NHS Devon

INTEGRATED CARE BOARD, BOARD MEETING (Public)
MINUTES

Date: 19 October 2022 Time: 09.00am – 12.30pm

Location: Via Microsoft Teams

Item	Discussion	*Decision taken by Organisation*
1	**Welcome and Apologies** SW extended a warm welcome to all in attendance. Apologies were noted from Sheena Asthana, Graham Clarke and Steve Brown. Several introductory matters were shared. It was highlighted that meetings of the NHS Devon Board although held in public are not public meetings. A change to the agenda was explained to move public questions to the end of the meeting rather than at the start of the meeting. SW expressed her gratitude to John Dowell on his last board meeting for his hard work and support as Interim Chief Finance Officer.	
2	**Declaration of Interests** No new declarations of interest were offered and no declarations for agenda items were noted. NA noted an error on his declaration which stated his relative was Director of the Board of the South West Academic Health Science Network which in fact should be that Nigel himself holds this role. **Action 11 – JHo to request an amendment to NA declaration on the Declaration of Interest register**	
3	**Minutes of previous meeting 21 September and action log** The minutes of 21 September were agreed as an accurate record of the meeting. It was advised that due to some of the open actions being scheduled on the agenda that the action log would be reviewed at the end of the meeting to allow for assurance to be given during the meeting and actions appropriately closed.	The board **approved** the minutes from 21 September as an accurate record
4	**Citizen's voice** A warm welcome was extended to Sanita Simadree, Chair of the Devon wide Ethnic Equality Network and Equality Diversity and Inclusion Lead for Torbay and South Devon Foundation Trust, who joined the board to share the experiences of international staff both within the NHS and social care who have qualified in other countries and now come to work in Devon.	

	Sanita shared a very powerful account of experiences that some people had faced coming to work in Devon. It was shared that the lack of diversity in the South West has sometimes resulted in individuals feeling isolated, unsupported and vulnerable. Social care colleagues have reported feeling unsafe, experiencing discrimination and racial abuse. During the pandemic the newly formed BAME Network was able to offer support in a safe space without reprisal. International Doctors and Nurses have provided vital support to the NHS, helping to ease the staffing crisis, however, to ensure this is viable for these individuals we need measures put into place to ensure their safety and improve their experiences. We heard of doctors and nurses facing their professional experience and knowledge not being recognised in Devon. There is a feeling of being under-valued, issues with language barriers including having been asked repeatedly to repeat themselves, there have been patients refusing care from individuals, individuals stereotyped, there are challenges finding affordable housing, and being able to challenge senior colleagues. The community is also challenged due to a lack of food provision such as Halal shops, lack of hairdressers for black hair, people are having difficulty understand parking restrictions and public transport systems. There have been experiences of not being served at restaurants and being ignored or stared at. Landlords have been rude and unaccommodating asking for guarantors before leasing properties. Torbay and South Devon Foundation Trust is working to a gold standard of support. There is a high quality induction and pastoral support which is award winning. There is an excellent adaptation course which is a coaching programme for our international nurses. There is a system wide anti racism charter being developed which would be strengthened if a system wide campaign was also launched to celebrate our international doctors and nurses and support communities to understand why they have come to work here and work with schools to build cultural awareness. Sanita requested the board to focus on action not words and to provide support in ensuring our international nurses feel supported to come and work within our organisations. There were strong feelings from members of the Board that there is more the organisation can do and this will be something that AM, DA and PR will work with Sanita on to ensure caring for staff coming in from overseas is strengthened in Devon. ST felt a reverse mentoring programme could help people understand challenges and experiences. SW thanked Sanita and extended heart felt thanks to all international nurses and doctors working in Devon and confirmed the Board are looking forward to working to ensure the improvements required are supported and invited Sanita to return to a board meeting in the next year to follow up on progress of some of the areas covered. **Action 12 – AM, DA and PR to will meet with Sanita to see where the board can support to improve international nurses' and other health and care professionals' experiences in Devon** **Action 13 – JHo to include on the board forward planner an inclusion item for Sanita to return later in the year**	

5	**Chair's report** The report was taken as read. There were no questions raised.	
6	**Chief Executive report** The report was taken as read. JM highlighted that the operating model which is on the agenda for the meeting aligns well with work happening at a national level. There had been a national NHS Chief Executive meeting which reaffirmed the focus on the work happening around system oversight and improvement as well as winter planning. JM thanked John Dowell for his excellent contribution to working with the NHS over the last 30 years and the many positive attributes John has brought to the organisation and wished him well for the future. JH thanked JM for the informative report presented and requested high level progress is included within the reports. HK requested that system reporting should be highlighted quarterly within the report as well as the Integrated quality and performance report (IQPR). **Action 14 – JM to include progress on work within the Chief Executive reports and system progress on a quarterly basis** **Action 15 – DA to include system progress within the IQPR on a quarterly basis.** TH requested to understand the temporary increase in beds set out in the winter planning section of the report and asked if there was scope to enable these beds to become permanent. JM confirmed that since the report was written it has been acknowledged regionally that the resources will be made more permanent. ST confirmed these beds would be evaluated to ensure that previous issues are not repeated. LD added it is not just about bed space in the acute hospitals but also about utilising capacity in the community as well.	
7	**Integrated quality and performance report** The report was taken as read. DA highlighted that the report has been strengthened to focus on particular areas, most of which will be covered in the performance section of the agenda.	
8	**Performance recovery** JF joined the meeting and shared a presentation on the urgent care challenges and external factors affecting elective recovery within the system. It was explained that factors included high numbers of patients with no right to reside due to care home and social services pressures utilising bed capacity, aged estates infrastructure impacting on flow, Covid, staff absence levels due to sickness and winter pressures amongst others. An overview of 2022/23 operational targets for elective recovery were shared which included diagnostics, cancer, outpatients and RTT long waits. Covid bed numbers and Elective Recovery Fund (ERF) performance across the system were shared in graph form showing the impact on recovery. Plans were shared on system working to improve cancer & diagnostics which included a funding request via Cancer Alliance approved for £1.6m for mobile capacity to deliver Trans Perineal biopsies, cystoscopies and hysteroscopies	

	across all providers, looking to expand Independent Sector support pilot for dermatology excisions from North Devon and a host of other plans. Elective recovery plans included 4 workstreams which will focus on demand management, maximising productivity, maximising capacity and outpatient transformation. These workstreams will work to eliminate over 104 week waits as a priority and maintain this through 2022/23. The '10 week challenge' was described which runs from 10 October to 16 December 2022 where NHSE has agreed a programme of support to expedite elective recovery and will be working with Devon to produce and then deliver a comprehensive individual provider and system medium- to long-term elective recovery plan. The expectation is that the plan will be ready in draft form by 31 October 2022. There is an urgent need for the system to deliver some short-term gains and deliver a reduction in the 104 week wait position during Q3. To achieve this, four key interventions will be focused on in line with NHSE recovery plan interventions: 1. Non-admitted reductions – a focus on outpatient activity and compliance with the NHSE guidance on non-admitted validation. 2. Waiting list management, oversight and governance – forensic attention to booking, scheduling, validation and EBI removals and new choice guidance. 3. Productivity and efficiency – with support from the GIRFT team with a focus on theatres. 4. Creating capacity – day case rates, medical length of stay, going further with independent sector capacity and mutual aid. KO shared with the board as chair of the finance committee he has requested a detailed update to be presented in November following which assurance and updates can be brought to the Board. It was also requested for the report to provide assurance around whether the targets are being met or what more support is required to make that happen. LD felt the workforce issue is the biggest risk factor to the performance issues. TL reminded the board about hearts and minds and the use of the word productivity sounds very negative and can leave people feeling under valued when everyone is working extremely hard. SLG highlighted that the mental health of the patients waiting for treatment will be impacted and requested to understand what is happening to support this. JF confirmed there is work happening around supporting patients on waiting lists and acknowledged that the voluntary sector could support further with this. The presentation was noted.	
9	**NHS Devon Month 5 Finance report** The report was taken as read. JD shared that the position to month 5 includes the final reported position of the NHS Devon CCG to the 30th June 2022 and that based on the year to date position the ICB is expecting to meet its target of break even for the year. The delivery of savings and efficiencies is off plan at	

	month 5 by £3.2m, driven by a slower than expected delivery of savings linked to placements and targets associated with the recovery programme that has yet to take shape. Savings plans are forecast to deliver to target by 31st March 2023 and actions are being taken to improve the delivery going forward. It was shared that the ICB risk profile has changed from month 4 due to expected non-recurrent flexibilities resulting in net risks to delivery totaling £3m. The budget profile will be reviewed and finalised in month 6, providing a clearer picture of the ICB variances.	
10	**Integrated Care System Month 5 Finance report** The report was taken as read. JD reiterated that there is a requirement that the system achieve a breakeven position by year end. On 20th June 2022, Devon ICS submitted an operational financial deficit plan of £18.2m to NHSE. This plan recognised a significant delivery risk against the breakeven expectation which was valued at £95.9m. At the end of month 5, the risk to delivery has improved however there are still efficiency savings of £138.9m required to meet the June plan. The risks to the plan were discussed some of which are moving the right direction, but the most significant risk is falling short of the £138.9m savings. The financial recovery efforts to recover this position is still pushing through individual organisation governance processes and using the system governance processes to improve the rate of delivery from CIP programmes which is being supplemented by several additional actions at system level. KO confirmed that the finance recovery position will be the main item at the next finance committee. JH felt some of the language used within the report is a little confusing to non-finance people and requested to understand if the plan is £18.2 deficit or break even. JD responded by clarifying that the ICS's first responsibility is to deliver the £18.2 deficit plan. If there can be improvements on this that is great, however this is extremely unlikely. There was also a concern raised around primary care efficiency savings and an acknowledgement that clarity is needed on where Medicines optimisation sits as part of primary care. **Action 16 – JD to provide clarity to JH where medicines optimisation sits as part of primary care in terms of efficiency savings.**	
11	**Planning and assurance for winter** NA shared a presentation and stated that it has been an ambition for the NHS for some time to reduce inpatient stays where possible and convert those to day cases and where possible convert day cases to outpatients and for people to spend time in hospital only for the things they cannot access elsewhere. There was formal acknowledgement of the work being undertaken across the voluntary sector, social care and health system not only for their day to day work but also in supporting with the plans presented today. The presentation provided details on the challenges going into winter which included Covid numbers as well as patients with no right to reside. There are	

	significant percentage of beds occupied by people not requiring hospital treatment. A graph was shared that modelled demand again bed equivalents for each acute hospital. This showed the expected level of demand in excess of the 90% bed occupancy if there were no additional mitigations. The plans to expand the capacity for winter were shared and consist of funding for 310 bed equivalents, or in some cases to manage patients differently avoiding the need to be in hospital, across Devon of £23.919m. part of this funding (£5.069m) has been ringfenced to support the ambulance waits for Plymouth but the remaining funds will be used for; 1. Acute Escalation Beds + Flow capacity £6m 2. Extended Virtual Ward £2m 3. Enhanced Discharge capacity £8.85m 4. Mental Health Capacity £1m 5. NHS 111 and other services £0.916m The modelling presented evidence that the peak of the bed gap was expected in November when demand is high but not all mitigation would be in place. With the planned mitigation in place this is expected to reduce the bed gap to relatively low levels by March 2023. Several immediate actions were shared with the Board which consisted of encouraging the public to take up the flu vaccination and Covid booster, this will offer protection to the people of Devon and for the staff to reduce the staff absence pressures. There has been an expansion of the ambulance catchment area for Royal Devon United Hospitals Trust for a short time to reduce some of the pressure seen in the acute. It was confirmed that the winter capacity funding had been allocated on the assumption that the funding will be made recurrent from 23/24. It is currently not confirmed whether the funding is recurrent and if it is recurrent whether this represents part year or full year recurrency. It was confirmed that clarification is expected when 2023/24 allocations are received in December 2022.	
12	**Workforce challenges** PR shared a presentation which highlighted the challenging time for the NHS workforce. *Pay and Pensions* The NHS pay award has not been accepted by any of the unions and the RCN has already balloted for industrial action which is likely to be in November. Other unions will follow suit. PR and the trust EPRR leads are working on a plan to ensure essential services continue to run during this time much like Christmas day plans. The plans will include what procedures may need to be stood down, all of which will have huge impact on already incredibly fragile services. There have also been some legitimate reforms to the pension scheme having an effect on staff where there are mandated changes which see people on lower bands being asked to contribute more to their pensions and the higher paid paying less. *Cost of Living*	

	There is a lot of work happening to look after colleagues where possible. Mileage rates have been increased for the rest of the financial year to ensure staff are not subsidising business travel, some trusts have negotiated a higher discounted rate on Stagecoach for travel to work requirements, there are signposting to intranet sites which include staff discounts, free financial advice and guidance as well as signposting to food banks where required. There is mixed economy around the trusts for car parking which is being reviewed as part of supporting our colleagues. PR has been working with staff partnership forums to identify any other areas we can support with. There has been an increase (from 2% to 4% over the year) of colleagues leaving who have indicated the financial package has played a part in making the decision to leave. JH requested to understand the use of foodbanks. It was confirmed that staff are needing to use foodbanks and trusts are sign posting where applicable. There were suggestions from members of the board in relation to ensuring non payroll support such as parking, and childcare is worked through with partners to ensure there is equity for staff. It was also highlighted that staff will also want to leave when they do the same thing over and over and a suggestion to focus on staff re-training as statistics have shown that 80% of general care can be provided by specialist staff so if the training was available which would also increase staff morale this would support many areas of work. It was also felt that staff wellbeing should be at the centre of any review into staff retention. TH asked if there was an opportunity to provide the leftover food from Trusts to staff who are in need. PR will look into the possibility of this as an option. SW asked if there could be something set up to spot individuals who are thinking about leaving an organisation to be able to discuss different options. PR confirmed that conversations have happened to see how a system where staff can request to move roles could be developed. FOK confirmed the staff pressures in primary care is immense and has never been so high. The retention of staff is the key concern. The board requested updates on the ongoing workforce challenges. **Action 17 – JHo to add workforce challenges updates to the forward planner**	
13	**Better care fund** ST shared that the Better Care Fund (BCF) was introduced in June 2013 and is a mandated policy to facilitate integration between health and social care and to combine funds for joint commissioning to enable people to stay well, safe and independent at home for longer and provide the right care in the right place at the right time. At the time of its inception there was already a lot of integration in place across the system, which gave a good basis to work from. The report being presented to the board is the 2022/23 plan which was required to be submitted to NHSE in December 2022. The process for the plan is to be signed off by the Health and Wellbeing Boards (HWB) and the ICB. The plan is	

	then submitted to NHSE who reviews and provides feedback. The NHS Devon board is required to sign off the final version of the plan in December. The board acknowledged the timeframes are not ideal given the plan is being signed off 9 months into the inception of the ICB and that this should be fed back to NHSE. It was confirmed that Devon County Council's BCF is £116.749m, Plymouth City Council is £37.8m and Torbay Council is £24.086m. Within the fund there is a separate line of protected adult social care fund which is for Devon is £15.896m, Plymouth £13.2m and for Torbay there is not a separate line due to the arrangement with the integrated care organisation. There is a recommendation to the board that the governance arrangements for the BCF would benefit from an internal audit review. There is also an evaluation underway around the services that are paid for by the BCF. JH highlighted the importance of this work and requested to understand if the plans are addressing the priorities the board are concerned with and if they are good value for money. ST confirmed this was one of the reasons for the recommendation of an internal audit. It was shared that the board could not be given assurance that all services are value for money. JM confirmed that the plans have also been through ICS Executives and the Plymouth had a peer review process of their BCF plan on 27 September 2022. AC felt there would be benefit from sharing the learning from the assurance review in Plymouth. **Action 18 – ST and AC to work together to share learning of the Plymouth peer review of the BCF** KO felt there is not enough information to endorse the plans, but they can be noted. Further work is needed to include a value for money element, workforce integration, the drive for health inequalities, visibility of where the money is being spent and the impact of the plans. KO was on the view that regardless of the NHSE requirement to submit the plans by December of the year to which they relate, the ICB should endeavor to sign them off much earlier in the financial year and preferably at the same time as we approve the main operating plan for the year. FOK agreed there was not enough information to endorse the plan and felt there remains concerns that the system working may not be working as a whole in line with the board objectives. JMc shared that as chair of the Devon Health and Wellbeing Board a review into these plans would be welcome to support with further integration. ST felt it would be difficult to pull back from where the plans are, given it is 6 months into the year where the money is already being invested and services provided. It was confirmed that he monetary values of the BCF before the financial year starts. There could be a commitment to ensure the services and funds are evaluated and reported back to board before the financial plans are drawn for 2023/24.	

	SW clarified that no services would come to an end if the board were not to endorse the plans. JD supports the review of the services supported by the BCF. There is the need to look as the now picture and ask if the money supporting the best value services for the health and social care divide rather than taking the approach that the services are not value for money. KO felt that there should be the same level of scrutiny of the £177m BCF as there is of the contracts with the Devon providers and that this should include an evaluation of value for money, quality outcomes and productivity. He also asked that the plans be scrutinised for the planned impact on health equity in Devon, prior to the Board approving them. SLG highlighted the organisations will need the time to get the qualitative information needed. **Action 19 – ST to liaise with regional colleagues to provide feedback of the inappropriate timelines for developing and implementing the BCF plans and inform that the plans from our organisation will be submitted at a later date to ensure these are in line with the Devon operational plan.** **Action 20 – ST work with locality leads and acute leads to ensure there is appropriate information available to the board ahead of the monies being allocated for 2023/24 for the BCFs.** JH felt that the board could support the submission of the plans to NHSE with a covering note that as a new organisation the ICB will undertake a detailed review of BCF prior to the next financial year. The board were in agreement with this.	The board **endorsed** the plans and recommended an internal audit review
14	**One Devon Operating Model** ST introduced the codesigned model which will be iterated over time. The key theme of the organisation is to learn by doing which will be the case for the model given the architecture is still maturing. The four statutory duties of One Devon were reiterated, improving outcomes in population health and healthcare, tackling inequalities in outcomes, experience and access and enhancing productivity and value for money and helping the NHS support wider social and economic development. The Devon values to which the operating model has been built were shared, putting Devon's people first, trusting each other and working as one system, making the best use of the Devon pound, expanding the scope of collaboration, and driving innovation. The presentation included architecture of One Devon as well as NHS Devon and the role of the strategic commissioner. The commissioning cycle was highlighted to remind the board of the duties of a commissioner which is one of the key duties. It was also highlighted that the process for resolving disputes will be at the ICB board. ST confirmed that once the model has been approved it will be presented to NHS provider boards and the implementation plan will also be brought back to the board for review. TC shared that the overriding feedback from system colleagues is that they would like to move from co-design into adoption so the design can continue to be improved.	

	SW expressed thanks to the coproduction of the model which has been an excellent example of collaborative working. It was highlighted again this is a 'living document' and will be iterative. **Action 21 -ST to present the One Devon Operating model implementation plan to the board when developed.** **Action 22 – JHo to add One Devon Operating Model Implementation plan to the forward planner**	The board **approved** the proposed Devon Operating Model as a 'work in progress' document
15	**ICB Priorities/strategic objectives** AM shared the objectives which have been refined following feedback at the last meeting. This included two options, both similar but with finite differences. The objectives have been simplified to ensure board agendas and committee agendas can be set using the objectives. The objectives will also form part of the board assurance framework and risk management of the organisation. SW reiterated that this will not be set in stone and the integrated care plan will drive our objectives. JM shared that the ask from chief executives has been to reduce the number of objectives and there have been discussions around how collective resources can be put into place. LD confirmed a framework to make collective decisions will be key so that we know how to use the objectives to make decisions as to where the focus is. Following detailed review of wording the board approved option 1 presented to the board but with the enablers included from option 2. SLG asked that the mental health section be strengthened to read 'particularly' mental health. LD felt the objectives would be a communication tool which will be used to frame conversations and work. NA felt the board should think about horizon setting to ensure we are setting the bar high enough. FOK suggested using the objectives to review the better care fund.	The board **approved** the objectives with the discussed amendment being made
16	**Assurance Committee updates and escalations** All reports were taken as read. SW suggested escalations from committees are captured to ensure these are discussed. The chairs will support to update the capture log. *Audit and Risk Committee* No escalations *Primary Care Transition Committee* No escalations. *People and Culture Committee* Innovation, workforce plan and growing our own will be worked on the next 3 months. *Quality and Performance Committee* Escalation of ambulance handover and transfer risk. The action recommended is consideration by the executive team to provide assurance there are actions in place to work and how these will be monitors.	

	Finance Committee Escalation of the financial plan. *Remuneration and Strategic Workforce Committee* NHS Staff survey has commenced and highlighted freedom to speak up (FTSU) month. Board members have been asked to make pledges. The FTSU team have requested a board session. SW shared that KO is the non-exec for FTSU. **Action 23 – JHo to add a freedom to speak up session to the forward planner**	
	Action log The actions and updates were reviewed. The actions requested to be closed were agreed. ST provided an update on action 7 which Kelvin Grabham is working to refine the data for adult social care to ensure the usefulness. **Actions closed – 1, 2, 4, 5, 8, 9 and 10**	
	Public Questions SW confirmed that the questions submitted were very detailed and will be provided with full responses. Mr Beresford, who was present in the meeting had submitted a number of operational question of the organisation and board which were responded to. It was shared that as one of the questions from Mr Beresford was in relation to one of the provider hospitals a full response would be provided directly from the trust. The meeting closed at 12.45. The next meeting of the board will be 16 November.	

Minutes approved	Date:	Signed by chair:

Members (attended** / apologies [A])	
Name and initials	*Title and organisation*
Andrew Millward (AM)**	Chief Communications and Corporate Affairs Officer, NHS Devon
Darryn Allcorn (DA)**	Chief Nursing Officer, NHS Devon
Frank O'Kelly (FOK)**	Primary Care Representative, NHS Devon
Graham Clarke (GC) [A]	Non-Executive Director, Audit and Risk, NHS Devon
Hisham Khalil (HK)**	Non-Executive Director, Quality and Performance, NHS Devon
Cllr James McInnes (JMc)**	Co-Chair Devon Integrated Care Partnership
Jane Milligan (JM)**	Chief Executive Officer and Accountable Officer, NHS Devon
John Dowell (JD) **	Chief Finance Officer, NHS Devon
Judy Hargadon (JH)**	Non-Executive Director, Primary Care, NHS Devon
Kate Shields (KS) **	Chief Executive Officer, Cornwall and Isles of Scilly ICB
Kevin Orford (KO)**	Non-Executive Director, Finance and Remuneration, NHS Devon

Liz Davenport (LD)**	Chief Executive Officer, Torbay and South Devon NHS Trust
Nigel Acheson (NA)**	Chief Medical Officer, NHS Devon
Paul Renshaw (PR)**	Director of Strategic Workforce, NHS Devon
Sarah-Lou Glover (SLG) **	Mental Health Representative, NHS Devon
Dr Sarah Wollaston (SW) Chair**	Independent Chair, NHS Devon
Sheena Asthana (SA) A	Non-Executive Director,
Simon Tapley (ST) **	Chief Transformation & Strategic Planning Officer, NHS Devon
Steve Brown (SB)**	Director of Public Health, Devon County Council
Thandiwe Hara (TH)**	Non-Executive Director, People and Culture, NHS Devon
Tracey Lee (TL)**	Director of Public Health, Plymouth City Council
Attendees	
Ginny Snaith (GS) **	Board Secretary, NHS Devon
Jodie Howland (JHo)** Minutes	Governance and Facilities Business Manager, NHS Devon
Helen Braid (HB)**	Head of Governance, NHS Devon
Tracey Cottam (TC)** items 13 and 14 only	ICB Organisational Development Programme Director
Warwick Heale (WH)** items 13 and 14 only	ICS Development Director
Anna Coles (AC)** item 13 only	Western Locality Director
Rebecca Harty (EH)** item 13 only	Deputy Eastern Locality Director
Derek Blackford (DB)** item 13 only	Southern Locality Director
John Finn (JF)** for item 8 only	Director of Commissioning Urgent & Elective Care
Guests	
Sanita Simedree** for item 2 only	Chair of the Devon wide Ethnic Equality Network
Mr Andrew Beresford**	Member of the Public
Minutes approved | Date:	Signed by chair: