeholders and provides support to children and young people who wish to address their alcohol or other drug use. There are 17 WTE staff delivering this service across Devon.
- RD&E have 1 Alcohol Liaison Nurse in post. Capacity is challenged due to both operational and strategic responsibilities.
- NDHT do not have an appointed person.

Potential Next Steps/Actions

Continued Collaboration

- Alcohol harm is a multifaceted condition and requires a range of stakeholders to effectively engage to improve outcomes for our patients. In Devon, the local partnership plan will create referral pathways, and hospital link workers promoting the Y-SMART treatment offer to children and young people. Torbay is seeking to form a multiple complex needs alliance, aiming to drive system change and improve patient experience within the service.

Data Granularity and Availability

- Understanding our patient cohort will assist with developing successful response plans. Sharing data fundamentally flows from collaboration and enables a wider audience to identify solutions to challenges.

Focussed strategies

- After successful collaboration, strategies must be developed to underpin future work centred on patient outcomes rather than targets. The SW peninsular consortium is reviewing and modifying inpatient provision for medically managed and medically monitored placements, aiming to improve both the availability and accessibility of this intervention to ultimately reduce unplanned hospital admissions requiring alcohol detox. Torbay are implementing a 3 year plan, commissioning the SSMTR (Supplementary Substance Misuse Treatment and Recovery) Program. Additionally, referral pathways are being reviewed and developed to support our communities.

Lesson Learned

- Re-evaluate successes such as the pilot conducted in Plymouth and consider extending to other system areas. Planned re-instatement of volunteer-led lifestyles screening programme in June 2022.

System wide investment

- System priorities should be adequately and sustainably funded.

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ICS Performance & Quality Outcomes

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Strategic Outcomes

Devon ICS Strategic Outcomes Framework

	Domain		latest period	England Latest	England trend	ICS latest	ICS Trend	SW Region Latest	SW region trend	Devon County Council Latest	Devon County Council Trend	Plymouth County council Latest	Plymouth County Council Trend	Torbay County council Latest	Torbay County Council Trend
Health of the Population	Early Years	Breast feeding prevalence at 6-8 weeks after birth	2020/21 Q4	49.5%						56.0%		41.0%		40.0%	
	Young people	Admission episodes for alcohol-specific conditions - Under 18s (Crude rate per 100,000 population) Rolling 12 month position	February			69.9				59.5		64.6		88.9	
	Older Adults	Admission episodes for alcohol-specific conditions - Over 65s (Crude rate per 100,000 population) Rolling 12 month position	February			1526.2				1264.4		1373.4		1555.6	
Health of the ICS Are people being appropriately and equitably support	Early Years	Take-up of health visitor checks Proportion of new birth visits completed within 14 days	2021/22 Q2	82.9%				73.1%		12.5%		83.3%		87.5%	
	Younger people	Children and young people accessing mental health services. Rolling 12 Months	February	41%		38%									
		Service users with crisis plans % of people in contact with mental health services	2019/20 Q2	12%		3%									
		Hospital admissions as a result of self harm (10-24 years) Directly standardised rate per 100,000	2020/21	422		519.8		624.9		494.7		668.8		700.7	
	Working Age	Proportion of eligible adults with a learning disability having a health check (%) (target 75%)	February			61.7%									
		Admission episodes for 18 - 65 alcohol-specific conditions (Crude rate per 100,000)	February			1223.6				1012.7		930.1		1695.7	
	Older Adults	Bed Occupancy Rates (Acute Hospitals excludes covid beds)	2122 Q3	86%		86%				83%		89%		86%	
		Dementia: Recorded prevalence (aged 65 years and over)	February			56%									
		Emergency admissions aged 65 and over (rate per 1000 population)	2122 Q3			5616.8				5073.2		3960.4		5896.1	

Quality Outcomes*

*Data collection in development for new metrics

Quality indicators

Domain		Definition	Target/Direction	latest period	ICS/CCG		RDEFT/Eastern		NDHT/Nothern		UHP/Western		TSDFT/Southern	
Individuals in receipt of funding from the NHS/CCG due to a statutory responsibility	Continuing Healthcare assessment are completed within 28 days	Number of referrals concluded within 28 Days	80%	Q3 2021/22	76%									
	Continuing Healthcare assessments take place within an acute hospital	Less than 15% of Continuing Healthcare assessments take place within an acute hospital	15%	Q3 2021/22	0%									
	Assessment for Continuing Healthcare determination over 12 weeks	Number of assessment for Continuing Healthcare determination over 12 weeks	0	March	6									
Primary care	Asthma RCP assessment	Proportion of GP assesment including Asthma RCP assessment	Higher is Better	2018/19			0.778		0.785		0.729		0.768	
	Mental Health comprehensive care plan	Annual Proportion of GP assesment including Mental health care plan	Higher is Better	2020			0.688		0.656		0.664		0.683	
	Diabetes Blood pressure reading 140/80 mmHg or less	Annual Type 1 Proportion of GP assesment including Diabetes Blood pressure reading	Higher is Better	2019			0.771		0.761		0.718		0.775	
		Annual Type 2 Proportion of GP assesment including Diabetes Blood pressure reading					0.717		0.717		0.709		0.738	
	Needs met at last GP appointment	Annual Proportion of GP assesment including Needs met	Higher is Better	2020			0.964		0.972		0.947		0.955	
	Cancer review within 6 months of diagnosis	Annual Proportion of GP assesment including Cancer reviews	Higher is Better	2020			0.918		0.937		0.882		0.905	
	Females, 25-64, attending cervical screening within target period	Proportion of GP assesment including Cervical screening 25 - 49	Higher is Better	Q2 2021/22			0.734		0.757		0.719		0.746	
		Proportion of GP assesment including Cervical screening 50 - 64					0.775		0.767		0.762		0.762	
	Persons, 60-69, screened for bowel cancer in last 30 months	Annual Proportion of GP assesment including bowl cancer	Higher is Better	2020			0.691		0.676		0.686		0.680	
	Child Imms DTaP/IPV/Hib/HepB (age 1 year)	Proportion of GP assesment including immunisations	Higher is Better	2020			0.944		0.955		0.960		0.952	
	CQC rating	Latest Care Quality Commission rating	Higher is Better					Good (Apr 2019)		Requires improvement (Nov 21)		Requires improvement (Jan 22)		Good (Jul 2020)
ICS	C-Diff Counts of Infection Episodes	Healthcare onset – healthcare associated	Lower is Better	March	8		4		1		4		1	
		Community onset – healthcare associated	Lower is Better	March	4		3		0		1		2	
		Community onset- indeterminate association	Lower is Better	March	1		0		0		1		0	
		Community onset-community association	Lower is Better	March	10		3		2		5		2	
	MRSA Counts of Infection Episodes	Community onset – healthcare associated	Lower is Better	March	0		1		0		0		0	
		Community onset-community associated	Lower is Better	March	0		0		0		0		0	
	MSSA Counts of Infection Episodes	Healthcare Associated	Lower is Better	March	14		4		1		7		5	
		Community onset-community associated	Lower is Better	March	10		0		3		8		3	

Quality Outcomes

Quality indicators

Domain		Definition	Target/Direction	latest period	ICS/CCG	RDEFT/Eastern	NDHT/Nothern	UHP/Western	TSDFT/Southern	DPT	Livewell
ICS	E.coli Counts of Infection Episodes	Healthcare associated	Lower is Better	March	27	6	5	9	8		
		Community onset-community associated	Lower is Better	March	47	17	5	13	19		
	Klebsiella Counts of Infection Episodes	Healthcare associated	Lower is Better	March	9	7	0	4	1		
		Community onset-community associated	Lower is Better	March	13	3	2	4	4		
	Pseudomonas Counts of Infection Episodes	Healthcare associated	Lower is Better	March	0	0	0	2	0		
		Community onset-community associated	Lower is Better	March	3	0	0	0	0		
	COVID 19 outbreaks	Snap shot of Definite Hospital acquired cases Transferred from another ward on the 1st on the month	Lower is Better	January		4	0	1	0		
		Staff cases snapshot as at 1st of the month	Lower is Better	April		60.7%	59.0%	61.5%	43.3%		
		Council Snap shot of Care Homes Reporting COVID Cases	Lower is Better	April				27	22	94	
Mental Health	Annual Physical Health Checks for those with Serious Mental Illness	% of completed comprehensive annual Physical Health Checks for those with a Serious Mental Illness	Higher is Better	February	30%						
	Dementia Diagnosis rate	Proportion of patients with dementia, ages 65+	66.70%	February	55.7%						
	% of people discharged from in-patient units who receive follow up at 48hrs	% of people discharged from in-patient units who receive follow up at 72hrs	Higher is Better	October	27.0%					75%	19%
	% of people discharged from in-patient units who receive follow up within 7 days	% of people discharged from in-patient units who receive follow up within 7 days	Higher is Better	February							95%
Childrens	Autism	Mean wait from referral to assessment Childerns number of Weeks data from Children and family Health Devon	Lower is Better	February	85.2						
	Eating Disorders:- routine	Children and Young people Eating disorders waiting times (routine 4 weeks)	Lower is Better	Q3 2021/22	44%				#N/A	46%	38%
	Eating Disorders:- urgent	Children and Young people Eating disorders waiting times (urgent 1 week)	Lower is Better	Q3 2021/22	61%				#N/A	76%	38%
	Children and Adolescent Mental Health Services: - Routine	DPT waiting over 18 weeks Livewell within 18 weeks	Lower is Better	January						610	309
	Children and Adolescent Mental Health Services: - Urgent	Referrals seen within 1 week DPT (local target) Livwell 24hr	Lower is Better	January						81%	100%
	Mean wait for Speech and Language Therapy	Mean wait from referral to assessment	Lower is Better	February							30
Community	End of Life measure Death in place of choice	Proportion of deaths in usual residence	Higher is Better	Rolling annual 2020/21 Q3 - 2021/22 Q2	58.31						

Quality Outcomes

Quality indicators

Domain		Definition	Target/Direction	latest period	ICS/CCG		RDEFT/Eastern		NDHT/Nothern		UHP/Western		TSDFT/Southern		DPT		Livewell	
Safety systems	Number of open Serious Incidents	Total number of Open Incidents	Lower is Better	March			24		14		37		33		93		24	
	Number of open Serious Incidents	Total number of Open Serious Incidents (Severe +Death)	Lower is Better	March			1		1		3		0		3			
	Number of Serious Incidents that are overdue	Total number of Serious Incidents that are overdue	Lower is Better	March			13		7		5		3		42		17	
	Number of Never events in last twelve months	Total number of Never events withina roling 12 month period	Lower is Better	March			0		0		0		0		0		0	
	PALS: Number of open complaints	Total number of open complaints	Lower is Better	March			0		0		0		0		0		0	
Safeguarding	Number of children receiving CP medicals	Torbay, Devon and Plymouth CC		January							329		149		639			
	Domestic abuse and sexual violence victims and perpetrators referred to specialist services.			January			8		13		30							
	Percentage of CIC receiving RHA's within timescales (this is 6 monthly for U5s and annually for Over 5s)			January											44%		13%	
	Percentage of CIC receiving IHA's within 20 working days of coming into care.			Q3 2021/22			0%		57%		26%		50%					
	Number of safeguarding adult enquiries (S42) regarding the service			January			18		9		4		2		11		0	
Maternity	Breast feeding rates	Proportion First feed breast milk	Higher is Better	December			60%		70%		68%		73%					
	Homebirth rate	Proportion of home births	Higher is Better	December					0%				3%					
	Midwife to Birth ratio		Higher is Better	February					84%		61%		69%					
	Still births/ Neonatal deaths	Number of still Births	Lower is Better	February					0		2		0					
	C/S rates	Proportion of Elective and emergency Caesarean section births	Lower is Better	December			33%		35.0%		30.4%		40.0%					
People	Sickness rate	Average sickness absence rate	Lower is Better	February			5.1%		4.3%		5.9%		5.0%		6.5%			
	Turnover rate	Average staff turnover rate rate	Lower is Better	February			13%		13%		11%		13%		12%			
	Bank as share of temporary workforce		Lower is Better	February			64%		80%		98%		70%		74%			
	Consultant vacancies	Total number of vacancies	Lower is Better	February			0.0		13.5		36.0		10.3		20.2			
	Nursing vacancies	Total number of vacancies	Lower is Better	February			61.5		99.1		108.2		173.8		151.1			
	HCA vacancies	Total number of vacancies	Lower is Better	February			50.1		43.1		162.0		102.6					
	AHP vacancies	Total number of vacancies	Lower is Better	February			25.7		59.8		23.3		38.4					

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Recovery & Activity

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Performance Key Targets

Performance Key Targets																		
			ICS			RDEFT			NDHT			UHP			TSDFT		
Indicator	Date range	Target/Plan	Previous Period	Latest Period	Change	Previous Period	Latest Period	Change	Previous Period	Latest Period	Change	Previous Period	Latest Period	Change	Previous Period	Latest Period	Change
Accident & Emergency type 1&2	MARCH 2021-22	95%	55%	52%	π	60%	55%	θ	71%	70%	θ	[illegible]	[illegible]	[illegible]	42%	37%	θ
Accident & Emergency All	MARCH 2021-22	95%	69%	68%	θ	68%	66%	θ	71%	70%	θ	[illegible]	[illegible]	[illegible]	61%	59%	θ
Accident & Emergency 12 hour	MARCH 2021-22	0	197	344	π	65	120	π	9	22	π				123	202	π
Referral To Treatment - Incompletes	FEBRUARY 2021-22	92%	55%	53%	θ	52%	50%	θ	59%	58%	θ	62%	60%	θ	55%	55%	θ
Referral To Treatment 52+ week waiters	FEBRUARY 2021-22	0	12974	13013	π	5942	5795	π	1300	1366	π	2994	3021	π	2572	2757	π
Diagnostics	FEBRUARY 2021-22	99%	58%	63%	π	58.5%	61.8%	π	39.2%	44.0%	π	70.8%	81.0%	π	58.7%	61.6%	π
Cancer 2 Weeks	FEBRUARY 2021-22	93%	66%	72%	π	67%	71%	π	71%	75%	π	83%	95%	π	46%	48%	π
Cancer breast symptomatic	FEBRUARY 2021-22	93%	32%	55%	π	16%	36%	π	20%	8%	()	37%	98%	π	39%	71%	π
Cancer 31 Day First	FEBRUARY 2021-22	96%	93%	94%	π	92%	92%	π	87%	87%	()	94%	96%	π	95%	96%	π
Cancer 31 Day Follow-up Drug	FEBRUARY 2021-22	98%	99%	99%	π	97%	100%	π	96%	89%	()	99%	100%	π	100%	100%	() π
Cancer 31 Day Follow-up Surgery	FEBRUARY 2021-22	94%	85%	83%	()	76%	77%	π	56%	71%	π	84%	86%	π	97%	92%	()
Cancer 31 Day Follow-up Radiotherapy	FEBRUARY 2021-22	94%	97%	98%	π	98%	99%	π	100%	50%	()	99%	99%	π	97%	98%	π
Cancer 62 Day Urgent	FEBRUARY 2021-22	85%	63%	58%	()	64%	61%	()	0%	53%	π	66%	59%	()	58%	55%	()
Cancer 62 Day screening	FEBRUARY 2021-22	90%	68%	66%	()	33%	0%	()	[illegible]	[illegible]	[illegible]	70%	61%	()	80%	86%	π
Cancer 62 Day upgrade	FEBRUARY 2021-22	85%	82%	77%	()	81%	74%	()	100%	80%	()	72%	63%	()	100%	100%	() π

Provider System Oversight Framework: Providers

		NDHT	RDEFT	TSDFT	UHP
Highest performing quartile		16	10	5	9
Interquartile range		8	18	18	15
Lowest performing quartile		10	4	9	9

The approach to the System Oversight Framework in 2021/22 comprises a set of around 100 indicators This framework describes NHS England and NHS Improvement's approach to oversight in 2021/22, which reinforces system-led delivery of integrated care. This reflects the vision set out in the NHS Long Term Plan, the White Paper: 'Integration and Innovation', and the 2021/22 Operational Planning Guidance.

NHS OF Metric Name	Period	NDHT	RDEFT	TSDFT	UHP
S005a: Daily discharges - as % of patients who no longer meet the criteria to reside in hospital	16/01/2022	27.2%	45.3%	32.5%	32.1%
S008a: Overall size of the waiting list	2021 11	17,340	66,194	32,216	39,739
S009a: Patients waiting more than 52 weeks to start consultant-led treatment	2021 11	1,235	6,288	2,146	2,855
S010a: Cancer - first treatments	2021 11	79	315	177	376
S010b: Cancer - urgent referrals seen	2021 11	718	2,162	1,602	2,379
S011a: Cancer - people waiting longer than 62 days	w/e 30/01/2022	137	177	206	125
S012a: Cancer - % meeting faster diagnosis standard	2021 11	39.3%	83.8%	53.8%	78.1%
S013a: Diagnostic activity levels - Imaging	2021 11	3,028	7,520	5,183	10,467
S013b: Diagnostic activity levels - Physiological measurement	2021 11	339	-	684	1,236
S013c: Diagnostic activity levels - Endoscopy	2021 11	364	729	837	805
S017a: Outpatient - % of all activity delivered remotely via telephone or video consultation	2021 10	26.5%	23.9%	15.5%	26.1%
S019a: Ambulance handover delays greater than 30 minutes (as reported by NHS Acute Trusts)	2021 03	33	48	118	920

NHS OF Metric Name	Period	NDHT	RDEFT	TSDFT	UHP
S021a: Maternity - % women on continuity of care pathway	2021 10	85%			
S022a: Maternity - number of Stillbirths per 1,000 live births	2019	3.13 per 1,000	3.37 per 1,000	2.74 per 1,000	4.07 per 1,000
S023a: Maternity - number of neonatal deaths per 1,000 live births	2019		1.56 per 1,000		1.02 per 1,000
S026a: Proportion of ED patients who turn up unheralded	2022 01	93.5%	94.4%	996.8%	99.2%
S034a: Summary Hospital-Level Mortality Indicator	2021 09	105.3%	95.9%	105.7%	118.4%
S035a: Overall CQC rating (provision of high-quality care)	2022 01	2 - Requires Improvement	3 - Good	3 - Good	2 - Requires Improvement
S036a: NHS Staff Survey Safety culture theme score	2020	6.89/10	6.74/10	6.63/10	6.79/10
S039a: National Patient Safety Alerts not completed by deadline	2022 01	4	0	0	0
S040a: Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infections	2021 12	0	0	0	0
S041a: Clostridium difficile infections	2021 12	0	2	4	6
S042a: E. coli blood stream infections	2021 12	1	5	6	10
S059a: CQC well-led rating	2022 01	2 - Requires Improvement	3 - Good	3 - Good	3 - Good
S062a: NHS Staff Survey Health and wellbeing theme score - Health and well-being index	2020	6.36/10	6.19/10	6.06/10	6.08/10
S063a: NHS Staff Survey Safe environment - Bullying and harassment theme score	2020	8.3/10	8.31/10	8.08/10	8.15/10
S064a: Proportion of staff who report that in the last three months they have come to work despite not feeling well enough to perform their duties	2020	39.8%	44.0%	46.5%	47.8%
S065a: Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns	2020	60.7%	52.6%	55.6%	52.2%
S067a: Leaver rate	2021 11	14.0%	15.9%	13.5%	12.5%
S068a: Sickness absence (working days lost to sickness)	2021 09	4.7%	5.4%	5.4%	6.3%
S069a: NHS Staff Survey Staff engagement theme score	2020	7.28/10	7.08/10	6.98/10	6.93/10
S070a: Number of people working in the NHS who have had a flu vaccination	2021 11	63.1%		61.3%	58.4%
S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability	2020	87.6%	87.3%	85.2%	84.8%
S073a: Nursing vacancy rate	2021 12	10.7%	3.3%	9.9%	

Devon System Oversight Framework: System

		CCG	ICS	MH provider	Provider
Highest performing quartile		1	9	0	1
Interquartile range		13	18	0	9
Lowest performing quartile		1	5	1	2

NHS OF Metric Name	Period	CCG	ICS	MH Provider	Provider
S001a: Appointments in general practice	w/e 30/01/2022	161,493			
S005a: Daily discharges - as % of patients who no longer meet the criteria to reside in hospital	16/01/2022		35.9%		
S008a: Overall size of the waiting list	2021 11		143,695		
S009a: Patients waiting more than 52 weeks to start consultant-led treatment	2021 11		12,471		
S010a: Cancer - first treatments	2021 11		820		
S010b: Cancer - urgent referrals seen	2021 11		2,444		
S011a: Cancer - people waiting longer than 62 days	w/e 30/01/2022				645
S012a: Cancer - % meeting faster diagnosis standard	2021 11		70.5%		
S013a: Diagnostic activity levels - Imaging	2021 11	24,928			26,198
S013b: Diagnostic activity levels - Physiological measurement	2021 11	2,208			2,259
S013c: Diagnostic activity levels - Endoscopy	2021 11	2,590			2,735
S014a: Cancer - proportion of people that survive cancer for at least 1 year after diagnosis	2018		75.4%		
S017a: Outpatient - % of all activity delivered remotely via telephone or video consultation	2021 10				23.3%
S019a: Ambulance handover delays greater than 30 minutes (as reported by NHS Acute Trusts)	2021 03				1,119

NHS OF Metric Name	Period	CCG	ICS	MH Provider	Provider
S021a: Maternity - % women on continuity of care pathway	2021 10		85.0%		
S022a: Maternity - number of Stillbirths per 1,000 live births	2019		3.43 per 1,000		
S023a: Maternity - number of neonatal deaths per 1,000 live births	2019		1.44 per 1,000		
S026a: Proportion of ED patients who turn up unheralded	2022 01		96.4%		
S029a: Reliance on specialist inpatient care for adults with a learning disability and/or autism	21-22 Q2		39 per 1,000,000		
S030a: Percentage of people aged 14+ on the GP learning disability register receiving an annual health check	21-22 Q3	35.2%			
S031a: Number of personalised care interventions	21-22 Q2		40,008		
S032a: Personal Health Budget	21-22 Q2		5,455		
S033a: Social Prescribing unique patient referrals	21-22 Q2		11,607		
S037a: Patient experience of GP services	2021		87.9%		
S039a: National Patient Safety Alerts not completed by deadline	2022 01				4
S040a: Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infections	2021 12	1			0
S041a: Clostridium difficile infections	2021 12	22			12
S042a: E. coli blood stream infections	2021 12	69			22
S044a: Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	Dec 2020 - Nov 2021	78.2%			
S044b: Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	Dec 2020 - Nov 2021	976.7%			
S045a: COVID-19 - % adults vaccinated	w/e 12/09/2021		93.4%		
S046a: Population vaccination coverage - MMR for two doses (5 years old) to reach the optimal standard nationally (95%)	21-22 Q2	92.6%			
S047a: Percentage of people aged 65 and over who received a flu vaccination	2021 11	81.1%			
S050a: Cancer - cervical screening coverage, females aged 25-64, attending screening within target period	21-22 Q1	75.4%			

NHS OF Metric Name	Period	CCG	ICS	MH Provider	Provider
S051a: Number of people supported through the NHS Diabetes Prevention programme	21-22 Q3		37.7%		
S052a: Diabetes patients that have achieved all the NICE recommended treatment targets (adults and children)	2020-21	32.9%			
S055a: General Practice Referrals to NHS Digital Weight Management Programme - Crude Rate/100,000 population	21-22 Q3	5 per 100,000			
S067a: Leaver rate	2021 11		12.5%		
S068a: Sickness absence (working days lost to sickness)	2021 09		5.7%		
S070a: Number of people working in the NHS who have had a flu vaccination	2021 11			29.8%	60.3%
S073a: Nursing vacancy rate	2021 12				6.7%
S081a: IAPT access (total numbers accessing services)	21-22 Q2		6,350		
S082a: IAPT recovery rate (%)	21-22 Q2		100%		
S083a: Estimated diagnosis rate for people with dementia	2021 12		56.0%		
S084a: Children and young people (ages 0-17) mental health services access (number with 1+ contact)	2021 11		11,740		
S085a: People with severe mental illness receiving a full annual physical health check and follow up interventions	21-22 Q3		3,643		
S086a: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (internal or external)	Sep 2021 - Nov 2021		2,665		
S086b: Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (external only)	Sep 2021 - Nov 2021		1		
S087a: Rate per 100,000 population of people in adult acute mental health beds with a length of stay over 60 days	2021 11		50 per 100,000		
S087b: Rate per 100,000 population of people in older adult acute mental health care with a length of stay over 90 days	2021 11		7.5 per 100,000		
S088a: Number of women accessing specialist community perinatal mental health services	Dec 2020 - Nov 2021		8.0%		
S089a: Waiting times for Urgent Referrals to Children and Young People's Eating Disorder services	Jan 2021 - Dec 2021		61.0%		
S089b: Waiting times for Routine Referrals to Children and Young People Eating Disorder Services	Jan 2021 - Dec 2021		44.2%		

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Devon ICS Finance Report Month 11

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Financial Framework

- The NHS financial framework has provided a fixed settlement for the first half (H1) of financial year 2021/22 which is very much in line with the temporary financial framework in place through 20/21. This funding is assumed to deliver the published elective activity trajectories of 70% (April), 75% (May), 80% (June), 85% (July onwards) of 19/20 activity.
- A fixed settlement for the second half of the financial year (H2) was agreed in line with H1 values but with an additional efficiency requirement and a 5% reduction to COVID in envelope funding.
- Elective Recovery Fund (ERF) income can be earned by each system, for H1 this was by delivering elective activity above the following percentages of 19/20 activity 70% April, 75% May, 80% June, 95% July – September.
- In H2 ERF can be earned if the activity is greater than 89% of 19/20 levels in terms of completed patient pathways both admitted and non admitted weighted by specialty.
- Some COVID funding will be reimbursed on top of the system envelope, this includes spend on testing, vaccinations and hospital discharge.

System surplus / deficit position

Organisation	Measure £'m	Year to date			Forecast		
		Plan	Actual	Variance fav / (adv)	Plan	Actual	Variance fav / (adv)
Devon CCG	Surplus/(Deficit)	4.4	4.4	0.0	5.3	5.3	0.0
Royal Devon & Exeter NHS FT	Surplus/(Deficit)	(6.2)	(2.8)	3.3	(8.7)	(6.3)	2.4
University Hospitals Plymouth Trust	Surplus/(Deficit)	(0.2)	3.0	3.2	2.1	2.2	0.1
Northern Devon Healthcare NHS Trust	Surplus/(Deficit)	(2.3)	(2.2)	0.1	(2.7)	(2.7)	(0.0)
Torbay and South Devon NHS FT	Surplus/(Deficit)	1.4	1.5	0.1	1.8	1.8	0.0
Devon Partnership Trust	Surplus/(Deficit)	(0.0)	0.0	0.0	(0.0)	0.0	0.0
Livewell South West	Surplus/(Deficit)	0.0	0.0	0.0	0.0	0.0	0.0
Total	**Surplus/(Deficit)**	**(2.8)**	**3.9**	**6.8**	**(2.2)**	**0.3**	**2.5**

- As at month 11 the Devon ICS had a surplus of £3.9m which is £6.8m favourable variance to plan. (M10 £7.7m)
- The forecast to the year end is £0.3m surplus (M10 £0.3m) which is £2.5m (M10 £2.5m) favourable against the £2.2m planned deficit.

Elective Recovery Fund (ERF)

Organisation	£'000		
	H1	H2 YTD	H2 Forecast
Devon CCG	44	-	-
Royal Devon & Exeter NHS FT	8,229	3,509	4,457
University Hospitals Plymouth Trust	10,315	6,206	7,775
Northern Devon Healthcare NHS Trust	3,207	741	900
Torbay and South Devon NHS FT	2,808	667	936
To allocate	797		
Total	**25,400**	**11,123**	**14,068**

- As at month 6 the Devon ICS has received £25.4m for the first half of the year ERF income into the system.
- The distribution is based on the agreed financial principles for ERF in the Devon system.
- As at month 11 the system has estimated to have earned a further £11.1m (M10 8.3m) and forecast to earn £14.1m. (M10 £14.1m)

In envelope COVID spend M1-11

COVID spend category	Royal Devon & Exeter NHS FT	University Hospitals Plymouth Trust	Northern Devon Healthcare NHS Trust	Torbay and South Devon NHS FT	Devon Partnership Trust	Total
Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other	499	42	494	-	1,568	2,603
Additional Sick pay at full pay for all staff policy - full pay for COVID-related staff absence (for those not normally entitled to sick pay)	-	-	177	-	-	177
Existing workforce additional shifts to meet increased demand	4,418	373	835	1,074	166	6,866
Backfill for higher sickness absence	348	2,153	409	1,396	477	4,783
Total Testing - In Envelope	687	353	481	-	-	1,521
PPE associated costs	242	333	29	-	26	630
Increase ITU capacity (incl Increase hospital assisted respiratory support capacity, particularly mechanical ventilation)	1,686	-	19	436	-	2,141
Remote management of patients	-	202	22	-	829	1,053
Support for stay at home models	-	174	-	-	-	174
Segregation of patient pathways	1,120	5,489	53	6,006	426	13,094
Decontamination	312	1,087	1,373	1,558	23	4,353
Ambulance Capacity	-	-	-	1,092	-	1,092
Additional PTS costs	-	-	-	54	-	54
After care and support costs (community, mental health, primary care)	-	-	-	-	132	132
Remote working for non-patient activities	46	491	31	-	228	796
Long COVID	106	-	79	-	-	185
Total	**9,464**	**10,697**	**4,002**	**11,615**	**3,875**	**39,653**

- As at month 11 the Devon ICS had spent £39.7m in envelope COVID areas. (M10 £35.9m)

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Activity vs Plan

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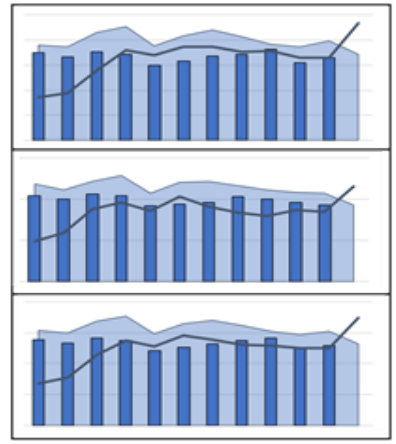
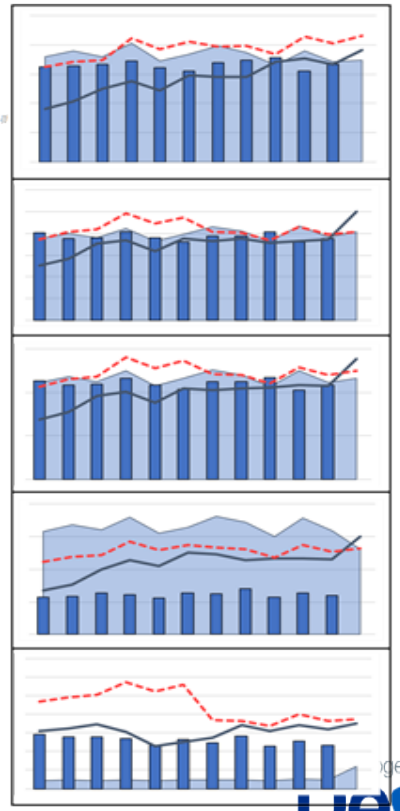
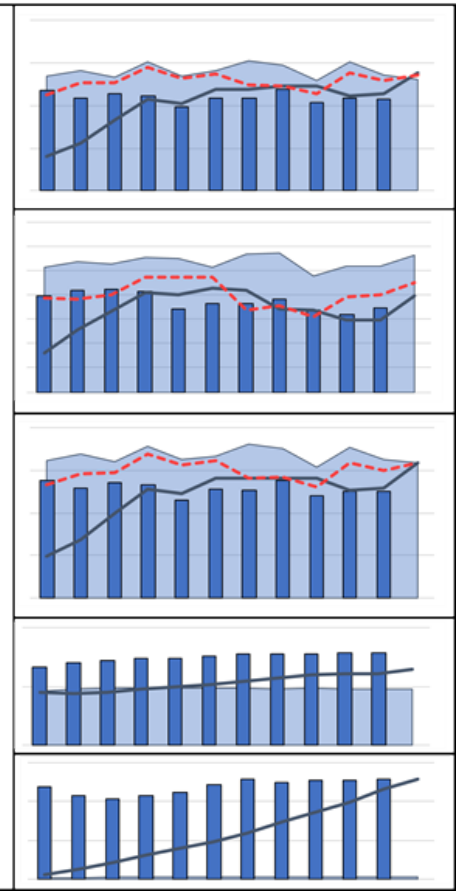
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DEMAND	GP REFERRALS	2019/20	18,912	18,664	21,395	22,588	18,834	20,849	21,945	20,686	19,160	18,555	19,719	17,129
		2020/21	8,601	9,461	13,879	17,890	16,960	18,685	18,689	17,602	17,731	16,405	16,512	23,269
		2021/22	17,396	16,536	17,690	17,035	14,930	15,782	16,813	17,147	18,163	15,480	16,463	
		Growth vs 19/20	-8%	-11%	-17%	-25%	-21%	-24%	-23%	-17%	-5%	-17%	-17%	
	OTHER REFERRALS	2019/20	11,851	11,172	12,178	12,844	10,780	12,059	12,151	11,643	11,148	10,818	10,753	9,333
		2020/21	4,920	5,951	8,843	9,644	8,592	10,298	9,104	8,352	7,947	8,696	8,456	11,508
		2021/22	10,421	10,026	10,623	10,402	9,171	9,420	9,651	10,298	10,067	9,633	9,307	
		Growth vs 19/20	-12%	-10%	-13%	-19%	-15%	-22%	-21%	-12%	-10%	-11%	-13%	
	TOTAL REFERRALS	2019/20	30,763	29,836	33,573	35,432	29,614	32,908	34,096	32,329	30,308	29,374	30,472	26,462
		2020/21	13,521	15,412	22,722	27,534	25,552	28,983	27,793	25,954	25,678	25,101	24,968	34,777
		2021/22	27,817	26,562	28,313	27,437	24,101	25,202	26,464	27,445	28,230	25,113	25,770	
		Growth vs 19/20	-10%	-11%	-16%	-23%	-19%	-23%	-22%	-15%	-7%	-15%	-15%	



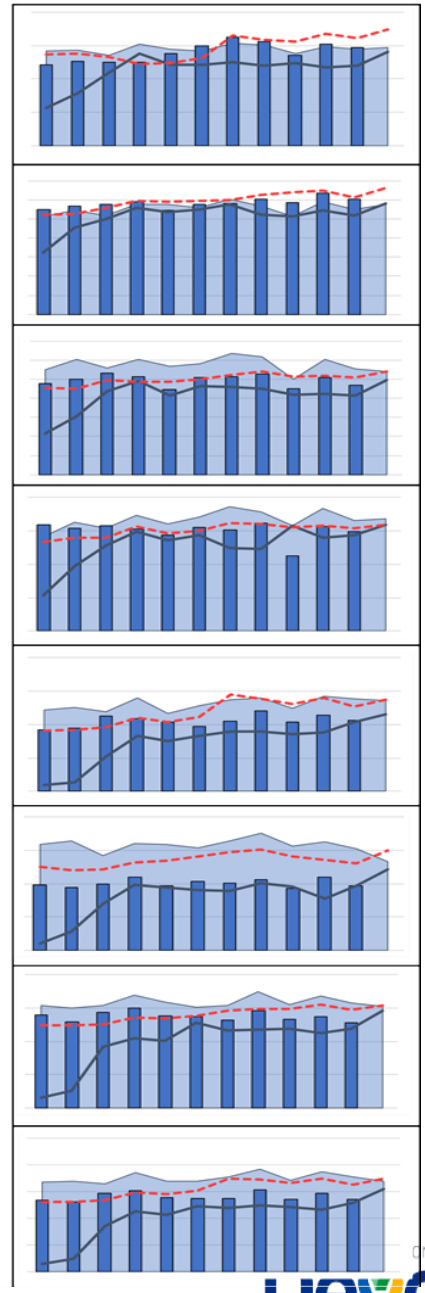
OUTPATIENTS	Consultant led first outpatient attendances	2019/20	36,047	37,903	35,832	40,596	34,665	36,709	39,826	37,519	33,033	38,045	34,127	34,791
		2020/21	17,965	20,544	25,081	27,533	24,492	29,621	29,107	29,134	34,145	35,346	33,318	38,322
		Plan	32,569	34,175	34,903	42,460	38,601	41,152	39,554	39,802	36,903	42,921	40,577	43,303
		2021/22	32,560	32,799	33,288	34,492	32,176	31,210	34,078	34,714	35,574	30,960	33,386	
		Plan vs 19/20	90%	90%	97%	105%	111%	112%	99%	106%	112%	113%	119%	
		Actual vs 19/20	90%	87%	93%	85%	93%	85%	86%	93%	108%	81%	98%	
	Consultant-led follow-up outpatient attendances	2019/20	74,917	79,688	76,240	84,618	73,046	79,254	86,105	82,389	73,141	87,013	76,991	81,548
		2020/21	50,368	56,401	70,669	73,249	63,795	75,207	73,048	75,411	71,489	72,741	74,331	99,976
		Plan	74,250	81,349	83,464	98,044	88,909	94,829	81,297	80,385	73,553	85,840	78,979	81,599
		2021/22	80,539	75,427	75,838	81,245	75,898	72,221	77,785	77,442	81,435	71,790	74,837	
		Plan vs 19/20	99%	102%	109%	116%	122%	120%	94%	98%	101%	99%	103%	
		Actual vs 19/20	108%	95%	99%	96%	104%	91%	90%	94%	111%	83%	97%	
	Total Outpatient attendance	2019/20	110,964	117,591	112,072	125,214	107,711	115,963	125,931	119,908	106,174	125,058	111,118	116,339
		2020/21	68,333	76,945	95,750	100,782	88,287	104,828	102,155	104,545	105,634	108,087	107,649	138,298
		Plan	106,819	115,524	118,367	140,504	127,510	135,981	120,851	120,187	110,456	128,760	119,556	124,902
		2021/22	113,099	108,226	109,126	115,737	108,074	103,431	111,863	112,156	117,009	102,750	108,223	
		Plan vs 19/20	96%	98%	106%	112%	118%	117%	96%	100%	104%	103%	108%	
		Actual vs 19/20	102%	92%	97%	92%	100%	89%	89%	94%	110%	82%	97%	
	Total outpatient attendances - Face to face	2019/20	158,653	168,235	160,210	179,794	155,885	164,882	180,844	171,837	150,710	178,111	158,845	131,239
		2020/21	67,109	76,713	99,542	114,575	104,735	125,517	123,298	114,651	116,161	116,498	115,504	150,877
		Plan	111,454	118,714	122,417	142,331	129,383	137,122	133,623	130,511	117,994	137,721	127,374	132,726
		2021/22	57,051	58,750	64,114	60,978	56,086	64,156	62,387	69,727	57,679	64,227	59,360	
		Plan vs 19/20	70%	71%	76%	79%	83%	83%	74%	76%	78%	77%	80%	
		Actual vs 19/20	36%	35%	40%	34%	36%	39%	34%	41%	38%	36%	37%	
	Total outpatient attendances - Telephone/Virtual	2019/20	4,466	4,888	4,450	5,026	4,492	4,588	5,000	4,882	4,441	5,342	4,982	11,853
		2020/21	30,793	32,160	34,512	30,537	23,029	25,126	27,518	34,272	30,773	34,146	31,745	35,177
		Plan	47,017	49,130	50,537	57,143	52,266	55,832	36,773	36,530	33,703	40,145	36,501	37,259
		2021/22	28,998	27,789	27,791	26,986	23,408	26,644	24,894	28,095	22,891	25,467	23,424	
		Plan vs 19/20	1053%	1005%	1136%	1137%	1164%	1217%	735%	748%	759%	751%	733%	
		Actual vs 19/20	649%	569%	625%	537%	521%	581%	498%	575%	515%	477%	470%	



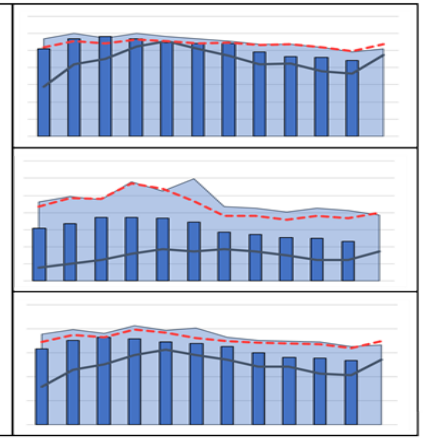
			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
ELECTIVES	Total Elective Admissions - Day Case	2019/20	13,510	14,183	13,382	15,103	13,542	14,106	15,270	14,716	12,966	15,130	13,647	13,031
		2020/21	4,124	5,595	8,287	10,711	10,264	11,933	11,970	12,349	12,330	11,117	11,449	13,928
		Plan	11,343	12,681	12,746	14,571	13,208	13,769	12,439	12,382	11,443	13,897	12,920	13,608
		2021/22	11,808	10,886	11,451	11,177	9,816	10,929	10,888	11,910	10,358	10,931	10,803	#N/A
		Plan vs 19/20	84%	89%	95%	96%	98%	98%	81%	84%	88%	92%	95%	
		Actual vs 19/20	87%	77%	86%	74%	72%	77%	71%	81%	80%	72%	79%	
	Total Elective Admissions - Ordinary	2019/20	2,571	2,685	2,624	2,775	2,754	2,568	2,848	2,870	2,379	2,579	2,583	2,803
		2020/21	801	1,289	1,665	2,055	2,005	2,127	2,087	1,697	1,683	1,474	1,482	1,989
		Plan	1,927	1,907	2,002	2,369	2,373	2,369	1,683	1,786	1,544	1,963	1,997	2,242
		2021/22	1,989	2,087	2,109	2,072	1,711	1,811	1,812	1,921	1,679	1,595	1,734	#N/A
		Plan vs 19/20	75%	71%	76%	85%	86%	92%	59%	62%	65%	76%	77%	
		Actual vs 19/20	77%	78%	80%	75%	62%	71%	64%	67%	71%	62%	67%	
	Total Elective Admissions	2019/20	16,081	16,868	16,006	17,878	16,296	16,674	18,118	17,586	15,345	17,709	16,230	15,834
		2020/21	4,925	6,884	9,952	12,766	12,269	14,060	14,057	14,046	14,013	12,591	12,931	15,917
		Plan	13,270	14,588	14,748	16,940	15,581	16,138	14,122	14,168	12,987	15,860	14,917	15,850
		2021/22	13,797	12,973	13,560	13,249	11,527	12,740	12,700	13,831	12,037	12,526	12,537	#N/A
		Plan vs 19/20	83%	86%	92%	95%	96%	97%	78%	81%	85%	90%	92%	
		Actual vs 19/20	86%	77%	85%	74%	71%	76%	70%	79%	78%	71%	77%	
	RTT Incomplete pathways	2019/20	92,215	95,238	96,319	96,979	98,176	97,636	97,368	96,283	96,899	95,777	96,157	94,760
		2020/21	90,579	88,030	90,090	94,617	99,428	103,521	108,999	114,168	120,683	121,377	122,332	128,734
		2021/22	133,890	139,801	143,499	147,480	149,026	151,724	155,745	155,489	155,766	156,866	158,188	
		Growth vs 19/20	45%	47%	49%	52%	52%	55%	60%	61%	61%	64%	65%	
	RTT 52 Week wait	2019/20	203	188	234	268	361	356	338	328	286	294	237	293
		2020/21	618	1,228	2,166	3,124	3,942	4,796	5,972	7,413	8,626	9,856	11,665	12,916
		2021/22	11,918	10,809	10,378	10,705	11,256	12,140	12,829	12,524	12,807	12,808	12,939	
		Growth vs 19/20	5771%	5642%	4329%	3894%	3018%	3310%	3695%	3718%	4385%	4263%	5359%	



			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DIAGNOSTIC TESTS	MAGNETIC RESONANCE IMAGING	2019/20	5,655	5,705	5,423	6,099	5,773	5,682	6,128	6,040	5,517	5,939	5,755	5,887
		2020/21	2,281	3,112	4,389	5,491	4,864	4,848	4,982	4,784	4,947	4,701	4,794	5,607
		Plan	5,481	5,524	5,304	4,866	4,948	5,271	6,604	6,358	6,242	6,678	6,447	6,968
		2021/22	4,856	5,069	5,006	5,010	5,498	5,959	6,475	6,232	5,424	6,103	5,889	#N/A
		Plan vs 19/20	97%	97%	98%	80%	86%	93%	108%	105%	113%	112%	112%	
		Actual vs 19/20	86%	89%	92%	82%	95%	105%	106%	103%	98%	103%	102%	
	COMPUTED TOMOGRAPHY	2019/20	10,297	10,870	10,368	11,555	11,583	11,179	12,081	11,368	10,281	11,782	10,974	11,501
		2020/21	6,511	9,060	10,047	11,175	10,729	11,008	11,533	10,498	10,238	10,930	10,398	11,643
		Plan	10,421	10,565	11,215	11,887	11,793	11,861	11,986	12,550	12,801	13,028	12,296	13,290
		2021/22	10,996	11,366	11,526	11,794	10,868	11,528	11,667	12,074	11,721	12,754	12,041	#N/A
		Plan vs 19/20	101%	97%	108%	103%	102%	106%	99%	110%	125%	111%	112%	
		Actual vs 19/20	107%	105%	111%	102%	94%	103%	97%	106%	114%	108%	110%	
	NON-OBSTETRIC ULTRASOUND	2019/20	11,040	12,078	11,148	12,063	11,398	11,659	12,760	12,334	10,009	12,071	11,095	10,855
		2020/21	4,357	6,111	8,783	9,794	8,249	9,271	9,153	9,005	8,414	8,458	8,314	9,906
		Plan	9,122	9,056	9,892	9,755	9,759	9,966	10,454	10,788	10,251	10,369	10,149	10,862
		2021/22	9,521	10,006	10,662	10,274	8,883	10,196	10,279	10,592	9,053	10,230	9,353	#N/A
		Plan vs 19/20	83%	75%	89%	81%	86%	85%	82%	87%	102%	86%	91%	
		Actual vs 19/20	86%	83%	96%	85%	78%	87%	81%	86%	90%	85%	84%	
	ECHOCARDIOGRAPHY	2019/20	2,818	3,264	3,079	3,480	3,220	3,421	3,727	3,562	3,150	3,675	3,314	3,371
		2020/21	1,075	1,949	2,565	2,987	2,716	2,890	2,482	2,454	3,159	2,810	2,889	3,180
		Plan	2,658	2,795	2,796	3,136	2,930	3,005	3,237	3,208	3,112	3,157	3,074	3,197
		2021/22	3,181	3,090	3,156	3,057	2,884	3,116	3,025	3,226	2,259	3,148	2,989	#N/A
		Plan vs 19/20	94%	86%	91%	90%	91%	88%	87%	90%	99%	86%	93%	
		Actual vs 19/20	113%	95%	103%	88%	90%	91%	81%	91%	72%	86%	90%	
	COLONOSCOPY	2019/20	1,215	1,253	1,191	1,400	1,172	1,281	1,372	1,402	1,243	1,423	1,387	1,365
		2020/21	100	138	524	838	757	826	892	903	854	888	1,036	1,158
		Plan	905	920	959	1,107	1,038	1,122	1,448	1,384	1,304	1,401	1,265	1,372
		2021/22	917	945	1,128	1,093	1,037	975	1,047	1,200	1,035	1,137	1,067	#N/A
		Plan vs 19/20	74%	73%	81%	79%	89%	88%	106%	99%	105%	98%	91%	
		Actual vs 19/20	75%	75%	95%	78%	88%	76%	76%	86%	83%	80%	77%	
	FLEXI SIGMOIDOSCOPY	2019/20	635	656	570	642	634	615	656	703	626	653	609	530
		2020/21	42	116	281	391	379	361	356	404	381	308	386	483
		Plan	499	480	487	527	538	561	588	604	561	543	523	597
		2021/22	395	377	396	439	386	413	402	423	374	439	385	#N/A
		Plan vs 19/20	79%	73%	85%	82%	85%	91%	90%	86%	90%	83%	86%	
		Actual vs 19/20	62%	57%	69%	68%	61%	67%	61%	60%	60%	67%	63%	
	GASTROSCOPY	2019/20	1,534	1,503	1,536	1,688	1,588	1,507	1,539	1,746	1,555	1,680	1,583	1,519
		2020/21	156	257	915	1,044	1,010	1,277	1,166	1,178	1,185	1,129	1,188	1,465
		Plan	1,240	1,243	1,258	1,359	1,339	1,379	1,462	1,483	1,481	1,550	1,472	1,541
		2021/22	1,394	1,298	1,436	1,503	1,383	1,376	1,322	1,465	1,326	1,376	1,286	#N/A
		Plan vs 19/20	81%	83%	82%	81%	84%	92%	95%	85%	95%	92%	93%	
		Actual vs 19/20	91%	86%	93%	89%	87%	91%	86%	84%	85%	82%	81%	
	TOTAL SCOPES	2019/20	3,384	3,412	3,297	3,730	3,394	3,403	3,567	3,851	3,424	3,756	3,579	3,414
		2020/21	298	511	1,720	2,273	2,146	2,464	2,414	2,485	2,420	2,325	2,610	3,106
		Plan	2,644	2,643	2,704	2,993	2,915	3,062	3,498	3,471	3,345	3,493	3,259	3,510
		2021/22	2,706	2,620	2,960	3,035	2,806	2,764	2,771	3,088	2,735	2,952	2,738	#N/A
		Plan vs 19/20	78%	77%	82%	80%	86%	90%	98%	90%	98%	93%	91%	
		Actual vs 19/20	80%	77%	90%	81%	83%	81%	78%	80%	80%	79%	77%	



			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&E	TYPE 1 & 2	2019/20	28,522	30,086	28,559	29,922	29,139	28,329	27,862	26,878	26,935	26,021	24,551	25,560
		2020/21	14,502	20,922	22,659	26,096	27,714	25,599	23,449	20,964	21,154	18,866	18,367	23,657
		Plan	25,957	27,701	27,111	28,227	27,782	26,972	27,219	26,699	26,787	25,966	24,867	26,819
		2021/22	25,595	28,446	29,126	28,446	27,354	27,182	27,045	24,621	23,133	22,921	22,157	
		Plan vs 19/20	91%	92%	95%	94%	95%	95%	98%	99%	99%	100%	101%	
		Actual vs 19/20	90%	95%	102%	95%	94%	96%	97%	92%	86%	88%	90%	
	TYPE 3 & 4	2019/20	9,256	9,832	9,552	11,599	10,485	11,978	8,681	8,554	8,041	8,524	8,265	7,684
		2020/21	1,538	2,052	2,469	3,175	3,753	3,502	3,719	3,489	3,044	2,479	2,431	3,431
		Plan	8,727	9,710	9,577	11,417	10,765	9,352	7,659	7,594	7,173	7,598	7,334	7,992
		2021/22	6,184	6,686	7,448	7,461	7,330	6,864	5,766	5,451	5,047	5,035	4,658	
		Plan vs 19/20	94%	99%	100%	98%	103%	78%	88%	89%	89%	89%	89%	
		Actual vs 19/20	67%	68%	78%	64%	70%	57%	66%	64%	63%	59%	56%	
	TOTAL A&E ATTENDANCES	2019/20	37,778	39,918	38,111	41,521	39,624	40,307	36,543	35,432	34,976	34,545	32,816	33,244
		2020/21	16,040	22,974	25,128	29,271	31,467	29,101	27,168	24,453	24,198	21,345	20,798	27,088
		Plan	34,684	37,411	36,688	39,644	38,547	36,324	34,878	34,293	33,960	33,564	32,201	34,811
		2021/22	31,779	35,132	36,574	35,907	34,684	34,046	32,811	30,072	28,180	27,956	26,815	
		Plan vs 19/20	92%	94%	96%	95%	97%	90%	95%	97%	97%	97%	98%	
		Actual vs 19/20	84%	88%	96%	86%	88%	84%	90%	85%	81%	81%	82%	
NON ELECTIVE	+1 LENGTH OF STAY	2019/20	9,470	9,536	9,128	9,384	9,156	9,095	9,484	9,271	9,726	9,606	8,668	8,852
		2020/21	6,010	7,482	7,935	8,411	8,778	8,619	8,892	8,080	8,380	8,212	7,589	7,087
		Plan	9,217	9,584	9,216	9,781	9,294	9,403	9,816	9,675	10,190	10,148	9,066	9,679
		2021/22	9,417	9,744	9,677	9,795	9,093	9,259	9,212	8,854	8,957	8,382	7,965	
		Plan vs 19/20	97%	101%	101%	104%	102%	103%	104%	104%	105%	106%	105%	
		Actual vs 19/20	99%	102%	106%	104%	99%	102%	97%	96%	92%	87%	92%	
	ZERO DAY LENGTH OF STAY	2019/20	3,766	4,057	3,690	3,806	3,880	3,819	4,050	4,017	4,195	4,392	4,154	4,203
		2020/21	2,266	3,237	3,748	4,171	4,099	4,095	3,971	3,495	3,533	3,222	3,288	4,275
		Plan	3,710	3,940	3,716	3,921	3,960	3,896	4,150	4,086	4,179	4,183	3,847	3,487
		2021/22	3,872	4,249	4,272	4,175	3,849	3,942	4,061	4,022	3,926	3,871	3,658	
		Plan vs 19/20	99%	97%	101%	103%	102%	102%	102%	102%	100%	95%	93%	
		Actual vs 19/20	103%	105%	116%	110%	99%	103%	100%	100%	94%	88%	88%	
	TOTAL NON ELECTIVES	2019/20	13,236	13,593	12,818	13,190	13,036	12,914	13,534	13,288	13,921	13,998	12,822	13,055
		2020/21	8,276	10,719	11,683	12,582	12,877	12,714	12,863	11,575	11,913	11,434	10,877	11,362
		Plan	12,927	13,524	12,932	13,702	13,254	13,299	13,966	13,761	14,369	14,331	12,913	13,166
		2021/22	13,289	13,993	13,949	13,970	12,942	13,201	13,273	12,876	12,883	12,253	11,623	
		Plan vs 19/20	98%	99%	101%	104%	102%	103%	103%	104%	103%	102%	101%	
		Actual vs 19/20	100%	103%	109%	106%	99%	102%	98%	97%	93%	88%	91%	
CANCER	URGENT CANCER REFERRALS (2 WEEKS)	2019/20	5,579	5,835	5,252	6,301	5,932	5,345	5,960	5,758	5,344	5,309	5,326	5,495
		2020/21	2,256	3,480	4,609	5,362	4,890	5,522	5,629	5,477	5,401	4,757	4,967	6,295
		Plan	6,228	6,398	6,052	6,866	6,237	6,179	7,281	7,395	6,330	6,868	6,658	7,359
		2021/22	6,483	5,835	7,280	6,646	6,322	6,894	6,959	7,506	6,861	6,754	6,533	
		Plan vs 19/20	112%	110%	115%	109%	105%	116%	122%	128%	118%	129%	125%	
		Actual vs 19/20	116%	100%	139%	105%	107%	129%	117%	130%	128%	127%	123%	
	CANCER TREATEMENT VOLUMES (31 DAY FIRST)	2019/20	911	953	852	1,029	912	933	1,002	930	849	973	778	1,049
		2020/21	715	604	705	761	786	895	794	846	801	772	750	918
		Plan	771	869	810	892	824	840	996	981	935	957	852	930
		2021/22	828	638	859	849	830	885	818	989	947	895	800	
		Plan vs 19/20	85%	91%	95%	87%	90%	90%	99%	105%	110%	98%	110%	
		Actual vs 19/20	91%	67%	101%	83%	91%	95%	82%	106%	112%	92%	103%	
	PATIENTS WAITING 63+DAYS AFTER REFERRAL (62 DAY URGENT)	2019/20	548	529	480	544	507	494	533	498	442	496	400	575
		2020/21	416	315	382	416	460	492	450	462	443	414	421	514
		Plan	428	467	461	436	426	421	499	483	452	415	400	384
		2021/22	484	353	470	472	472	508	471	572	520	434	444	
		Plan vs 19/20	78%	88%	96%	80%	84%	85%	94%	97%	102%	84%	100%	
		Actual vs 19/20	88%	67%	98%	87%	93%	103%	88%	115%	118%	88%	111%	



NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Governing Body Effectiveness report 2021/22				
Date of committee: 28 April 2022 **Date report produced: 11 April 2022**				
Author (s) Name and Title: **Jodie Howland, Governance and Facilities Business Manager** **Nikki Coombes, Senior Executive Assistant** **Contact Details:** **Jodie.howland@nhs.net** **Nikki.coombes@nhs.net**		**Supporting Executive:** **Name and Title: Andrew Millward** **Contact Details: andrew.millward@nhs.net** **Report Reviewed and approved by:** **Ginny Snaith, Board Secretary** **g.snaith@nhs.net** **Date 13.04.22**		
Public or Private (Governing Body only):	**Public**	**X**	**Private**	
Please state reason for inclusion as a private paper (and mark as CONFIDENTIAL):				

Executive Summary:
The purpose of this paper is to present the findings of the review of effectiveness of the Governing Body, which was undertaken using an electronic questionnaire, to celebrate what has gone well within Devon CCG Governing Body and recommendations for transitioning into an ICB. The report also summarises the effectiveness review process.

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:

Not applicable

Key recommendations and actions requested:

The Governing Body are asked to note the responses and review and take forward additional changes to improve effectiveness and support decision making of the ICB.

Additional changes which would improve effectiveness and support decision making of the ICB

- Better, more considered information outside of board meetings
- Streamlined paperwork, presenters of items not re-stating information that has already been circulated, time for debate.
- An updated guide to writing board papers, including workforce issues as a key discussion point in any reports and proposals. No embedded documents/appendices attached to papers. Key points must be in the paper and additional information summarised in appendix.
- Shorter reports, taken as read, focussed on key issues, assurance and decision-making. Encourage board to contribute to strategy formulation - bring genuine options not draft decisions to the board. Board members need to ask powerful, carefully crafted, questions about delivery (e.g constitutional standards) and understand the difference between assurance and reassurance - reassurance is when someone tells you all's well; assurance is when they tell you what's happening, show you the evidence, and you can judge for yourself if all's well. We need to reduce the risk of assurance blind spots – hidden by the extensive reporting burden that is not clearly aligned to assurance or operational needs. Sometimes, too many papers are provided "for information", and the ask of the GB or committees is not always clear, which undermines a risk-based approach. We also need to ensure that the board sets clearly identified outcomes against which delivery can be monitored and consequences for non-delivery need to be defined.
- Opportunity to discuss issues in private beforehand; we need longer than the half hour allotted to some of the bigger issues. GB development is key.

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	If the Governing Body is not effective there is a risk that the CCG strategic objectives will not be fulfilled	

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.

Governing Body Effectiveness Report

1. Executive Summary

1.1 Effective committee meetings are a key part of an effective governance structure and provide evidence that the CCG Code of Governance principles are being met. This is particularly important to ensure that governance arrangements are robust. Undertaking such a review of effectiveness provides further assurance to the CCG members as it progresses through the five-year forward view and the components of the NHS England assurance framework.

1.2 The main function of the Governing Body is to ensure that Devon CCG has arrangements in place to exercise all their functions effectively, efficiently and economically and in accordance with any generally accepted principles of good governance.

The Governing Body is responsible for:

- Assurance, including audit and remuneration
- Assuring the decision-making arrangements
- Oversight of arrangements for dealing with conflict of interest
- Agreeing the vision and strategy
- Formal approval of commissioning plans on behalf of the CCGs
- Oversight of performance
- Providing assurance of strategic risks

All other duties are delegated to the Sub-Committees of the Governing Body.

1.3 The purpose of this paper is to present the findings of the review of effectiveness of the Governing Body, which was undertaken using an electronic questionnaire, to celebrate what has gone well within Devon CCG Governing Body and recommendations for improvement for transitioning into an ICB. The report also summarises the effectiveness review process. This report is further supported by a summary from the monthly effectiveness reviews undertaken following each Governing Body Session for 21/22 and findings are presented at the end of this paper.

1.4 The Governing Body will receive reports of the effectiveness of all of its sub-committees via Chairs reports.

2. Purpose of report

2.1 The CCG has undertaken a review of its Governing Body effectiveness using the NHS clinical commissioning groups code of governance and Healthcare Financial Management Association (HFMA) audit committee handbook as best practice guides and using the following principles:

- The need for committees to be clear about their roles in strengthening the governance arrangements of the CCG and support the Governing Body in the achievement of their CCG's strategic objectives, as well as acknowledging their own committee objectives outlined in the terms of reference.
- The requirement for a committee structure that strengthens the role of the Governing Body in strategic decision making and supports the role of non-executive directors / lay members in appropriately challenging the executive management.
- Maximising the value of the input from Non-Executive Directors / Lay Members, given their limited time commitment
- Supporting the Governing Body in fulfilling their roles, given the nature and content of the committee's agenda.

2.2 The current governance for the CCGs is provided through a properly constituted Governing Body established in accordance with the CCGs constitutions. The Governing Body has the following approved committees:

- Audit Committee
- Finance and Performance Committee
- Quality Assurance Committee
- Remuneration and Strategic Workforce Committee
- Primary Care Commissioning Committee

Effectiveness reviews will be presented through each Chair's report for 21/22 to the Governing Body.

2.3 The principles for this review were to celebrate the good work undertaken by the Governing Body during the year and to share good practice ahead of the transition into an ICB. The review has incorporated the following.

- What worked well
- What should be celebrated
- What could be strengthened
- Changes to benefit the ICB

2.4 Reporting arrangements and cycle of business have also been reviewed to ensure that this is adequate and meets constitutional requirements.

3. Key Findings

3.1 The four-question effectiveness review was issued to all GB members and attendees, 5 anonymous narrative responses have been received.

3.2 The chair is asked to note that there was a shared consensus that the chair should have an equal relationship with all non-executives and Governing Body members to allow conversations to continue that are perceived to be difficult and to be able to hold to account where needed. It was commented that all directors are collectively and corporately accountable for performance and should be able to constructively challenge rather than this being preserved for the non-executives.

3.3

What worked well?

- Members felt that the regular Governing Body briefings on key issues worked well, however it was noted that these sessions should not get used to fill other gaps. It is important to keep regular opportunities for joint executive and non-executive exploration of key strategic and challenging issues, bringing all brains into play.

- The opportunity for discussion and questioning of the executive team was felt to be beneficial as was the broad reach of non-executives covering various geographies, backgrounds, experience and interests.

- It was felt that the patient and public voices heard in public meetings keeps members connected with reality.

What would you like to celebrate?

- It was felt that the board development and improved working of the board should be celebrated. This allowed for strong leadership of the Covid 19 pandemic across the system with a willingness to speak out if needed and hold challenging but not confrontational conversations. There was robust consideration of a wide range of matters which allowed the ability to be challenging and supportive.

- The patient story at each Governing Body meeting, being positioned at the beginning of the day so it reminds us of the CCG's purpose.

- Shaping of a positive culture, improved staff survey results, improved staff well-being which was also evident in the closeness of the Non-Executive Director relationships.

What could be strengthened?

- One member felt the quality of papers could be improved as well as publishing papers earlier.

- It was felt that earlier engagement of Governing Body in new developments would be beneficial so that decision making is time appropriate.

Changes to benefit good decision making of the ICB

The Chair of the Governing Body is requested to note changes responders thought would benefit good effectiveness to support decision making of the ICB the following:

- Better more considered information outside board meetings
- A review of paperwork to include shorter reports, reports taken as read so that key issues can be discussed. A guide to writing board papers, including workforce issues as a key discussion point in any reports and proposals. No

embedded documents/appendices attached to papers. Key points must be in the paper and additional information summarised in appendix.

- Encourage board members to contribute to strategy formulation - bring genuine options not draft decisions to the board. Board members need to ask powerful, carefully crafted, questions about delivery (e.g constitutional standards) and understand the difference between assurance and reassurance.
- We need to reduce the risk of assurance blind spots provided by too many papers which are “for information”.
- Ensure that the board sets clearly identified outcomes against which delivery can be monitored and consequences for non-delivery need to be defined.
- Opportunity to discuss issues in private beforehand. We need longer than the half hour allotted to some of the bigger issues. GB development is key.

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4. Effectiveness of Governing Body meetings held remotely 21/22

Although this report covers the effectiveness of our Governing Body meetings held remotely during 21/22. We have been able to capture this data through the survey links that are circulated following each meeting.

Key Findings

The CCG has implemented a process that following each meeting of the Governing Body an effectiveness review is issued to all Governing Body members. During the period from September 2021 to February 2022 an average of 5 anonymous responses have been received.

The key findings from the responses have been collated into general themes, the comments relating to each theme are as follows:

1. **How effective overall was the Governing Body Day?**
    1. For the 6-month period the average score was 7 out of 10 with 10 being most effective.

2. **What do you think was the best thing of the meeting?**
    1. Microsoft Teams works well and is effective for asking questions and seeing everyone
    2. Focused, balanced and depth of discussions on key topics
    3. Virtual meetings allow for everyone to have a chance to participate
    4. Well chaired
    5. The patient experience, which gave a reminder of the reality of the services currently being provided
    6. Having the public meeting first

3. **What do your think was the worst thing about the meeting?**
    1. Length of day
    2. Difficulty balancing timings of agenda within timing available
    3. Sitting down for long periods and tiredness – more breaks required

4. Not being able to have face to face conversations with fellow members during breaks
5. Constant refreshing of supporting papers

4. What three things could be done to make the next meeting more effective?

1. Ensure agenda balanced and not overloaded
2. Ensure items have sufficient time for discussion
3. Reduce amount of discussion in private to only those things that cannot be done in the public meeting
4. More opportunity to discuss and read issues prior to formal GB meetings
5. Time management
6. Increased number of breaks

5. Materials and papers provided?

1. Generally, of a good standard
2. Lots of updates means duplication of reading
3. Summaries are helpful
4. Helpful when papers are updated that changes are indicated

6. The timings of the day?

1. Tendency for meetings to overrun, but progress is being made
2. More breaks to be built in
3. Try to do too much in day

7. Your opportunity to contribute

1. Good chairing
2. Hand-up feature in Microsoft Teams makes it easier to contribute
3. Amount of agenda items on occasion stifles discussion
4. Much greater engagement as a result of the organisational development work

Integrated Care System for Devon (ICSD) Update for Board and Cabinet members

April 2022

The purpose of this regular report is to:

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

This update features:

1. **Royal Devon University Healthcare NHS Foundation Trust formed**
2. **Mental Health, Learning Disability and Autism Provider Collaborative**
3. **General Practice Strategy for Devon**
4. **Integrated Care System development**
5. **Workforce Strategy update**
6. **Engagement on protected elective capacity**
7. **Digital Locum GP Service**
8. **Nightingale offering range of services**
9. **Devon and Cornwall Care Record**
10. **CCG staff transitioning to ICB consultation**
11. **Integrated Care Partnership engagement summary published**

1. Royal Devon University Healthcare NHS Foundation Trust formed after merger

The Royal Devon and Exeter NHS Foundation Trust (RD&E) and Northern Devon Healthcare NHS Trust (NDHT) have formally merged to become the Royal Devon University Healthcare NHS Foundation Trust.

The new Trust, which began on 1 April 2022, has two acute and 20 community hospitals, and almost 17,000 staff. While the Trusts have merged, the same services continue to be offered from all hospitals and teams.

Together for Devon

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

The name of the overall Trust has changed, but North Devon District Hospital, the Royal Devon and Exeter Hospital (Wonford and Heavitree) and the Trust's community services – including community hospitals – will continue to be known by their existing names.

Chief executive officer, Suzanne Tracey, and new chair, Dame Shan Morgan, have explained what the merger means to staff and patients in a short video. Further information is also available on the Trust's website.

2. Mental Health, Learning Disability and Autism Provider Collaborative

Ambitious plans to transform community mental health in Devon have reached a key milestone as local NHS organisations have agreed to formally work alongside the Voluntary, Community, Social Enterprise and Independent Sector (VCSEI) to support those with a severe mental illness.

Devon Mental Health Alliance
Working together for better mental health across Devon

Closer partnership working with VCSEI partners is one of the core features of Devon's Community Mental Health Framework, which aims to better support those with a severe mental illness. Following extensive engagement during 2021, an alliance of VCSEI organisations was formed to support this work. The alliance comprises Improving Lives Plymouth; Devon Mind; Shekinah; Step One; CoLab Exeter; and Rethink Mental Illness.

Devon Partnership NHS Trust and Livewell Southwest – the providers of mental health services in Devon and Plymouth – are leading the Framework developments and have been working collaboratively with the Alliance to agree on a contract, which has now been signed-off.

The Alliance will work across four areas: Northern, Eastern, Western and Southern covering Devon's five Local Care Partnership footprints with an initial focus on recruiting Locality Managers and Recovery Practitioners who will play an important role in supporting individuals.

Service provision will be shaped through an ongoing process of learning and co-production involving partners and service users.

A new Locality Manager role will be recruited for each area, with post-holders due to be in place soon. They will act as the primary point of contact for the Alliance for their respective area, working with both statutory and other VCSEI partners.

Alongside this, a new Recovery Practitioner role will be created and based in the Mental Health Multi-Agency Teams and aligned to Devon's 31 Primary Care Networks (PCNs). The Alliance hopes to recruit to 20 posts.
For more information, visit www.mentalhealthdevon.co.uk

3. General Practice Strategy for Devon

There has been substantial progress during March on the new General Practice Strategy for Devon. Engagement is being carried out in three identified phases:

- Phase 1 – Gathering (1 February – 31 March 2022)
- Phase 2 – Collation of material gathered and production of report (April)
- Phase 3 – Engagement on draft document (May)

All the original reference group meetings have taken place within the Phase 1 schedule; 13 in total. This includes groups with GPs, practice managers, Healthwatch, patient groups, external provider organisations through to internal CCG colleagues. There has been strong interest and engagement within these sessions and the output from each has been noted, with the themes being fed back to each group to clarify content recorded.

Three additional reference groups will be arranged – these are the Urgent Care Commissioners, Children and Young People's Mental Health and the Mental Health Learning Disability and Autism group. These will take place during April, alongside the collation of material gathered and production of the initial draft.

Two surveys have been issued to enable wider gathering of views from individuals. One, aimed at healthcare professionals, has been circulated widely across practices (for all practice staff), all reference group attendees, promoted via bulletins and the CCG's GP webinar, shared with Clinical Directors, nursing groups, the GP Strategic Operational Group (GPSOG), the Workforce Improvement Group (WIG) and Governing Body members.

The other survey, aimed at patients, public and elected representatives, has been circulated to system partners, practices and Healthwatch asking them to share this onwards to reach as many patients as possible through their networks and Patient Participation Groups (PPGs). Both surveys closed on 8 April.

As the information-gathering phase now closes, focus will turn to collating all materials gathered and preparing an early draft strategy during April. This draft will be shared with key stakeholders and the CCG's Primary Care Commissioning Committee for further engagement during May, providing an opportunity for early review and feedback by members. The expectation is that the final version will be signed off and published in July 2022.

4. Integrated Care System development

Work is underway by the Integrated Care System (ICS) Development Programme to strengthen collaborative working and support people and communities.

Following a workshop in November last year, a system working group have co-produced a shared high-level view of ICS programme priorities for the next 12-18 months. The group includes colleagues from primary care, secondary care, mental health, local authorities, the voluntary sector and Healthwatch.

In parallel, the programme has responded to immediate needs to develop:

- A system Leadership Programme to support the establishment of pan-system groups, including the Integrated Care Board (ICB), and to strengthen system leadership within professional groups
- Plans for a series of Devon Conferences to strengthen mindsets, skills and actions for system working
- A Devon Plan and draft ICS maturity assessment
- In May, ICB and ICS Executives will be invited to review the design phase work and agree the ISD Programme Implementation Plan, kick-starting the next exciting phase in our ICS development.

The programme is key to achieving the changes necessary to deliver Devon's long-term plan and shared vision of equal chances for everyone to lead long and healthy lives.

5. Workforce Strategy Update

Work continues to produce a system-wide action plan to improve staff health and wellbeing, with a view to reducing and better managing absences. The current focus is on working with providers to complete reviews and generate an action plan.

This plan will focus on ensuring we have standardised best practice processes for managing absence based on the NHSE/I publication 'Deep dive into factors affecting non-Covid sickness absence North West NHS Trusts 2020'.

An Employee Assistance Programme is in place for all staff across Devon and the programme is assessing the extent to which we need to add to /change our proactive health and wellbeing offer.

System partners are working together to review the outcome of the NHS staff survey and agree actions to tackle the issues identified.

6. Engagement on protected elective capacity

NHS organisations in Devon are working together on a local engagement programme to consider measures that could help protect planned operations from being postponed when hospitals face very demand for their urgent care services.

On 8 February 2022, the Department of Health and Social Care published the NHS Elective Recovery Plan that describes how the NHS will tackle the backlog of care built up during the Covid-19 Pandemic.

The plan aims to eliminate waits of longer than 18 months for planned care by April 2023 and waits longer than a year by March 2025. It refers to protecting elective capacity as a principal way of tackling the NHS backlog. Protected elective capacity (PEC) means separating planned from emergency care to avoid the current challenge where emergency cases can disrupt routine operations and cause cancellations or delays.

Between 2 March and 8 April 2022, the NHS in Devon undertook a period of targeted engagement events with people who this work impacts the most (for example, those currently on waiting lists for surgery or staff working in these areas). Over a series of nine focus groups, staff and patients were invited to share emerging thinking and discuss how we can protect elective capacity in Devon.

Focus groups also specifically included insights from people with disabilities, people from the Deaf Community, patients from diverse ethnic backgrounds, people from rural areas and people from the LGBTQ+ community in Devon. Feedback will be used to support options development, which require consultation, later this year.

7. Digital Locum GP Service

The NHS in Devon is working with partners to lead the way in developing digital solutions for general practice with its game changing 'GP in the Cloud' digital locum technology.

At a time when NHS organisations are seeing sustained high demand on services while managing high staff absence due to Covid, this ground-breaking technology is a welcome addition, providing much-needed extra resources for general practice.

The innovative technology enables a GP to be located anywhere in the UK to carry out online consultations to patients across Devon via the internet, using a secure cloud-based virtual desktop (VDI), based within the Devon information technology infrastructure.

The digital locum service offers many uses, including:

- Support for clearing a backlog of digital work at busy times to help free up staff on the ground to do more face-to-face clinics
- Providing short-notice extra GP cover
- Cover for annual leave or other planned absences.

The 'Digital Locum Service' is delivered through a partnership of Devon Clinical Commissioning Group, Delt Shared Services Limited, National Association of Sessional GPs (NASGP) and Lantum.

8. Nightingale offering range of services

The NHS Nightingale Exeter is now offering a range of orthopaedic, ophthalmology, diagnostic and rheumatology services to local people, helping to further reduce waiting times.

The facility was initially part of the national response to the first wave of the pandemic, providing emergency in-patient care for nearly 250 patients with COVID-19 from across Devon, Somerset and Dorset.

After being decommissioned as a COVID-19 hospital in March 2021, the Nightingale was purchased by the Royal Devon University Healthcare NHS Foundation Trust on behalf of NHS organisations across Devon and the South West region. The site has since been used to provide thousands of important diagnostic scans to local people

and support the delivery of COVID-19 vaccine studies, as well as acting as a training centre to support new staff arriving from overseas.

In May 2021, it was announced that the Nightingale would receive a share of funding from the National Accelerator Systems Programme, which was awarded to Devon to support the reduction in waiting times.

As a result of a clinically led redesign programme, the Nightingale has now been transformed into a state-of-the-art facility and is home to the following services:

- Southwest Ambulatory Orthopaedic Centre, which has two operating theatres for day case and short stay elective orthopaedic procedures
- Centre of Excellence for Eyes, which operates diagnostic screening services for ophthalmology patients and will run a high-volume cataract treatment hub
- Devon Diagnostic Centre, which is providing CT, MRI, X-ray, ultrasound, echocardiograms and fluoroscopy services
- The RD&E's Rheumatology department which provides outpatient care and day case infusions.

For more details, visit: https://royaldevon.nhs.uk/news/devon-nightingale-s-legacy-continues-as-the-hospital-tackles-the-region-s-waiting-lists/.

9. Devon and Cornwall Care Record

Across Devon and Cornwall, a programme of digital work is underway to deliver a new system called the Devon and Cornwall Care Record that will transform the way we provide services to patients. It is part of a national programme to transform information sharing across health and social care.

Throughout March and April, the programme team have been holding webinars for general practice, Healthwatch and other key stakeholders to brief them on the programme and what it means for patients, GP practices and the wider system.

The programme will continue to work with GP practices and other stakeholder organisations to increase the number of data sharing agreements in place. This will enable the wider health and care community to benefit fully from accessing information and provide better care for patients.

Extensive testing will also continue behind the scenes with system partners and their IT teams. This testing ensures that when new organisations come on board, the system works, patient information is displayed correctly, and the appropriate authorised clinicians and healthcare workers can access the patient's record.

10. CCG staff transitioning to ICB – consultation

A staff consultation on the transition to becoming an Integrated Care Board (ICB) was launched by NHS Devon Clinical Commissioning Group (CCG) on 6 April.

NHS Devon ICB is expected to be a statutory organisation on 1 July 2022, replacing the CCG as the organisation responsible for planning, buying and monitoring healthcare services.

As part of the transition, the CCG is required to consult with all staff who will automatically transfer to the ICB under TUPE regulations and are protected by NHS England's employment commitment.

For many staff, this will mean little or no changes to their roles on 1 July, however some may see changes to job title and/or line management arrangements.

The consultation, which is open until 4 May, follows last month's announcement about the ICB's new Board and executive team members.

11. Engagement summary published

NHS England and NHS Improvement is working closely with the Local Government Association (LGA) and the Department of Health and Social Care (DHSC) to support system leaders as they develop Integrated Care Partnerships (ICPs).

In September 2021, they published a joint engagement document that presented a vision for how ICPs can provide the foundations for strong, effective partnership working. A summary of the ICP engagement response, which also includes further information and case studies, has recently been published.

ENDS

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Locality update report

Locality:	West LCP
Period covered by update:	February 2022
Person completing template:	Emma Herd – Deputy Locality Director South & West

Key achievements/progress

Draft priority plan and associated workstreams reviewed and supported by Exec LCP group and delivery group in February 2022

Key priority areas:

- Supporting the local population when they need urgent care and enabling support close to (or in) their home
- Improving Mental Health diagnosis, support, and outcomes
- Improving population health and the lives of those living with health conditions
- Improving workforce resilience and creating a sustainable work force for the future

- NHSEI Place Based development programme launched and initial sessions covering population health management, governance, function and finance and leadership taking place throughout April

- Confirmation of funding for Ageing well funding for Enhanced Health in Care Homes for the West LCP, falls prevention funding and voluntary Sector support for hospital discharge, teams are now moving to implementation of the schemes and understanding the baseline position to ensure evidence can be gathered to support impact assessment:

    1. Admiral nurse for West LCP in partnership with Dementia UK appointed
    2. Accommodation secured for Strength and balance offer to be used as part of frailty pathway providing access in West LCP locations - due to commence early May 2022
    3. Restore2 training in care homes and wider training for Care home staff under main Enhanced Care in Care Homes Framework
    4. Recruitment commencing for VCSE in hospital discharge support roles in Tavistock and Kingsbridge, ensuring full use of local VCSE offers to enhance ability and timeliness of discharge
- Carers needs assessment process commenced
- Hypertension LES supported by LCP delivery group with recommendation to support for West LCP, work in conjunction with Plymouth LCP
- Agreement of Adult Social care dataset for regular review by LCP, and initial view of Mental Health, Learning Disability and Autism (MHLDA) data to be provided by mid April 2022

- Commencing review of all Community/Primary Care multi-disciplinary team (MDT) approaches in West LCP to understand gaps/impact and improvement requirements
- Inpatient/day case/diagnostic data being developed by UHP at West LCP level to best inform how LCP can support patients awaiting elective treatment
- Mental health position against core standards being collated for review at a West LCP level to understand collaborative approach and actions to promote improvement, learning from Plymouth LCP experiences

Key priorities for the next three months

West LCP:

- Continue to develop West LCP relevant dataset to enable review of performance/quality/position against emerging priorities and impact analysis of funded projects that are currently being implemented
- Ongoing development and implementation engagement plan to further develop year 1 and longer-term project plans to deliver against priorities
- NHSEI place development programme – ensure various modules provide required outputs; leadership vision and LCP ambition summary; defined governance, function/roadmap and new interventions for areas identified via PHM module approach.
- Implement proposals around known funding pots for schemes identified as described above
- Confirm Virtual ward priority areas for West LCP in conjunction with Plymouth LCP and system partners

Issues of concern or risk

- Lack of capacity to mobilise all programmes/projects identified, some has been assigned from the South and West ICS/CCG commissioning team. Lack of capacity from LCP partners to provide input into all programmes.

- Lack of intelligence to accurately assess and prioritise performance/quality/outcomes for population. This includes ability to look at West LCP population specific information regarding performance against constitutional standards, ambulance delays and also the position in terms of achievement of MHLDA standards.

Support required and/ or barriers to progress

None at present.

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Locality update report

Locality:	South Locality
Period covered by update:	March 2022
Person completing template:	Derek Blackford – Locality Director (S&W)

Key achievements/progress

Local system:
The local health and care system in South Devon & Torbay has experienced some improvement and easing of demand from where it had been and the sustained period of pressure over the last 4 months. With attention turning to recovery planning there is still significant challenge but coupled with the expectation that things are swiftly reverting to 'business as usual'. With a rise in the last week or so of COVID-19 cases and the continued workforce pressures across all sectors still impacting, set against this backdrop it poses a challenge which teams are working hard to mitigate.

A particular challenge across the Devon system is the responsiveness of ambulance services to demands in the system set against the pressure in relation to ambulance handover delays at our acute hospitals. This poses a significant risk to patient care if not managed effectively and is a focus of systemwide escalation calls and ongoing review between system partners and with NHS England & Improvement.

System flow:
The focus of the system flow improvement plan is directed toward the aspects of admission avoidance, internal hospital flow and discharge and out of hospital provision. This plan is being refined with local system partners and will be overseen through the South Urgent Care Board/LCP Flow Group. The latest position on some of the key components is set out below:

- **Urgent Community Care:** The model for the minor injuries service remains under development after the last Urgent Care Working group agreed to revisit the model and costings. The group is also exploring the community pharmacy offer in support of the community urgent care strategy. Development of the workforce blueprint continues with the programme lead meeting the new Advanced Clinical Practice Lead at Newton Abbot's Urgent Treatment Centre in April.
- **Urgent Community Response (UCR):** the picture continues to develop and work to assess the utilisation and impact as an alternative to being directed to the Emergency Department. This is in addition to focus on the next stages in particular setting out a response to the latest planning guidance and what the next tranche of available funding can support. The newly procured domiciliary care is working well across Torbay but issues remain in South Devon due to the chosen provider struggling to deliver in the current climate with high levels of Covid-19 in the locality.
- **Improved Discharge Support & Co-ordination** extending the current in-hospital discharge support worker arrangements with the voluntary sector through the

Discharge Cell alongside other measures developed with local partners has been implemented. The impact, including additional rapid response and home from hospital arrangements, an Admiral nurse to support people living with dementia and their families around transitions into and out of hospital-based care, will be monitored through the Local Care Partnership (LCP) Delivery Group. There is also an increased focus on discharge processes to support earlier discharge, increase weekend discharges, reduce length of stay and short-term services recruitment.

Local Care Partnership (LCP) development:
We are working to support delivery and performance and improvement through an Executive Group, a Delivery Group, and a Performance Group. Work is also underway with partners in the system including through the Health & Wellbeing Boards to better align delivery and promote visibility of impact. Our work focusses on personalised care, workforce, urgent services, and health inequalities, and developing a set profiled and prioritised plans. Work is also underway to assess the organisational development and resource requirements at place to support the further development of our partnership arrangements and the infrastructure to support delivery.

The focus of these sessions in the last month has been in the following areas:

- Stakeholder engagement session on the development of the Primary Care Strategy.
- Progress update and consideration of the oversight arrangements in relation locality Health & Wellbeing Developments.
- An update on the findings of the Special Educational Needs and Disabilities (SEND) inspection for Torbay and plans to develop further our work with parents, carers, children and young people to ensure the support needs are met through a written statement of action.
- LCP Priorities – Self-harm and Suicide Prevention Review.
- Long-term Plan incl. Game Changers, Integrated Care Framework, Elective Care, Health Inequalities – beginning to assess the development of a workplan to support delivery at place.
- Organisation Development support and Roadmap for LCP Development.

A lack of data in some cases and intelligence more broadly in support of LCPs to understand and triangulate the quality/experience, outcomes for the population and service performance for the locality is an immediate priority.

Current Leadership arrangements

The LCP leadership arrangements are in place with a review underway at present as planned. At present, Simon Tapley, Deputy Chief Executive (Integrated Care System for Devon (ICSD) and NHS Devon Clinical Commissioning Group (CCG)) is taking the role of the Chair with Liz Davenport, Chief Executive, Torbay & South Devon NHS Foundation Trust (T&SDFT) being vice-chair.

All local system partners are engaged in the development of the local care partnership arrangements in both the Executive group, Delivery group and broader system planning and engagement aspects.

Key priorities for the next three months

The key priorities for the next three months are:

1. Working with partners to support delivery of recovery actions with a focus on workforce, discharge and capacity with local providers and investment in the voluntary sector.
2. Refocussing the South Urgent Care Board/Local System Flow Group on our Urgent & Emergency Care Improvement Plan.
3. Working with local system partners to deliver against the ambitions and challenges highlighted through the approach with Torbay H&WB to 'Turning the Tide on Poverty'.
4. Delivery against the local priority ambitions, the Operating Plan and Long-term plan.
5. Urgent Community Care - Newton Abbot Urgent Treatment Centre and enhanced minor injuries services.
6. Urgent Community Response capacity as alternative to admission.
7. Working with ICS system leads - prevention, planned care, mental health, learning disability and autism with locality level support prioritised and resourced appropriately.

Issues of concern or risk

The main areas to consider are:

- Workforce capacity, recovery, and resilience - incident response, significant operational challenges, restoration of services, development of place-based arrangements and delivery against the long-term plan priority ambitions.
- The lack of data and intelligence at LCP level to ensure that outcomes, performance/quality, and experience is visible and better informs short and longer term workplan development.
- Ambulance handover delays and response times within the local system context.

Support required and/ or barriers to progress

- Support to access Strategic, Business and Public Health Intelligence resources to inform work planning and decision-making in localities.
- Support to strengthen the arrangements at place to support delivery against the urgent care improvement plan.
- Support to develop the arrangements at place through a focus on organisational and local system development

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Locality Update Report

Locality:	Eastern Devon
Period covered by update:	March- April 2022
Locality Director:	Tim Golby

Issues of concern or risk

- Discharge & Flow – The Royal Devon and Exeter (RDEFT) will not meet the trajectory set by NHS England in the Level 4 performance instructions for numbers waiting to be discharged from acute hospital. The reasons for this are well understood, including very high patient numbers and acuity levels alongside high care home outbreak numbers. This is being managed with operational leads within the Trust and an action plan developed.
- Community Mental Health Framework – Ongoing issues regarding recruitment to mental health roles (particularly band 6 senior mental health practitioners). This is a local and national issue and support is being sought from the recruitment and HR teams at Devon Partnership Trust.

Key achievements/progress

Trust Merger

- From Friday 1 April 2022, the Royal Devon and Exeter NHS Foundation Trust (RDEFT) and Northern Devon Healthcare NHS Trust (NDHT) have formally merged to become the Royal Devon University Healthcare NHS Foundation Trust (RDUH).
- The new Trust has two acute and 20 community hospitals, and nearly 17,000 staff who work together to deliver core services to our local communities and specialist services across the whole of the peninsula.

Urgent and Emergency Care

- A task and finish group has been formed to look into low acuity attendances at the emergency department (ED) which could be dealt with in enhanced primary care same day settings. GPs from one Exeter Primary Care Network (PCN) will work with the secondary care clinicians to develop and pilot a new delivery model to reduce pressure at the ED from lower acuity attendances from their area. The aim is to trial a model for 3 months before reviewing, evaluating, and sharing findings and then developing a business case for a winter scheme that can be considered for Winter 2022.
- A second group is being formed to look into frequent attenders within health and social care, similarly, to develop a pilot model reflecting on the successes found in North Devon with their High Flow project.

Community Services and Flow

- Resource and capacity in line with the winter plan continue to be monitored via the system Patient Flow work programme. An audit, initiated by NHS England, of discharge and flow processes internally within Trusts has provided some valuable tests of the capacity available as well as the analysis and counting of patients. The action plan from this work is being led by the operational leads within Royal Devon & Exeter NHS Foundation Trust (RDEFT). Key actions include focused process mapping of internal processes for patients on P1-3 pathways to identify efficiency gains, increasing community rehab to short-term care home placements, increasing in-reach from clusters to the acute for P2 and 3 patients to improve time to transfer.

Long Term Conditions

- Bids have been invited and received from professionals who work in diabetes care across the locality for an allocation of the 2022/2023 diabetes transformation budget.
- A project pharmacist role funded by transformation funds has been advertised and will be employed by the CCG.
- Diabetes Foot Care and Root Cause Analysis task and finish groups have been established and met this month.

Prevention

- An LCP planning group has been established to take forward action from the LCP conference including task and finish group about the prevention priorities and planning the LCP next conference.
- An Eastern Locality Voluntary Community and Social Enterprise (VCSE) reference group has met to support Eastern Local Care Partnership (LCP) moving forward.
- The Eastern Locality continue to support the coordination of health services for local refugee cohorts placed in the locality. Most of the immediate health screening and provision for residents has been set up/delivered or planned across the three hotels.

Mental Health – Community Mental Health Framework (CMHF)

- 10 out of 11 Multi Agency Team (MAT) meetings have been established across the locality and the new care model is developing across the Woodbury, Exmouth and Budleigh (WEB) PCN with senior mental health practitioners working into the PCN. Recruitment action continues across the locality to fill band vacancies and year 1 roles for the Additional Roles Reimbursements Scheme. A number of PCNs have noted interest in joining the 2022/23 ARRS scheme and recruitment action can begin once system budgets are confirmed. Strong links have been made with the newly formed MH VCSE Alliance and engagement events will be taking place across the locality in the next two months.

Planned Care Recovery

- The South West Ambulatory Orthopaedic Centre (SWAOC at the Nightingale) had its first patient on Monday 14 March. This comprises two theatres on a Monday and Tuesday and one theatre on a Wednesday morning. They're currently running 5 operating lists a week (Monday to Wednesday lunchtime), building up to 4 patients on each list over the first few weeks. All patients are out with only 1 overnight stay, majority are day case. All patients have been home within 24 hours.
    - w/c 14/03 – 10 patients treated
    - w/c 21/03 – 12 patients treated

  - w/c 28/03 – will treat 18 patients, and 18 each week for the foreseeable future. Aspiration is to ramp this up.

- Case mix to date: 12 hips, 8 knees, 2 uni-knees (partial replacement). 50% of activity has been day case with everything else being one overnight stay before being discharged the next day. There has been good representation from the various Trusts, with RDEFT having 5 sessions. Next Monday is the first eight joint day (knees) as part of productivity improvement plan. There has been really positive feedback from clinicians and staff working there. Surgeons are thrilled to be operating again.

Key priorities for the next three months

- To support focus on hospital flow and community discharge planning.
- To act within the Devon-wide Winter Response team, responding to escalation and pressure within Urgent and Emergency Care.
- To progress the overarching workplans of the Eastern LCP for the 5 thematic areas, including the Community Mental Health Framework (CMHF) and aligning to the ICS Strategic Outcomes Framework.
- To continue progress made by the Diabetes Transformation Programme and work across the local system.
- To continue progress of the locality prevention priorities and Public Health Management programme.

Support required and/ or barriers to progress

- Barrier: Managing the demands of winter pressure response alongside the daily developmental work within the LCP

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Locality Update Report

Locality:	Northern Devon
Period covered by update:	March- April 2022
Locality Director:	Tim Golby

Issues of concern or risk

- The Northern system remains in an extremely pressured place for Urgent and Emergency Care. Covid and emergency admissions have increased demand, while community capacity issues have reduced outward flow. This congested flow has impacted directly on ED with volatile but occasionally seriously sub-standard figures for ambulance handover delays, variable numbers of >12 hour DTA delays and mostly sub 80% 4 hr performance.
- The two MIUs remain closed, and Devon Doctors have difficulty staffing the Northern part of their service model and both of these factors drive demand into the congested ED.
- Acute discharges have not delivered the reduction required on Pathways 1-3 by the end of March.

Key achievements/progress

Long Term Conditions

Diabetes:

- Bids have been received from professionals who work in diabetes care across the Locality for consideration for allocation of the 2022/2023 diabetes transformation budget. The meetings to sign off on the proposals are scheduled in mid-April.

Prevention

- Enhanced Health in Care Homes (EHiCH) – 2021/22 monies have been allocated to support Strength and Balance Activity for Care Home residents to support falls prevention and recondition residents following covid restrictions. The work is being led by Primary Care Collaborative Board with cross system input (CCG, One Northern Devon, Devon County Council, Northern Devon Healthcare Trust, Primary Care Networks). A Band 6 therapist to lead the activities is being recruited. Care homes are expressing interest/engaging through the local Care Home forum to access the funds.

- The One Northern Devon Healthy Ageing North Devon (HAND) service design team successfully applied for CCG prevention funds in 2021/22 to prototype activities to enable a rapid ‘test and learn’ phase that would inform the design brief for the Prevention domain. The objective was to test community activities that

would contribute to keeping older people well and address the specific needs identified by older people, their families and the professionals working with them. It was hoped that there would be learning around what communities can offer; what the associated costs and benefits of that offer are, and whether those benefits could potentially be scaled up with ongoing funding. Five projects were funded directly, and two projects were indirectly through the time of the Community Developer. Three further projects in venues were initiated at the end of March 22. An evaluation report is currently being written to assess the schemes already underway.

- Active Travel forum is involved in the Local Cycling and Walking Infrastructure Plan (LCWIP). There have been initial proposals received for Barnstaple, Bideford and Northam and the launch of the Northern Devon 'People and Place' project for the Joint Local Plan review. They are continuing to work with the NDHT 'Our Future Hospital' team on access to the site, active travel to, from and within the hospital grounds and staff engagement to promote their health and wellbeing by being active and encouraging active conversations with patients. A survey to canvas views on e-bikes and co-cars is underway across the locality to help gain insight into its scope in reducing motor vehicle use.

- OND has begun an engagement process with its partners, citizens and service users to help inform a refresh of their 10-year strategy that was published in January 2020. The strategy aims to reflect necessary improvements that are currently impacting the lives of local people and how services could be changed to better meet needs. There is a focus on the most disadvantaged areas. A workshop is being planned for June 2022 with a view to relaunching the strategy in November 2022.

- The One Northern Devon Culture, Health & Wellbeing Case Study aimed to test how the culture sector could work with community and statutory partners to support health and wellbeing. It targeted activity at people experiencing specific health inequalities. The stage one pilot ran participatory creative projects in Bideford, South Molton, Braunton and Torrington. Early evidence from the case study shows broad and, in some cases, transformative impact on the small groups taking part. The project in Bideford with isolated adults and the project in Braunton with anxious 16-24 year olds have been evaluated using measures from the Warwick Edinburgh Wellbeing scale and in both cases show improvements in participants' confidence, optimism and sense of connectedness to others, as well as the potential for a longer term community legacy. In both these towns the Case Study showed the power of effective three-way partnership between a creative partner, a community partner and the local NHS, facilitated by a creative project manager. An evaluation report is currently being written to assess the schemes fully.

Mental Health – Community Mental Health Framework (CMHF)

- The collaborative educational programme – 'Serious Mental Illness and Physical activity – a knowledge and skills toolkit' offered to all health and social care professionals across Devon in January 22 will be embedded into Devon Training Hub's Personalised Care Programme offer for the next 2 years. Discussions with

Devon Partnership Trust on strategic engagement that supports the 'Transitions to primary care' for mental health professionals is ongoing.

- A Workplace Wellbeing programme to support local businesses is being developed with Southwest Business Council leaders and Department for Work and Pensions using CRF funding. The evaluated and accredited scheme will engage with 20 local businesses initially to promote healthier lifestyles for the workforce, increase mental health awareness and creating a local workplace health champion network. Key delivery targets by the end of June 22 include establishing a workplace health champion network and designing a OND workplace wellbeing accreditation programme.

Planned Care Recovery

- Nightingale Hospital Orthopaedic activity – The South West Ambulatory Orthopaedic Centre (SWAOC at the Nightingale) had its first patient on Monday 14 March. This comprises two theatres on a Monday and Tuesday and one theatre on a Wednesday morning. They're currently running 5 operating lists a week (Monday to Wednesday lunchtime), building up to 4 patients on each list over the first few weeks. All patients are out with only 1 overnight stay, majority are day case. All patients have been home within 24 hours.
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    - w/c 28/03 – will treat 18 patients, and 18 each week for the foreseeable future. Aspiration is to ramp this up.

  Case mix to date: 12 hips, 8 knees, 2 uni-knees (partial replacement). 50% of activity has been day case with everything else being one overnight stay before being discharged the next day. There has been good representation from 3 trusts, with NDHT having 2 sessions. Next Monday is the first eight joint day (knees) as part of productivity improvement plan.

Key priorities for the next three months

- To continue progress of the locality prevention priorities and PHM programme.
- EHiCH Activity co-ordinator for Care homes to be appointed and a bespoke programme to be rolled out with in build evaluation
- OND Workplace Wellbeing project management to engage with businesses, promote a series of webinars and establish a network of wellbeing champions
- Continued development of the Northern LCP following the successful Development session held on 6th April 22. A number of key priorities and next steps have been identified and will be taken forward by the LCP membership

Support required and/ or barriers to progress

- Managing the demands of winter pressure response alongside the daily developmental work within the LCP

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- Pressure on healthcare system and restrictions of covid are limiting access and safety in engaging fully with care homes for falls prevention and reconditioning work
- Need for increased project management time for Workplace Wellbeing Programme to enable delivery of required CRF elements.

NHS Devon Clinical Commissioning Group

Locality update report

Locality:	Plymouth/West Devon
Period covered by update:	**APRIL 2022**
Locality clinical representative:	Dr Shelagh McCormick
Locality Director:	Anna Coles/Derek Blackford
Locality non-executive representative:	Nick Ball

Key achievements/progress

Plymouth:

- West End Wellbeing Centre – PCC Planning Application in December 2021; communication and engagement approach being finalised.
- Plymouth LCP Executive maintaining focus on whole system pressures.
- Continued pressure related to delayed discharges with a combination of workforce gaps and infection control in home care and care homes pathways but improving position.
- The commencement of a dynamic decision group for partners to oversee system decision making and supporting the escalation process.
- Tactical command approach in place for community provision to reduce over prescribing of care, maximise use of voluntary sector and manage finite domiciliary care capacity in Plymouth.
- Planning and implementation of investment further to CCG Executive approval of recurrent investment into services for people with complex needs and a range of services to enhance wellbeing, prevention and community empowerment.
- Change in SRO for the Discharge Improvement Programme, review of metrics and re-prioritisation of the next stage of work.
- Supporting the mobilisation of the Mayflower GP Contract by Livewell

Plymouth & West Devon

- COVID vaccination programme continues to demonstrate positive examples of integrated working between PCNs, community and acute providers. COVID Booster programme underway
- Independent Sector (IS) providers working well with the NHS and supporting treatment of long wait patients.
- Planning started as a system for the 2021/22 operating plan and Phase 4 Recovery and Restoration.
- Continued working with the Integrated Care Partnership on Transformation programmes.
- System Pressures – continuation of work on same day urgent care, pathway transformation.
- Planning investment to prevent falls and fractures using Prevention Funding
- Planning investment to continue implementation the Enhanced Health in Care Homes programme as part of Ageing Well.
- Admiral nurses for Plymouth and West LCPs in partnership with Dementia UK
- Investment into additional voluntary and community services to support admission avoidance and discharge.

West LCP

- NHSEI Place Based development programme launched and initial sessions covering population health management, governance, function and finance and leadership taking place throughout April
- Confirmation of funding for Ageing well funding for Enhanced Health in Care Homes for the West LCP, falls prevention funding and voluntary sector support for hospital discharge, teams now moving to implementation of schemes and understanding baseline position to ensure evidence can be gathered to support impact assessment:
- Admiral nurse for West LCP in partnership with Dementia UK appointed
- Accommodation secured for Strength and balance offer to be used as part of frailty pathway providing access in West LCP locations - due to commence early May 2022
- Restore2 training in care homes and wider training for Care home staff under main Enhanced Care in Care Homes Framework
- Recruitment commencing for Voluntary, Community and Social Enterprise (VCSE) in hospital discharge support roles in Tavistock and Kingsbridge, ensuring full use of local VCSE offers to enhance ability and timeliness of discharge
- Carers needs assessment process commenced
- Hypertension LES supported by LCP delivery group with recommendation to support for West LCP, work in conjunction with Plymouth LCP
- Agreement of adult social care dataset for regular review by LCP, and initial view of mental health, learning disability and autism (MHLDA) data to be provided by mid-April 2022
- Commencing review of all Community/Primary Care multi-disciplinary team (MDT) approaches in West LCP to understand gaps/impact and improvement requirements
- Inpatient/Day case/diagnostic data being developed by University Hospitals Plymouth (UHP) at West LCP level to best inform how LCP can support patients awaiting elective treatment
- Mental Health position against core standards being collated for review at a West LCP level to understand collaborative approach and actions to promote improvement, learning from Plymouth LCP experiences

Key priorities for the next three months

Plymouth:

- Retaining social care workforce and managing significant unmet community demand through ongoing risk stratification.
- Community in-reach approach to discharges from UHP in partnership with increased voluntary sector capacity.
- Remodelling of older people's mental health (OPMH) offer to support admision avoidance and care home liaison for discharge maximisation
- Focus on system resilience through winter for patient safety, quality and experience, wellbeing of workforce and performance
- Completion of patient engagement of three surgeries linked to the Wellbeing Centre and Quality Equality Impact Assessments (QEIA's).
- Mobilisation of any additional capacity including the short-term care centre (Feb 22), Woolwell House DE Step Down (Jan 22) and additional beds following capital works circa (15 DE late Dec/Jan).
- A review of needs, inequalities, outcomes, priorities, and opportunities to inform key areas of Equity Funding investments as agreed by LCP Delivery Group
- Continuing support for discharge planning including a visit from Local Government

Association national team in March to offer support and review progress.
- A review of continuing needs for capacity and resources to support the urgent care system.

West LCP:
- Continue to develop West LCP relevant dataset to enable review of performance/quality/position against emerging priorities and impact analysis of funded projects that are currently being implemented
- Ongoing development and implementation engagement plan to further develop year 1 and longer-term project plans to deliver against priorities
- NHSEI place development programme – ensure various modules provide required outputs; leadership vision and LCP ambition summary; defined governance, function/roadmap and new interventions for areas identified via public health management module approach.
- Implement proposals around known funding pots for schemes identified as described above
- Confirm Virtual ward priority areas for West LCP in conjunction with Plymouth LCP and system partners

Plymouth/West Devon:
- Embedding the governance for the Integrated Care Partnership with system governance
- With UHP and Livewell Southwest and stakeholders, a stocktake of Year 1 of the Integrated Care Partnership, a review of priorities and setting priorities and trajectories for Year 2
- Engagement with Primary Care regarding proposed changes to the Community Podiatry pathway and thresholds, to improve quality and safety
- Delivery against Urgent Care Locality improvement plan with particularly focus on Same day emergency care (SDEC) and Discharge.
- Further develop Performance and Improvement group for LCPs
- Implementation of initiatives funded using Fair Shares funding (Complex Needs, Wellbeing, iCOPE, Prevention and VCSE)
- Continuation and further development of work for Place based Population Health Management when appropriate for both LCPs (timetable for which has been amended given service pressures and operational priorities)
- Aiming to treat elective patients according to clinical need and secondly by priority. Additional capacity coming online over the next few months to include modular theatre provision and outsourcing support.
- Focus on reducing potential 104-week waiters for elective care.
- Locality involvement in Devon-wide Operational Planning
- LCP level information to provide baseline assessment against priorities and ongoing monitoring of progress against KPIs. There is no analytical support to provide this LCP level information for the West in particular and most data is not currently captured at a West footprint level.
- As part of the Devon Population Health Management Programme, aiming for sign-up of all organisations in order to achieve maximum benefit for the population
- PCN-level workshops to commence on estates review. Will include invites to LCP organisations

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Issues of concern or risk

- Staffing capacity across the whole system
- Community capacity across all areas
- Levels of unmet need in community including significant levels of Domiciliary Care waiters
- Urgent and Emergency care demand impacting on the restoration of planned care services.
- Clinical workforce capacity at Mayflower Medical Group
- Lack of data and analytical support at LCP level to ensure full understanding of baseline position across priorities and to generate robust benefits realisation plans

Support CCG/system or barriers to progress

NHS
Devon
Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Finance & Performance Committee

Date of Governing Body: 28 April 2022

Dates of Committees covered in this report: 21 April 2022

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

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

Contact Details: g.turner5@nhs.net

Reports discussed and assurances received

- **Risk Register Reports** – see Risk Register review below.
- **Quality & Performance Report** –This report provided a consolidated update on key measures of outcomes, performance, quality and activity, including escalation of key issues from LCPs and system groups, and highlighting any significant risks.
- The Committee noted that the Devon System is in a sustained position of increased risk, including delays in urgent care, delayed discharges due to poor community capacity and COVID-19 related staff absences. This has led to pressures in Emergency Departments (EDs) due to poor patient flow resulting in a stepping down of some planned procedures.
- The following areas were highlighted: -
    - Quality
        - Planned Care: risk to patients, due to long waits. Initial GIRFT programme underway to review improvements in 4 months, in addition to increased capacity and communication with patient workstreams.
        - Urgent & Emergency Care: risk of long waits across whole pathway; 111, 999, ambulances through to EDs. System SI agreed, as well as local analysis and improvement plans already in place.
        - Primary Care: impact on workforce and capacity, due to long waits within planned and urgent care.
        - Community Care: risk due to discharge delays and long waits for packages of care.
        - IPC: On-going infection rates (COVID-19) impacting on both patients and staff in health and social care settings.
    - Performance
        - Planned Care: risk to RTT, diagnostic & cancer target delivery. Although improving position, 104 week waits trajectory gap of 860 at end June 2022.
        - Urgent & Emergency Care: ED 4 hour under-performance (68%) and 60-minute handover delay breaches at all four acute hospitals (226.9 hours > 15 mins in March).
        - Discharge: delays continue to impact on flow throughout the entire system & NCTR targets unmet, although a total of 91 additional beds have been mobilised.
        - IUCS: 111 and Out of Hours service seeing continued capacity problems, although improvement actions progressing.
        - Children's & Mental Health: Reported improvement in Ockenden actions. Autism and

Eating Disorder services continue to underperform.

- Workforce
  - Staffing continues to be challenging across the whole healthcare sector with the following issues all impacting on each other.
  - Sickness: Absence is currently at a high across Devon at 9.1% with Covid absence attributing 5.1%.
  - Turnover: has remained static in recent months (11.8%), although it is higher than this time last year (9.3%).
  - Agency Spend: Agency spend has reduced from last month and is now within normal control limits.
  - Vacancies: Have reduced in all areas bar Allied Health Professionals.

Reports received and noted

- **Devon CCG Monthly Finance Report** – A verbal report confirmed the provisional outturn for 2021/22 - a surplus of £5.3m for the year, in line with the plan.
- **ICS Monthly Finance Report** – presented for information to the committee, outlining the position at Month 11. The NHS financial framework has provided a fixed settlement for the second half of the financial year (H2) in line with H1 values but with an additional efficiency requirement and a 5% reduction to COVID-19 in envelope funding. At month 11 the Devon ICS had a surplus of £3.9m, which is £6.8m favourable variance to plan (M10 £7.7m). The forecast to the year-end is £0.3m surplus, which is £2.5m favourable against the £2.2m planned deficit, the same as at month 10.
- As at month 11 the ICS had made efficiency savings of £31.5m (M10 £25.9m) of which £8.8m (M10 £7.9m) are recurrent. The system forecasts to achieve savings of £43.3m (M10 £43.5m) of which £10.2m (M10 £11.4m) is recurrent.
- As at month 11 the ICS was: -
  - underspent on substantive staff by £20.8m (M10 £17.4m). The forecast underspend at year end is £22.8m. (M10 £17.7m)
  - overspent on agency by £1.0m (M10 £0.9m underspend). There is a forecast overspend on agency of £1.5m. (M10 £2.0m). All trusts are in breach of the agency ceiling apart from University Hospitals Plymouth.
  - overspent on bank by £8.6m (M10 £7.2m). The forecast overspend at month 11 is £9.4m. (M10 £7.2m)
- **Operational Plan 2022/23** – the committee received the latest draft financial operating plan for the CCG and wider Devon System for 2022/23 financial year, and noted that the plan was being submitted to NHS England on 28 April 2022, the day of the Governing Body meeting**.**
- The committee further noted: -
  - the level of efficiency requirements set out,
  - the provisional distribution of the system allocation
  - that the draft plan does not currently demonstrate that expenditure can be contained within the total resources available,
  - that the draft plan does not currently meet the required activity targets,
  - that, accordingly, the draft plan currently is not compliant with the expectations set by NHSE, and therefore,
  - that further action is required to identify whether any changes in the financial figures and activity levels can be made between the current draft and final submission.
- This is the subject of a separate report on this agenda

Risk Register Review (changes and areas of concern)

- There have been no new risks and no risks recommended for closure.
- At its last meeting the Committee asked for a re-evaluation of the score of Risk 160 - the risk that the operational plan for 2022/23 is not deliverable within the resources allocated to the system, and the potential for this to jeopardise the wider system plan and the exit from SOF level 4. The Committee

reviewed this matter again and agreed that the risk score should be increased from 9 to 16 (L=4, I=4).

Committee Decisions

- 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:

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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
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Clinical Commissioning Group

GOVERNING BODY

Report title: Committee Chair Report – Primary Care Commissioning Committee (Public)

Date of Governing Body: 28th April 2022

Date of Committee covered in this report: 7th April 2022

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

Chair's Name and Title: Alison Davis

Contact Details: a.davis10@nhs.net

Recommendations brought to Committee for approval or agreement

Practice closure SOP (Standard Operating Procedure)

- Following a recommendation from Internal Audit and the learning identified from a previous practice closure, the Primary Care Team has developed a SOP for GP practice emergency unplanned closures, this will be a working document which will be regularly updated with any relevant changes as and when necessary.

The committee agreed that this is a well thought out paper, and framework, which reflects learning and is flexible enough to adapt to the challenge of differing situations and **approved the SOP,** which will be enacted when there is an unexpected interruption to the provision of primary care medical services, where an immediate solution cannot be identified and therefore needs to be managed as a major incident.

Boundary Reduction Requests – Mewstone PCN

- Applications have been received from Dean Cross Surgery, Church View Surgery, Wembury Surgery and Yealm Medical Centre to reduce their practice boundaries (Appendices 1-4). These four practices make up Mewstone Primary Care Network (PCN) and they all wish to exclude the Sherford Development and surrounding areas.
- Assurance was given that existing patients would not need to re-register.
- Assurance was given that, although a small part of the proposed site would only be covered by one practice, Beacon is a large practice with 6 sites and a good range of clinicians and good staffing levels. If a patient had a practice-wide issue, then other practices would take an 'out of bounds' patient.

The PCCC agreed to approve the recommendation to approve the boundary change application subject to Primary Care Officer assurance following responses to any outstanding issues raised by PCOG members.

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

The **Deputy Director's report** highlighted:

- Assurance given that a constructive discussion was held at LMC re ambulance delays, when the whole system is working above capacity, there will be knock-on effects which cause problems in other areas of the system.
- GP strategy: good progress is being made and is near the end of phase one. Additional engagement groups have not delayed the start of phase 2 collation work.
- Winter Access Fund: feedback from practices is that WAF has helped to keep heads above water – a lifeline to them.
- GP retainer underspend: after a couple of years of exponential growth this has just returned to the original gradual rate.

Finance Report Detailing the financial position to 28th February 2022 (month 11).

In addition to the contents of the paper six areas were highlighted:

- CCG end of year position work is well underway.
- Primary Care budget setting for 2022/23 – the CCG has yet to receive the guidance on how to handle the first 3 months of the year (before ICB status) this will cause some complexity.
- Updated contract documentation was released by NHSE on the 1st April detailing what will be paid for each contract area.
- Devon have done well in using the funding supplied by NHSE for different purposes.
- The Primary Care budget setting paper will be produced to bring to the June PCCC meeting.
- The budgetary overspend, with regard to the support given to Mayflower, will be funded by the underspend in the contingency fund.

The **Risk Report was** discussed at the meeting, and noted:

- the addition of risk 161 SAS sub-contracted providers risk score 9
- the closure of risk 145 Re-procurement of contracts in 2021/22
- the closure of risk 155 Lack of primary care data/data sharing
- the reduction in risk score Risk 118 COVID- 19 - Primary Care Team. Risk score reduced from 16 to 9

Primary Care Strategy Report – at end of year noted:
Two areas which have been marked as red

- Direct booking for Extended access – slots are coming back online, after the difficulties of COVID repurposing, and will be tailored to patient need and new requirements.
- PCN plans for all areas which were a little late but are now in place in all areas

Two areas of Celebration **–**

- Devon's excellent usage of its MIG (minor improvement grant) funding allocation has been at the top of the region for another year.
- Quality dashboard is in place, is being used regularly to inform thinking around quality, safety, and risks, and continues to be improved, expanded, and updated.

Recommendations for Governing Body

None

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

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NHS
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GOVERNING BODY

Report title: Committee Chair Report – Quality Assurance Committee (QAC) Public Part 1

Date of Governing Body: 28th April 2022

Dates of Committees covered in this report: 21 April 2022

Chair's Name and Title: Glynis Atherton Non-executive lay member for Assuring Quality of Services, NHS Devon CCG

Contact Details: **glynis.atherton@nhs.net**

Reports discussed and assurances received

The Committee received updated reports as detailed below

- **Quality and Safety Report**
  Areas highlighted included:
  1. Planned care 104 week wait risk position,
  2. Work within primary care to develop incident reporting processes,
  3. Maternity care and the implication of the Ockenden Report (March 22),
  4. CAMHs waiting list where 610 children waiting more than 18 weeks for assessment in January
  5. Gender Services, with 3183 people out of a total waiting list of 3445 waiting more than 18 weeks for assessment.

NB: Further detail on actions and mitigation will be within May's QAC report (CAMHS and Gender Services).

- **The Safeguarding Annual Report**
  This report provides assurance that the CCG has met its statutory safeguarding requirements and outlines some of the activity of the safeguarding team over 2021/22.
  QAC noted the exceptional work undertaken by the Safeguarding team, particularly in relation to Domestic Abuse and Sexual Violence.
- **General Practitioners with a Special Interest / in an Enhanced Role (GPwSI)**
  NHS Devon CCG in conjunction with NHS Kernow CCG has undertaken a GPwSI accreditation process for a number of years. Due to staff changes and the changing NHS environment this has been reviewed and a number of changes are proposed.
  QAC discussed the proposal for a quality assurance group; was this required? An action has been taken to discuss this further with the contracting team.
- **AOB**
  1. QAC were advised on the changes to national IPC guidance April 2022. Partners will take the changes through their GOLD command process.
  2. QAC agreed they would invite the new Quality Committee NED to the next meeting and that a process of collating learning and hand over was required.

Reports received and noted

Nil

Risk Register Review Updates
Quality Risk & Assurance Report including Risk Register: Risk 162 Personal Assistant Training has been added as a new risk with a score of 12 (L=4, I=3). Personal Health Budgets (PHBs) /Direct Payments can be used to pay for Personal Assistants (PAs) to provide care and support to individuals in receipt of Continuing Healthcare Funding. The PAs are employed by the Budget Holder. There is a risk that PHB Holders do not know the tasks they need to complete when they employ PAs, including: *Ensuring the PAs are adequately trained, to include core skills training and Delegated Healthcare Tasks (DHTs) and * Understanding their roles and responsibilities as a legal employer (Appendix 4)
Committee Decisions
Risk 102 Overdue Serious Incident Reporting is recommended for closure as it is felt the risk can be tolerated on the directorate risk register and following recommendation from Quality Assurance Committee and the responsible director Agreed- as above: risk 102
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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