NHS Devon Integrated Care Board (ICB) Meeting

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

29 May 2025

09.30 – 11.30

One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Agenda for meeting in public

The quorum for meetings of the Board is:
a) Chair or Vice Chair
b) At least two Executive Directors
c) At least two additional independent members
d) At least one Partner Member
e) At least one of the members must be a registered clinician.

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1.		Introductory Items	Lead	Action	Time
1.1	ICB25 -001	Welcome, introduction and apologies for absence	Kevin Orford, Chair	Discussion	09:30
1.2	ICB25 -002	Declarations of interest	Kevin Orford, Chair	Information	
1.3	ICB25 -003	Minutes of the meeting held on 27 March 2025	Kevin Orford, Chair	Approval	
1.4	ICB25 -004	Action Register	Kevin Orford, Chair	Approval	09:35
2.		**Leadership Reports**	**Lead**	**Action**	**Time**
2.1	ICB25 -005	Chair's Report	Kevin Orford, Chair	Information	09:55
2.2	ICB25 -006	Chief Executive's Report	Steve Moore, Chief Executive	Information	10:15
3.		**National Oversight Framework Segment 4**	**Lead**	**Action**	**Time**
3.1	ICB25 -007	Progress on the Requirements of the NHS Oversight Framework – Segment 4	Libby Ryan Davies, Chief Strategic Commissioning and Planning Officer & Deputy CEO	Assurance	10.25
3.2	ICB25-008	Self assessment of performance against key NOF measures	Philippa Harding, Director of Governance and Interim Communications and Corporate Affairs Officer	Assurance	10.35
4.		**Discharging NHS Devon's responsibilities in 2025/26**	**Lead**	**Action**	**Time**
4.1	ICB25 -009	Delivery of the 2025/26 NHS Devon Operational Plan	Libby Ryan Davies, Chief Strategic Commissioning and Planning Officer & Deputy CEO	Assurance	10.55
4.2	ICB25 -010	Annual Plan 2025/26 Next Steps	Libby Ryan Davies, Chief Strategic Commissioning and Planning Officer &	Assurance	11.15

			Deputy CEO		
4.3	ICB25 -011	Developing NHS Devon's Health Care Strategy	Libby Ryan Davies, Chief Strategic Commissioning and Planning Officer & Deputy CEO	Assurance	11.30
4.4	ICB25 -012	Consolidation of Primary Percutaneous Coronary Intervention Services in Devon	Peter Collins, Chief Medical Officer Libby Ryan Davies, Chief Strategic Commissioning and Planning Officer & Deputy CEO	Approval	11.45
		BREAK			**12.05**

5.		**Governance, Performance and Assurance Reports**	**Lead**	**Action**	**Time**
5.1	ICB25 -013	Board Assurance Framework	Philippa Harding, Director of Governance	Assurance	12.15
5.2	ICB25 -014	NHS Devon 2024/25 Annual Plan – Delivery Assurance Close Down Report	Libby Ryan-Davies, Chief Strategic Commissioning and Planning Officer & Deputy CEO	Assurance	12.30
5.3	ICB25 -015	Mental Health Assertive and Intensive Outreach Action Plan Update	Peter Collins, Chief Medical Officer	Assurance	12.40
5.3	ICB25 -016	Finance Reports – Month 12 i. NHS Devon Finance Report ii. One Devon Finance Report	Kirsty Denwood, Interim Chief Finance Officer	Assurance	12.50
6.		**Committee Chair Reports**	**Lead**	**Action**	**Time**
6.1	ICB25 -017	Chair's Report: Finance and Performance Committee – 10 April and 08 May 2025	Kaye Bentley, Independent Non-Executive Member	Assurance	13.00
6.2	ICB25 -018	People and Organisational Development Committee – 09 April 2025	Salma Ali, Independent Non-Executive Member	Assurance	13.05
6.3	ICB25 -019	Quality and Patient Experience Committee – 10 April 2025	Thandiwe Hara, Independent Non-Executive Member	Assurance	13.10
6.4	ICB25 -020	Audit and Risk Committee – 06 May 2025	Graham Clarke, Independent Non-Executive Member	Assurance	13.15
6.5	ICB25 -021	Population Health Improvement Committee – 07 May 2025	Lopa Patel, Independent Non-Executive Member	Assurance	13.20

7.		Closing Items	Lead	Action	Time
7.1	ICB25-022	Questions from Members of the Public	Kevin Orford, Chair	Discussion	13.35
7.2	ICB25-023	Any Other Business	Kevin Orford, Chair	Discussion	13.45
		Close			**14.00**

NHS Devon Integrated Care Board Register of Interest - 29 May 2025

Employee	Role	Interest Type	Active / Date Ended	Interest Description	Interest Category	Mitigating Actions
Kevin Orford	Chair, NHS Devon	Declaration of Interest	Active	Advisor to the Board of Parental Minds C.I.C. (non-remunerated)	Non-Financial Professional	Should there be any issue relating to Parental Minds, there will be a discussion with the Director of Governance and the Chief Executive to ensure that no conflict of interest ensues.
Allison Williams	Contractor (part of SOF4 Mandated support via NHSE Intensive Support Team)	Nil Declaration	Active	N/A	N/A	N/A
Donna Manson	Local Authority Partner Member	Declaration of Interest	Active	CEO Of Devon County Council	Financial	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.
Francis O'Kelly	Primary Medical Services Partner Member	Declaration of Interest	Active	GP Partner at Amicus Health Group. As well as providing the full range of Primary Care Services the practice is also a provider of Surgical Services (dermatology, carpal tunnel, vasectomies and minor ops) and Dermatology Services. Part of the merged practice is also dispensing.	Financial	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
				Blundell's School Lead Doctor	Financial	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
				Member of the National Armed Forces Reference Group	Non-Financial Professional	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
				Attends Tiverton High School Welfare Meeting fortnightly	Non-Financial Professional	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
				Contributor to FASD Forum	Non-Financial Professional	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
				5 adopted children, 2 with recognised learning difficulties both recieving PIP and with residential or supported living in Devon	Financial	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
				Wife is a book-keeper for STEER Eduction	Financial	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
				I attend a monthly online meeting of Primary Care Partner Members, which is organised and Chaired by the NHS Confederation	Non-Financial Professional	Will be declare on Conflict of Interests at meetings.

NHS Devon Integrated Care Board Register of Interest - 29 May 2025

Employee	Role	Interest Type	Active / Date Ended	Interest Description	Interest Category	Mitigating Actions
				My GP practice (Amicus Health) merged with the Mid Devon Medical Practice on 1.10.24 - Dr. Alex Degan (Medical Director for Primary Care at NHS Devon) is a partner in Mid Devon Medical Practice	Indirect	I have declared the business of Amicus Health Group and will declare it at the start of any meeting where a conflict arises
				member of the SW People Board	Non-Financial Professional	To be managed in line with the conflicts of interest policy
				Son is being assessed for Continuing Healthcare.	Financial	Conflict will be managed in line with the Conflict of Interest Policy and advise from the Governance Team. 5.5.25 - I am not certain of the exact date but this is no longer happening.
				Amicus Health of which I am a partner, employs General Practitioners with a Special Interest (GPSI) in both dermatology and surgery. We provide dermatology and surgery services in the community and employ additional GPSIs in both these services. We have GP registrars who are doing specialist modules in the practice in both these specialties.	Non-Financial Professional	To be managed in line with the Conflict of Interest Policy and guidance from the Governance Team
Graham Clarke	Independent Non-Executive Member	Declaration of Interest	Active	Non-Executive Director of Medicine Discovery Catapult	Financial	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.
				Non Execuitve Member at the Deparment of Health & Social Care	Financial	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.
				Trustee and Treasurer of the Cornwall Community Foundation	Non-Financial Professional	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.
				Spouse is CEO of Cornwall Partnership Foundation Trust	Indirect	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.

NHS Devon Integrated Care Board Register of Interest - 29 May 2025

Employee	Role	Interest Type	Active / Date Ended	Interest Description	Interest Category	Mitigating Actions
				Spouse is a Board Member of Cornwall & Isles of Scilly ICB	Indirect	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.
				Member, Institute of Cancer Research. It is a both a charity and a college within London University with Membership (c 50 in total).	Non-Financial Professional	To be managed in line with the Standards of Business Conduct Policy.
Helen Braid	Governance & Assurance Manager and Board Secretary	Nil Declaration	Active	N/A	N/A	N/A
John Finn	Acting Chief Operating Officer	Nil Declaration	Active	N/A	N/A	N/A
Kate Shields	Chief Executive Officer, Cornwall and Isles of Scilly ICB	Nil Declaration	Active	N/A	N/A	N/A
Kaye Bentley	Independent Non-Executive Member	Declaration of Interest	Active	Provision of consultancy and advice services to the NHS via KB consulting, a sole trader	Financial	Each assignment to be considered on a case by case basis to ensure there are no conflicts of interest with Devon INEM role. No work will be undertaken in the Devon system
				Independent Chair of the South West specialised services committee. Payment via Somerset ICB to KB consulting	Financial	Committee members representing the 7 ICBs in the South West and NHSE representatives on the committee have considered and agreed there is no conflict as the Chair is not a voting member of the committee.
				Trustee of The Budleigh Salterton Hospital League of Friends, also known as the Budleigh Fund	Non-Financial Personal	Remove from any decision making involving the Budleigh Fund or Seachange.
				Working with the NHSE national finance team on a fixed term contract providing support to the NHS financial reset	Financial	To be managed in line with the Conflict of Interest Policy and Governance advice.
Kirsty Denwood	Interim Chief Finance Officer	Nil Declaration	Active	N/A	N/A	N/A
Libby Ryan-Davies	Chief Strategic Commissioning and Planning Officer	Nil Declaration	Active	N/A	N/A	N/A
Lincoln Sargeant	Local Authority Partner Member	Nil Declaration	Active	N/A	N/A	N/A
Lopa Patel	Independent Non-Executive Member	Declaration of Interest	Active	My daughter is undertaking a research-based PhD funded by AstraZeneca PLC, a supplier to the healthcare sector.	Indirect	Will seek advice from the Chair / step out of the room if there are commissioning decisions related to AstraZeneca PLC
				Currently there are 12 members of my family, including my sister, nephews and nieces who work as doctors, dentists and pharmacists in the NHS, although none currently in the NHS Devon ICB commissioning region.	Indirect	Will seek the advice from the Chair and declare any direct interests if they arise.

NHS Devon Integrated Care Board Register of Interest - 29 May 2025

Employee	Role	Interest Type	Active / Date Ended	Interest Description	Interest Category	Mitigating Actions
				Currently Chair of equality charity, Diversity UK which is focusing on addressing inequalities, particularly for women and ethnic minorities. As a charity, Diversity UK, may receive donations from companies, organisation or individuals to help it deliver its mission. Donations are declared as per Charity Commission guidelines.	Financial	Will seek the advice from the Chair and declare any direct interests if they arise.
				Board Member, Enterprising Women Programme at Murray Edwards College, University of Cambridge. The programme is sponsored by a number of companies, philanthropists and private donors including AstraZeneca UK, C Hoare & Co Private Bank, Innovate UK and others. The purpose of the programme is to create spin-outs from the University of Cambridge created by female postgraduates, researchers and staff. The programme currently does not accept under-graduates but this may change in the future.	Non-Financial Professional	I will excuse myself from any discussions related to the NHS or NHS Devon.
				I have been a judge for the The King's Awards for Enterprise Innovation Panel since 27 November 2017. This work is carried out with The King's Awards Office, part of the Department for Business & Trade (DBT) under a confidentiality agreement with recommendations from the innovation panel being put forward to the Prime Minister's Advisory Committee. However, I have recently been asked to promote the awards on social media with text and video clips. I have also previously been asked by DSIT/DBT & the Lord Lieutenancy to take part in online and in-person events to promote the awards.	Non-Financial Professional	Although I do not foresee any conflict of interest, there may be business applicants from the Devon area for whom I may have to declare an interest at panel (if they are a supplier to NHS Devon ICB) to ensure impartiality at the judging stage.
Mark Cooke	Managing Director (Strategy, Oversight & Regulation)	Declaration of Interest	Active	Non paid Director National Centre for Rural Health and Care	Non-Financial Professional	Declare when necessary
				Director non-paid Bristol City Robins Foundation	Non-Financial Professional	Declaration when appropraite
				Director/trustee Quantock Education Trust	Non-Financial Personal	Declare when appropriate
Mary Aspinall	Health and Wellbeing Chair - Plymouth	Declaration of Interest	Active	Elected member of Plymouth City Council and Chair of The Plymouth Health and Wellbeing Board	Financial	To be managed in line with the Conflict of Interest Policy and Governance advice.
Penny Smith	Chief Nursing Officer	Nil Declaration	Active	N/A	N/A	N/A
Peter Collins	Chief Medical Officer	Declaration of Interest	Active	Trustee for Orchestras Live (charity promoting widening participation and community engagement within the orchestral sector)	Non-Financial Personal	To be managed in line with the Conflicts of Interest Policy

NHS Devon Integrated Care Board Register of Interest - 29 May 2025

Employee	Role	Interest Type	Active / Date Ended	Interest Description	Interest Category	Mitigating Actions
Philippa Harding	Director of Governance	Declaration of Interest	Active	Founding Director of Harding Advisory Ltd, a professional services company providing corporate governance expertise.	Financial	The company is currently dormant. Should any conflicts relating to NHS Devon be identified they will be managed as they arise in line with the NHS Devon Standards of Business Conduct Policy
Phillip Mantay	Mental Health Partner Member	Declaration of Interest	Active	Employed as Chief Executive Officer of Devon Partnership Trust since June 2024	Financial	Declaration of relationship prior to offering opinion or recommendation.
				Children and Family Health Devon delivered services for Devon Partnership NHS Trust of which I am Chief Executive Officer	Financial	To be managed in line with the conflict of interest policy and guidance from Corporate governance
Piers Tetley	Chief People Officer	Nil Declaration	Active	N/A	N/A	N/A
Salma Ali	Independent Non-Executive Member	Declaration of Interest	Active	Non- Executive Director for Birmingham Community Health Care Foundation Trust.	Financial	To be managed in line with the Conflict of Interest Policy and Corporate Governance advice
				Director- SKSN Consultancy & Advice which supports the NHS with bespoke pieces of work. The company is currently dormant. It did not trade during 2024/25 and there are now plans for it to do so now or going forward.	Financial	To be managed in line with the Conflict of Interest Policy and Corporate Governance guidance.
				Trustee of Black County Women's Aid with no Executive responsibilities..	Non-Financial Professional	To be managed in line with the Conflict of Interest Policy and Corporate Governance guidance.
Sam Higginson	NHS Trust and Foundation Trusts Partner Member	Declaration of Interest	Active	Chair of Enfield Unity Primary Care Network	Non-Financial Professional	To be managed in line with the Standards of Business Conduct and Conflicts of Interest Policies
				Chief Executive Officer, Royal Devon University Healthcare NHS Foundation Trust	Financial	To be managed in line with the Standards of Business Conduct and Conflicts of Interest Policies.
Steve Moore	Chief Executive Officer	Nil Declaration	Active	N/A	N/A	N/A
Thandiwe Hara	Independent Non-Executive Member	Declaration of Interest	Active	Trustee of Plymouth and District Racial Equality Council, a voluntary organisation that work to promote race equality.	Financial	There should be no conflict of interest in current circumstances, but this may arise if, they became a provider during the course of time. I will declare my interest at any meeting that may result in them being considered for service provision and leave
				Member on the NIHR SW Clinical Research Network Board.	Financial	There should be no conflict of interest in current circumstances, but this may arise if, they became a provider during the course of time. I will declare my interest at any meeting that may result in them being considered for service provision and leave

DRAFT Minutes of a meeting of NHS Devon Integrated Care Board held in public at the Boardroom, Aperture House, Pynes Hill, Exeter, EX2 5AZ and via Microsoft Teams on Thursday 27 March 2025 between 09:30 and 13:30	
Name	*Title and organisation*
Board Members:	
Kevin Orford	Chair, NHS Devon
Steve Moore	Chief Executive Officer, NHS Devon
Salma Ali	Independent Non-Executive Member, NHS Devon
Kaye Bentley	Independent Non-Executive Member, NHS Devon
Graham Clarke	Non-Executive Member, Audit and Risk, NHS Devon
Dr Peter Collins	Chief Medical Officer, NHS Devon
Kirsty Denwood	Interim Chief Finance Officer, NHS Devon
Dr Thandiwe Hara	Non-Executive Member, Citizen and Community Involvement, NHS Devon
Judy Hargadon	Non-Executive Member, Primary Care, NHS Devon
Sam Higginson	Partner Member for NHS Trusts and Foundation Trusts, Chief Executive of Royal Devon University Healthcare NHS Foundation Trust
Phill Mantay	Partner Member for Mental Health, Chief Executive, Devon Partnership NHS Trust
Dr Frank O'Kelly	Partner Member for Primary Medical Services Providers, Amicus Health
Lopa Patel	Independent Non-Executive Member, NHS Devon
Penny Smith	Chief Nursing Officer, NHS Devon
Martin Sykes	Interim Non-Executive Member, NHS Devon
Also in attendance:	
Councillor Mary Aspinall	Chair, One Devon Integrated Care Partnership
Nicola Bonas	Deputy Director of Communications and Engagement, NHS Devon (Items 1.5 and 1.6)
Helen Braid	Governance and Assurance Manager, NHS Devon
Philippa Harding	Director of Governance and Interim Chief Communications & Corporate Affairs Officer, NHS Devon
Louise Higgins	Locality Director (North and East), NHS Devon
Sarah Lonton	Operational Lead, Healthwatch (Items 1.5 and 1.6)
Libby Ryan-Davies	Transformation Director
Richard Schofield	Director of System Co-Ordination, NHS England South West
Kate Shields	Chief Executive Officer, NHS Cornwall and the Isles of Scilly
Piers Tetley	Chief People Officer, NHS Devon
Sam Wadham-Sharpe	Winter Director and Director of Performance
Allison Williams	System Recovery Director, NHS England
Apologies for absence	
Mark Cooke	Managing Director (Strategy, Oversight & Regulation), NHS England South West
John Finn	Acting Chief Operating Officer, NHS Devon
Dr Lincoln Sargeant	Partner Member, Local Authorities (Population Health and Prevention), Director of Public Health, Torbay

Item	Ref	Discussion
1.		**Introductory Items**
1.1	ICB24 - 118	**Welcome, Introductions and Apologies** The Chair welcomed Board members to the meeting. It was noted that apologies for absence had been received from John Finn, Lincoln Sargeant and Mark Cooke. The three newly appointed Independent Non-Executive Members, Salma Ali, Kaye Bentley and Lopa Patel were welcomed to their first Board meeting in public. Welcomes were extended to Louise Higgins, Locality Director (North and East) deputising for John Finn, and Richard Schofield, Director of System Co-Ordination, NHS England South West, who was deputising for Mark Cooke and also to Sarah Lonton, Operational Lead, Healthwatch and Nicola Bonas, Deputy Director of Communications and Engagement.
1.2	ICB24 - 119	**Declarations of Interest** The Chair informed the meeting that a declaration of interest for Richard Schofield was not included in the Register of Interests circulated with the agenda, but that since its publication a nil declaration had been received. Kaye Bentley highlighted her interest in agenda item 4.3 as she held the position of Chair of the South West Joint Specialised Services Commissioning Committee. The Board **noted** the Register of Interests.
1.3	ICB24 - 120	**Minutes of Previous Meeting** The Chair referred the meeting to a comment that had been received regarding the accuracy of the minutes from Dr Imraan Jhetam who had submitted a question to the January meeting. Since that time Dr Jhetam had been in correspondence with the Chief Medical Officer and within his most recent letter there was an assertion that his question was not raised at the meeting or recorded in the minutes. The Chair drew the attention of members to section 8.1 of the minutes which provided an overview of the question and the response to it. A written response had also been provided to Dr Jhetam. The minutes of the meeting in public held on 30 January 2025 were **approved** as a correct record.
1.4	ICB24 –121	**Action Register** The Board: • **Agreed** the closure of actions 69, ICB24-009, 038, 091 and 102ii • **Noted** the updates in respect of actions ICB24-1-2i and 111.
1.5	ICB24 –122	**Our People and Communities: Experiences of Health and Social Care** Sarah Lonton, Operational Lead, Healthwatch, provided the Board with a presentation on the manner in which Healthwatch and NHS Devon worked together. She emphasised the benefits of joint working, referencing in particular recent engagement activities in support of the development of the NHS 10-Year Plan. 50 engagement workshops had been delivered across the One Devon integrated care System, which was approximately 10% of the total delivered across England and Wales.

		The presentation also provided a flavour of the messages received from members of communities across Devon. In consideration of the presentation, the following points were highlighted: • It would be beneficial if the information gathered through the NHS 10-Year Plan engagement could be profiled to see how reflective it was of Devon's socio-economic demographics. • Public involvement should be seen as the glue that can bind services together, through a systemised way of finding out what matters and happens to people. • The partnership between NHS Devon and Healthwatch was extremely valuable and needed to be nurtured for the future. The continuous engagement that this relationship facilitated would be key to ensuring that the NHS was guided properly through challenging times ahead. The Board **noted** the presentation.
1.6	ICB24-123	**People and Communities Framework** Deputy Director of Communications and Engagement, Nicola Bonas, introduced the report which proposed the adoption of a new People and Communities Framework which articulated a consistent approach to genuinely inclusive engagement, with better alignment across health and care services in Devon. It was the first time that action had been taken to establish a means of sharing the outcomes of engagement activities across the One Devon Integrated Care System, which would enable a better understanding of consistent themes arising from these activities. Board members commended the Communications and Engagement team on Framework. The following points were highlighted in discussion of the item: • It was important that there was clarity about how the information gathered was being used – members of the public became frustrated if they considered that they were providing information that wasn't being used. It was envisaged that this would initially be achieved through the production of a report which would set out how various pieces of work were being used. • Consideration would need to be given to how to ensure that the Devon Engagement Partnership (DEP) was as reflective as possible of Devon communities over time. It was acknowledged that the membership of the DEP needed to become wider, but initially it was considered that chances of success would be much higher with a smaller group that could be expanded over time. Consideration was already being given to the inclusion of Local Authorities. • Whilst it was appropriate that information about public involvement was provided to the Population Health Improvement Committee for assurance, it was noted that there were connections between public involvement and patient experience, in which case consideration might need to be given to sharing this information with the Quality and patient Experience Committee. It was confirmed that there was close working between the Communications and Engagement team and the Patient Experience team. • It was noted that a number of NHS providers already had online platforms to gather information about patient experience and engage patients on key issues. Consideration should be given to whether it was possible to "piggyback" on these platforms. As there was a provider member of the DEP, this was something that would be worked through in due course. The Board: • **Approved** the People and Communities Framework.

		• **Took satisfactory assurance** from the development of the Devon Engagement Partnership and the intention to embed the approach into the governance of NHS Devon. • **Noted** the approach to the 10 Year Plan as the blueprint for effective collaboration on inclusive and meaningful engagement.
2.		**Leadership Reports**
2.1	ICB24 - 124	**Chair's Report** The Chair, Kevin Orford (KO), introduced the report and highlighted the following points: • The announcement of the disestablishment of NHS England and the requirement for significant reductions in the staffing costs of Integrated Care Boards. Further guidance was awaited to understand the detail of the requirement and the Board, staff and stakeholders would be appraised of any developments. • Thanks to Judy Hargadon and Martin Sykes whose terms of office as Independent Non-Executive Members would come to an end on 31 March 2025. • The conclusion of the of the annual review of Board roles including the appointment of Lopa Patel as Deputy Chair. • An additional recommendation that the role of Health and Wellbeing Guardian should be included within the Independent Non-Executive Member Board roles and that Salma Ali should be appointed to the role. • The appointments made under delegated authority of the Board to the Board sub-committees. The Board: • **Noted** the contents of the report. • **Approved** the proposed allocations of Board roles and responsibilities, including the appointment of Salma Ali to the role of Health and Wellbeing Guardian. • **Noted** the exercise of authorities delegated by the Board.
2.2	ICB24 - 125	**Chief Executive Officer's Report** Chief Executive Officer, Steve Moore (SM) introduced his report which provided an update on key events since the last meeting of the Board. Recent announcements relating to the future of NHS England and the requirement for significant reductions in the staffing costs of integrated care Boards meant that NHS Devon was entering a further period of uncertainty and organisational change. The Executive team had made the commitment to staff that information would be shared with them as soon as possible. Colleagues would need to support each other during this period and recognise the difficulties that all were likely to experience in focussing on delivering business as usual whilst amidst significant change. The Board **noted** the content of the report.
2.3	ICB24 - 126	**Staff Survey Results 2024** Chief People Officer, Piers Tetley (PT) introduced a report which presented the findings of the NHS Devon Staff Survey 2024, offering an overview of staff perceptions and experiences across our organisation The following points were highlighted during consideration of this item: • The detailed findings of the survey had been discussed by the people and Organisational Development Committee. It was important that consideration was given to the context which colleagues were experiencing when completing the survey and that the qualitative data was considered alongside the quantitative responses.

		• Although the organisation was required to consider further organisational change, the survey indicated that there was much to be learned about how to undertake this in a supportive way. • Now more than ever the work cultural work that had been started was even more important – the organisation had much to do to ensure that the organisational development plan was implemented appropriately. • It was noted that there was real value in undertaking more frequent, if less detailed surveys to check the "temperature" or "pulse" of the organisation. **Actions:** • Consideration to be given to the implementation of more frequent "pulse" of the organisation. The Board **noted** the content of the report and supported the next steps described.
3.		**National Oversight Framework Segment 4**
3.1	ICB24-127	**Progress on the Requirements of the NHS Oversight Framework – Segment 4** Consideration was given to the report which sought to provide the necessary assurance to the Board on the progress against the agreed criteria and metrics required to exit Segment 4 of the NHS Oversight Framework (NOF4) in Q1 of 2025/26. The report detailed the system position on the criteria for strategy, leadership, urgent and emergency care (UEC), elective care and finance recovery, accompanied by a locality position on delivery against trajectory and the key actions to either maintain or improve performance. The following points were highlighted during consideration of this item: • The question of whether the Board had satisfactory assurance in respect of elective care performance was given consideration. It was noted that the system has not met the long waiters target. It was confirmed that the NHS England Regional team was satisfied with the work that had been done in relation to this issue; however, continued focus was required to ensure that performance remained appropriate. • It was noted that the intent of the NHS Oversight Framework was to address the degree of improvement that an organisation or system had achieved, rather than focussing on binary objectives. There was a degree of tolerance with regard to the judgement of achievements and it was clear across the domains there was evidence of improvement across the 2024/25 year. • A self-assessment of performance against the requirements of the NHS Oversight Framework was being undertaken by each of the One Devon Integrated Care System organisations in NOF4. This would be presented to the Board at its meeting in May 2025. • The NHS Oversight Framework was about to be replaced. It was unclear how the organisations within the One Devon Integrated Care System would be assessed under the new Performance Assessment Framework. The Board: • **Agreed** the assurance ratings relating to achievement of each of the NOF4 exit criteria by the One Devon Integrated Care System of limited for UEC and satisfactory for all others:

Criteria	Assurance
Strategy	Satisfactory
Leadership	Satisfactory
UEC	Limited

		<table><tr><td>Elective</td><td>Satisfactory</td></tr><tr><td>Finance</td><td>Satisfactory</td></tr></table> • **Took assurance** that adequate plans were in place to mitigate the risks relating to the delivery NOF4 exit identified in Locality Planning and Delivery Meetings, and System Leadership Group.
4.		**For Approval or Endorsement**
4.1	ICB24 - 128	**NHS Devon Strategic Intent** Chief Executive Officer, Steve Moore (SM) introduced the reports which: • outlined the proposed updated 5-Year Joint Forward Plan, and approach to the development of the NHS Devon Health and Care Strategy which would form the foundation of the 5-Year Joint Forward Plan to be updated next year. • presented NHS Devon's 2025/26 Annual Plan • proposed a new approach for the Board Assurance Framework (BAF) for the 2025/26 financial year The suite of reports was recognised as a step change in the way that the Board would be working, ensuring consideration of both short and longer term plans. The following points were highlighted during consideration of this item: • Reference was made to the fact that the One Devon Integrated Care System received an allocation that was in excess of its "fair share". It was vital that the Health and Care Strategy set out a roadmap to addressing this issue. It was something that needed to be addressed both with urgency in the short term, but also in order to achieve sustainability in the longer term. • It was noted that real change to service provision would be required in order to address the strategic challenges that faced the One Devon Integrated Care System. The Health and Care Strategy would be key to ensuring that the work of providers and provider collaboratives were aligned to the requirements of the whole system. • The papers had been drafted for the Board in advance of recent national announcements about the future of Integrated Care Boards; thought would need to be given to whether the objectives set out in the 2025.26 Annual Plan remained appropriate within the new operating context. There was also a risk that the changes associated with these announcements would results in significant distractions which could delay much needed work on both in-year delivery and strategy development. • There was some concern that the resource requirements to deliver the 2025.26 Annual Plan were not as clear as they should be. It was noted that this would be addressed via the detailed review of delivery plans via the Board Assurance Committees. The Board: • **Approved** One Devon's updated 5-Year Joint Forward Plan • **Agreed** the proposal to begin rapid development of NHS Devon Health and Care Strategy which will form the foundation of the 5-Year Joint Forward Plan to be updated next year. • **Approved** NHS Devon's 2025/26 Annual Plan. • **Noted** the update provided in respect of the 2025/26 Operational Plan. • **Approved** the proposed approach to articulation of the Board Assurance Framework in 2025/26; and • **Approved** the proposed approach to the articulation of the Risk Appetite Statement for 2025/26

4.2	ICB24-129	**Review of the NHS Devon Corporate Governance Framework**
		The Director of Governance and Interim Chief Communications and Corporate Affairs Officer, Philippa Harding (PH) introduced the report which provided the NHS Devon Integrated Care Board with information about the proposed amendments to the essential documents which form the NHS Devon corporate governance framework and proposed that these documents are reviewed on an annual basis from now on.
		
		Points highlighted during consideration of this item included:
		• Following the delegation of specialised services from NHS England to NHS Devon, decisions in respect of these services would be taken collaboratively by the South West Joint Specialised Services Committee which would report through to the NHS Devon Executive.
		• The name of the Remuneration and Internal ICB Workforce Committee would be updated should the proposed amendments of the NHS Devon Constitution be approved by NHS England.
		• Discussions would take place with the Local Counter Fraud Service with regard to the compliance of the Fraud, Bribery and Corruption Policy with current legislation.
		
		On behalf of the Board, the Chair thanked the Governance team for their work in undertaking the review of the Corporate Governance Framework.
		
		The Board:
		• **Approved** the proposed amendments to the following essential documents from the NHS Devon corporate governance framework:
		  ○ NHS Devon Constitution (including Standing Orders) for onward submission to NHS England (Annex A)
		  ○ Corporate Governance Handbook (Annex B)
		  ○ Key Policies (Annex E)
		• **Approved** that no amendments should be made to the following essential documents from the NHS Devon corporate governance framework:
		  ○ Scheme of Reservation and Delegation (Annex C)
		  ○ Standing Financial Instructions (Annex D)
		• **Noted** that the Operational Scheme of Delegation had been reviewed and would be presented to the NHS Devon Executive for approval at its meeting on 01 April 2025.
		• **Approved** the proposed amendments to the terms of reference of the Board's Committees and Committee membership in 2025/26 (Annex F)
		• **Took satisfactory assurance** from the progress made against the Governance Improvement Plan in 2024/25
		• **Approved** the Governance Improvement Plan for 2025/26 (Annex G)
		• **Noted** the proposed Terms of Reference for the NHS Devon Commissioning Group and **took assurance** from the information provided with regard to how the functions previously discharged by the Primary Care Commissioning Transition Committee will be fulfilled via Executive structures in the future. (Annex H).
		• **Agreed** that authority to make any detailed amendments to the Corporate Governance Framework is delegated to the appropriate Committee.

4.3	ICB24-130	**Specialised Commissioning – delegation arrangements** Locality Director (North and East), Louise Higgins, provided an update on the progress and delivery of the specialised services delegation programme, and sought Board approval of the arrangements supporting the delegation of commissioning responsibilities to Integrated Care Boards (ICBs) with effect from 01 April 2025 The following points were highlighted during consideration of this item: • Whilst ICBs were taking on responsibility for specialised commissioning, accountability for it remained with NHS England – it was possible that this

		arrangement may change in light of recent announcements about the future of NHS England and ICBs; however, it was important that the Board acted on what it knew, rather than on speculation about the future. • In the future it would be useful to have a discussion about where specialised services were not provided well in the South West, in order to understand how to better commission these. This would be a key lever for ICBs to be able to address health inequalities. The Board **approved** the acceptance of delegated specialised commissioning responsibility from NHSE and the proposed arrangements to support this delegation.
4.4	ICB24 - 131	**NHS Devon Finances – Equity** Board members considered the report which provided information about the equity position in Devon. It was noted that the report had been shared and discussed with Plymouth City Council in advance of its submission to the Board. Board members noted the importance of being cognisant of how the resources allocated to the One Devon Integrated Care System were distributed; however they also noted that the Integrated Care Board had more active role than simple allocation – it needed to be able to address inequalities in different groups across the population. In order to do this, NHS Devon needed to shift the allocation of resources from acute healthcare provision to community services, prevention and population health. The Board • **Agreed** that no specific adjustments to the distribution of resources based on this analysis are made until the recovery programme for Sothern Locality is understood and impact assessed. • **Agreed** that the equitable use of resource continues to be updated and monitored as part of its objective for the equitable improvement of access and reduction of health inequalities. • **Agreed** that as the system works through recovery and the provider deficits are eradicated, the focus should shift towards targeting strategic equity of provision by rebalancing health spend between acute, mental health, primary care and community services and that this should be reinforced through the introduction of a key priority for Locality Care Partnerships (LCPs) to reduce secondary care consumption by identifying better value services in prevention, population health and community/primary care services.
5.		**Governance, Performance and Assurance Reports**
5.1	ICB24 -132	**Quality Report** Chief Nursing Officer, Penny Smith (PS) introduced the report which provided a summary of key quality information, in the format of both quantitative and qualitative data from sources including NHS Devon data collection including patient experience; and direct from the NHS Devon Nursing and Quality Directorate team's involvement in partner meetings, groups, quality committees and workstreams. The following points were highlighted during consideration of this item: • Breadth and depth – the importance of the report was emphasised; however, consideration needed to be given to ensuring that the Board and Quality and Patient Experience Committee were not overwhelmed by information. In light of this, a quality dashboard was being developed in line with national requirements. NHS Devon was a member of the national strategy group, which would ensure that it did not lose sight of strategic developments whilst experiencing significant organisational change.

		• Vaccine hesitancy amongst NHS staff – this had been highlighted as an issue in the people and Organisational Development Committee. National research had indicated a number of ways in which Integrated Care Boards could provide leadership in order to ensure sustained services for patients, such as mobile vaccination opportunities and incentives. • Periods of significant change could lead to a lack of focus on quality. It was key that quality continued to be the foundation of all proposed changes to improve performance. The ongoing oversight of Equality Quality Impact Assessments would be vital in holding this line. The Board **noted** the overall assurance level relating to the quality position of the ICS as satisfactory and supported the position that adequate plans are in place to mitigate and improve quality risks.
5.2	ICB24 - 133	**Torbay Joint Targeted Area Inspection (JTAI) Closure** Consideration was given to the update provided on the progress taken to address the recommendations of the Torbay Joint Targeted Area Inspection (JTAI) that took place in November 2023. The Board **took satisfactory assurance** from the progress of the Torbay Joint Targeted Area Inspection action plan and the future governance and monitoring arrangements through the Torbay Safeguarding Children Partnership.
5.3	ICB24 -134	**Committee Chair's Report: Quality and Patient Experience Committee – 13 March 2025** The Chair of the Quality and Patient Experience Committee, Thandiwe Hara (TH), introduced the report which provided the Board with an overview of the issues considered by the Committee at its meeting on 13 March 2025. The Board **took assurance** from the report of the Chair of the Quality and Patient Experience Committee.
5.4	ICB24 - 135	**Finance Reports** KD introduced the Month 10 Finance Reports for NHS Devon and for the One Devon Integrated Care System which sought to provide the necessary assurance on the financial position and risk relating to the financial plans for the year ending 31 March 2025. The Board: • **Took satisfactory assurance** from the information provided with regard to the NHS Devon financial position as at the period ended 31 January 2025. • **Agreed** the overall assurance level relating to the financial position of the One Devon Integrated Care System of **satisfactory** and that adequate plans are in place to mitigate the risks relating to the delivery of planned savings and efficiencies and to the management of the financial risks identified at plan stage.
5.5	ICB24 - 136	**Chair's Report: Finance and Performance Committee – 12 February and 12 March 2025** The Chair of the Finance and Performance Committee, Martin Sykes (MS), introduced the reports which provided the Board with an overview of the issues considered by the Committee at its meetings on 12 February and 12 March 2025. The Board: • **Took assurance** from the reports of the Chair of the Finance and Performance Committee; and • **Noted** the escalations for information contained in the report of the meeting held on 12 February 2025 in respect of the One Devon Finance Shared Service; the

		importance of recurrent rather than non-recurrent CIPs; and the need for the Committee to consider the detailed financial plan for 2025/26.
		• **Noted** the escalations for information from 13 March 2025 in respect of the Committee's concerns around:
		  ○ the underlying financial position and how that might affect the system's exit from NOF4 and moving into 2025/26;
		  ○ the underlying run rate and WTEs were still risks in the finances
		  ○ there was still a risk around UEC;
		  ○ workforce controls and the drift on WTEs; and that
		  ○ discussions had started in respect of the assurance that the Committee and the NHS Devon Board would need in respect of the 2025/26 financial plan.
		• **Agreed** the recommendation to **approve** the implementation of a single financial and procurement system through a Digital Partnership with NHS Shared Business Services.

5.6	ICB24-137	**Board Assurance Framework (BAF)** PH introduced a report which provided the Board with an update on the high-level strategic risks that might impact on the achievement of NHS Devon's strategic objectives in the current financial year. The Board **approved** the content of the latest iteration of the 2024/25 BAF risks to achieving the strategic objectives of NHS Devon.
6.		**Partnership Working**
6.1	ICB24-138	**One Devon Integrated Care Partnership Update** Chair of the One Devon Integrated Care Partnership, Councillor Mary Aspinall (MA), introduced a report which provided an overview of the work undertaken at the meeting held on 11 March 2025. It was noted that a development session was to be held to agree the way in which the ICP would operate and commence the development of its operational plan to deliver its responsibilities in delivering the Joint Forward Plan. Further consideration would also be given to the membership of the ICP to ensure that the right people were around the table. The Board **noted** the report.
6.2	ICB24-139	**Cornwall and Isles of Scilly ICB Update** Kate Shields, Chief Executive at NHS Cornwall and Isles of Scilly introduced the report which highlighted emerging issues and significant developments within the Cornwall and Isles of Scilly integrated care system. The Board **noted** the report.
7.		**Committee Chair Reports**
7.1	ICB24 - 140	**Committee Chair's Report: Audit and Risk Committee – 03 March 2025** The Chair of the Audit and Risk Committee, Graham Clarke (GC), introduced the report which provided the Board with an overview of the issues considered by the Committee at its meeting on 03 March 202. The Board: • **Took assurance** from the report of the Chair of the Audit and Risk Committee • **Noted** the escalations to the Board for information in respect of:

		○ Amending the Corporate Governance Framework if NHS Devon accepts the proposal to take on delegated responsibility for specialised commissioning from NHSE. ○ Ensuring more visibility as to how NHS Devon was performing against the Mental Health Investment Standard (MHIS); and BOARD TIME TO UNDERSTAND THIS - ACTION ○ The proposed approach for linking across the System Audit, Assurance and Risk Chairs' Forum, the Finance and Performance Committee and the People and Organisational Design Committee regarding progress on implementation of recommendations from the RSP System-wide Workforce Controls Audit Review and in addition, on future work being undertaken on workforce controls. • **Noted** the recommendation that the Board: ○ Approves proposed amendments to the following essential documents from the NHS Devon Corporate Governance Framework: ▪ NHS Devon Constitution (including Standing Orders) ▪ Corporate Governance Handbook ▪ Key Policies ○ Makes no amendments to the following essential documents from the NHS Devon Corporate Governance Framework: ▪ Scheme of Reservation and Delegation; and ▪ Standing Financial Instructions.
7.2	ICB24 - 141	**Committee Chair's Report: Population Health Improvement Committee – 12 March 2025** The Chair of the Population Health Improvement Committee, Thandiwe Hara (TH), introduced the report which provided the Board with an overview of the issues considered by the Committee at its meeting on 12 March 2025. The Board: • **Took assurance** from the report of the Chair of the Population Health Improvement Committee; and • **Noted** the recommendation that the Board approves the People and Communities Framework, which was done earlier in the meeting.
7.3	ICB24 - 142	**Committee Chair's Report: People and Organisational Development Committee – 12 February and 19 March 2025** The Chair of the People and Organisational Development Committee, Judy Hargadon (JH) introduced the report which provided the Board with an overview of the issues considered by the Committee at its meetings on 12 February and 19 March 2025. The Board: • **Took assurance** from the reports of the Chair of the People and Organisational Development Committee. • **Noted** the escalation to the Board for information of the Committee's views of the 2024 Staff Survey Results and the impact of any decision by the government to de-fund Level 7 apprenticeships. • **Agreed** the Committee's recommendation to approve the Gender Pay Gap Report 2024/25.
8.		**Closing Items**
8.1	ICB24 - 143	**Questions from Members of the Public** The following question had been received from a member of the public: "*Please can you share your vision for the future of dementia care and the impact of an ageing population on healthcare provision in Devon?"*

		It was reported that the Mental Health, Learning Disability and Neurodiversity (MHLDN) Collaborative had been taking the lead in terms of stakeholder engagement in relation to the One Devon integrated Care System's Dementia Strategy, which was nearing completion. The focus of this strategy needed to be on early diagnosis and supporting people with dementia, their carers and communities to live as full a life as possible close to their home. Understanding how to optimise care for those with advanced or complex dementia would also be important. However, it would only be possible to deliver these improvements through collaboration and, once the strategy was finalised, the Board would need to spend time giving it full consideration and determining the next steps required to implement it.
8.2	ICB24 - 144	**Any Other Business** It was noted that the next meeting of the Board in public would be on 29 May 2025.
		Meeting Closed

Integrated Care Board Meetings in Public - Action Log								
Action Reference	Date of Meeting	Action - issue to be addressed	Target Date	Lead	Progress on action	Date Closed	By whom	Status
ICB24 -102i	30.01.2025	A specific risk in respect of capacity to deliver to the organisational development plan to be developed.	27.03.2025	Piers Tetley	22.05.2025 - risk has now been articulated			Propose to close
ICB24-111	30.01.2025	Report in respect of Children & Young People's Service Recovery - Autism to be brought back to the Board no sooner than six months time.	25.09.2025	Penny Smith	19.03.2025 - Included in 2025/26 Board Forward Plan for September 2025.			In progress
ICB24-126	27.03.2025	Consideration to be given to the implementation of more frequent “pulse” surveys of the organisation	01.07.2025	Piers Tetley	22.05.2025 - these will be implemented as quarterly surveys from the start of July 2025. Consideration is also being given to the possibility of more frequent "check ins" in relation to how staff are feeling.			In progress

NHS Devon Integrated Care Board

Chair's report

Date of meeting	Date report produced
29 May 2025	14 May 2025

Author(s)		Report approved by	
Name and title:	Sam Cush, Communications Manager Philippa Harding, Director of Governance and Interim Chief Communications and Corporate Affairs Officer	**Name and title:**	Kevin Orford, Chair
Phone:		**Date:**	21 May 2025
Email:			

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

Executive summary
This report provides an update from the Chair.

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

Key recommendations and actions requested
NOTE the contents of the report.
APPROVE the proposed amendments to the Terms of Reference to the following Board Committees: • NHS Devon Executive • Finance and Performance Committee • Population Health Improvement Committee
NOTE the exercise of powers in respect urgent decisions and ratify the decision to approve a Deed of Variation to the tripartite S.75 Agreement in place between NHS Devon, Torbay and South Devon NHS Foundation Trust and Torbay Council.

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	N/A
Improve services and reduced unwarranted variation	N/A
Make more efficient use of our resources	N/A
Develop our culture and how we operate	N/A

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	N/A
Health inequalities	N/A
Workforce	N/A
Resources and finance	N/A
Legal	N/A
Digital and Data	N/A
Involvement, Engagement and consultation	N/A

Chair's report

ICB transformation

1. Recent national developments – including NHS England's letter of 1 April and the draft Model ICB Blueprint – set out a clear vision for how Integrated Care Boards (ICBs) will be expected to operate in the year ahead and beyond. The proposals point towards leaner, more streamlined NHS commissioning, with ICBs playing a strategic role in improving population health, tackling inequalities and supporting system-wide reform.

2. There is much within the blueprint that we can support. The increased emphasis on strategic commissioning, collaboration and prevention are positive steps. However, it is equally clear that the expectations on systems are significant – and that the timescales ambitious.

3. Reducing ICB running costs by 50% while also redesigning functions and preparing for possible structural changes is no small task. Our Board has a key role to play in making sure this process is managed responsibly – with clear oversight, open engagement, and a strong focus on the needs of our population.

4. The proposed "clustering" of NHS Devon with NHS Cornwall and Isles of Scilly is a practical response to the direction of travel nationally. It offers an opportunity to build scale and resilience – but we must also ensure that the distinctive character, geography and priorities of both systems are not lost in the process.

5. As a Board, we are mindful that this transition will be challenging for our staff and partners. We are grateful for the way our executive team is approaching this – with openness, compassion and a real commitment to engaging people in shaping what comes next. It is reassuring to see the support measures already in place, and the steps being taken to work closely with colleagues in Cornwall to manage change collaboratively.

6. At the same time, we must maintain a close eye on risk. It is important that any changes to functions or responsibilities are approached carefully – especially where they relate to statutory duties or areas of service that are already under pressure. We must ensure that any transfer or delegation of work is done in a way that protects quality and continuity. We must also be conscious of the pressures that our partners are simultaneously under – including NHS trusts having to make significant savings and the local government reforms.

7. The next few months will be crucial. While we are working within a national framework, there is still scope to influence how the blueprint is applied locally – and how the new arrangements can best serve the people of Devon. Our Board will continue to provide strong leadership and challenge, working closely with partners, staff and communities to make sure our response is both realistic and rooted in local need.

8. Thank you for your continued commitment and support as we navigate this period of change together.

Proposed amendments to Board Committee Terms of Reference

9. Following the appointment of our new Chief Strategic Commissioning and Planning Officer, I am proposing that section 3.5 of the Terms of Reference of the following Board Assurance Committees are amended so that reference to Chief Operating Officer is replaced by reference to Chief Strategic Commissioning and Planning Officer:

    - Finance and Performance Committee
    - Population Health Improvement Committee

10. Similarly, it is proposed that section 3.5 of the Terms of Reference of the NHS Devon Executive should also be amended so that reference to Chief Operating Officer is replaced by reference to Chief Strategic Commissioning and Planning Officer.

The Board is asked to approve the proposed amendments to the Terms of Reference to the following Board Committees:

- **NHS Devon Executive**
- **Finance and Performance Committee**
- **Population Health Improvement Committee**

NHSE approval of amended NHS Devon Constitution

11. Following the Board's approval of the proposed amendments to the NHS Devon Constitution at its meeting in public on 27 March 2025, these were submitted to NHSE for final approval. I am pleased to be able to confirm that NHSE has approved all proposed amendments. The final updated version of NHS Devon Constitution is appended to this report.

Urgent Decision taken - S.75 Agreement Deed of Variation

12. Board members will be aware that Section 4.9 of the Standing Orders, appended to the NHS Devon Constitution allows for urgent decision-making as follows.

    Urgent decisions

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

4.9.5 The powers which are reserved or delegated to the board, may for an urgent decision be exercised by the Chair and Chief Executive (or relevant lead director in the case of committees)[108] subject to every effort having made to consult with a minimum of two Non-Executive Members in the given circumstances.

4.9.6 The exercise of such powers shall be reported to the next formal meeting of the board for formal ratification and the Audit Committee for oversight

13. On 31 March 2025, Steve Moore (Chief Executive) and I (in consultation with the Chairs of the Audit and Risk and the Finance and Performance Committees) took the urgent decision to approve a Deed of Variation to the tripartite S.75 Agreement that is in place between NHS Devon, Torbay and South Devon NHS Foundation Trust and Torbay Council. This agreement, which was approved by the Board in March 2024, enables the delivery of integrated Adult Social Care services in Torbay from April 2025 to March 2030. This Deed of Variation, which was agreed by all parties to the Agreement stipulates that, within the first 6 months of the commencement date of the Agreement (i.e. 01 April 2025), any party may give written notice to terminate the Agreement by 30 September 2025, with such notice to take effect on 1 October 2026. After 30 September 2025, any party may terminate the Agreement by giving not less than 12 months' written notice to the other parties, with such notice to take effect on 1 April in any given period.

The Board is asked to note the exercise of powers in respect urgent decisions and ratify the decision to approve a Deed of Variation to the tripartite S.75 Agreement in place between NHS Devon, Torbay and South Devon NHS Foundation Trust and Torbay Council.

Recommendations

14. The Board is asked to:

- **NOTE** the contents of the report.
- **APPROVE** the proposed amendments to the Terms of Reference to the following Board Committees:
  - NHS Devon Executive
  - Finance and Performance Committee
  - Population Health Improvement Committee
- **NOTE** the exercise of powers in respect urgent decisions and ratify the decision to approve a Deed of Variation to the tripartite S.75 Agreement in place between NHS Devon, Torbay and South Devon NHS Foundation Trust and Torbay Council.

NHS Devon
Integrated Care Board

CONSTITUTION

Version	Date approved by the ICB	Effective date
V1.0	01 July 2022	01 July 2022
V1.2	18 October 2022	18 October 2022
V2	To be presented to Board 27 March 2025	

1. Introduction 6

1.1 Background/ Foreword 6

1.2 Name 6

1.3 Area Covered by the Integrated Care Board 6

1.4 Statutory Framework 6

1.5 Status of this Constitution 8

1.6 Variation of this Constitution 8

1.7 Related Documents 9

2 Composition of the Board of the ICB 10

2.1 Background 10

2.2 Board Membership 11

3 Appointments Process for the Board 12

3.1 Eligibility Criteria for Board Membership 12

3.2 Disqualification Criteria for Board Membership 12

3.3 Chair 14

3.4 Deputy Chair and Senior Non-Executive Member 15

3.5 Chief Executive Officer 15

3.6 Partner Member - NHS Trusts and Foundation Trusts 15

3.7 Partner Member - Providers of Primary Medical Services. 16

3.11 Chief Medical Officer 21

3.12 Chief Nursing Officer 21

3.13 Chief Finance Officer 21

3.14 Non-Executive Members 22

3.15 Board Members: Removal from Office 23

3.16 Terms of Appointment of Board Members 24

4 Arrangements for the Exercise of our Functions 24

4.1 Good Governance 24

4.2 General 24

4.3 Authority to Act 24
4.4 Scheme of Reservation and Delegation (SoRD) 25
4.5 Functions and Decision Map 25
4.6 Committees and Sub-Committees 26
4.7 Delegations made under section 65Z5 of the 2006 Act 27

5 Procedures for Making Decisions 28
5.1 Standing Orders 28
5.2 Standing Financial Instructions (SFIs) 28

6 Arrangements for conflict of interest management and standards of business conduct 28
6.1 Principles 28
6.2 Conflicts of Interest 29
6.3 Declaring and Registering Interests 29
6.4 Standards of Business Conduct 30

7 Arrangements for ensuring Accountability and Transparency 30
7.2 Principles 31
7.3 Meetings and publications 31
7.4 Scrutiny and Decision Making 32
7.5 Annual Report 32

8 Arrangements for Determining the Terms and Conditions of Employees 33

9 Arrangements for Public Involvement 34

Appendix 1: Definitions of Terms Used in this Constitution 36

Appendix 2: Standing Orders 39

1. Introduction 39

2. Amendment and review 39

3. Interpretation, application and compliance 39

4. Meetings of the Integrated Care Board 40

4.1. Calling Board Meetings 40

4.2 Chair of a meeting 40

4.3 Agenda, supporting papers and business to be transacted 41

4.4 Petitions 41

4.5 Nominated Deputies 41

4.6 Virtual attendance at meetings 41

4.6.1 The Board of the ICB and its committees and sub-committees may meet virtually using telephone, video and other electronic means, unless the terms of reference prohibit this 41

4.7 Quorum 41

4.8 Vacancies and defects in appointments 42

4.9 Decision making 42

4.10 Minutes 43

4.11 Admission of public and the press 44

5 Suspension of Standing Orders 44

6 Use of seal and authorisation of documents. 45

1. Introduction

1.1 Background/ Foreword

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

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

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

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

1.2 Name

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

1.3 Area Covered by the Integrated Care Board

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

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

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

1.4 Statutory Framework

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

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

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

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

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

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

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

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

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

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

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

1.5 Status of this Constitution

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

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

1.6 Variation of this Constitution

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

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

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

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

1.7 Related Documents

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

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

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

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

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

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

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

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

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

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

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

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

2 Composition of the Board of the ICB

2.1 Background

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

2.1.2 Further information about the individuals who fulfil these roles can be found on our website [click here]

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

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

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

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

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

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

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

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

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

2.2 Board Membership

2.2.1 The ICB has 4 Partner Members

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

2.2.2 The ICB has also appointed the following further Ordinary Members to the Board:

a) At least 2 and up to 3 additional Non-Executive Members
b) 1 member who brings the perspective of Mental Health services (known as the Mental Health member)
c) 1 member who brings the perspective of the voluntary, community and social enterprise sector (known as the VCSE Member)

2.2.3 The Board is therefore composed of the following members:

a) Chair
b) Chief Executive Officer
c) 1 Partner Member - NHS Trusts and Foundation Trusts
d) 1 Partner Member - Primary Medical Services
e) 2 Partner Members - Local Authorities
f) Mental Health Member
g) VCSE Member
h) At least 5 and up to 6 Non-Executive Members (one of which, but not the Audit and Risk Committee Chair, will be appointed Deputy Chair, and one of which, who may be the Deputy Chair or the Audit and Risk Committee Chair, will be appointed the Senior Non-Executive Member)
i) Director of Finance (known as Chief Finance Officer)
j) Medical Director (known as Chief Medical Officer)
k) Director of Nursing (known as Chief Nursing Officer)

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

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

2.3 Regular Participants and Observers at Board Meetings

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

2.3.2 Participants will receive advanced copies of the notice, agenda and papers for Board meetings. They may be invited to attend any or all of the Board meetings, or part(s) of a meeting by the Chair. Any such person may be invited, at the discretion of the Chair to ask questions and address the meeting but may not vote.

2.3.3 Participants and / or observers may be asked to leave the meeting by the Chair in the event that the Board passes a resolution to exclude the public as per the Standing Orders.

3 Appointments Process for the Board

3.1 Eligibility Criteria for Board Membership

3.1.1 Each member of the ICB must:

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

3.2 Disqualification Criteria for Board Membership

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

a) A Member of Parliament.

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

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

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

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

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

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

- that it was not in the interests of, or conducive to the good management of, the Health Service Body or of the health service that the person should continue to hold that office
- that the person failed, without reasonable cause, to attend any meeting of that Health Service Body for three successive meetings,
- that the person failed to declare a pecuniary interest or withdraw from consideration of any matter in respect of which that person had a pecuniary interest, or
- of misbehaviour, misconduct or failure to carry out the person's duties;

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

- the person's suspension from a register held by the regulatory body, where that suspension has not been terminated
- the person's erasure from such a register, where the person has not been restored to the register

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

h) A person who is subject to:

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

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

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

- section 7 of the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990(f) (powers of the Court of Session to deal with the management of charities), or
- section 34(5) or of the Charities and Trustee Investment (Scotland) Act 2005 (powers of the Court of Session to deal with the management of charities).

3.3 Chair

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

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

3.3.3 Individuals will not be eligible if:

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

3.3.4 Subject to NHS England's national policy and requirements and as set out in the letter of appointment to the role, the term of office for this role will be a

maximum 3 years in duration and the maximum number of terms which may be served is 3.

3.4 Deputy Chair and Senior Non-Executive Member

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

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

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

3.5 Chief Executive Officer

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

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

3.5.3 In addition to the eligibility criteria specified at **Error! Reference source not found.**, the Chief Executive Officer must be an employee of the ICB or a person seconded to the ICB who is employed in the civil service of the State or by a body referred to in paragraph 19(4)(b) of Schedule 1B to the 2006 Act.

3.5.4 Individuals will not be eligible if

a) Any of the disqualification criteria set out in 3.2 apply
b) Subject to clause 3.5.3, they hold any other employment or executive role

3.6 Partner Member - NHS Trusts and Foundation Trusts

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

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

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

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

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

3.6.5 The appointment process will be as follows:

a) The ICB will create a role description for the role, which will set out the requirements associated with the role including the expected skills, knowledge, time commitment and term of office.
b) The ICB will issue the role description to the partners referred to at **Error! Reference source not found.**, together with a timeline for the nomination and setting out any further information about the selection process.
c) The nomination process will be managed by the ICB's governance team.
d) The aim of the nominations process shall be for the partners, by consensus, to determine a jointly agreed list of individuals to be put forward for appointment.
e) Those participating in the nominations process shall have regard to any guidance published by NHS England in relation to the selection of candidates, and the applicable eligibility and disqualification criteria set out in this constitution.
f) The partners identified at **Error! Reference source not found.** will submit their joint nomination(s) to the ICB Board Appointments Panel, which will undertake a selection process. Each partner may make one nomination.
g) Appointment will be made as a result of a formal assessment against the eligibility and disqualification criteria for Board membership as set out above, and to ensure the individual has the ability to contribute effectively to the overall functioning of the Board. The ICB Board Appointments Panel will make a recommendation to the Chair of the ICB, for approval.
h) The Chair of the ICB will determine whether to approve the appointment and report the appointment decision to the next meeting of the Board of the ICB.
i) Should no individual be nominated or appointed, then the nominations process described above shall be repeated.
j) Any re-appointment at the end of a term will follow the process as described in **Error! Reference source not found.**a to i.
k) An individual will only be eligible for further nomination and reappointment if they continue to meet the relevant eligibility and disqualification criteria outlined above.

3.6.6 The term of office for this Partner Member is 3 years. After each term a full nomination and selection process will be carried out.

3.7 Partner Member - Providers of Primary Medical Services.

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

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

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

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

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

3.7.6 The appointment process will be as follows:

a) The ICB will create a role description for the role, which will set out the requirements associated with the role including the expected skills, knowledge, time commitment and term of office.
b) The ICB will issue the role description to the partners referred to at **Error! Reference source not found.**, together with a timeline for the nomination and setting out any further information about the selection process.
c) The nomination process will be managed by the ICB's governance team.
d) The aim of the nominations process shall be for the partners to determine a jointly agreed list of individuals to be put forward for appointment.
e) Those participating in the nominations process shall have regard to any guidance published by NHS England in relation to the selection of candidates, and the applicable eligibility and disqualification criteria set out in this constitution.
f) The partners identified at **Error! Reference source not found.** will submit their joint nomination(s) to the ICB Board Appointments Panel, which will undertake a selection process. Each partner may make one nomination.
g) Nomination(s) will be considered to have been agreed by the partners identified at 3.7.1 unless more than 25% of the providers of primary medical services eligible to nominate register a formal objection to the Nomination(s). If more than 25% of eligible providers register a formal objection, the nomination process will be re-run until a consensus is reached on the nomination(s) put forward.

h) Appointment will be made as a result of a formal assessment against the eligibility and disqualification criteria for Board membership as set out above, and to ensure the individual has the ability to contribute effectively to the overall functioning of the Board. The ICB Board Appointments Panel will make a recommendation to the Chair of the ICB, for approval.
i) The Chair of the ICB will determine whether to approve the appointment and report the appointment decision to the next meeting of the Board of the ICB.
j) Should no individual be nominated or appointed, then the nominations process described above shall be repeated.
k) Any re-appointment at the end of a term will follow the process as described in **Error! Reference source not found.**a to i.
l) An individual will only be eligible for further nomination and reappointment if they continue to meet the relevant eligibility and disqualification criteria outlined above.

3.7.7 The term of office for this Partner Member will be 3 years. After each term a full nomination and selection process will be carried out.

3.8 Partner Members - Local Authorities

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

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

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

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

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

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

3.8.5 The appointment process will be as follows:

a) The ICB will create role descriptions for the roles, which will set out the requirements associated with the roles including the expected skills, knowledge, time commitment and term of office.
b) The ICB will issue the role descriptions to the partners referred to at **Error! Reference source not found.**, together with a timeline for the nomination and setting out any further information about the selection process.
c) The nomination process will be managed by the ICB's governance team.
d) The aim of the nominations process shall be for the partners, by consensus, to determine a jointly agreed list of individuals to be put forward for appointment.
e) Those participating in the nominations process shall have regard to any guidance published by NHS England in relation to the selection of candidates, and the applicable eligibility and disqualification criteria set out in this constitution.
f) The partners identified at **Error! Reference source not found.** will submit their joint nomination(s) to the ICB Board Appointments Panel, which will undertake a selection process. Each partner may make one nomination.
g) Appointment will be made as a result of a formal assessment against the eligibility and disqualification criteria for Board membership as set out above, and to ensure the individual has the ability to contribute effectively to the overall functioning of the Board. The ICB Board Appointments Panel will make a recommendation to the Chair of the ICB, for approval.
h) The Chair of the ICB will determine whether to approve the appointment and report the appointment decision to the next meeting of the Board of the ICB.
i) Should no individual be nominated or appointed, then the nominations process described above shall be repeated.
j) Any re-appointment at the end of a term will follow the process as described in section **Error! Reference source not found.**a to i.
k) An individual will only be eligible for further nomination and reappointment if they continue to meet the relevant eligibility and disqualification criteria outlined above.

3.8.6 The term of office for this Partner Member will be 3 years. After each term a full nomination and selection process will be carried out.

3.9 Mental Health Member

3.9.1 This member must fulfil the eligibility criteria set out at **Error! Reference source not found.** and shall have knowledge and experience in connection with services relating to the prevention, diagnosis and treatment of mental illness.

3.9.2 Individuals will not be eligible for this role if any of the disqualification criteria set out in **Error! Reference source not found.** apply.

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

3.9.4 The appointment process will be as follows:

a) The ICB will create a role description for the role, which will set out the requirements associated with the role including the expected skills, knowledge, time commitment and term of office.
b) Expressions of interest for the role will be sought from partners within the ICS as determined by the ICB Board Appointment Panel.
c) Appointment will be made as a result of a formal assessment against the eligibility and disqualification criteria for Board membership as set out above, and to ensure the individual has the ability to contribute effectively to the overall functioning of the Board. The ICB Board Appointments Panel will make a recommendation to the Chair of the ICB, for approval.
d) The Chair of the ICB will determine whether to approve the appointment and report the appointment decision to the next meeting of the Board of the ICB.
e) Should no individual be appointed, then the process described above shall be repeated.
f) Any re-appointment at the end of a term will follow the process as described in **Error! Reference source not found.**4a to d.
g) An individual will only be eligible for reappointment if they continue to meet the relevant eligibility and disqualification criteria outlined above.

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

3.10 VCSE Member

3.10.1 This member must fulfil the eligibility criteria set out at **Error! Reference source not found.** and shall have knowledge and experience in connection with the voluntary, social and community enterprise sector.

3.10.2 Individuals will not be eligible for this role if any of the disqualification criteria set out in **Error! Reference source not found.** apply.

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

3.10.4 The appointment process will be as follows:

a) The ICB will create a role description for the role, which will set out the requirements associated with the role including the expected skills, knowledge, time commitment and term of office.
b) Expressions of interest for the role will be sought from partners within the ICS as determined by the ICB Board Appointments Panel.
c) Appointment will be made as a result of a formal assessment against the eligibility and disqualification criteria for Board membership as set out above, and to ensure the individual has the ability to contribute effectively to the overall functioning of the Board. The ICB Board

Appointments Panel will make a recommendation to the Chair of the ICB, for approval.

d) The Chair of the ICB will determine whether to approve the appointment and report the appointment decision to the next meeting of the Board of the ICB.
e) Should no individual be appointed, then the process described above shall be repeated.
f) Any re-appointment at the end of a term will follow the process as described in **Error! Reference source not found.**4a to d.
g) An individual will only be eligible for reappointment if they continue to meet the relevant eligibility and disqualification criteria outlined above.

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

3.11 Chief Medical Officer

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

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

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

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

3.12 Chief Nursing Officer

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

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

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

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

3.13 Chief Finance Officer

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

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

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

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

3.14 Non-Executive Members

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

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

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

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

3.14.4 Individuals will not be eligible if

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

3.14.5 The term of office for a Non-Executive Member is a maximum of 4 years. Non-Executive Members may serve a further term (both terms must not exceed 8 years in total) after which they will no longer be eligible for re-appointment.

3.14.6 Initial appointments may be for a shorter period in order to avoid all non-executive members retiring at once. Thereafter, new appointees will

ordinarily retire on the date that the individual they replaced was due to retire in order to provide continuity

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

3.15 Board Members: Removal from Office

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

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

a) If they no longer fulfil the requirements of their role or become ineligible for their role as set out in this Constitution, regulations or guidance
b) If they fail to attend a minimum of 60% of the meetings to which they are invited unless agreed with the Chair in extenuating circumstances
c) If they are deemed to not meet the expected standards of performance (e.g. at their annual appraisal)
d) If they have behaved in a manner or exhibited conduct which has or is likely to be detrimental to the reputation and/or interest of the ICB and is likely to bring the ICB into disrepute. This includes but is not limited to breach of the ICB's human resources policies; dishonesty; misrepresentation (either knowingly or fraudulently); defamation of any member of the ICB (being slander or libel); abuse of position; non-declaration of a known conflict of interest; seeking to manipulate a decision of the ICB in a manner that would ultimately be in favour of that member whether financially or otherwise
e) If they are deemed to have failed to uphold the Nolan Principles of Public Life
f) If they are subject to disciplinary proceedings by a regulator or professional body

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

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

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

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

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

3.16 Terms of Appointment of Board Members

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

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

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

4 Arrangements for the Exercise of our Functions

4.1 Good Governance

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

4.2 General

4.2.1 The ICB will:

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

4.2.2 The ICB will develop and implement the necessary systems and processes to comply with (a)-(f) above, documenting them as necessary in this

Constitution, its Governance Handbook and other relevant policies and procedures as appropriate.

4.3 Authority to Act

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

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

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

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

4.4 Scheme of Reservation and Delegation (SoRD)

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

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

4.4.3 The SoRD sets out:

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

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

4.5 Functions and Decision Map

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

4.5.2 The Functions and Decision Map is published [click here]

4.5.3 The map includes:

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

4.6 Committees and Sub-Committees

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

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

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

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

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

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

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

4.6.8 The following committees will be maintained:

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

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

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

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

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

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

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

4.7 Delegations made under section 65Z5 of the 2006 Act

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

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

4.7.3 Each delegation made under section 65Z5 of the Act will be set out in a delegation arrangement which sets out the terms of the delegation. This may, for joint arrangements, include establishing and maintaining a pooled

fund. The power to approve delegation arrangements made under this provision will be reserved to the Board.

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

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

5 Procedures for Making Decisions

5.1 Standing Orders

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

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

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

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

5.2 Standing Financial Instructions (SFIs)

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

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

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

6.1 Principles

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

a) The Nolan Principles
b) Ensuring clear policy guidance is provided to all those performing a role on behalf of the ICB
c) Monitoring compliance in accordance with published guidance

d) Ensuring interests are proactively declared at the point individuals become involved in decision making
e) Adopting a proportionate, common sense approach to the management of conflicts of interest
f) Keeping an audit trail of actions taken.

6.2 Conflicts of Interest

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

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

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

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

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

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

a) Act as a conduit for members of the public and members of the partnership who have any concerns with regards to conflicts of interest
b) Be a safe point of contact for employees or workers to raise any concerns in relation to conflicts of interest

c) Support the rigorous application of conflict of interest principles and policies
d) Provide independent advice and judgment to staff and members where there is any doubt about how to apply conflicts of interest policies and principles in an individual situation
e) Provide advice on minimising the risks of conflicts of interest.

6.3 Declaring and Registering Interests

6.3.1 The ICB maintains registers of the interests of:

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

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

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

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

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

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

6.4 Standards of Business Conduct

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

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

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

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

6.4.2 Individuals contracted to work on behalf of the ICB or otherwise providing services or facilities to the ICB will be made aware of their obligation to declare conflicts or potential conflicts of interest. This requirement will be

written into their contract for services and is also outlined in the ICB's Standards of Business Conduct Policy.

7 Arrangements for ensuring Accountability and Transparency

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

7.2 Principles

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

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

7.3 Meetings and publications

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

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

7.3.3 Annual accounts will be externally audited and published.

7.3.4 A clear complaints process will be published.

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

7.3.6 Information will be provided to NHS England as required.

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

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

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

a) describe the health services for which the ICB proposes to make arrangements in the exercise of its functions
b) explain how the ICB proposes to discharge its duties under sections 14Z34 to 14Z45 (general duties of integrated care boards) and sections 223GB and 223N (financial duties)
c) propose steps to implement the joint local health and wellbeing strategies and integrated care strategy
d) set out any steps that the ICB proposes to take to address the particular needs of children and young persons under the age of 25
e) set out any steps that the ICB proposes to take to address the particular needs of victims of abuse (including domestic abuse and sexual abuse, whether of children or adults).

7.4 Scrutiny and Decision Making

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

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

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

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

7.5 Annual Report

7.5.1 The ICB will publish an annual report in accordance with any guidance published by NHS England and that sets out how it has discharged its

functions and fulfilled its duties in the previous financial year. An annual report must in particular:

a) explain how the ICB has discharged its duties under section 14Z34 to 14Z45 and 14Z49 (general duties of integrated care boards)
b) review the extent to which the ICB has exercised its functions in accordance with the plans published under section 14Z52 (forward plan) and section 14Z56 (capital resource use plan)
c) review the extent to which the ICB has exercised its functions consistently with NHS England's views set out in the latest statement published under section 13SA(1) (views about how functions relating to inequalities information should be exercised)
d) review any steps that the ICB has taken to implement any joint local health and wellbeing strategy to which it was required to have regard under section 116B(1) of the Local Government and Public Involvement in Health Act 2007.

8 Arrangements for Determining the Terms and Conditions of Employees

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

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

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

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

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

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

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

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

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

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

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

9 Arrangements for Public Involvement

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

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

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

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

a) put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS

b) start engagement early when developing plans and feed back to people and communities how it has influenced activities and decisions
c) understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect
d) build relationships with excluded groups – especially those affected by inequalities
e) work with Healthwatch and the voluntary, community and social enterprise sector as key partners
f) provide clear and accessible public information about vision, plans and progress to build understanding and trust
g) use community development approaches that empower people and communities, making connections to social action
h) use co-production, insight and engagement to achieve accountable health and care services
i) co-produce and redesign services and tackle system priorities in partnership with people and communities
j) learn from what works and build on the assets of all partners in the ICS – networks, relationships, activity in local places.

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

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

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

Appendix 1: Definitions of Terms Used in this Constitution

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

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

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

Appendix 2: Standing Orders

1. Introduction

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

2. Amendment and review

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

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

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

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

3. Interpretation, application and compliance

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

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

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

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

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

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

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

4. Meetings of the Integrated Care Board

4.1. Calling Board Meetings

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

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

a) The Chair may call a meeting at any time by giving not less than 14 calendar days' notice in writing.
b) One third of the members of the Board may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Board members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all members of the board specifying the matters to be considered at the meeting.
c) In emergency situations the Chair may call a meeting with one working day notice by setting out the reason for the urgency and the decision to be taken.

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

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

4.2 Chair of a meeting

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

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

4.2.3 If both the Chair and Deputy Chair are absent or disqualified from participating by a conflict of interest, the assembled members shall appoint a temporary deputy for the purpose of chairing the meeting.

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

4.3 Agenda, supporting papers and business to be transacted

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

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

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

4.4 Petitions

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

4.5 Nominated Deputies

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

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

4.6 Virtual attendance at meetings

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

4.7 Quorum

4.7.1 The quorum for meetings of the Board will be members, including:

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

4.7.2 For the sake of clarity:

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

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

4.8 Vacancies and defects in appointments

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

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

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

- Either the Chief Executive Officer or the Chief Finance Officer
- At least one Non-Executive Member
- At least one Partner Member

4.9 Decision making

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

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

a) All members of the Board who are present at the meeting will be eligible to cast one vote each.

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

Disputes

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

Urgent decisions

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

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

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

4.10 Minutes

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

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

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

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

4.11 Admission of public and the press

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

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

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

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

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

5 Suspension of Standing Orders

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

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

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

6 Use of seal and authorisation of documents.

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

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

END

NHS Devon

NHS Devon Integrated Care Board

Chief Executive Officer's report

Date of meeting	Date report produced
29 May 2025	14 May 2025

Author(s)		Report approved by	
Name and title:	Sam Cush, Communications Manager Philippa Harding, Director of Governance and Interim Chief Communications and Corporate Affairs Officer	**Name and title:**	Steve Moore, Chief Executive Officer
Phone:		**Date:**	22 May 2025
Email:			

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

Executive summary
This report provides an update from the Chief Executive Officer.

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

Key recommendations and actions requested
NOTE the contents of the report
ENDORSE the transition to a formal Trade Union Recognition Agreement to replace the existing Staff Partnership Forum arrangement
APPROVE the Emergency Preparedness, Resilience and Response (EPRR) policy

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	N/A
Improve services and reduced unwarranted variation	N/A
Make more efficient use of our resources	N/A
Develop our culture and how we operate	N/A

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	N/A
Health inequalities	N/A
Workforce	N/A
Resources and finance	N/A
Legal	N/A
Digital and Data	N/A
Involvement, Engagement and consultation	N/A

Chief Executive Officer's report

Model ICB Blueprint and local plans

1. On 1 April 2025, NHS England wrote to ICB and provider leaders outlining how we will work together in 2025/26 to deliver our core priorities and lay the foundations for reform.

2. Delivering these core priorities will require a leaner and simpler way of working, where every part of the NHS is clear on their purpose, what they are accountable for, and to whom.

3. Over the last couple of months, NHS England has worked with ICBs leaders across the country to co-produce a draft Model ICB Blueprint that clarifies the role and purpose of ICBs, recognising the need to build strong strategic commissioning skills to improve population health and reduce inequalities, and focus on the delivery of the three strategic shifts – sickness to prevention, hospital to community, analogue to digital.

4. The blueprint will support ICBs to create locally driven indicative plans to achieve the model approach by the end of May 2025, ensuring these are affordable within the reduced running cost envelope and implemented by the end of quarter three 2025/26 (December).

5. Reducing costs of ICBs by 50% will be a challenge, but it's important to move on this as quickly as possible to seize the opportunities of ICBs in the future landscape, recognising the critical role they will play in the delivery of the forthcoming 10 Year Health Plan.

6. The draft Model ICB Blueprint has functional implications for different parts of the system and the next steps will need to be developed through close working with partners nationally and within local systems over the coming months. In light of this, no specific timeframes are provided at this stage for functions set out in the blueprint.

Functional changes

7. ICBs have a critical role to play as strategic commissioners, improving population health, reducing inequalities and ensuring access to high quality care.

8. The draft Model ICB Blueprint identifies a number of functional changes that ICBs will have to manage and indicates the responsibilities they may look to grow, adapt or review for transfer.

9. The list of responsibilities isn't exhaustive or prescriptive and, where specific functions are identified, it will be for regional and system teams to work together to determine their future shape.

10. As ICBs focus on system leadership for population health, they will need to develop capabilities that support better understanding of population needs and pathway design, and that enable efficient resource allocation aligned to long-term population health outcomes.

11. ICBs will also need to consider how they best adapt existing functions to unlock greater focus on priority areas, such delivering some functions at scale, or utilising automation.

12. To support development of the future model, ICBs will also have to review functions and activities that might be safely transferred to other parts of the system over time, such as national bodies, regional teams or providers.

Clustering and mergers

13. The draft Model ICB Blueprint indicates that, to fulfil their future functions effectively and within the running costs cap of £18.76 per head of population, there may need to be a minimum viable size at which ICBs operate. Systems will need to work on larger footprints to benefit from the efficiencies of working at scale.

14. As ICBs design their cost reduction plans, they are expected to actively explore how they work together to share functions and agree clustering arrangements to plan and deliver services to best meet local needs. Over the past few weeks, we have been discussing with our regional colleagues our preferred future footprint – a separate update on this is below.

15. Clustering ICBs might make joint senior appointments and establish joint committees, and may formally merge in future to give greater stability. To unlock the potential of clustering, NHS England is removing barriers preventing ICB chief executives holding more than one role, enabling all senior appointments to be joint across clustering ICBs.

16. Clustering ICBs will remain separate legal entities, each responsible for ensuring they meet their statutory duties and manage their financial position.

17. ICBs will need to recognise emerging strategic local authority boundaries and new unitary authorities as part of the Local Government Reform Process. NHS England will advise ICBs on footprints for clustering and merging, informed through discussion with DHSC and other government departments.

Statutory duties

18. To support development of the future model and streamline operations, ICBs should explore and identify functions and activities that are already done by other parts of the system and can be safely transferred to reduce duplication without compromising statutory responsibilities.

19. Statutory duties relating to special educational needs and disabilities (SEND) provision and safeguarding are considered “ancillary” to ICBs’ core

commissioning duties and cannot safely be separated through delegation, while secondary legislation prohibits the delegation of continuing healthcare (CHC) decision-making.

20. NHS England will work with ICBs on the future of those statutory duties which are not core to strategic commissioning but cannot be simply delegated.

Other duties

21. The draft Model ICB blueprint is clear that strong user involvement and co-design functions will be fundamental if services are to meet the needs of the populations they serve. Communications teams will therefore have a key role in the future model as ICBs adapt and streamline their core organisational operations.

Our preferred footprint for the future

22. Following discussions with NHS England and ICBs in the south west, I can confirm that we are proposing to form a wider ICB "cluster" with our neighbouring colleagues at NHS Cornwall and Isles of Scilly.

23. This would be one of three ICBs in the south west:

    a. Devon, Cornwall and Isles of Scilly
    b. Gloucestershire and Bristol, North Somerset and South Gloucestershire (BNSSG)
    c. Bath and North East Somerset, Swindon and Wiltshire (BSW), Somerset and Dorset.

24. I want to stress that this is very much a proposal, which will need to be worked through in more detail with our colleagues in Cornwall and Isles of Scilly, taking into account the discussions we have been having with stakeholders, scrutinised by NHS England and will go through a national approval process.

25. We are now in the process of redesigning how our ICB could work to best meet the needs of our local population within a mandated reduction in organisational running costs and under the proposal to form a wider ICB "cluster" with neighbouring colleagues at NHS Cornwall and Isles of Scilly.

26. Design discussions have taken into account a range of considerations such as population size and needs, patient flows, the need to discharge statutory duties, partnership arrangements and the imperative for maintaining strong 'place' based geography to support development of neighbourhood health in the future.

27. All ICBs are required to submit their proposals by 30 May, which will then be reviewed by the national NHS England team.

28. Once given the go-ahead, reshaped ICBs are expected to come together under 'clustering' arrangements from later this year, with a view to formal merger from either April 2026 or April 2027, once any changes to local authority boundaries have been settled.

29. Our transition lead for this programme is Piers Tetley, Chief People Officer, supported by Kirsty Denwood, Interim Chief Finance Officer, and Philippa Harding, Interim Chief Communications and Corporate Affairs Officer.

30. We remain committed to supporting our staff during this uncertain period in an open, compassionate and timely manner. We have held regular briefing sessions and published written updates, as well as introduced new support mechanisms, including drop-ins, office walk-throughs, FAQs and bespoke 'Ask Us Anything' sessions where colleagues can raise questions, queries and worries.

31. We will also shortly be launched an additional wellbeing package that will cover a wide range of topics, including: looking to the future; leading through change; working through transition; workplace wellness sessions; and outplacement & career coaching support.

32. I am also hugely grateful to colleagues across our organisation who are pulling together to offer additional support to staff including our Staff Partnership Forum, Wellbeing Champions, Mental Health Champions, Freedom to Speak Up Guardians and Domestic Abuse Sexual Violence Response Champions.

33. We are also working closely with NHS Cornwall and Isles of Scilly, not only to develop our proposal, but also in the way we communicate with, engage and support staff across both organisations.

34. Finally, I want to reassure colleagues that our priority remains to serve the population of Devon in the best possible way, working closely with, and remaining accountable to, all local health and care partners.

Chief Strategic Commissioning and Planning Officer and Deputy Chief Executive appointment

35. I am pleased to announce that Libby Ryan-Davies has been appointed as our Chief Strategic Commissioning and Planning Officer and Deputy Chief Executive, following an external recruitment process.

36. Libby, who started her new role at the end of April, has a wealth of experience in health strategy and transformation and will therefore be hugely valuable to our organisation and system.

37. As we have seen in the recent national announcements, ICBs will have a much greater focus on strategic commissioning, so Libby's role will be crucial in shaping what we do and how we do it.

38. In her new role, Libby will provide executive oversight of strategic commissioning and planning across our health and care system, ensuring the delivery of transformational change programmes that integrate services and resources to improve outcomes for our population.

39. As a member of our executive team and Board, Libby will also lead the Transforming Devon Programme and development of our NHS Devon strategy.

40. Libby joined us last August on a temporary secondment funded by NHS England's Recovery Support Programme as a Transformation Director. Her role has been to lead and drive our out-of-hospital delivery programme and the development of a medium-term plan to support our local communities as an alternative to hospital.

41. Prior to her role with us, Libby was the Integrated Health Community Director for Betsi Cadwaladr University Health Board and Strategic Programme Director at Hywel Dda University Health Board in Wales.

42. I am sure colleagues will join me in congratulating Libby on her appointment, and I look forward to continuing to work with her in her new role.

Transition to a Formal Trade Union Recognition Agreement

43. NHS Devon recognises the significant benefits of effective communication, engagement, joint consultation, and, where appropriate, negotiation between management and employees. We are committed to fostering a positive culture of openness and participation, where every member of staff is valued.

44. Effective formal consultation mechanisms are essential to support this culture, ensuring that staff interests are represented. Many NHS organisations have established formal partnership agreements with recognised Trade Unions (TUs), as their formal consultative body requiring organisations to share information, discuss, and negotiate workforce matters in a timely manner. Such agreements typically cover issues affecting employees, including organisational change and changes to terms and conditions of employment.

45. In 2013, to ensure effective staff representation, a staff vote established the Staff Partnership Forum (SPF), comprised of elected employee representatives. Since then, the SPF has served as our formal consultative body for matters requiring collective consultation or bargaining.

46. The SPF has provided valuable insight, challenge, and support, and is now a familiar arrangement for staff. TU representatives have always been welcome to attend SPF meetings and engage in discussions, as reflected in the SPF's terms of reference. TUs have continued to support individual employee matters and have been kept informed during recent change programmes.

47. Over time, however, the TUs have increasingly advocated for NHS Devon to sign a formal TU Recognition Agreement, aligning with standard practice across most NHS organisations. NHSE has also recommended that ICBs formalise TU recognition, although this is not mandatory.

48. There is also a growing concern that employee-elected representatives may face challenges during significant organisational change, especially when directly affected themselves. This can create conflicts of interest and potentially compromise impartiality. In contrast, direct engagement with TUs could be viewed as a more effective and impartial means of managing collective consultation.

49. In light of this the NHS Devon Executive took the decision at its meeting on 20 May that a Recognition Agreement should be implemented as soon as possible ahead of any upcoming change processes associated with the “clustering” of NHS Devon and NHS Cornwall and Isles of Scilly.

50. Direct engagement with TUs will not diminish our commitment to transparent and inclusive communication with all staff. During major change processes, consultation papers and relevant information will continue to be shared widely with all affected employees, ensuring access to the same information and opportunities to contribute feedback. Furthermore, “staff voice” can continue to be heard through various other mechanisms (e.g. “Ask us anything”, staff briefings, wellbeing champions etc) and the organisation will review this to ensure there are appropriate mechanisms to communicate with staff, especially during the upcoming change process.

51. I would also like to express my thanks to the many staff who have been part of the Staff Partnership Forum since 2013. They have provided fantastic representation to our colleagues and have helped to make our organisation a better place to work for all.

The Board is asked to endorse the transition to a formal Trade Union Recognition Agreement to replace the existing Staff Partnership Forum arrangement

GP collective action update

52. General Practitioners Committee (GPC) England’s advice to primary care remains clear: although the national dispute between primary care and the government is no longer active, practices and Local Medical Committees (LMCs) should maintain collective action locally by targeting commissioning gaps. GP collective action is therefore not a transient response but a sustained change in how general practice is prepared to interact with ICBs.

53. Despite this, general practice activity in Devon remains up by *16%* compared to pre-pandemic levels. However, this masks substantial pressures being managed below the surface, with many practices withdrawing from historical informal or unfunded activity. This has a direct impact on patients, pathways, provider workload, and NHS Devon reputational and operational risk.

54. Our Primary Care Medical Director continues to chair a bi-weekly meeting with providers in order to identify issues from the ongoing action and identify mitigations for consideration. Additionally, NHS Devon liaises with NHSE and other ICBs in the South West Region. Each ICB has its unique set of issues and

risks but many of the issues, for example the pressure on resources and unmitigated issues and risks, are common.

Emergency Preparedness, Resilience and Response (EPRR) policy for approval

55. All NHS organisations have a responsibility to prepare for, and respond to, emergency incidents and other disruptive events that impact upon their community or their service delivery. This is generally known as Emergency Preparedness, Resilience and Response (EPRR)

56. NHS Devon has a leadership role both in ensuring that the delivery of essential healthcare to the community is maintained and in leading the local health response to emergencies that affect our communities. In order to fulfil this, it has a policy, which requires approval by the Board, the implementation of which enables NHS Devon to integrate its response into the wider NHS response to emergencies in the community. This policy also enables NHS Devon to maintain its critical functions, despite disruption affecting its services.

57. This policy has recently been reviewed in light of change to organisational structures and is now being presented to the Board for approval. It is appended and an annex to his report.

The Board is asked to approve the Emergency Preparedness, Resilience and Response (EPRR) Policy

Amendment of the One Devon Collaborative Corporate Service Business Case

58. The One Devon Shared Collaborative Corporate Service (CCS) aims to unify corporate functions, focusing initially on Finance, Procurement, People Services, Digital Operational Services, and Business Intelligence.

59. The proposal was brought to the Board in February 2025, and the Board:

- Approved the implementation of a single finance system.
- Approved the implementation of an interoperable procurement system, with final sign-off authority delegated by each sovereign organisation to its Chief Executive Officer, to be exercised via the One Devon System Leadership Group.

60. Since approval, NHSE has confirmed it is unable to support the cost of change incorporated within the business case, given the level of national deficit support funding already received by the One Devon Integrated Care System and the impact on equity to other systems in the South West.

61. In order to enable the progression of the business case, work has been undertaken on progressing with a different commercial partnership model with

NHS SBS. This has resulted in a reduction in the total cost of change required to deliver the business case of £15k with no upfront costs in 2025/26, a small surplus in year of go live 2026/27 and a financial surplus of £1.8m per annum in steady state.

NHS Devon Executive meeting business

62. The NHS Devon Executive's Terms of Reference require a report to be provided at each NHS Devon Board meeting, to demonstrate how the Committee has discharged its responsibilities (since the last meeting of the NHS Devon Board).

63. The NHS Devon Executive met on 01 and 29 April 2025 and then weekly in May 2025, in light of the level of business required to be transacted. Set out below is a summary of that business.

01 April 2025

64. The Executive reviewed the following performance assurance reports:

- Progress towards NOF4 exit
- 2024/25 Annual Plan Progress Update
- An oral update on quality-related issues
- NHS Devon Integrated Care Board and One Devon Integrated Care System Finance Reports
- The Corporate Risk Register

65. The following additional issues were also considered:

- Use of the Company Seal – an update on the usages of the NHS Devon Seal in 2024/25, in advance of consideration of this issue by the Audit and Risk Committee
- Devon Investment Group: Prioritisation Process and Impact – oversight and assurance of the investments prioritisation process and the recommendations made by the Devon Investment Group, specifically in relation to shortlisting of investment proposals for 2025/26 and prioritisation and scoring outcome of 2025/26 investment proposals.
- UEC Investment Review – a review of the proposed 2025/26 schemes which were planned to support urgent care improved performance.
- 2024/25 Draft Annual Report & Accounts - the content of the draft Annual Report for NHS Devon for the period of 1 April 2024 to 31 March 2025 and a brief update on the submission of the Accounts for that period, in advance of the consideration of these by the Audit and Risk Committee.
- Children strategic commissioning intention - procurement of community children's services
- Diabetes - Hybrid Closed Loop (HCL) - an overview of the first year's implementation of NICE TA 943 and the financial planning for 2025/26
- Freedom to Speak Up (FTSU) Quarterly Update - information about current FTSU cases, and plans for future development of guardians

- Quarterly Contracting review including Single Action Waivers – an update on procurement activity in advance of the consideration of this issue by the Audit and Risk Committee
- BCF Negotiating Plan - an overview of the three Better Care Fund Plans for Devon, Plymouth and Torbay Health and Wellbeing Board areas
- Internal Audit Update - an update on the progress of the 2023/24 internal audit programme and the closure of actions in response to internal audit recommendations.

29 April 2025

66. The Executive reviewed the following performance assurance reports:

- Progress towards NOF4 exit
- An oral update on quality-related issues
- NHS Devon Integrated Care Board and One Devon Integrated Care System Finance Reports
- An oral update on the proposed revised approach to the Board Assurance Framework in 2025/26

67. The following additional issues were also considered:

- Options Appraisal Anti-Psychotic Prescribing - Following the outcome from GP collective action, Devon LMC have written to GPs urging them to review their prescribing and monitoring and where patients are not covered by an appropriate enhanced service, to consider serving notice for patient benefits and to reduce clinical risk. The Executive gave consideration to the most appropriate response to this situation.
- GP Collective Action (see section earlier in this report for more information)
- Mental Health Assertive Outreach Response – a report on this can be found elsewhere on the agenda for this meeting of the Board
- Proposal for Delivery of Additional Urgent Dental Care Appointments 2025/26 - NHS Devon's total target for UDC delivery in 2025/26 is therefore 81,705 appointments, which represents a 42.3% increase above when baseline data was collected.
- Novating Contracts for Provider Organisational Restructure – the response to HMRC rules in relation to the application of VAT.
- Information Governance & Information Security - an overarching update in respect to all items within the Information Governance (IG) agenda as well as assurance regarding IT and cyber security of NHS Devon.
- Policy Framework Update - an update on the status of NHS Devon's non-clinical policies.

06 May 2025

68. The Executive reviewed the following performance assurance reports:

- NHS Devon Annual Plan 24/25 Closedown Report

- Board Assurance Framework

69. The following additional issues were also considered:

- Demand Management – the actions due to be taken by NHS Devon in 2025/26 in order to support the One Devon Elective Improvement Programme.
- Assurance of NHS Devon's adherence to choice regulations following redistribution of elective activity from the independent sector to achieve sufficient NHS Acute RTT capacity
- NHS Devon Self-Assessment Against the NHS Oversight Framework – a report on this can be found elsewhere on the agenda for this meeting of the Board
- One Devon Integrated Care System NHS Partners Self -Assessment Against the NHS Oversight Framework – a report on this can be found elsewhere on the agenda for this meeting of the Board

13 May 2025

70. The Executive reviewed the following issues:

- Cardiology – an oral update on the development of commissioning intentions with regard to the consolidation of Primary Percutaneous Coronary Intervention Services in Devon – a report on this can be found elsewhere on the agenda for this meeting of the Board.
- Emergency Department (ED) Demand Management Programme - the actions due to be taken by NHS Devon in 2025/26 to mitigate ED demand by enhancing capacity within primary care, improving respiratory care access, refining 111 validation processes, and building on existing Care Coordination models to implement effective patient navigation.

20 May 2025

71. The Executive reviewed the following issues:

- Trade Recognition Agreement (see section earlier in this report for more information)
- Population Health Business Cases - the approval of two business cases to support population health improvement interventions.
- Finance Shared Services (see section earlier in this report for more information)
- Health & Care Strategy – a report on this can be found elsewhere on the agenda for this meeting of the Board.
- Delivery of 2025/26 Annual Plan – a report on this can be found elsewhere on the agenda for this meeting of the Board.

Recommendations

72. The Board is asked to:

- **NOTE** the contents of the report
- **ENDORSE** the transition to a formal Trade Union Recognition Agreement to replace the existing Staff Partnership Forum arrangement
- **APPROVE** the Emergency Preparedness, Resilience and Response (EPRR) Policy

Emergency Preparedness, Resilience & Response Policy

NHS Devon

Version	Version 1.4 DRAFT
Policy Sponsor	Chief Medical Officer
Policy Lead	Senior EPRR Manager
Approved by	NHS Devon Board
Approved on	29/05/2025
To be reviewed by	30/06/2027

Document change history (to add rows, copy and paste)		
Date	**Change**	**Comments**
17/06/2019	New Policy	V0.1 - New EPRR Policy for NHS Devon CCG, replacing predecessor policies and frameworks
17/06/2019	New Policy	V1.0 – New Policy
November 2020	Policy Amendment	V1.1 – Revised following pandemic first wave
June 2022	Policy Amendment	V1.2 – Revised for transition to ICB
01/06/2023	Policy Amendment	V1.3 – Revised to replace reference to Governing Body
31/03/2025	Policy Review	V1.4 – Review following ICB restructure

Equality, diversity and inclusion statement

NHS Devon is committed to the promotion of equal opportunities, addressing health inequalities and fostering of good relations between people protected under the terms of the Equality Act 2010, the Health and Social Care Act 2012 and Human Rights legislation. We are equally committed to the elimination of unlawful discrimination, harassment and victimisation. To demonstrate this commitment, we develop, promote and maintain policies, strategies and operating procedures. Every effort is made to ensure that patients, employees, contractors or visitors do not experience discrimination; either directly or indirectly, because of their vulnerability; disadvantage; age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion and belief; sex (gender) or sexual orientation.

All staff must comply with this policy. Compliance must reflect our organisational commitment to and policy on, equality, diversity and inclusion. In addition, each manager and member of staff involved in implementing this policy must give due regard to the needs of those protected under law.

If you, or any other groups, believe you are discriminated against under the terms of the Equality Act, the Health and Social Care Act 2012 or Human Rights legislation by anything contained in this document; or you need this document in an alternative format, for example, large print, Braille, Easy

read or other languages; please contact our Patient Advice and Complaints Team (PACT):
Tel: 0300 123 1672 Email: d-icb.patientexperience@nhs.net

Contents

Section	Title	Page
1	Introduction	4
2	Purpose and objectives	4
3	Scope	4
4	Definitions	4
5	EPRR Policy Content	5
5.1	Legislation and Policy	5
5.2	Governance	5
5.3	Resources	6
5.4	On-Call System	6
5.5	Emergency Plans	6
5.6	Business Continuity Management System	7
5.7	Participation in Health and Multi-Agency EPRR Structures	7
5.8	Training and Exercising	8
5.9	Annual EPRR Assurance	9
6	Accountabilities, duties and responsibilities	10
7	Implementation	12
8	Approval and review	13
9	Monitoring compliance and effectiveness	13
10	Quality and Equality Impact Assessment	13
11	References	13
Appendix A	Quality and Equality Impact Assessment	14
Appendix B	Procedural document implementation plan	18

1. Introduction

1.1. All NHS organisations have a responsibility to prepare for, and respond to, emergency incidents and other disruptive events that impact upon their community or their service delivery.

1.2. NHS Devon Integrated Care Board (ICB) has a leadership role both in ensuring that the delivery of essential healthcare to the community is maintained and in leading the local health response to emergencies that affect our communities.

1.3. By implementing this policy, the ICB will integrate its response into the wider NHS response to emergencies in the community; it will also enable the ICB to maintain its critical functions, despite disruption affecting its services.

2. Purpose and objectives

2.1 This Policy sets out how NHS Devon will ensure that it meets its Emergency Preparedness, Resilience and Response (EPRR) responsibilities, as required by statute and national policy.

3. Scope

3.1 This policy applies to all staff of NHS Devon.

4. Definitions

Terms	Definition
AEO	Accountable Emergency Officer – an Executive Director with responsibility for discharging the organisation's EPRR duties under the NHS Act 2006, Section 252A
BCMS	Business Continuity Management System – the system through which business continuity preparedness will be managed
BCP	Business Continuity Plan – a plan for how the response to a disruptive incident will be managed, ensuring that the organisation's critical functions are maintained or swiftly re-established
CRR	Community Risk Register – a risk assessment of the hazards and threats faced by the local area, undertaken by LRF participants based upon historical evidence and the advice of national experts.
EPRR	Emergency Preparedness, Resilience and Response – this is the nationally used NHS term for what was previously known as Emergency Planning
LHRP BMB	Local Health Resilience Partnership Business Management Board (LHRP BMB) – an EPRR practitioner group responsible for implementing the strategic direction set out by the LHRP Executive.
LHRP Exec	Local Health Resilience Partnership Executive – a national policy mandated group of NHS Accountable Emergency Officers from all NHS organisations in Devon, Cornwall and the Isles of Scilly

	(DCIoS), who provide an integrated strategic direction to the EPRR work undertaken by their constituent organisations.
Loggist	An individual trained to record decisions in a manner that promotes the credibility and defensibility of the Incident Log in which the organisation's incident response decisions are written
LRF	Local Resilience Forum – a statutory process under the Civil Contingencies Act 2004, whereby emergency responding organisations co-operate and co-ordinate their emergency planning to promote an integrated emergency response – chaired by the Police and based upon Police Force boundaries. Divided into an Exec group – Chief Officers Executive Board (COEB) and an EPRR practitioners' group – Monthly on Thursday (MOT)

5. EPRR Policy Content

5.1 Legislation and Policy

5.1.1. As an NHS organisation, the ICB is subject to certain pieces of legislation and national policy that govern the EPRR landscape; these are set out below.

Legislation

- NHS Act 2006, Sections 252A & 253 (as amended by the Health & Social Care Act 2012)
- Civil Contingencies Act 2004
- Health and Social Care Act 2012
- Health and Care Act 2022

Policy

- NHS England EPRR Framework 2022
- NHS England Business Continuity Management Toolkit 2023
- NHS England Core Standards for EPRR

5.1.2. As a consequence of becoming an ICB, NHS Devon became a Category 1 emergency responder organisation under the Civil Contingencies Act 2004. This places six statutory duties upon the organisation, specific to EPRR, which are:

- Risk assessment
- Business continuity management
- Emergency planning
- Maintaining public awareness and arrangements to warn, inform and Advise the public.
- Co-operation
- Information sharing

5.2 Governance

5.2.1 In order that EPRR policy and plans are properly scrutinised and authorised, they will be signed off through the following routes:

Description	Governance Process
EPRR Policy	Scrutinised by Accountable Emergency Officer and authorised by the Board
EPRR Plans	Authorised by Accountable Emergency Officer
Business Continuity Plans	Directorate BCPs are authorised by the individual Directorates' Executive Director The ICB's corporate BCP is authorised by the Accountable Emergency Officer
Annual National NHS England mandated EPRR Assurance	Scrutinised by Accountable Emergency Officer and accepted by Board
Annual Business Continuity Audit	Authorised by Accountable Emergency Officer

5.3 Resources

5.3.1 The Board will ensure that sufficient resource is provided to fulfil the EPRR function, in order that the ICB may effectively fulfil its obligations under statute and national policy.

5.4 On-Call System

5.4.1 The On-call system will comprise a two tier on-call rota with a Director on-call rota staffed by Executive Directors and Band 9 senior managers, and a Manager on-call rota staffed by Band 8D and 8C senior managers.

5.4.2 On-call staff will participate in an On-call rota that allocates them to 2-day shift duty periods.

5.4.3 On-call staff will be activated via a single point of contact telephone number which will enable partners and staff to contact whoever is on-call at the time they dial the number.

5.4.4 On-call staff will be supported by an On-call pack prepared and maintained by EPRR.

5.4.5 On-call staff may swap duty periods by the method of finding another rota participant to cover their duty period and the notifying EPRR of the change; EPRR will then amend the on-call rota.

5.4.6 On-call periods covering Christmas, New Year and Easter, will be covered in duty periods of individual days in order to share these holidays equitably across rota participants.

5.5. Emergency Plans

5.5.1 As required by the NHS England Core Standards for EPRR, the ICB has a responsibility to develop and exercise a suite of emergency plans. The plans that are required will provide for a response to (this list is not exhaustive):

- Emergency incidents
- Severe Weather
- Fuel disruption
- Pandemic Influenza
- Communicable Disease
- Mass Casualty

5.5.2 Risk Assessment

The ICB's suite of emergency plans will be based upon assessed risk. This risk assessment will take into consideration the assessment of risks undertaken by the Local Resilience Forum (LRF) and published in the Community Risk Register (CRR); it will also take into consideration any risk assessment undertaken by the Local Health Resilience Partnership (LHRP).

5.5.3 These EPRR risks will be monitored and maintained by the Senior EPRR Manager and, where a risk is identified as High or Very High, consideration must be given to escalating it onto the ICB Corporate Risk Register.

5.6. Business Continuity Management System

5.6.1. In order to be able to maintain its critical business functions, the ICB will put in place a Business Continuity Management System (BCMS). This BCMS will be maintained by the Senior EPRR Manager, supported by Directorate Business Continuity (BC) Leads.

5.6.2. The BCMS will comprise the following elements:

- ICB Business Continuity Plan – maintained by EPRR
- Directorate Business Continuity Plans – maintained by Directorate Business Continuity Leads

5.6.3. The ICB BCMS will be aligned with ISO 22301 'Societal Security – Business Continuity Management Systems'.

5.6.4. All business continuity plans will be reviewed when substantive change has occurred that affects the content, or annually, whichever is earlier.

5.7. Participation in Health and Multi-Agency EPRR Structures

5.7.1 Local Health Resilience Partnership (Executive)
The Local Health Resilience Partnership (LHRP) for Devon, Cornwall and the Isles of Scilly (DCIoS) provides the strategic direction for Health EPRR work within its area.

5.7.2 It is an Executive level group attended by AEOs from all ICBs and NHS Providers, a Head of EPRR for NHS England, and the Head of Resilience for SWAST. The Partnership is co-chaired by the NHS Devon AEO/ NHS Cornwall AEO and a lead local Director of Public Health. The two ICB AEOs will share one co-chair role.

5.7.3 The ICB will be represented at the LHRP (Executive) by the AEO; in their absence another Executive or Deputy must be nominated to attend in their place.

5.7.4 Local Health Resilience Partnership (Business Management Group)
The Local Health Resilience Partnership (BMG) is the EPRR practitioner level group with the responsibility for implementing the strategic direction of the LHRP.

5.7.5 It is chaired by the NHS Devon Senior EPRR Manager, and its purpose is to implement the strategic direction provided by the LHRP (Exec).

5.7.6 Local Resilience Forum
The Local Resilience Forum (LRF) is a statutory process for the integration of emergency preparedness in the local area, to the benefit of the community. It's functions are required by the Civil Contingencies Act 2004.

5.7.7 The LRF has an Executive meeting element (Chief Officers Executive Board (COEB)) and a number of emergency planning practitioner elements.

5.7.8 The Devon System is formally represented at the LRF COEB by the AEO, and at the LRF practitioner level by the Senior EPRR Manager.

5.7.9 Both the NHS Devon AEO and Senior EPRR Manager are the lead representatives for the NHS in the meetings that they attend, speaking for the Devon system.

5.7.10 NHS Devon is classed as a Category 1 emergency responding organisation under the Civil Contingencies Act 2004.

5.8. Exercising and Training

5.8.1 To ensure that they are prepared for their on-call role, the ICB's key staff must undergo regular training. This training required for different roles is set out below:

Training	Who	Frequency
On-call Induction training	All on-call staff	Once, prior to first on-call duty
On-call Refresher training	All on-call staff	Annually
Principles of Health Command Training	Directors on-call	Every three years
Media training	CEO or selected Execs	Once (recommended)
Surviving Public Inquiries	Directors on-call	Once (recommended)
Decision Loggist training	Loggist volunteers	Every three years
BC Lead training	Directorate BC Leads	Every three years

5.8.2 All NHS organisations are required to exercise their emergency and business continuity plans and the NHS England Core Standards for EPRR sets out the following frequencies:

- A communications exercise every six months
- A table-top exercise every year
- A live exercise every three years*
  *This requirement may also be met by a live incident response which has required a plan to be activated, followed by a post-incident debrief, with lessons identified and a post-incident report having been written.

5.8.3 The responsibility for ensuring that the training and exercising requirements are met lies with the Senior EPRR Manager.

5.9. Annual EPRR Assurance

5.9.1 Each year, NHS England requires that all NHS organisations are assured against the NHS England Core Standards for EPRR.

5.9.2 The responsibility for undertaking the assurance of Devon's NHS providers lies with the ICB and will be carried out by the Senior EPRR Manager. NHS England will undertake an assurance of the ICB's preparedness.

5.9.3 The outcomes of the EPRR assurance process referred to in 5.9 will be submitted to a Public Board by the AEO.

5.9.4 NHS England will hold a confirm and challenge meeting on the emergency preparedness of the system with the ICB AEO and Senior EPRR Manager. The outcome of this meeting will be fed into the National assurance process through Region.

5.9.6 The ICB will then present to the November LHRP Executive meeting the EPRR Assurance outcomes for the ICB and all Devon providers.

6 Accountabilities, Duties and Responsibilities

Chief Executive Officer	The Chief Executive Officer has ultimate accountability for the strategic direction and operational management of NHS Devon, including compliance with all legal, statutory and policy requirements. The Chief Executive Officer (CEO) is accountable for the preparedness of the ICB and for its response to emergency incidents and other disruptive events; this may be delegated to another Executive Director in the role of Accountable Emergency Officer.
Policy Sponsor	The Policy Sponsor is responsible for: • ensuring that policy is appropriate for consideration for approval; • endorsing this policy ahead of submission for approval; • with the Policy Lead, maintaining and updating procedures/protocols and other supporting documents for this policy; • ensuring the implementation of the Policy.
Policy Lead / Author	It is the responsibility of the Policy Lead / author to: • ensure as far as possible that the policy is in line with Department of Health and Social Care guidance, legal requirements and advice from clinical bodies; • to complete a QEIA and Implementation Plan where required • undertake a fair and proportionate consultation period with the relevant stakeholders as part of the document's development • to ensure that the policy is in alignment with NHS Devon's strategy and values • ensure that the policy is developed, approved, disseminated and monitored as set out in the document; with Policy Sponsors, maintaining and updating procedures / protocols and other supporting documents for this policy.
Accountable Emergency Officer	The Accountable Emergency Officer (AEO) is an Executive Director to whom the CEO has delegated the executive responsibility for the ICB's EPRR obligations. The AEO fulfils the role of Policy Sponsor The managerial oversight of the EPRR function is delegated to the Head of System Delivery and Improvement.
Non-Executive Director	A Non-Executive Director on the Board is appointed to support the AEO in their role; this role is that of a 'critical friend' on the Board.
Head of System	Head of System Delivery and Improvement has had the managerial oversight of the EPRR function delegated to them and is responsible for ensuring that

Delivery and Improvement	the ICB's operational requirements in respect of EPRR are delivered to an acceptable standard. The line management of the Senior EPRR Manager sits with the Head of System Delivery and Improvement.
Senior EPRR Manager	The Senior EPRR Manager is the EPRR Policy Lead. They are responsible for the day-to-day delivery of the EPRR function, ensuring that the ICB meets its statutory and other obligations in line with the NHS England Core Standards for EPRR. The delivery of this function will require the post-holder to undertake the annual EPRR Assurance process on behalf of the ICB, liaising with provider EPRR Leads and NHS England South West EPRR Team as necessary to delivering this. The primary functions of EPRR within the ICB are to: • Develop and maintain emergency plans; • Develop and support business continuity preparedness within the ICB; • Maintain and support the 24/7 On-call system; • Develop and arrange/ deliver the training necessary for key staff to enable preparedness; • Develop and arrange/ deliver exercises to validate emergency and business continuity plans; • Liaise with Health and multi-agency partners, as necessary, in the pursuit of the above; • Prepare and provide evidence in support of the ICB submission for the annual EPRR Assurance; • Undertake the annual EPRR Assurance of Devon NHS Providers as part of the national process.
On-Call Staff	On-call staff are responsible for leading the ICB and System's response to any emergency incident or disruptive event, requiring a response from the ICB, that occurs during their period of on-call duty. They have the delegated authority to commit and direct ICB resources in support of the Health response to an incident, as they deem it necessary and appropriate. During an emergency incident in the community which only affects Devon, the Director on-call will be the NHS strategic lead. Should the incident have an impact wider than only Devon, or be terrorism, the NHS strategic lead will be held by NHS England SW, with the ICB On-call staff leading the Devon system in support of the response. On-call staff are to be available and contactable 24/7 for the duration of their period of duty. On-call staff are required to ensure their preparedness and familiarity with the role by committing themselves to:

	• On-call Induction training prior to commencement of on-call duties. • Annual On-call Refresher training. • Principle of Health Command training, with a refresher undertaken at least every three years. • Other training identified as necessary for undertaking the On-call role. • Participation in internal ICB, external Health and Multi-Agency emergency preparedness exercises, to validate their training and the ICB's plans.
Business Continuity Leads	Each Directorate is required to nominate a Business Continuity (BC) Lead who will lead on their business continuity preparedness and, with training and direction from the Senior EPRR Manager, develop their Directorate Business Continuity Plan. Directorate BC Leads will have the necessary seniority and knowledge of their Directorate to be able to complete the Business Continuity Plan (BCP) template sufficiently well for it to provide a robust basis for a response to a disruptive event.
Loggists	The Loggist role is recognised in national policy as being necessary to ensure that decisions made during emergency incident responses are recorded in a sufficiently robust manner, that the Incident Log itself will be defensible in a court or Public Inquiry. Sufficient Loggists will be trained to enable On-call staff to be supported by them in the fulfilment of their duties, and a list of loggists maintained by the Senior EPRR Manager. On-call staff will be briefed on the role of the Loggist in order to understand their importance to them and the ICB, and how best to work with them.
Line Managers	Line managers have a responsibility to ensure their staff comply with NHS Devon policies and standards within their areas of responsibility.
All Staff	Employed or engaged staff have a duty to comply with NHS Devon policies and standards as outlined in their contracts of employment and codes of conduct.

7 Implementation

7.1 All staff will be informed of the approval of the Policy via the Staff Bulletin which will provide a link to the document on the NHS Devon Intranet.

7.2 NHS Devon Senior Managers, or their designated representatives, will implement this policy by:

- Notifying all staff of its existence. New staff will be informed of this policy as part of their induction.
- Destroying all superseded paper-based versions of the policy and electronic versions retained in their area.
- Having adequate knowledge of, and / or access to, all relevant legislation in order to ensure that compliance with such legislation is maintained.
- Discussing with staff as part of their regular one-to-ones how they seek to achieve their individual objectives around policy review and maintenance.

8 Approval and Review

8.1 The Accountable Emergency Officer will present this policy to the NHS Devon Board for authorisation.

8.2 This policy will be reviewed every three years, or sooner if required, in order to ensure that it is current, relevant and reflects the strategic aims, objectives, organisational structures and responsibilities of NHS Devon.

9 Monitoring compliance and effectiveness

9.1. This policy will be reviewed by the Senior EPRR Manager at least every three years, or before, should substantive changes require it. This review will ensure that the policy reflects the:

- NHS England Core Standards of EPRR;
- the NHS England EPRR Framework;
- the NHS Act 2006; and
- the Civil Contingencies Act 2004 and associated statutory and non-statutory guidance.

9.2. The policy will also be reviewed annually by NHS England South West as part of the nationally mandated EPRR Assurance process, measured against compliance with the NHS England Core Standards for EPRR.

10 References

Other related policy documents

10.1 N/A

Legislation and statutory requirements

10.2 Civil Contingencies Act 2004 & associated statutory and non-statutory guidance;

NHS Act 2006 as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022;

Best practice recommendations and other key guidance

10.3 NHS England EPRR Framework

ISO 22301 Societal Security: Business Continuity Management System - Requirements

ISO 22313 Societal Security: Business Continuity Management Systems – Guidance

Appendix A: Quality & Equality Assessment

Project lead name:	Phil Coutie
Project lead title/group:	Senior EPRR Manager
Who holds overall responsibility?	Accountable Emergency Officer (AEO)
Who else has been involved in the decision?	N/A
Summary of proposed change: New Policy	
Policy review undertaken following ICB restructure	
Supporting Documents:	N/A
Date of change & duration:	31/03/2025 – duration 3 years
Version:	1.4
Impact checker:	
[mandatory completion: No substantive changes required, mainly role titles.	
Adversely affect patient safety or clinical effectiveness	☐
Adverse effect as a result of variations or deviations from national guidance e.g. NICE requirements, CQC, Equality Act, Care Act etc.	☐
Adversely affect patient, carers or service user experience	☐
Adversely affect staff experience	☐
Adversely affect access to services	☐
Adversely affect people with protected characteristics	☐
None of the above	☒

Safety, effectiveness and experience: [Please use the Safety, effectiveness and experience considerations below]				
Groups affected	**Impact identified (negative or positive)**	**Action taken (including by whom)**	**Further action/ review required?**	**Measurements to monitor effectiveness of actions**
Staff: ☐ Patients: ☐	N/A			
Staff: ☐ Patients: ☐				
Staff: ☐ Patients: ☐				

Safety, effectiveness and experience considerations:	
Safety:	Avoidable harm to patients, Waiting leading to harm, Impact on safeguarding, Suitably qualified and experienced staff, Safe staffing levels, Infrastructure, Clean and safe environment, Treatment procedures, Communication, Administration
Effectiveness:	HCAI/ NICE/ National evidence base/ Use of evidence, Effect on health outcomes, Promotion of self-care, Leadership, Competence, Reliability, Responsiveness, System working – i.e.: models of care
Experience:	Waiting, Patient autonomy, dignity, respect and compassion, Travel to place of care, Informed choice, control or care, Responsiveness, empathy & caring, Experience measures i.e. friends and family tests, complaints, PALs

Actions identified: Guidance required for completion of new paperwork		
Mitigating action:	**Timescales:**	**Lead colleague/group:**
N/A		

Please include any organisations this change may affect:	NHS Devon only
Please details any system considerations: [Please use the System considerations below]	N/A

System considerations: N/A	
System:	N/A

Equality: [Please only mark those groups affected]				
Protected Groups	**Potential people with protected characteristics**	**Does this group currently use the service?**	**What impact will there be on the group [Neutral/positive]**	**Number of people affected**
Sex/Gender	Women			
	Men			
	Gender reassignment			
Race/Ethnic Group	Asian			
	Asian British			
	Black			
	Black British			
	Chinese			
	Gypsy or Roma			
	Irish			
	Mixed Heritage			
	White			
	White British			
	Other ethnic backgrounds			
Disability	Learning disability			
	Mental disability			
	Neurodiversity (autism, Asperger's etc.)			
	Hearing			
	Speech/additional communication need			
	Vision			
	Physical			
	Intellectual (Dementia/brain damage etc.			
Age	<5 years old			
	5 – 18 years old			
	18 – 65 years old			
	65 – 85 years old			
	>85 years old			
Sexual orientation	Lesbian			
	Gay			
	Bisexual			
	Other			
Maternity & pregnancy				

Marriage & Civil partnership				
Faith or Belief				
Service families				
Carer status				
Prisoners				
No fixed abode				
Rurally isolated				

19 – NHS Devon Emergency Preparedness, Resilience & Response Policy

NHS Devon

NHS Devon Integrated Care Board

Progress Report on the Requirements of the NHS Oversight Framework – Segment 4

Date of Meeting	Date Report Produced
29 May 2025	24 April 2025

Author(s)		Report Approved By	
Name and title:	Libby Ryan-Davies, Chief Strategic Commissioning and Planning Officer Philippa Harding, Interim Chief Communications and Corporate Affairs Officer John Finn, Acting Chief Operating Officer Ben Chilcott, Deputy Director of Finance	**Name and title:**	Kirsty Denwood Interim Chief Finance Officer
Phone:		**Date:**	30 April 2025
Email:	l.ryan-davies@nhs.net Philippa.harding4@nhs.net john.finn@nhs.net Ben.chilcott@nhs.net		

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

One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Executive Summary

This report seeks to provide necessary assurance on the progress against the agreed criteria and metrics required to exit Segment 4 of the NHS Oversight Framework (NOF4) in Q1 of 2025/26.

The report details the system position on the criteria for strategy, leadership, urgent and emergency care (UEC), elective, and finance recovery, accompanied by a locality position on delivery against trajectory and the key actions to either maintain or improve performance.

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance	Trend from previous month
Strategy	Satisfactory	No Change
Leadership	Satisfactory	No Change
UEC	Partial	Improvement
Elective	Satisfactory	No Change
Finance	Satisfactory	No Change

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

Reviewed by the NHS Devon Executive at its meeting on 06 May 2025.
Reviewed by the Finance and Performance Committee at its meeting on 08 May 2025.

Key recommendations and actions requested

AGREE the assurance ratings relating to each of the NOF4 progress positions of the One Devon Integrated Care System of **partial for UEC** and **satisfactory for all others** and that satisfactory assurance can be taken that adequate plans are in place to mitigate the risks relating to the delivery NOF4 exit identified in Locality Planning and Delivery Meetings, and the System Leadership Group.

Impact on NHS Devon Objectives

Objective	Impact
Improve Population Health	All
Improve Services and Reduce Unwarranted Variation	
Make More Efficient Use of Our Resources	
Develop Our Culture and How We Operate	

Outline the implications of matters covered in this report for the following areas	
Area	
Quality of Services	Delivery of access standards.
Health Inequalities	None
Workforce	None
Resources and Finance	Delivery of financial sustainability.
Legal	None
Digital and Data	None
Engagement and Consultation	None

Progress Report on the Requirements of the NHS Oversight Framework – Segment 4

Introduction and background

1. NHS Devon is currently in Segment 4 of the National Oversight Framework (NOF4) and in receipt of mandated support from NHS England (NHSE) as set out in the national Recovery Support Programme (RSP). The criteria to move from Segment 4 to Segment 3 have been agreed and require robust recovery and improvement plans to be in place with clear oversight via NHS Devon's governance framework.

2. The expectation is that when NHS Devon's Board considers that the NOF4 exit criteria have been met, with the associated evidence, a proposal will be presented for evaluation by the NHSE South West Regional Team, and a recommendation made to the national team for a change in segmentation. The same applies to all NHS provider trusts within Devon, who would also require NHS Devon's support of their assessment.

3. NHS Devon did not meet its original timeline for NOF4 exit of Q1 of 2024/25 and as such, all NOF4 exit criteria and exit measures were refreshed for 2025/26.

4. The monthly oversight process in Locality Planning and Delivery Meetings in which each locality's progress against the criteria is discussed, including plans to mitigate performance deficits. It should be noted that due to significant pressures and reduced capacity relating to Operational Planning in March 2025, these meetings were stood down.

Leadership (see detail in slide 3 and slide 9 of the NOF4 Assurance Report)

5. Ways of working have improved significantly, supported by refreshed system oversight and assurance structures. This has resulted in improved strategic clarity both in the medium and long-term meaning that the system is well placed to ensure that its Integrated Care Strategy (the strategy) and Joint Forward Plan (JFP) respond to the NHS 10 Year Plan when it is published. It has also resulted in better delivery of improvement plans and significantly better performance in relation to the management of winter pressures.

6. The system has developed a greater clarity on shared programmes to deliver improved sustainability, as evidenced by the successful receipt of the Medium-Term Financial Plan (MTFP) at the NHSE RSP Escalation meeting in October 2024. The Transforming Devon Programme has now been fully established and there is improved grip in relation to the delivery of shared system objectives. Alongside this, the system has agreed that a One Devon Collaborate Corporate

Services (CCS), hosted by a single organisation, should be adopted to provide services to all NHS partners. A vision and set of overarching principles have been agreed, against which the business case will be guided for the proposed end state. The business case will be subject to approval by all six sovereign organisations before the end of 2024/25.

7. There has been greater visibility and co-ordination in relation to quality issues across the system in 2024/25. The System Quality Group (SQG) has taken the lead on ensuring a supportive system-wide approach to learning from concerns raised by regulators. All maternity units in Devon are on the Maternity Safety Support Programme (MSSP). This is due to the system's NOF4 status and all units receiving 'Requires Improvement' at their latest CQC inspection (University Hospitals Plymouth NHS Trust (UHP) 2022, Royal Devon University Healthcare NHS Foundation Trust (RDUH) and Torbay and South Devon NHS Foundation Trust (TSD) 2023). The programme consists of six phases – initiation, implementation, diagnostic, improvement, sustainability and exit. UHP are in the improvement phase and are beginning to implement improvements outlined in their Maternity and Neonatal Improvement Plan (MNIP) and are agreeing exit criteria. TSD and RDUH are currently in the diagnostic phase with diagnostic reports anticipated in Quarter 4 of 2024/25. Specific workforce and governance diagnostics are underway in each organisation

8. The Board can take **satisfactory assurance** that the current plans in place and assurance provided from providers will enable the meeting of the leadership NOF4 criteria.

Strategy (see detail in slide 4 and slide 10 of the NOF 4 Assurance Report)

9. NHS Devon has committed to and put in plans for the development of a comprehensive Health and Care Strategy, to be completed by September 2025. Health and Care Strategy aims to outline our vision and plans to improve the health outcomes for the local population, that is ambioutius operationally and financially sustainable.

10. This strategy will form the foundation of our Joint Forward Plan for 2026–31 and will set out how we will respond to the NHS 10-Year Plan, the Integrated Care Partnership's Integrated Care Strategy, and local Health and Wellbeing Board Joint Local Health and Wellbeing Strategies (JLHWS). Further, the Strategy will align with the MTFP as part of its development.

11. The development of NHS Devon's Health and Care Strategy (Joint Forward Plan) will take a pathway approach to transforming services for all age groups, including the following key components:

    - Population health and prevention
    - Out-of-hospital and community care including children services
    - Children and Young People
    - Primary Care

- Mental Health
- Acute Services (including maternity)
- BCF

12. Ongoing work within Acute Provider Collaborative and Community Services will be included as part of the Health and Care Strategy and developed further.

UEC (see detail in slide 5,11 and 12 of the NOF 4 Assurance Report)

13. The system position for urgent care remains improved from the 2023/24 position in most performance areas during March 2025, with improvements seen in most metrics from December 2024, however, is not currently meeting trajectory against any key indicators.

14. All providers missed trajectory for both 4-hour performance and ambulance handover delays in March 2025. The 4-hour performance position for the system in March 2025 remained unchanged from February 2025 at 68.6% of patients meeting the standard. Whilst performance was reduced at 2 providers and improved at 1, the movements since February 2025 were not material. The position was an improvement on March 2024 (68.5%), maintaining the system record of improved performance on 2023/24 throughout the year. To support an understanding of Devon provider performance in comparison to the rest of the country, the table below illustrates the position in terms of ranking for February 2025 and March 2025.

	Performance since last month	All Types Performance (March)	Rank (March)	All Types Performance (February)	Rank (February)
Devon System	No Change	68.60%	36/42	68.60%	34/42
University Hospitals Plymouth NHS Trust	Decreased	65.80%	109/123	66.40%	104/123
Torbay And South Devon NHS Foundation Trust	Increased	69.80%	92/123	68.90%	85/123
Royal Devon University Healthcare NHS Foundation Trust	Decreased	70.00%	91/123	70.10%	78/123

15. Time lost due to ambulance handovers worsened from 6,299 in February 2025 to 8,129 in March 2025. It should also be noted that the numbers of 8 hour and 6-hour ambulance handover delays have decreased significantly within Q4 in line with the regional ambulance extremis SOP. It is expected that this target will lower to 4 hours in March 2025.

16. Category 2 response times have reduced from 38 minutes to 39 minutes in March 2025. Despite the improvement in ambulance handover performance compared to FY23/24, the category 2 position remains 2 minutes worse than the 2023/24 position.

17. The system continues to work to develop actions to support a reduction in Type 1 demand. Plans are being co-produced to achieve this. Additional support has been sought from the national UEC team to support this diagnostic and to reflect within the 2025/26 out of hospital programme.

18. There is currently only **partial assurance** regarding the meeting of the UEC exit criteria based on current performance being behind trajectory and the risks

identified by the system as they remain significant, particularly as the system manages winter.

Elective (see detail in slide 6, 13 and 14 of the NOF 4 Assurance Report)

19. Improvements continue to be made in the clearance of long waiting patients; however, the original trajectories will not be met. The system continues to exceed the national standard for 28-day faster diagnosis standards in cancer however with a February 2025 position of 84.2% against a trajectory of 78.5%.

20. All providers re-forecast their elective long wait trajectories in December of 2024, and the below table shows performance against these revised trajectories. With the exception of TSD's 65ww performance, there continues to be a negative variance against revised plan despite continued improvement overall.

Provider	January 78ww	February 78ww	February78ww Trajectory
RDUH	22	15	0
TSD	10	12	0
UHP	22	23	0

Provider	January 65ww	February 65ww	February65ww Trajectory
RDUH	358	333	96
TSD	199	201	218
UHP	235	193	0

21. Risks remain for the clearance of all long waiting patients within the 78 and 65 week wait cohorts for the end of the financial year. The unvalidated trajectory for the end of March 2025 for all providers shows a 78ww position of 9 at RDUH, 7 at TSD and 12 at UHP, all against a plan of 0. The unvalidated position for the 65ww trajectory shows a position of 179 at RDUH, 141 at TSD and 121 at UHP all against a target of 0.

22. It is recommended that the Board and takes **satisfactory assurance** that the elective NOF4 criteria will be met. Whilst it is recognised that trajectories will not be met in 2024/25, all providers are showing an improved overall position, with individual operational plans in place to support continued improvement. Additional assurance should be sought through NHS Devon providers de-escalating from Tier 1 oversight in November 2024 as a result of progress made over past 18 months.

23. The majority of challenges in the recovery of the long waiter cohorts remain in a small number of specialities. Oversight and discussion around mitigations within these specialities will take place at each Locality Planning and Delivery Meeting, as well as the weekly Tier 2 meeting. An additional NHSE SW support meeting

will be installed in April 2025 to support oversight and performance challenge and recovery across the system.

Finance (see detail in the Finance Report M12, and slide 7, 15 and 16 of NOF 4 Assurance Report)

24. The outturn for 2024/25 is £19.8m adverse to plan for the system. The system variance reflects the re-forecast in Month 11.

25. The One Devon Integrated Care System (ICS) is reporting £223.0m efficiency achievement for the year. This is £9.7m above plan.

26. The 2024/25 plan states that 70% of savings are to be recurrent, however achievement for the year was 58% of the total savings. The reduction in the proportion of savings that is recurrent is partly as a result of the Month 8 re-forecast whereby NHS Devon delivered additional non-recurrent CIP through balance sheet and reserves flexibility to maintain the overall system plan at that time. The system achieved 87% of the planned recurrent savings for the year.

27. The shortfall in recurrent savings against plan of £20.2m was offset by delivery of non-recurrent savings £29.9m above plan.

28. It is recommended that the Board takes **satisfactory assurance** that the finance NOF4 criteria will be met.

Assurance and Recommendations

29. Based on the discussions held with ICS organisations and review of the performance and finance highlight reports from each organisation, it is recommended that the overall level of assurance that the ICS will achieve the planned NOF 4 exit for 2024/25 as at Month 12 is as follows:

Section	Assurance	Trend from previous month
Strategy	Satisfactory	No Change
Leadership	Satisfactory	No Change
UEC	Partial	Improvement
Elective	Satisfactory	No Change
Finance	Satisfactory	No Change

30. Based on the content within this report, the Board is asked to **AGREE** the assurance ratings relating to each of the NOF4 progress positions of the One Devon Integrated Care System of: **partial for UEC** and **satisfactory for all others** and take satisfactory assurance that adequate plans are in place to mitigate the risks relating to the delivery NOF4 exit identified in Locality Planning and Delivery Meetings, and the System Leadership Group.

NHS Oversight Framework – progress against Segment 4 exit criteria

April 2025

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

NOF4 exit criteria and self-assessment ratings (M12)

Key to Ratings:
On track and with clear evidence to meet the exit criteria by the planned date
Emerging risk of inability, or no clear evidence of ability to meet exit criteria by the planned exit date
Off track with high risks of inability to meet exit criteria by planned date
Exit criteria achieved and embedded
Resources just deployed, too early to tell

NHS Oversight Framework Domain	NOF 4 exit criteria theme	NOF 4 exit criteria	Rating (M12)	NOF4 Exit Forecast (Q1 25/26)
Local Strategic Priorities	Strategy	Delivery of Phase 2 of the Acute Services Sustainability Programme		
		Develop and commence implementation of a plan to eliminate unwarranted duplication of specialist DGH services across Devon		
Leadership and Capability	Leadership	Demonstrate collaborative decision-making in delivering all the RSP exit criteria at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system		
People	-	-	-	-
Quality of Care, Access and Outcomes	Urgent and Emergency Care (UEC)	Make demonstrable progress towards achieving national UEC objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement.		
	Elective Care	Make demonstrable progress towards achieving national elective and cancer objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement		
Preventing Ill Health and Reducing Inequalities	-	-	-	-
Finance and Use of Resources	Finance	Develop and deliver a short-term financial plan (2024/25) that is signed off regionally and nationally		
		Deliver reductions in the run rate for each consecutive quarter		
		To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones		

Exit Criteria Measures - Leadership

Exit Measure	Progress update	
Review of the **ICS strategy** (developed by the ICS Board) and Joint Forward Plan (developed by the ICB) during 2024/25 and agree priorities and timelines for delivery	Review of ICS strategy has been ongoing throughout 2024/25. In light of the national development work, local engagement activity has focused on local priorities within the framework of 10 Year Plan in order to inform the revision of the ICS strategy in 2025/26. The Joint Forward Plan for 2024/25 was agreed in March 2024. The Joint Forward Plan for 2025/26 is the subject of a light touch refresh to ensure that it is ready for approval by the ICB in March 2025, following its consideration by the refreshed ICP. The refresh will focus on updating workstreams, financial content, and governance arrangements to align with key local developments, including the development of the Medium-Term Financial Plan (MTFP).	
Revised NOF4 **system architecture** to reflect learning from 2023/24 RSP process. This will need to include effective governance arrangements for making collective decisions which have financial implications across organisational boundaries including control of workforce, service investments, cost reductions and productivity improvements.	New system governance and delivery architecture embedded. This was been created with input and oversight of Recovery Support Programme (RSP). The System Leadership Group (SLG) is overseeing delivery of the 2025/26 Operating Plan, development of the MTFP and system wide decision making. Review of effectiveness considered December with minor amendments approved by the SLG in January 2025	
Development and delivery of organisational and system **improvement plans** with clear trajectories aligned to the exit criteria and 2024/25 operational plan to include: ○ Named SROs for organisational and system programmes ○ Clear accountability and reporting arrangements	The system has developed a greater clarity on shared programmes to delivery improved sustainability, as evidenced by the successful receipt of the Medium Term Financial Plan (MTFP) at the NHSE RSP Escalation meeting in October 2024. The Transforming Devon Programme has now been fully established and there is improved grip in relation to the delivery of shared system objectives.	
Agree which services will be delivered as part of a system-wide 'shared-services' programme and ensure realistic but stretching delivery plans are developed and progressed.	The system has agreed that a One Devon Collaborate Corporate Services (CCS), hosted by a single organisation, should be adopted to provide services to all NHS partners. A vision and set of overarching principles have been agreed, against which the business case will be guided for the proposed end state. The business case will be subject approval by all six sovereign organisations before the end of 2024/25.	
Review and adapt **Devon Operating Model** and Governance Architecture in response to ICB governance review and the restructure aligned to reduced management costs	Alongside the delivery of the system architecture changes set out above, a behavioural compact, based on the foundational work developed by NHSE has been agreed for adoption by all Boards. Work is ongoing to include local inferences and principles of accountability, including holding oneself and others to account when behaviours are not those that have been agreed. The co-creation of a System Development Plan is also being facilitated by the ICB, describing the priority areas for OD support across the Devon system, including a single leadership development programme and maximising opportunities to share learning and development resources and expertise across all partners.	
Develop, agree and deliver specific improvement plans to address quality and performance issues raised by regulators. This will include any **CQC notices and requirements of MSSP.**	Improvement plans for quality issues raised by regulators including CQC notices and requirements of the Maternity Safety Support Programme are reviewed through the NHS Devon Quality and Patient Experience Committee, with escalation levels agreed through the System Quality Group which has provider and regulator membership.	
Summary rating	Overall progress in line with expectations	

Exit Criteria Measures - Strategy

Exit Measure	Progress update	
Phase 2 to be launched in May 2024. Maternity services to be brought into the Programme with workshops complete before end July	Complete	
Detailed modelling of the scenarios already developed for paediatric, medicine and surgical assessment services to be completed by September 2024 and Maternity by end November 2024	Complete.	
Draft Case for Change developed and socialised with key stakeholders during the summer of 2024	Draft completed and socialized in 2024.It is being updated in view of the 10 yr plan and other internal and external requirements.	
Final Case for Change agreed and signed off by Boards by November 2024	Feedback from local engagement on the NHS 10-year plan to inform final draft of Case for Change. To Be complete by June 2025.	
Options appraisal to be undertaken in advance of public consultation process being activated (date TBC before end Q4 2024/25)	Full scenario planning and options will be generated following detailed modelling based on demographics covering the next 5 and 10 yrs, triangulated with workforce, operations, estates and finance. These will be assessed against a set of evaluation criteria and will inform the final recommendations.	
Integrated solutions developed, agreed and in progress for a minimum 6 Fragile services	Tactical Service Change: PIDs developed for each project: Stroke, OMFS, Dermatology, Interventional radiology, Cardiology, Diagnostics, Urology and Surgery in Children to support project implementation at pace. Fortnightly meetings in place to oversee implementation. Further projects assessed for potential impact: Sarcoma, Ophthalmology, gynae and head and neck cancers.	
Proposal for elimination of unwarranted duplication of ‘specialised services’ agreed, and implementation plans underway		
Public consultation process and timeline agreed with Region	For discussion with the region Q1 25/26	
Summary rating	Phase 2 complete. Governance and plans for phase 3 through to PCBC agreed with different stakeholders. For formal approval in April 2025.	

Exit Criteria Measures - UEC

Exit Measure	Progress update	
Improvements in line with agreed baseline and plan, over two quarters, in ambulance handover delays (>15 minutes & > 3 hours)	Time lost due to ambulance handovers deteriorated from 6,283 in February to 8,130 in March.	
Improvements in line with agreed baseline and plan, over two quarters, in ambulance response times for Category 2 incidents to 30 minutes on average	Category 2 response times increased by 1 minute from 38 minutes in February to 39 minutes in March	
Improvements in line with agreed baseline and plan, over two quarters, in 4 hour performance & 12-hour breaches	The system 4-hour performance position decreased slightly from 68.59% in February to 68.58% in March. The March 25 performance is an improvement on both the February 24 position (68.4%) and the FY23/24 average position (64.10%).	
Month on month improvements, over one quarter, in pre-midday Discharges against agreed baseline and trajectories	The system is not currently meeting its internal trajectory of 33% with performance remaining static relatively static over the year and reduced from 12.7% in February to 12.6% in March.	
Achieve and sustain a reduction in number of patients who no longer meet the “criteria to reside in hospital"	The system has not met its NCTR trajectory at the end of M12. NCTR increased from 12.10% in February to 12.29% in March.	
CQC confirmation of UHP compliance with Conditions on the trust’s Licence	CQC reinspected March 24, conditions were not reissued. UHP One Plan in place to address section 29a conditions and expecting further unannounced inspection by end of 2024.	
Meet and maintain the exit criteria for national Tier 1 for UEC.	The M12 position have only seen improved performance in 4hr performance and ambulance handovers within 15 mins.	
Summary rating	Progress has been made on UEC performance including Cat 2 response, time lost on ambulance handover delays and the % of ambulance handovers within 15 mins from M1 to M12. At end of M12 the system did not achieve plan trajectories for 4 hour performance, ambulance handovers within 15 mins and 12hr or more spent in ED.	

Exit Criteria Measures – Elective care

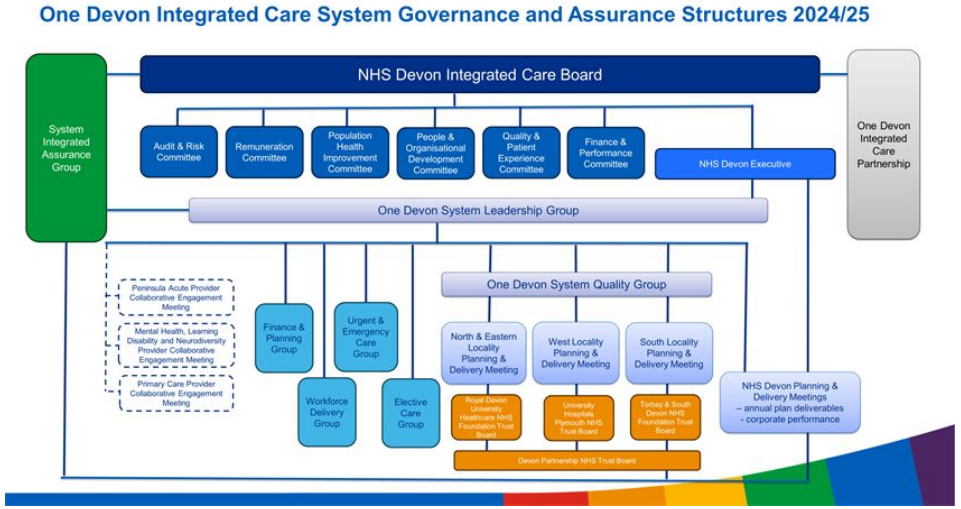
Exit Measure	Progress update	
Elimination of waits over 104 weeks and 78 weeks, in line with agreed plan and operational planning guidance.	The number of patients waiting beyond 78 weeks for treatment reduced from 54 in January to 50 February. RDU reduced from 22 to 15 however TSD and UHP increased by 1 and TSD by 2 in M11.	
Virtually eliminate waits over 65 weeks for elective care in line with agreed plan and operational planning guidance.	The number of patients waiting longer than 65 weeks for treatment improved from 792 in January to 727 in February. The system trajectory of zero was not met with no individual provider meeting their trajectory.	
Meet and maintain the exit criteria for national Tier 1 for Elective, by all trusts	NHS Devon providers de-escalated from Tier 1 to Tier 2 in November 2025 and continue to track re-forecasted trajectories.	
Summary rating	Progress continues to be made on long waiter trajectories; and while original trajectories will not be met, all providers are either meeting or close to meeting revised trajectories. NHS Devon providers de-escalated from Tier 1 oversight in November 24 as a result of progress made over past 18 months. Risk remains to meeting trajectories in certain specialties and will continue to de discussed and mitigated at each Locality Planning and Delivery Meeting.	

Exit Criteria Measures – Finance

Exit Measure	Progress update	
Develop and deliver a financial plan for 2024/25 that is signed off regionally and nationally. This will include, but not limited to: • Confirmation of the exit underlying run rate from 2023/24 and an improvement in the actual recurrent run rate in the 2024/25 plan (Q1 24/25) • The 2024/25 plan shows an improvement in productivity compared to 2023/24 (Q1 24/25) as agreed with NHS England • A system-wide shared services programme is developed that has all appropriate back-office functions within scope and includes accompanying timelines and delivery plans • The system delivers the financial plan for 2024/25 recurrently for two successive quarters (Q4 24/25) • The system delivers improvements in productivity for two successive quarters compared to [baseline year to be determined] (Q4 24/25).	• The underlying run rate has improved on 23/24 and is currently being refreshed as part of the 25/26 operational planning process. • New 24/25 productivity metrics for M9 have been published. NHSE have changed the methodology for measuring acute productivity by improving the granular detail of the activity by increasing coverage and recognising complexity. Using this methodology the data shows a 3.6% productivity gain compared to 2023/24 for Devon. • A system wide shared services programme is underway with Angela Hibbard nominated as SRO. There is a timeframe to realise a single CSS across the 9 service functions by FY27/28. A business case has been developed and been through organisational and system sign off. Cost of change implications are being discussed with national team and delivery of business case is predicated on a positive outcome to these discussions. • Due to the winter pressures being experienced by Trusts the 24/25 financial position of the Devon system has been reviewed. The original deterioration in UHP and TSD reported in Month 8 was largely offset by the utilisation of flexibility with the ICB. It has now been deemed necessary to use this flexibility for its original intention which was to mitigate any winter pressure within the system. Following a review of the financial position it has been agreed to deteriorate the overall system financial position by £20m. This deterioration mainly reflects the changes in forecast made at Month 8 for TSD .	
To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones	The system has updated the Medium-Term Financial Plan, which clearly articulates the recurrent and non recurrent trajectories to financial balance over the next five years, with breakeven achieved in 2027/28 (excluding convergence and debt repayment). This plan will be underpinned by the Financial Improvements delivered by the strategic signature moves as well as business as usual Cost Improvements. The system modelled for SIAG in January the differing planning scenarios provided by the region to ascertain the impact on the base case submitted in October. National planning guidance has now been received and a top down high level plan produced with a bridge to explain movements since the original MTFP developed in October. Detailed bottom up plans for 25/26 are being developed as part of the Operational Planning round.	
Develop and agree a Capital Plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.	A system wide prioritised estate exercise has been undertaken, and this is currently being extended to include digital and equipment with prioritisation meetings undertaken in January 2025. The system has also undertaken an analysis of any risks due to a reduced capital allocation and identifying future schemes with no current funding scheme identified. A full report has been completed and shared and the recommendations are being progressed. Within the reduced allocation we will determine the optimal split of strategic capital requirements and ongoing equipment and building maintenance. This was used to inform capital allocations from 25/26 onwards.	
Develop and agree a workforce plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.	System WTE totals remain adverse to plan at month 12 (684 WTE) and pay expenditure remains above plan. £12.1m of the £57.8m adverse position is due to delivery of new funded activity. Workforce plan aligned to strategic priorities are in development as part of MTFP and 25/26 planning.	
Summary rating		

Oversight and Assurance mechanisms

- The first round of the new Locality Planning and Delivery Meetings (LPDMs) took place w/c 12 August 2024.
- Actions identified in these meetings were refined at the System Leadership Group (SLG) meeting w/c 19 August 2024.
- This report reflects the outcomes of the SLG meeting. It has been signed off by the Chief Executives of each organisation. It is intended to provide the System Integrated Assurance Group (SIAG), as well as the individual Boards of each organisation within the system with a “single version of the truth” in respect of assurance about the overall delivery of the NOF4 exit criteria and each individual organisation’s contribution to this.
- The report is supported by Locality Planning and Delivery packs, which contain local level performance data and the key lines of enquiry for performance improvement. These packs also include an outline of the key discussion points and the actions due to completed within the next month.
- The focus in the first round of initial LPDMs and the SLG has been on the identification of specific actions to enable a return to agreed trajectory (where necessary); the next round of meetings will address the delivery of these actions and their anticipated impacts.



The data packs supporting each Locality Planning and Delivery Meeting and reports of issues considered at those meetings can be found in the adjacent table:

	South	West	North and East
Data pack	April 2025 - uth LPDM Data Pa	April 2025 - uth & West LPDM	April 2025 - & East LPDM Data
Report of meeting	April meeting stood down.	April meeting stood down.	April meeting stood down.

Leadership

Exit criteria	Assessment
Demonstrate collaborative decision-making in delivering all the RSP exit criteria at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system	

Ways of working have improved significantly, supported by refreshed system oversight and assurance structures. This has resulted in improved strategic clarity both in the medium and long term (see section on strategy below for more detail) meaning that the system is well placed to ensure that its Integrated Care Strategy (the strategy) and Joint Forward Plan (JFP) respond to the NHS 10 Year Plan when it is published. It has also resulted in better delivery of improvement plans and significantly better performance in relation to the management of winter pressures.

The system has developed a greater clarity on shared programmes to delivery improved sustainability, as evidenced by the successful receipt of the Medium Term Financial Plan (MTFP) at the NHSE RSP Escalation meeting in October 2024. The Transforming Devon Programme has now been fully established and there is improved grip in relation to the delivery of shared system objectives. Alongside this, the system has agreed that a One Devon Collaborate Corporate Services (CCS), hosted by a single organisation, should be adopted to provide services to all NHS partners. A vision and set of overarching principles have been agreed, against which the business case will be guided for the proposed end state. The business case will be subject approval by all six sovereign organisations before the end of 2024/25.

There has been greater visibility and co-ordination in relation to quality issues across the system in 2024/25. The System Quality Group (SQG) has taken the lead on ensuring a supportive system-wide approach to learning from concerns raised by regulators. All maternity units in Devon are on the Maternity Safety Support Programme (MSSP). This is due to the system's NOF4 status and all units receiving 'Requires Improvement' at their latest CQC inspection (UHP 2022, RDUH & TSD 2023). The programme consists of six phases – initiation, implementation, diagnostic, improvement, sustainability and exit. UHP are in the improvement phase and are beginning to implement improvements outlined in their Maternity and Neonatal Improvement Plan (MNIP) and are agreeing exit criteria. TSD & RDUH are currently in the diagnostic phase with diagnostic reports anticipated in Q4 2024/25. Specific workforce and governance diagnostics are underway in each organisation

SLG Escalations and Responses		
Area of plan identified as off track by system	Actions agreed by system to return to plan	System's anticipated impact of action
N/A	N/A	N/A

Strategy

Exit criteria	Assessment
Delivery of Phase 2 of the Acute Services Sustainability Programme	
Develop and commence implementation of a plan to eliminate unwarranted duplication of specialist DGH services across Devon	

Tactical Service Change

- PIDs developed for each project: Stroke, OMFS, Dermatology, Interventional radiology, Cardiology, Diagnostics, Urology and Surgery in Children to support project implementation at pace.
- Extending scope of work for stroke, cardiology, OMFS and paeds to extend to consolidation of services. Sarcoma has been included in the workstream.
- Fortnightly meetings held with project teams to maintain momentum
- Data analysis underway
- Sarcoma, gynae and H&N added to the programme.

Strategic Service Change

- Phase 2 completed.
- Feedback from local engagement on the NHS 10-year plan to inform final draft of Case for Change. To be complete by June 2025
- May – July will scope opportunities with a ‘joint center’ and ‘2x eye centres’
- Full scenario planning and options will be generated following detailed modelling based on demographics covering the next 5 and 10 yrs, triangulated with workforce, operations, estates and finance. These will be assessed against a set of evaluation criteria and will inform the final recommendations.
- Approach /plans for phase 3 agreed in principle.

SLG Escalations and Responses		
Area of plan identified as off track by system	Actions agreed by system to return to plan	System’s anticipated impact of action
N/A	N/A	N/A

Urgent and Emergency Care (UEC) - System

Exit criteria	Assessment
Make demonstrable progress towards achieving national UEC objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement.	

UEC 2024/25 Summary
Throughout a challenging year, the system has demonstrated an improved position across the majority of key metrics, thus reflecting an amber assessment.

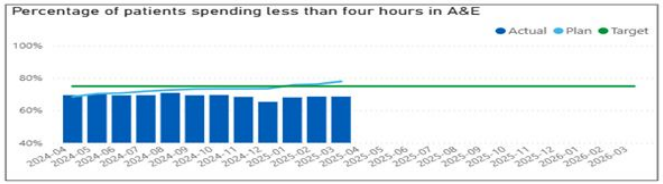
The system 4-hour performance position decreased slightly from 68.59% in February to 68.58% in March. The March 25 performance is an improvement on both the February 24 position (68.4%) and the FY23/24 average position (64.10%). The system all type YTD position is currently 68.94% maintaining a 4.84% improvement from the 23/24 position.

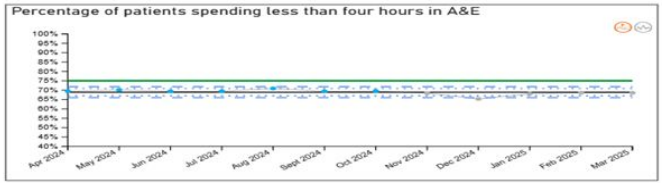
Category 2 response times increased by 1 minute from 38 minutes in February to 39 minutes in March. The improvement in ambulance handover performance compared to FY23/24 remains 8 minutes better on average.

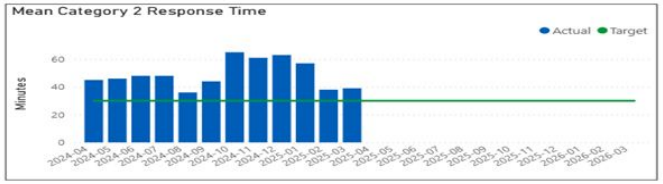
Time lost due to ambulance handovers deteriorated from 6,283 in February to 8,130 in March. March's position is the third best this financial year and an improvement of approximately 6,000 hours compared to March 2024.

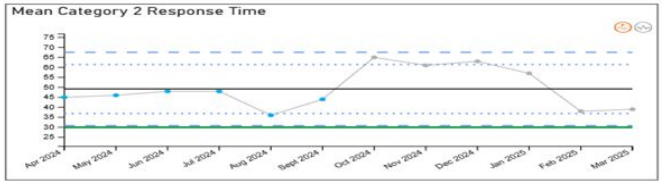
There was a slight improvement in the percentage of ambulances handed over within 15 minutes in March to 17.6% from 17.4% in February. Current performance forecasting shows further improvements in April.

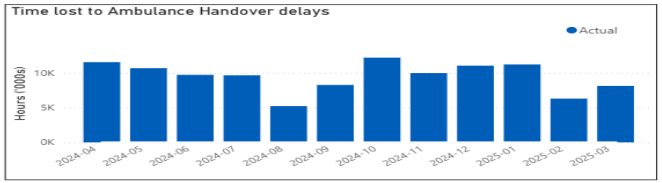
The number of patients spending more than 12 hours within emergency departments deteriorated to 3,423 in March from 3,027 in February. This performance remains similar to that of FY23/24.

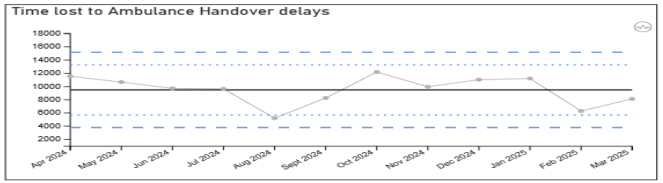


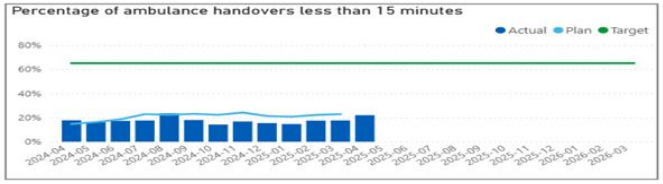


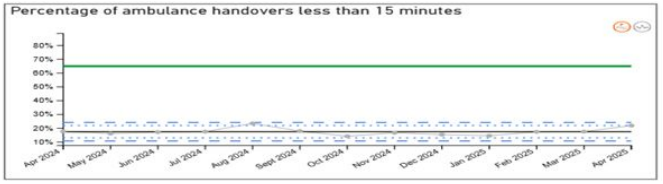


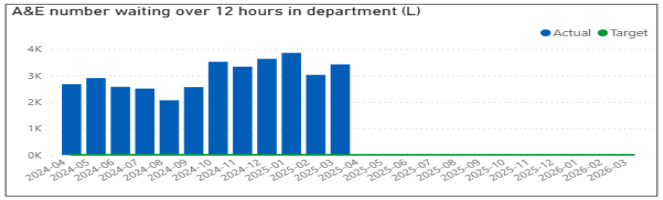


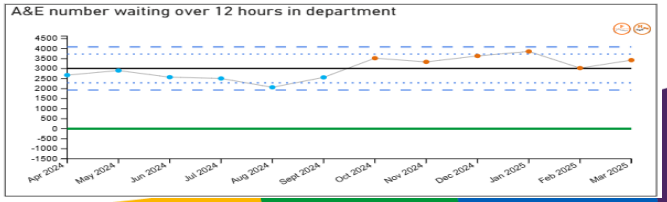












The Locality Planning and Delivery packs contain the local level performance data and the key lines of enquiry for performance improvement. These packs also include an outline of the key discussion points and the actions due to completed within the next month.

All actions to be completed in next 4 weeks unless otherwise stated

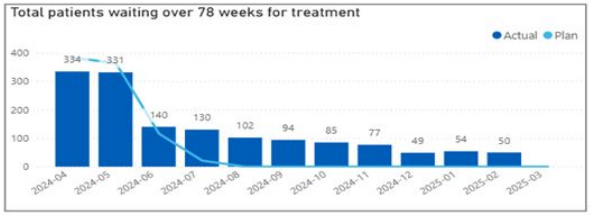
Urgent and Emergency Care (UEC) - Providers

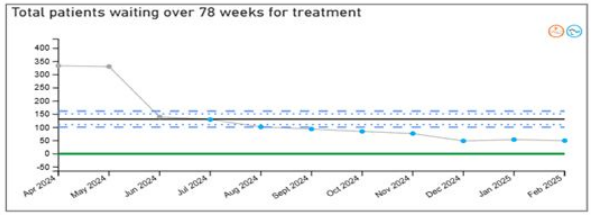
Outcomes of Locality Planning and Delivery Meetings				
	South	**West**	**North and East**	**NHS Devon**
Areas of underperformance identified	4-hour performance **69.84%** v trajectory of **75%** in M12. **21.5%** of ambulances handed over within 15 mins v trajectory of **42%,** and **1268** hours lost which is an improvement from M11.	4-hour performance **69.84%** v trajectory of **75%** in M12. **14.2%** of ambulances handed over within 15 mins v trajectory of **20.71%,** and **5414** hours lost which is a significant deterioration from M11.	4-hour performance **70.02%** v trajectory of **79.66%** in M12. **17.7%** of ambulances handed over within 15 mins v trajectory of **15.35%,** and **1447** hours lost which is an improvement from M11.	
Actions agreed to address underperformance		•Share the 5 strategic goals and their PDSA areas for next quarter **– Jo Beer** •Link with Allison Williams and Mark Hackett on the NOF4 narrative to demonstrate the improvements in UEC performance **– Jo Beer**	• Link with RDUH colleagues and Lou Higgins to map out a plan for 2025/26 and what activities will be in place, including NCTR in order to support agreeing funding levels and capacity **– Sam Higginson** • Capture learning through the Winter Review from the critical incident safety concerns and share with the System Quality Group for oversight and review **- John Palmer** • Submit a shared learning report for oversight at the May Mental Health Planning & Delivery meeting on: - The review of day-to-day management of mental health liaison in Devon with Chelsea & Westminster Hospital's CEO - The identified opportunities for a QI led mental health transformation programme in Devon with support from the Hackney Director of Social Services - **John Palmer**	• Clarify if the change in DCCs process of ensuring all referrals go through SCR before going out to market will impact on P1-3 discharges and feedback to Sam Higginson **– Lou Higgins** • Link with the Mental Health Collaborative on the 10-point plan report due for presentation to SLG **– Peter Collins**
Anticipated impact of agreed actions	The April meetings were stood down.			
Any unmitigated risks remaining				

Elective Care- System

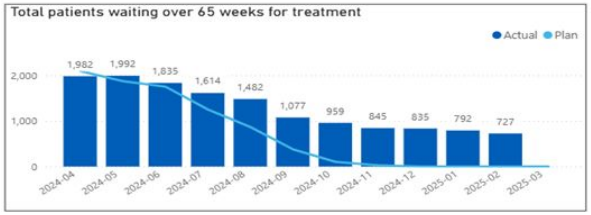
Exit criteria	Assessment
Make demonstrable progress towards achieving national elective and cancer objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement	

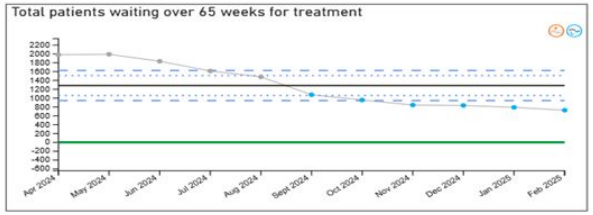
The number of patients waiting beyond 78 weeks for treatment decreased from 54 in January to 50 in February. Both UHP and TSD had increases, 1 and 2 patients, respectively.



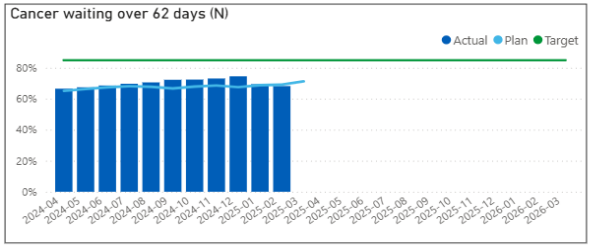


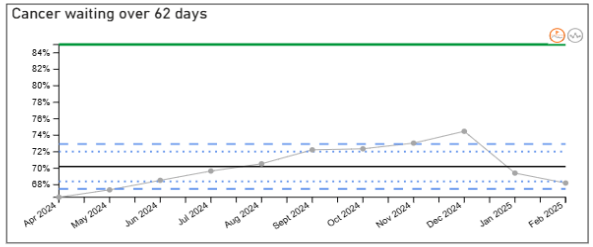
The number of patients waiting longer than 65 weeks for treatment improved from 792 in January to 727 in February. The system trajectory of zero was not met with no individual provider meeting their trajectory. RDUH reduced their waiting list by 25 patients, whilst UHP reduced theirs by 42. TSD saw their waiting list increase by 3 patients.



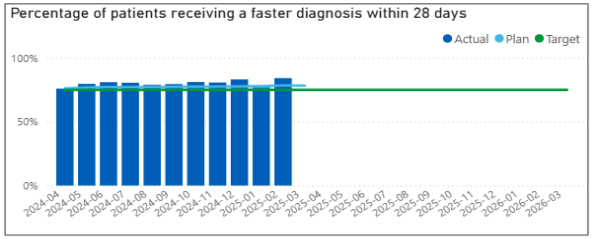


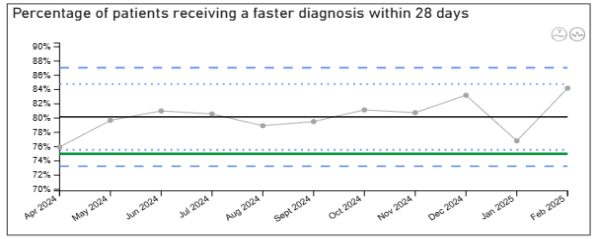
The system did not meet its 62-day trajectory with a performance of 68.2% v trajectory of 69.1%. This is the second month in a row where performance reduced. February's position is also the third lowest this financial year.





The system continues to exceed the national standard for 28-day faster diagnosis standards with performance in February of 84.2% and also exceeded the planned trajectory of 78.5%. This was an improvement from 76.8% in January. All providers met both the national standard and their individual targets in February.





The Locality Planning and Delivery packs contain the local level performance data and the key lines of enquiry for performance improvement. These packs also include an outline of the key discussion points and the actions due to completed within the next month.

Elective Care - Providers

Outcomes of Locality Planning and Delivery Meetings				
	South	**West**	**North and East**	**NHS Devon**
Areas of underperformance identified	78ww performance was **12** v trajectory of **0**. 65ww performance was **201** v trajectory of **0**. **Revised Trajectory** 78ww performance was **12** v trajectory of **0** 65ww performance was **201** v trajectory of **218**	78 ww performance was **23** v trajectory of **0**, and 65ww performance was **193** v trajectory of **0.** **Revised Trajectory** 78ww performance was **23** v trajectory of **0** 65ww performance was **193** v trajectory of **0**	78 ww performance was **15** v trajectory of **0**, and 65ww performance was **333** v trajectory of **0**. **Revised Trajectory** 78ww performance was **15** v trajectory of **0** 65ww performance was **333** v trajectory of **96**	
Actions agreed to address underperformance		• Link with Cornwall Elective Leads to understand the review into the viability of the Sarcoma service and feedback to Jo Beer **– Tryphaena Doyle**		
Anticipated impact of agreed actions	The April meetings were stood down.			
Any unmitigated risks remaining				

All actions to be completed in next 4 weeks unless otherwise stated

Finance - System

Exit criteria	Assessment
Develop and deliver a short-term financial plan (2024/25) that is signed off regionally and nationally	
Deliver reductions in the run rate for each consecutive quarter	
To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones	

At the year end, an overspend of £20m has been reported. The original deterioration reported in month 8 at UHP and TSD was largely offset by the utilisation of flexibility within the ICB to forecast a balanced year end revenue position. It has now been deemed necessary to use this flexibility for its original intention, which was to mitigate any winter pressure within the system. The net deterioration across the organisations has crystalised in TSD.

Organisation	Outturn		
	Plan surplus / (deficit) £000	Actual surplus / (deficit) £000	Variance favourable / (adverse) £000
Devon ICB	28,419	28,419	0
Devon Partnership NHS Trust	3,591	3,599	8
Royal Devon University NHSFT	(2,790)	(2,743)	47
Torbay and South Devon NHSFT	(13,624)	(33,538)	(19,914)
University Hospitals Plymouth NHST	(15,596)	(15,584)	12
Total	**(0)**	**(19,847)**	**(19,847)**

Organisation	Outturn		
	Plan CIP delivery	Actual CIP delivery	Variance favourable / (adverse)
Devon ICB	37,228	55,017	17,789
Devon Partnership NHS Trust	15,739	15,799	60
Royal Devon University NHSFT	63,610	66,574	2,964
Torbay and South Devon NHSFT	39,900	27,889	(12,011)
University Hospitals Plymouth NHS Trust	56,801	57,732	931
Total	**213,278**	**223,011**	**9,733**

The ICS has reported £223.0m efficiency achievement at the year end against a plan of £213.3m (Overachievement £9.7m)

	24/25 plan	24/25 actual	Variance fav/(adv)
Recurrent Efficiencies	150,076	129,897	(20,178)
NR Efficiencies	63,202	93,114	29,912
Total efficiencies	**213,278**	**223,011**	**9,733**
Recurrent efficiencies	70%	58%	
NR efficiencies	30%	42%	

At year end there is a shortfall in recurrent savings of £20.2m, which has been offset by delivery of non-recurrent savings.

Pay expenditure: The ICS is reporting a 2.9% (£57.8m) adverse expenditure against plan on workforce expenditure at the year end, an increase in the variance by £23.8m on month 11. £12.1m of the overspend is offset by additional funding.
Agency is over spent at year end by £0.3m which is 74% of the agency ceiling.
Due to the delay in year end returns, the split by substantive, bank and agency spend is not available.

SLG/System Escalations and Responses

Area of plan identified as off track by system	Actions agreed by system to return to plan	System's anticipated impact of action
• Due to winter pressures system revenue deteriorated to £20m year end deficit. • Full year CIP delivery is above plan but recurrent CIP delivery is below plan in both TSD and UHP thereby putting underlying exit position at risk. • Workforce costs ytd over plan, but partly offset by additional income.	• Turnaround support to TSD. • Additional work to understand impact on underlying exit position for both UHP and TSD.	• Development of key recovery actions for TSD • Confirmation of underlying financial positions for providers

Finance - Providers

Outcomes of Locality Planning and Delivery Meetings				
	South	**West**	**North and East**	**Devon ICB**
Areas of underperformance identified	Financial position YTD is **(£33,528)** v plan of **(£13,624)** CIP delivery is **£12m** below plan at M12.	Financial position YTD is **(£15,584k)** v plan of **(£15,596k)** CIP delivery is **£0.9m** ahead of plan at M12.	Financial position YTD is **(£2,743k)** v plan of **(£2,790k)** CIP delivery is **£2.9m** below plan at M12.	Financial position YTD is **£28,419** v plan of **£28,419k**
Actions agreed to address underperformance			• Discuss with Peter Collins and Lou Higgins the plan for the health inequalities pilots for 2025/26 and identify if these will be embedded into the work of the ICB **– Sam Higginson**	
Anticipated impact of agreed actions	The April meetings were stood down.			
Any unmitigated risks remaining				

All actions to be completed in next 4 weeks unless otherwise stated

NHS Devon Integrated Care Board

System self assessment of performance against key NOF measures

Date of meeting	Date report produced
29 May 2025	14 May 2025

Author(s)		Report approved by	
Name and title:	Philippa Harding, NHS Devon Director of Governance and Interim Chief Communications and Corporate Affairs Officer	**Name and title:**	Steve Moore, NHS Devon Chief Executive Officer
Phone:		**Date:**	19 May 2025
Email:	philippa.harding4@nhs.net		

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

Executive summary
This report provides a summary position, at system level, of the progress made by the One Devon Integrated Care System in relation to the requirements of Segment 4 of the NHS Oversight Framework.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
Considered by the NHS Devon Executive at its meeting on 06 May 2025. Reviewed by the Finance and Performance Committee at its meeting on 08 May 2025. Considered by the System Leadership Group at its meeting on 20 May 2025.

Key recommendations and actions requested
TAKE SATISFACTORY ASSURANCE from the information provided with regard to the One Devon Integrated Care System's position and achievements against the agreed NOF4 exit criteria, whilst noting the significant challenges still faced by the system, particularly in relation to the delivery of its 2025/26 Operational Plan.

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	All
Improve services and reduced unwarranted variation	
Make more efficient use of our resources	
Develop our culture and how we operate	

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	All
Health inequalities	
Workforce	
Resources and finance	
Legal	
Digital and Data	
Involvement, Engagement and consultation	

Self assessment of performance against key NOF measures

Introduction and background

1. The One Devon Integrated Care System (ICS) is currently in Segment 4 of the National Oversight Framework (NOF) and in receipt of mandated support from NHS England (NHSE) as set out in the national Recovery Support Programme (RSP). The criteria to move from Segment 4 to Segment 3 have been agreed and delivery against these monitored by NHS system partners through the One Devon System Leadership Group (SLG) and by NHSE through the System Integrated Assurance Group (SIAG).

2. The expectation is that when NHS Devon's Board considers that the NOF4 exit criteria have been met, with the associated evidence, a proposal will be presented for evaluation by the NHSE South West Regional Team, and a recommendation made to the national team for a change in segmentation. The same applies to all NHS provider trusts within Devon, who would also require NHS Devon's support of their assessment.

3. This report sets out a self assessment informed by all NHS system partners with regard to the One Devon ICS position and achievements against the agreed NOF4 exit criteria. It sets out a system perspective, supported by the perspectives of each individual organisation currently within NOF4.

Progress against individual exit criteria themes - Leadership

Exit Measure
Review of the ICS strategy (developed by the ICS Board) and Joint Forward Plan (developed by the ICB) during 2024/25 and agree priorities and timelines for delivery
Revised NOF4 system architecture to reflect learning from 2023/24 RSP process. This will need to include effective governance arrangements for making collective decisions which have financial implications across organisational boundaries including control of workforce, service investments, cost reductions and productivity improvements.
Development and delivery of organisational and system improvement plans with clear trajectories aligned to the exit criteria and 2024/25 operational plan to include: ○ Named SROs for organisational and system programmes ○ Clear accountability and reporting arrangements
Agree which services will be delivered as part of a system-wide 'shared-services' programme and ensure realistic but stretching delivery plans are developed and progressed.
Review and adapt Devon Operating Model and Governance Architecture in response to ICB governance review and the restructure aligned to reduced management costs
Develop, agree and deliver specific improvement plans to address quality and performance issues raised by regulators. This will include any CQC notices and requirements of MSSP.

Summary - *Demonstrate collaborative decision-making in delivering all the RSP exit criteria at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system*

4. The system has seen a significant amount of change in terms of the individuals leading organisations within it over the past two years and this, in turn, has resulted in a tangible shift in leadership behaviours and culture. Ways of working have improved significantly, supported by refreshed system oversight and assurance structures. This has resulted in improved strategic clarity both in the medium and long term (see section on strategy below for more detail) meaning that the system is well placed to ensure that its Integrated Care Strategy (the strategy) and Joint Forward Plan (JFP) respond to the NHS 10 Year Plan when it is published. It has also resulted in better delivery of improvement plans and significantly better performance in relation to the management of winter pressures (for example there were three system critical incidents declared in 2023/24 and only one in winter 2024/25). This was as a result of the OPEL scoring status being revised following the previous winter and a clear mechanism designed for triggering a system critical incident (the 3 system critical incidents declared in 2023/24 were declared despite the system not meeting the threshold). In common with the rest of the country, the system was not able to avoid breaches of 4 hour waiting times in Emergency Departments (EDs) and metrics related to ambulance performance, such as category 2 response times and ambulance handover delays; however, through shared system leadership there was a reduction in the levels of waits as Winter progressed.

5. The system has developed a greater clarity on shared programmes to deliver improved sustainability, as evidenced by the successful receipt of the Medium Term Financial Plan (MTFP) at the NHSE RSP Escalation meeting in October 2024. The Transforming Devon Programme has now been fully established and there is improved grip in relation to the delivery of shared system objectives. Alongside this, the system has agreed that a One Devon Collaborate Corporate Services (CCS), hosted by a single organisation, should be adopted to provide services to all NHS partners.

6. There has been greater visibility and co-ordination in relation to quality issues across the system in 2024/25. The System Quality Group (SQG) has taken the lead on ensuring a supportive system-wide approach to learning from concerns raised by regulators. All maternity units in Devon are on the Maternity Safety Support Programme (MSSP). This is due to the system's NOF4 status and all units receiving 'Requires Improvement' at their latest CQC inspection (UHP 2022, RDUH & TSD 2023). The programme consists of six phases – initiation, implementation, diagnostic, improvement, sustainability and exit. UHP are in the improvement phase and are beginning to implement improvements outlined in their Maternity and Neonatal Improvement Plan (MNIP) and are agreeing exit criteria. Specific workforce and governance diagnostics are underway in each organisation.

Progress against individual exit criteria themes - Strategy

Exit Measure
Phase 2 to be launched in May 2024. Maternity services to be brought into the Programme with workshops complete before end July
Detailed modelling of the scenarios already developed for paediatric, medicine and surgical assessment services to be completed by September 2024 and Maternity by end November 2024
Draft Case for Change developed and socialised with key stakeholders during the summer of 2024
Final Case for Change agreed and signed off by Boards by November 2024
Options appraisal to be undertaken in advance of public consultation process being activated (date TBC before end Q4 2024/25)
Integrated solutions developed, agreed and in progress for a minimum 6 Fragile services
Proposal for elimination of unwarranted duplication of 'specialised services' agreed, and implementation plans underway
Public consultation process and timeline agreed with Region

Summary -

- *Delivery of Phase 2 of the Acute Services Sustainability Programme*
- *Develop and commence implementation of a plan to eliminate unwarranted duplication of specialist DGH services across Devon*

7. The Peninsula Acute Provider Collaborative (PAPC) has continued to provide leadership with regard to the Acute Services Sustainability Programme. Phase 2 of the programme was successfully launched in May 2024, with Boards agreeing to bring maternity services into the scope of the Programme.

8. Clinical Reference Groups (CRGs) have been supporting the detailed modelling of activity, workforce and transport and the approach to modelling workforce and finance have been agreed. Detailed modelled scenarios are on track to be available by the end of 2024/25. The generation of Options will be completed following conclusion of modelling. Evaluation criteria for the appraisal of these Options have also been developed.

9. The change of government and introduction of the NHS 10 Year Plan has impacted on the system's ability to deliver a number of the exit criteria related to strategy. With the agreement of NHSE colleagues, the system has not progressed with the approval of a Case for Change and associated public consultation. Despite this, the system has continued to progress the work required to ensure that it continues to develop the strategic vision it requires for sustainability. Public engagement to support the NHS 10 Year Plan has also been designed to support the development of the Case for Change. Modelling also continues for all clinical scenarios to describe implications for activity, workforce, travel, finance and estates for each.

10. With regard to fragile services and the duplication of District General Hospital (DGH) specialist services, the PAPC has agreed these into a single workstream – 'Tactical Service Change'. Projects are underway with appropriate resources for: Stroke, Oral and Maxillofacial Services (OMFS), Dermatology, Interventional radiology, Cardiology, Microbiology, Urology and Paediatric Surgery. This has been incorporated into the Transforming Devon Programme and will be overseen

through the programme governance structures agreed by the System Leadership Group.

Progress against individual exit criteria themes – Urgent and Emergency Care (UEC)

Exit Measure
Improvements in line with agreed baseline and plan, over two quarters, in ambulance handover delays (>15 minutes & > 3 hours)
Improvements in line with agreed baseline and plan, over two quarters, in ambulance response times for Category 2 incidents to 30 minutes on average
Improvements in line with agreed baseline and plan, over two quarters, in 4 hour performance & 12-hour breaches
Month on month improvements, over one quarter, in pre-midday Discharges against agreed baseline and trajectories
Achieve and sustain a reduction in number of patients who no longer meet the “criteria to reside in hospital"
CQC confirmation of UHP compliance with Conditions on the trust’s Licence
Meet and maintain the exit criteria for national Tier 1 for UEC.

Summary - *Make demonstrable progress towards achieving national UEC objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement.*

11. This section includes performance against the following urgent care measures:

- 4-hour A&E waits (all types)
- Ambulance handover delays
- Category 2 ambulance response times

4-hour A&E Waits (all types)

12. Performance against the 4-hour A&E waiting times target has improved since June 2022. Nationally submitted data shows the following position, with Torbay and South Devon NHS Foundation trust (TSD) seeing a significant improvement since June 2022:

	Jun-22	Jun-24	Latest
National	72%	75%	73%
NHS Devon	66%	69%	69%
RDUH	71%	73%	70%
TSD	55%	71%	69%
UHP		64%	66%

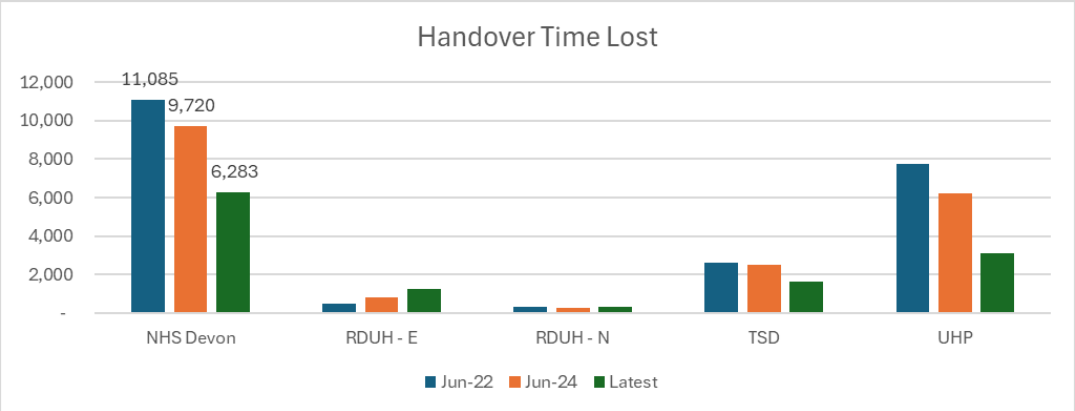
13. University Hospitals Plymouth NHS Trust (UHP) were not submitting national A&E waiting times data in 2022, as they were a pilot site for the proposed changes to UEC monitoring, however internal monitoring showed performance of 43% in June 2022. When added to other provider performance as shown above, the NHS Devon position would have reduced from that shown to a performance of 59.6% with UHP included. The improvement of UHP performance from 43% in June 2022 to 66% in the latest month increased the NHS Devon position by 10% to 69%. The national position has remained relatively static during this same period.

14. Based on the data provided, a clear improvement has been made in 4-hour performance since June 2022, with UHP improving by 23%, TSD by 14% and the system by ~10%. Royal Devon University Healthcare NHS Foundation Trust (RDUH) has remained stable in its performance across this period.

15. NHS Devon's position against other Integrated Care Boards (ICBs) nationally has also improved over this period from an ICB consistently ranking 40th of 42 ICBs to ranking 34th of 42 ICBs. In the latest published comparison data, UHP were shown as the third most improved provider for 4-hour performance in 24/25 with TSD currently the 20th most improved nationally over the same period.

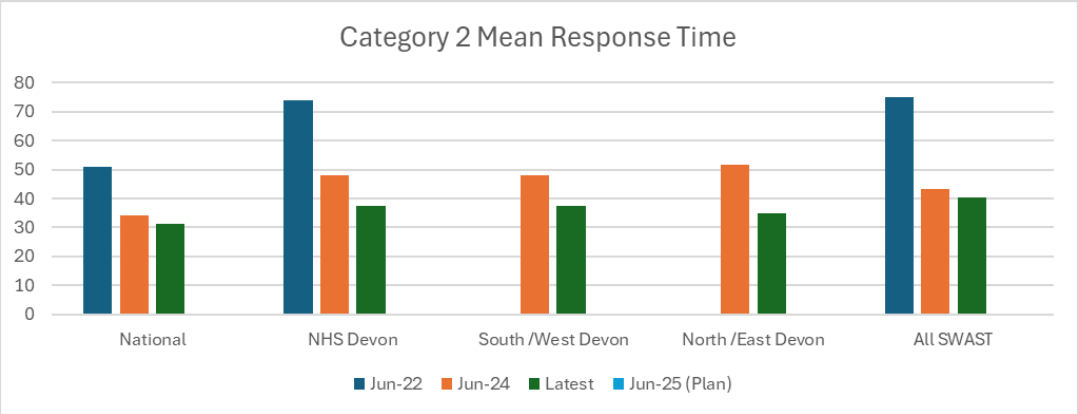
Ambulance Handover Delays

16. From the June 2022 baseline ambulance handover delays over 15 minutes had improved by 12% by June 2024 and by 43% in the latest month (February 2025). This is a reduction of almost 5,000 hours as can be seen in the chart below. UHP delays reduced by 60% and TSD by 37% from June 2022 to the latest month.



Category 2 Ambulance Response Times

17. Category 2 response times improved by 49% in Devon from June 2022 to the latest month (February 2025) compared to a 39% improvement nationally.



Progress against individual exit criteria themes – Elective Care

Exit Measure
Elimination of waits over 104 weeks and 78 weeks, in line with agreed plan and operational planning guidance.
Virtually eliminate waits over 65 weeks for elective care in line with agreed plan and operational planning guidance.
Meet and maintain the exit criteria for national Tier 1 for Elective, by all trusts

Summary - *Make demonstrable progress towards achieving national elective and cancer objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement*

18. This section looks at performance against the following measures:

- RTT waiting list
- RTT 18-week performance
- RTT over 104 week waits
- RTT over 78 week waits
- RTT over 65 week waits
- Cancer 28-day waits
- Cancer 62-day waits

RTT Waiting List

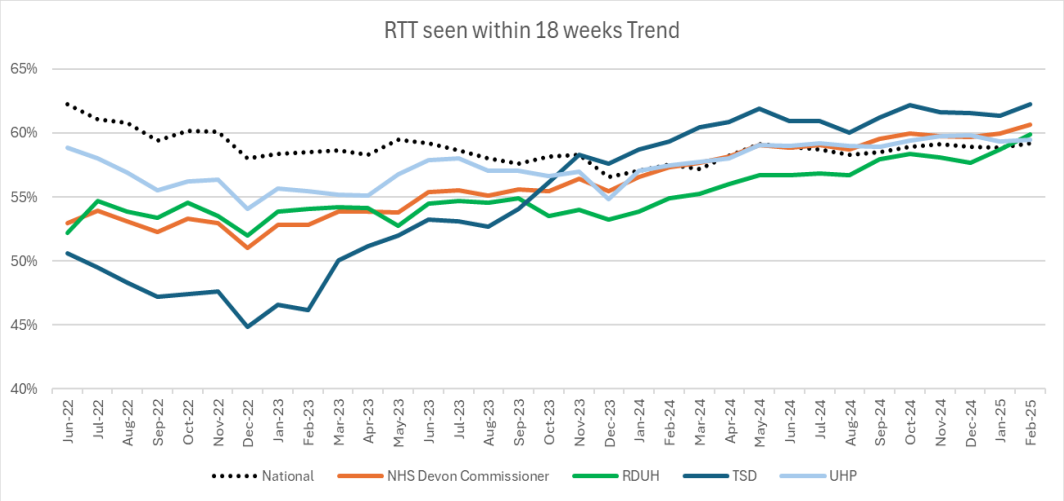
19. The RTT waiting list in Devon has fallen by 12% since June 2022 compared to a 4% increase nationally. RDUH and TSD have both seen significant reductions and whilst there has been a 5% rise at UHP the list size has remained static during the past two years.

	Jun-24	Jan-25
National	6%	4%
NHS Devon	-9%	-12%
RDUH	-13%	-17%
TSD	-19%	-19%
UHP	6%	5%

Waiting list growth since June 2022

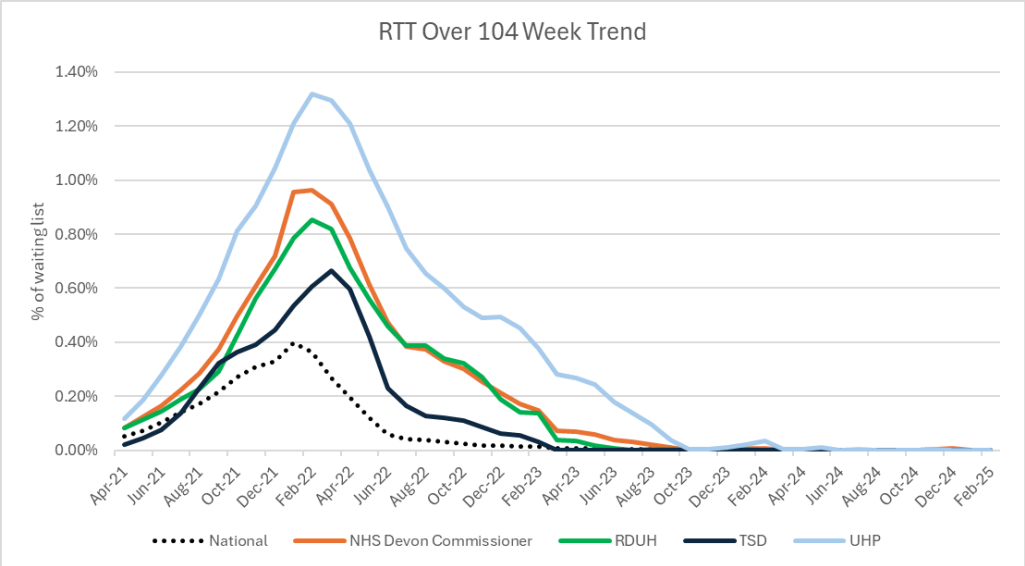
RTT 18-Week Waits

20. NHS Devon has improved from 52.9% against the 18-week RTT target in June 2022 to 60.7% in the latest month (February 2025) with all providers seeing an improvement during this time (TSD up 11.7%, RDUH up 7.7% and UHP up 0.7%). In comparison the national position has fallen by 3.0% with NHS Devon moving from bottom quartile to 15th out of the 42 ICBs.



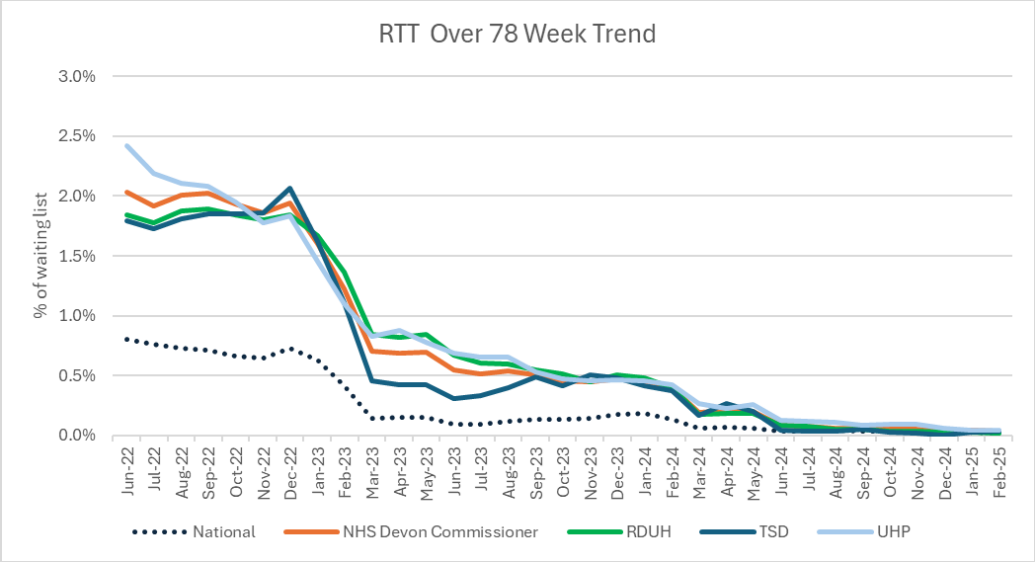
RTT 104-Week Waits

21. Since peaking in February 2022 when NHS Devon had the longest waits nationally, over 104-week waits reduced to minimal levels by October 2023 and are now at the national average. The chart below shows over 104-week waits as a proportion of the total waiting list.



RTT 78-Week Waits

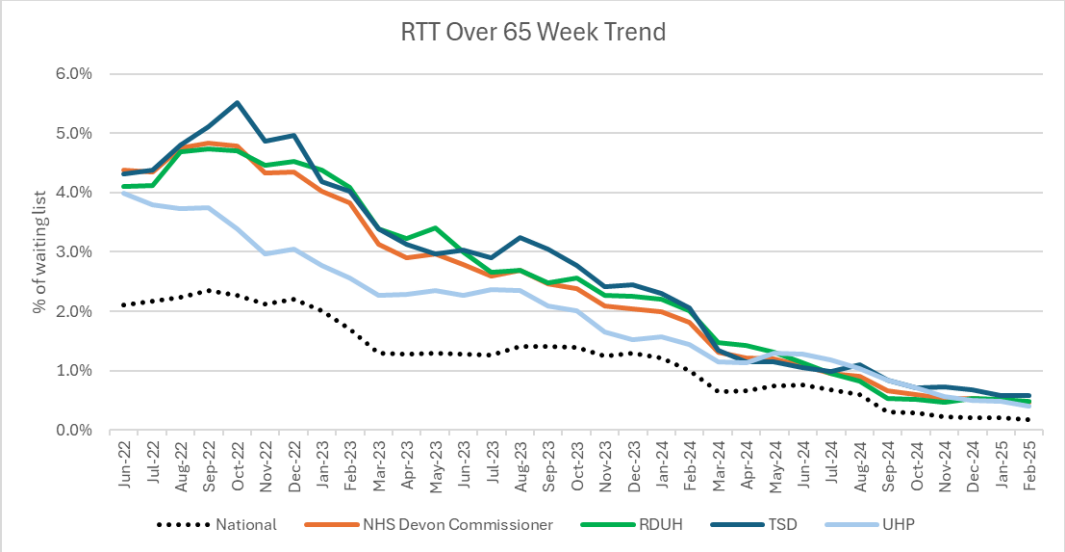
22. Over 78-week waits have also fallen sharply in Devon since 2022, reducing to minimal levels by June 2024. The proportion of waits over 78-weeks fell by 2.0% in Devon from June 2022 to February 2025 compared with a 0.8% fall nationally during this period.



RTT 65-Week Waits

23. The proportion of patients waiting over 65 week waits fell by 3.9% in Devon between June 2022 and the latest month (February 2025) compared to a 1.9% fall nationally. RDUH, TSD and UHP all saw the proportion of over 65-week breaches fall between 3.5% and 4%.

24. In June 2022 the Devon position was 4.37% over 65 week waits as a proportion of the waiting list against the national position of 2.10%. This has fallen to 0.46% and 0.18% respectively in February 2025, reducing the gap between Devon and the national position from 2.27% to 0.29%.



Cancer 28 day waits

25. Devon providers' performance against the 28-day target continues to be above the standard and average national position. All providers perform consistently well against this measure with significant improvement seen at all providers compared to the June 2022 position.

	Jun-22	Jun-24	Feb-25
National	70.1%	76.1%	80.2%
NHS Devon Commissioner	73.4%	69.6%	83.9%
RDUH	75.1%	80.5%	83.0%
TSD	64.9%	81.1%	83.2%
UHP	76.9%	81.5%	86.3%

Cancer 62 day waits

26. Devon providers have all improved performance against the 62-day waiting times standard, albeit remaining under the national target. Performance has improved

above the national position, with Devon consistently above the national average and ranked 16th out of 42 ICBs in the latest month.

	Jun-22	Jun-24	Feb-25
National	63.8%	67.8%	67.0%
NHS Devon Commissioner	60.0%	69.9%	68.9%
RDUH	62.7%	70.4%	69.9%
TSD	58.4%	77.8%	68.7%
UHP	57.2%	64.7%	65.9%

Progress against individual exit criteria themes – Finance

Exit Measure
Develop and deliver a financial plan for 2024/25 that is signed off regionally and nationally. This will include, but not limited to: • Confirmation of the exit underlying run rate from 2023/24 and an improvement in the actual recurrent run rate in the 2024/25 plan (Q1 24/25) • The 2024/25 plan shows an improvement in productivity compared to 2023/24 (Q1 24/25) as agreed with NHS England • A system-wide shared services programme is developed that has all appropriate back-office functions within scope and includes accompanying timelines and delivery plans • The system delivers the financial plan for 2024/25 recurrently for two successive quarters (Q4 24/25) • The system delivers improvements in productivity for two successive quarters compared to [baseline year to be determined] (Q4 24/25).
To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones
Develop and agree a Capital Plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.
Develop and agree a workforce plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.

Summary -

- *Develop and deliver a short-term financial plan (2024/25) that is signed off regionally and nationally*
- *Deliver reductions in the run rate for each consecutive quarter*
- *To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones*

Financial Plan Delivery

27. The following have been achieved at a system level:

- Recovery support recognised for TSD and action taken with support from NHS Devon and the Recovery Support Programme (RSP)
- Under the revised analysis of overall productivity improvement Devon scores 3.6% across system compared to 2.3% nationally (old method 7.9% overall productivity vs 1.5% nationally)
- Development of truly system wide corporate back office programmes which are at varying stages of development/implementation – these include people digital, shared financial ledger, one devon financial services. Shared procurement service model is operational
- Achieved £223.0m against £213m planned savings programme
- Medium Term Financial Plan (MTFP) developed and submitted to NHSE in October 2024. The MTFP will require refreshing following the change in planning assumptions and business rules that were issued for the 25/26 planning round.

Productivity

28. Implied Productivity as at Month 9 based on the new approach shows that Devon compares well at 3.6% against national average of 2.3%.

New comparison approach	M1-9 compared to 2023/24		
Organisation	Inflation adjusted expenditure growth	Cost weighted activity growth	Implied productivity growth
Royal Devon University NHS FT	1.7%	6.6%	4.9%
Torbay and South Devon NHS FT	1.6%	5.8%	4.1%
University Hospitals Plymouth NHST	8.0%	9.7%	1.5%
Devon	**3.9%**	**7.7%**	**3.6%**
National	**3.5%**	**5.9%**	**2.3%**

Financial Position

29. Right hand column shows where TSD have deteriorated their plans. Offsets for this were available but in negotiation by region were implemented in 24/25 and therefore recognised that Devon did meet its planned position for NOF4 reporting purposes.

Organisation	Month 12 Outturn		
	Plan for the year surplus / (deficit) £000	Forecast surplus / (deficit) £000	Variance favourable / (adverse) £000
Devon ICB	28,419	28,417	(2)
Devon Partnership NHS Trust	3,591	3,599	8
Royal Devon University NHS FT	(2,790)	(2,743)	47
Torbay and South Devon NHS FT	(13,624)	(33,546)	(19,922)
University Hospitals Plymouth NHST	(15,596)	(15,585)	11
Total	**(0)**	**(19,858)**	**(19,858)**

Savings Delivery

30. Significant savings delivered with only TSD not forecast to achieve plan. There was a shortfall in delivery of recurrent CIP by £20m but overall the savings plan was over achieved by £9.7m

Organisation	Efficiency delivered 2024/25		
	Plan CIP total £000	achieved £000	benefit / (adverse) £000
Devon ICB	37,228	55,017	17,789
Devon Partnership NHS Trust	15,739	15,799	60
Royal Devon University NHS FT	63,610	66,574	2,964
Torbay and South Devon NHS FT	39,900	27,889	(12,011)
University Hospitals Plymouth NHS Trust	56,801	57,732	931
Total	**213,278**	**223,011**	**9,733**

CIP delivery 2024/25			
	Plan CIP delivery £000	Actual CIP delivery £000	Variance benefit / (adverse) £000
Recurrent efficiencies	150,076	129,897	(20,179)
Non-recurrent efficiencies	63,202	93,114	29,912
Total	**213,278**	**223,011**	**9,733**
Recurrent %	70.4%	58.2%	
Non-recurrent %	29.6%	41.8%	

Financial Recovery Trajectory

31. The ICB led the development of the system Medium-Term Financial Plan (MTFP). The system has worked to a consolidated system wide MTFP for a number of years and has a robust model, with system wide agreed assumptions and methodology. The MTFP was last refreshed in October 2024, prior to the 25/6 planning round. After working through a number of scenarios locally, the version presented to, and recognised by, the national team showed a trajectory to breakeven in 27/8 prior to convergence and deficit repayment.

32. The national financial framework has materially shifted during the 25/6 planning round, and the next step is to update and rerun the MTFP model during May and June, reflecting the 24/5 outturn and exit ULP, 25/6 plan and ULP, and updated assumptions over the medium term. During this refresh the system will iterate to include the impact of the Devon Health and Care Strategy, and the Transforming Devon Programme.

Capital

33. The use of capital in 2024/25 was set out and summarised in our Joint Capital Resource Usage Plan which is published on our website.

34. The 2024/25 distribution of core CDEL was based mainly on priority backlog maintenance, planned replacement programmes, and existing lease commitments. Applications and bids against national priorities were coordinated through the ICB to ensure maximum reflection of need within the system and to avoid duplication where possible. The 25/6 plan for capital investment builds on this system coordinated base to further incorporate system priorities such as New Hospital Programme, Elective Recovery, Community Diagnostics, Urgent and Emergency delivery, and Primary Care. The system has prioritised plans against national programmes for Estates Safety, Return to Constitutional Standards, Mental Health out of area placements, and Primary Care Utilisation Fund.

Workforce

35. Six workforce finance recovery workstreams were implemented in 24/25;

- Workforce grip & control
- Non-medical temporary staffing
- Medical temporary staffing
- Rostering
- Medical productivity
- Workforce transformation

36. Workstreams are led by an executive level SRO and has a steering group of system wide stakeholders and all workstreams report through to Workforce Delivery Group to provide assurance on delivery of agreed priorities.

37. All providers have implemented improvements in their local workforce grip and control throughout 2024/25. These initiatives have been further enhanced with

System level grip and control measures, including a System Vacancy Control Panel (VCP) and the design and implementation of the System Workforce Dashboard which tracks in month and year to date delivery against operational plan WTE and pay bill expenditure and is reviewed at Workforce Delivery Group and corrective actions taken in month. In addition, six Workforce Financial Recovery Plan workstreams were implemented in 2024/25 to further support the workforce performance across Devon providers.

38. The key areas of workforce grip and control implemented across providers include;

- Vacancy Control Panels (VCPs) to manage recruitment within budgetary limits.
- Workforce Level Reporting - review of service line, divisional and organisation level reporting of workforce levels compared to budgeted establishments.
- Monitoring of absence and sickness levels (service line, divisional and organisational level) and ensuring regular board-level reviews and actions taken when problem areas identified.
- Leave policy compliance monitoring.
- Overtime and agency use approval process and compliance monitoring.
- Rostering efficiency and compliance with rostering practises and policy.
- Development and implementation of locum exit plans to review and remove high-cost locums.
- Strengthening of budget controls at service live, divisional and organisational level.

39. Recognising the need to continue to have robust grip and control measures in place, a key indicator of the impact that workforce grip and control has made is the improvement in operational plan delivery between the 2023/24 performance (prior to workforce grip and control measures being implemented) and 2024/25 performance.

2023/24 Workforce Performance Summary:

WTE Plan	31,823	Pay expenditure Plan	£1,701,159,000
WTE Actual	33,963	Pay expenditure Actual	£ 1,787,702,000
Variance	2,140 over plan	Variance	£86,543,000 overspent

2024/25 Workforce Performance Summary:

WTE Plan	33,733	Pay expenditure Plan	£1,977,692,000
WTE Actual	34,417	Pay expenditure Actual	£2,027,435,000
Variance	684 over plan	Variance	£49,743,000 overspent

40. Improvements have been made in System level reporting and assurance of workforce data and delivery against the operational plan and workforce finance recovery deliverables with the implementation of the Workforce Delivery Group, with CPO, CFO, CNO, CMO and other key stakeholder representation across System partners as well as the launch of the System Workforce dashboard.

Challenges

41. Whilst, as set out above, the system has made significant progress against the agreed NOF4 exit criteria, it continues to face many challenges.

42. In their individual assessments, two of the system partners (UHP and TSD) have confirmed limited assurance in respect of their delivery against the NOF4 exit criteria.

43. The system has recently experienced challenges in respect of the finalisation of its 2025/26 Operational Plan.

44. As a whole, the 2025/26 Operational Plan, while compliant, is high risk and challenging to deliver. A new approach to performance management and oversight will be needed to be enacted to ensure the plan's delivery. In order to enact this, NHS Devon is creating a "ring fenced" delivery unit, bringing together expertise from across teams to maintain a system focus on delivery.

45. Operational planning activity took place in the context of NHS Devon receiving an allocation in 2025/26 that is £163.3m (4.81%) above that level which it should receive according to need, also known as its 'fair share' target. This target is based on a national formula that uses population demographics and needs factors, such as age, sex, and deprivation, to identify what a fair share of the NHS resource should be.

46. The System Financial Plan reached breakeven with the availability of £53.8m deficit funding from NHSE. Current modelling suggests that delivery of the 2025/26 plan will reduce the Underlying Position (ULP) of the system by approximately £30.0m going into 2026/27. There will need to be significant further action to close the level of overfunding received by NHS Devon

47. Given the scale of the challenge over the coming years it is apparent that sustainability can only come from taking a more transformational long term approach, therefore in order to inform planning for 2026/27 (and beyond) NHS Devon has immediately commenced the development of a Health and Care Strategy (Joint Forward Plan) that will describe the strategic change required alongside a refreshed Medium Term Financial Plan (MTFP) that will be presented to Board by September 2025

48. These significant challenges are compounded by the risk associated with organisational change arising from the recently announced requirement that Integrated Care Boards reduce their running costs by 50%. As NHS Devon works through the implication of this and moves to a potential cluster arrangement with NHS Cornwall and Isles of Scilly, there is a very real risk that the focus needed to deliver the required savings will result in a lessening on the focus needed to deliver an already high risk Operational Plan.

Conclusion

49. The Board is asked to **TAKE SATISFACTORY ASSURANCE** from the information provided with regard to the One Devon Integrated Care System's position and achievements against the agreed NOF4 exit criteria, whilst noting the significant challenges still faced by the system, particularly in relation to the delivery of its 2025/26 Operational Plan.

Appendices

- NHS Devon Self-assessment of progress against the requirements of Segment 4 of the NHS Oversight Framework
- Royal Devon University Healthcare NHS Foundation Trust - Self-assessment of progress against the requirements of Segment 4 of the NHS Oversight Framework
- Torbay and South Devon NHS Foundation Trust - TSD Self assessment of progress against the requirements of Segment 4 of the NHS Oversight Framework
- University Hospitals Plymouth NHS Trust - Self-assessment of progress against the requirements of Segment 4 of the NHS Oversight Framework

NHS Devon Integrated Care Board

NHS Devon Self-assessment of progress against the requirements of Segment 4 of the NHS Oversight Framework

Date of meeting	Date report produced
29 May 2025	01 May 2025

Author(s)		Report approved by	
Name and title:	Philippa Harding, NHS Devon Director of Governance and Interim Chief Communications and Corporate Affairs Officer	**Name and title:**	Steve Moore, NHS Devon Chief Executive Officer
Phone:		**Date:**	
Email:	philippa.harding4@nhs.net		

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

Executive summary
This report provides information about the progress of NHS Devon against the requirements of Segment 4 of the NHS Oversight framework (NOF4)

One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Committees that have previously discussed/agreed the report, and outcomes of that discussion
Considered by the NHS Devon Executive at tis meeting on 06 May 2025. Reviewed by the Finance and Performance Committee at its meeting on 08 May 2025.

Key recommendations and actions requested
TAKE SATISFACTORY ASSURANCE from the information provided with regard to NHS Devon's position and achievements against the agreed NOF4 exit criteria.

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	All
Improve services and reduced unwarranted variation	
Make more efficient use of our resources	
Develop our culture and how we operate	

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	All
Health inequalities	
Workforce	
Resources and finance	
Legal	
Digital and Data	
Involvement, Engagement and consultation	

Self assessment of progress against the requirements of Segment 4 of the NHS Oversight Framework

Introduction and Background

1. The One Devon Integrated Care System (ICS) is currently in Segment 4 of the National Oversight Framework (NOF) and in receipt of mandated support from NHS England (NHSE) as set out in the national Recovery Support Programme (RSP). The criteria to move from Segment 4 to Segment 3 have been agreed and delivery against these monitored by NHS system partners through the One Devon System Leadership Group (SLG) and by NHSE through the System Integrated Assurance Group (SIAG).

2. The expectation is that when NHS Devon's Board considers that the NOF4 exit criteria have been met, with the associated evidence, a proposal will be presented for evaluation by the NHSE South West Regional Team, and a recommendation made to the national team for a change in segmentation. The same applies to all NHS provider trusts within Devon, who would also require NHS Devon's support of their assessment.

3. This report sets out a self assessment informed by all NHS system partners with regard to the One Devon ICS position and achievements against the agreed NOF4 exit criteria. It sets out a system perspective, supported by the perspectives of each individual organisation currently within NOF4.

Progress against individual exit criteria themes - Leadership

Exit Measure
Review of the ICS strategy (developed by the ICS Board) and Joint Forward Plan (developed by the ICB) during 2024/25 and agree priorities and timelines for delivery
Revised NOF4 system architecture to reflect learning from 2023/24 RSP process. This will need to include effective governance arrangements for making collective decisions which have financial implications across organisational boundaries including control of workforce, service investments, cost reductions and productivity improvements.
Development and delivery of organisational and system improvement plans with clear trajectories aligned to the exit criteria and 2024/25 operational plan to include: ○ Named SROs for organisational and system programmes ○ Clear accountability and reporting arrangements
Agree which services will be delivered as part of a system-wide 'shared-services' programme and ensure realistic but stretching delivery plans are developed and progressed.
Review and adapt Devon Operating Model and Governance Architecture in response to ICB governance review and the restructure aligned to reduced management costs
Develop, agree and deliver specific improvement plans to address quality and performance issues raised by regulators. This will include any CQC notices and requirements of MSSP.

Summary - *Demonstrate collaborative decision-making in delivering all the RSP exit criteria at both system and organisational levels, based on the principle of delivering*

the best, most sustainable and most equitable solutions for the whole population served by the system

4. With the agreement of NHSE colleagues, NHS Devon paused work on the review of the system's strategy, to ensure that it did not run ahead of the work being undertaken nationally on the development of the NHS 10 Year Plan. However, NHS Devon has continued to map the work required to deliver a review of the strategy in 2025/26. NHS Devon also took the lead in co-ordinating local engagement activity to support NHSE's development of the 10 Year Plan, ensuring that local priorities were incorporated into these activities to inform the planned strategy review. Work continues on the strengthening of relationships with provider collaborative colleagues and other system partners. NHS Devon has been leading work to refresh the Integrated Care Partnership (ICP) and support the election of a Health and Wellbeing Board Chair as the new ICP Chair. This has ensured that an appropriate framework is in place to progress the planned review of the strategy with system partners in 2025/26. The refreshed ICP considered and supported the proposed 2025/26 Joint Forward Plan (JFP) in March 2025 ahead of its submission to the ICB Board for approval. In line with guidance received from NHSE, the 2025/26 JFP was the subject of a light touch refresh focussing on updating workstreams, financial content, and governance arrangements to align with key local developments, including the development of the MTFP.

5. The membership of the ICB Board was refreshed in 2024/25, with the appointment of a new Chair, three new Non-Executive Members, a Chief Medical Officer, and a Chief Nursing Officer. The Executive team has also seen a change of personnel and structure, the latter as a result of work led by the Chief Executive Officer with the Board to clarify the role and purpose of the organisation. As a result, the role of Chief Operating Officer has been removed from the Executive team, to be replaced by the roles of Chief Strategic Commissioning and Planning Officer and Chief Primary Care, Partnerships and Place-Based Delivery Officer (although the latter role is on hold pending the development of ICB operational models in light of the requirement to reduce costs by 50%). These personnel changes have taken place alongside changes to enhance the governance of NHS Devon. The Terms of Reference of all Board Assurance Committees were clarified, as were executive governance arrangements. As a result of an initial internal governance review in early 2024/25 a Governance Improvement Plan was approved by the Board in July 2024. Good progress has been made against this plan and a further internal corporate governance framework review was completed to inform a 2025/26 Governance Improvement Plan for approval by the Board in March 2025. After two years of receiving a "Limited" Head of Internal Audit Opinion, NHS Devon is expected to receive a "Satisfactory" Opinion for 2024/25.

6. NHS Devon led a complete refresh of the Devon Operating Model in 2024/25. A revised system oversight and assurance architecture was established with input and oversight from the Recovery Support Programme (RSP). The creation of the System Leadership Group (SLG) has enabled NHS partner Chief Executive Officers to act as a coherent group and has facilitated the delivery of the 2024/25 Operating Plan, the development of the Medium Term Financial Plan (MTFP) and

improved system wide decision making. Alongside the SLG, the Chair of NHS Devon has created a System Chairs' Forum to ensure that the Chairs of the NHS partners are fully engaged in system issues and able to hold their executives to account for agreed delivery priorities. The creation of Locality Planning and Delivery Meetings and, more recently, the Mental Health Planning and Delivery Meeting, has ensured a greater level of shared accountability between NHS devon and NHS partners with regard to the delivery of improvement plan and Operational Plan objectives. NHS Devon's grip on financial and operational issues was demonstrated by the agreement with RSP to second the ICB's Chief Finance Officer into Torbay and South Devon NHS Foundation Trusts when its financial challenges were identified.

7. Alongside the delivery of the structural changes set out above, NHS Devon has been instrumental in leading development sessions with the Chief Executive Officers of NHS partners across the system. A behavioural compact, based on the foundational work developed by NHSE has been agreed for adoption by all Boards. Work is ongoing to include local inferences and principles of accountability, including holding oneself and others to account when behaviours are not those that have been agreed. This work is being co-created by Executive and Senior Leaders across the system. The co-creation of a System Development Plan is also being facilitated by NHS Devon, describing the priority areas for OD support across the Devon system, including a single leadership development programme and maximising opportunities to share learning and development resources and expertise across all partners.

Progress against individual exit criteria themes - Strategy

Exit Measure
Phase 2 to be launched in May 2024. Maternity services to be brought into the Programme with workshops complete before end July
Detailed modelling of the scenarios already developed for paediatric, medicine and surgical assessment services to be completed by September 2024 and Maternity by end November 2024
Draft Case for Change developed and socialised with key stakeholders during the summer of 2024
Final Case for Change agreed and signed off by Boards by November 2024
Options appraisal to be undertaken in advance of public consultation process being activated (date TBC before end Q4 2024/25)
Integrated solutions developed, agreed and in progress for a minimum 6 Fragile services
Proposal for elimination of unwarranted duplication of 'specialised services' agreed, and implementation plans underway
Public consultation process and timeline agreed with Region

Summary -

- *Delivery of Phase 2 of the Acute Services Sustainability Programme*
- *Develop and commence implementation of a plan to eliminate unwarranted duplication of specialist DGH services across Devon*

8. NHS Devon has improved its working relationship with the Peninsula Acute Provider Collaborative (PAPC) throughout 2024/25; however, there is more to be done to clarify this and strengthen the strategic direction provided to the PAPC. Alongside this, whilst work had started on engaging the Executive team of NHS Cornwall and Isles of Scilly ICB to facilitate the strategic alignment of both ICBs

alongside the Acute Services Sustainability Programme, there was more to be done to ensure that this is effective. This work has been paused whilst work is undertaken to assess the possibility of a clustering arrangement between the two ICBS, following recent requirements to reduce ICB running costs by 50%.

9. Alongside improving relationships between the NHS Devon Board and the PAPC, NHS Devon has implemented a renewed focus on strategic commissioning. An Executive Commissioning Group has been established, which is working through the strategic commissioning framework that should be adopted by NHS Devon (in line with the anticipated publication of the NHSE Strategic Commissioning Framework). NHS Devon will also be working to ensure that it has a strategy to align population health improvement with any proposed service reconfiguration. To accelerate this key element of our strategy development, NHS Devon will wish to explore the opportunity for central financial support in order to create a population health management system (£800,000 over 3 years).

Progress against individual exit criteria themes – Urgent and Emergency Care (UEC)

Exit Measure
Improvements in line with agreed baseline and plan, over two quarters, in ambulance handover delays (>15 minutes & > 3 hours)
Improvements in line with agreed baseline and plan, over two quarters, in ambulance response times for Category 2 incidents to 30 minutes on average
Improvements in line with agreed baseline and plan, over two quarters, in 4 hour performance & 12-hour breaches
Month on month improvements, over one quarter, in pre-midday Discharges against agreed baseline and trajectories
Achieve and sustain a reduction in number of patients who no longer meet the “criteria to reside in hospital"
CQC confirmation of UHP compliance with Conditions on the trust’s Licence
Meet and maintain the exit criteria for national Tier 1 for UEC.

Summary - *Make demonstrable progress towards achieving national UEC objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement.*

10. Whilst UEC performance continues to be challenging within Devon, the following progress has been made since June 2022:

- Performance against the 4-hour A&E waiting times target has improved from 60% in June 2022 to 69% in the latest month, significantly greater improvement when compared to the national movement from 72% to 73%. UHP moved from 43% to 66% in this period and TSD from 55% to 69%, with RDUH maintaining stable performance.
- There has also been a notable improvement in 12-hour performance, with UHP one of top ten most improved Trusts (an 18% reduction in breaches) whilst RDUH is in the top 15 Trusts for both absolute performance and improvement on 2023/24.
- From the June 2022 baseline ambulance handover delays over 15 minutes had improved by 43% in the latest month (February 2025). This is a reduction

of almost 5,000 hours, with UHP delays reduced by 60% and TSD by 37% from June 2022 to the latest month.
- Category 2 response times improved by 49% in Devon from June 2022 to the latest month (February 2025) compared to a 39% improvement nationally.
- The number of patients with NCTR and not discharged was around 300 in June 2022 compared to an average of around 275 to date in 2025. Challenges remain at UHP to reduce the disproportionate number of Cornish patients delayed in receiving care in the right place.

Progress against individual exit criteria themes – Elective Care

Exit Measure
Elimination of waits over 104 weeks and 78 weeks, in line with agreed plan and operational planning guidance.
Virtually eliminate waits over 65 weeks for elective care in line with agreed plan and operational planning guidance.
Meet and maintain the exit criteria for national Tier 1 for Elective, by all trusts

Summary - *Make demonstrable progress towards achieving national elective and cancer objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement*

11. During 2024/25 there has been significant progress in improving elective performance, including the impact of additional capacity through capital programmes and optimisation of ERF incentives.

12. We continue to focus on reducing waits for our patients and our achievements are:

Referral to Treatment

- The RTT waiting list in Devon has fallen by 12% since June 2022 compared to a 4% increase nationally. RDUH and TSD have both seen significant reductions and whilst there has been a 5% rise at UHP the list size has remained static during the past two years
- NHS Devon has improved from 52.9% against the 18-week RTT target in June 2022 to 60.7% in the latest month (February 2025) with all providers seeing an improvement during this time (TSD up 11.7%, RDUH up 7.7% and UHP up 0.7%). In comparison the national position has fallen by 3.0% with NHS Devon moving from bottom quartile to 15th out of the 42 ICBs.
- Since peaking in February 2022 when NHS Devon had the longest waits nationally, over 104-week waits have been eliminated at all Trusts.
- Over 78-week waits have also fallen sharply in Devon since 2022, reducing to minimal levels by June 2024. The proportion of waits over 78-weeks fell by 2.0% in Devon from June 2022 to February 2025 compared with a 0.8% fall nationally during this period
- The proportion of patients waiting over 65 week waits fell by 3.9% in Devon between June 2022 and the latest month (February 2025) compared to a 1.9% fall nationally. RDUH, TSD and UHP all saw the proportion of over 65-week breaches fall between 3.5% and 4%.

- In November 2024, RDUH moved from Tier 1 to Tier 2 for Elective and Diagnostics as a result of its improved position

Cancer and Diagnostics

- Devon providers' performance against the 28-day target continues to be above the standard and average national position. All providers perform consistently well against this measure with significant improvement seen at all Trusts compared to the June 2022 position
- Devon providers have all improved performance against the 62-day waiting times standard, albeit remaining under the national target. Performance has improved above the national position, with Devon consistently above the national average and ranked 16th out of 42 ICBs in the latest month
- Diagnostic waiting times performance (DM01) have also improved. RDUH have exited tier 1 for diagnostics and UHP have moved from 25.2% seen outside of the 6-week wait standard in April 2024 down to 11.5% in February 2025, within the Trust's submitted operating plan trajectory.

Progress against individual exit criteria themes – Finance

Exit Measure
Develop and deliver a financial plan for 2024/25 that is signed off regionally and nationally. This will include, but not limited to: • Confirmation of the exit underlying run rate from 2023/24 and an improvement in the actual recurrent run rate in the 2024/25 plan (Q1 24/25) • The 2024/25 plan shows an improvement in productivity compared to 2023/24 (Q1 24/25) as agreed with NHS England • A system-wide shared services programme is developed that has all appropriate back-office functions within scope and includes accompanying timelines and delivery plans • The system delivers the financial plan for 2024/25 recurrently for two successive quarters (Q4 24/25) • The system delivers improvements in productivity for two successive quarters compared to [baseline year to be determined] (Q4 24/25).
To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones
Develop and agree a Capital Plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.
Develop and agree a workforce plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.

Summary -

- *Develop and deliver a short-term financial plan (2024/25) that is signed off regionally and nationally*
- *Deliver reductions in the run rate for each consecutive quarter*
- *To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones*

13. NHS Devon has delivered its planned surplus of £28.4m for 24/25 and exceeded its savings target by £17.8m. It has:
    - Delivered a £28.4 surplus in 24/25 (£36.4m 2023/4)
    - Delivered the financial plan for 24/25 whilst also creating headroom to support delivery of the system wide financial position
    - Delivered £55.0m CIP which was above plan by £17.8m
    - Introduced robust programme management processes for CIP monitoring and reporting
    - Developed a budget holder manual and delivered awareness training to all new budget holders following the organisational restructure to ensure continued grip and control
    - Contributed to the model for Corporate Shared Services System Business Case

Financial Recovery Trajectory

14. NHS Devon led the development of the system Medium-Term Financial Plan (MTFP). This demonstrated continued financial sustainability with planned surpluses in excess of £30m over each of the 5 years of the plan. The MTFP will require refreshing following the change in planning assumptions and business rules that were issued for the 25/26 planning round.

Capital

15. The use of capital in 2024/25 was set out and summarised in our Joint Capital Resource Usage Plan which is published on our website.

Workforce

16. NHS Devon's workforce has been re-configured to deliver the 30% running cost reduction and implementation of the re-structure has been completed in 2024/25.

17. The recent announcement of further cuts to running costs for ICBs and the restructuring that will follow will undoubtedly have an impact on NHS Devon's ability to sustain its financial performance. The impact on staff and capacity to deliver the 2025/26 savings plan needs to be recognised.

18. NHS Devon continue to deploy robust workforce grip and control and have a vacancy control process which includes financial and executive oversight and assurance. Recruitment approval controls have been further strengthened following the recent announcements of further cuts to running costs.

Conclusion

19. The Board is asked to **TAKE SATISFACTORY ASSURANCE** from the information provided with regard to NHS Devon's position and achievements against the agreed NOF4 exit criteria.

Royal Devon University Healthcare NHS Foundation Trust

Self-assessment of progress against the requirements of Segment 4 of the NHS Oversight Framework

Date of meeting	Date report produced
Report circulated electronically for comment and approval	27 March 2025

Author(s)		Report approved by	
Name and title:	John Palmer, Chief Operating Officer Chris Tidman, Deputy Chief Executive Officer Angela Hibbard, Chief Finance Officer	**Name and title:**	Sam Higginson, Chief Executive Officer
Phone:		**Date:**	
Email:	john.palmer13@nhs.net		

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

Executive summary

This report contains a self-assessment undertaken by Royal Devon University Healthcare NHS Foundation Trust in respect of the Trust's progress against the NOF4 exit criteria, and includes the following areas of focus:

- Position in relation to the NOF in July 2022
- Improvements made since July 2022
- Current position against the NOF
- Further support required to ensure sustained improvement

The assurance ratings in this report are based on the outcomes of the review and are as follows:

Section	Progress	Trend
Leadership	Resources just deployed, too early to tell	
Strategy	Resources just deployed, too early to tell	

Urgent and Emergency Care	Off track, with high risks of inability to meet exit criteria by the planned date	Sustained challenge in delivery, particularly through and across Winter 24/25
Elective Care	On track and with clear evidence to meet the exit criteria by the planned date	Sustained improvement through 2024/25
Finance	Emerging risk of inability, or no clear evidence of ability to meet exit criteria by the planned exit date	

Progress Definitions
The following definitions, drawn from the Devon System NOF4 progress reports, are utilised within this report in assessing the Trust's progress against the exit criteria measures.

	Off track with high risks of inability to meet exit criteria by planned date
	Emerging risk of inability, or no clear evidence of ability to meet exit criteria by the planned exit date
	On track and with clear evidence to meet the exit criteria by the planned date
	Exit criteria achieved and embedded
	Resources just deployed, too early to tell

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

The Trust's Board of Directors receives at every meeting an update as to the System's progress in respect of requirements of the NHS Oversight Framework Segment 4 (NOF4), the Recovery Support Programme (RSP) and the exit criteria for the Trust and the Devon system.

In addition, the Trust's Board of Directors receives through the Trust's Integrated Performance Report on a monthly basis, a self-assessment as to the Trust's current position in respect of each of the aforementioned exit criteria.

The Trust's Finance and Operational Committee received a formal progress update against the financial and operational (both elective and UEC) exit criteria at its meeting in January 2025.

Key recommendations and actions requested

The Trust's Board of Directors is asked to consider and to agree the following recommendations

- to note the improvements outlined within the report as made by the Trust
- to formally approve the Trust's self-assessment against each of the agreed NOF4 exit criteria
- to endorse the request for further support outlined within this report

Status

Decision	Approval	Discussion	Information
	X		

Links to Strategy / Assurance Framework

Successful delivery of the Trust's exit criteria are integral to many of the Trust's strategic objectives, notably including for

- delivery of an equitable recovery and capacity for further change, and
- to work in partnership to improve the health of our communities.

The exit criteria are interwoven with many of the Trust's financial and operational plan commitments, and thereby with the following BAF risks relating to financial and operational delivery

- Risk 3 – Trust unable to invest in its Capital Plans
- Risk 4 – Non Delivery of the Financial Plan
- Risk 5 – Elective Demand and Waiting List backlogs are not delivered
- Risk 10 – Urgent and Emergency Care Targets are not delivered.

Self-assessment of progress against the requirements of Segment 4 of the NHS Oversight Framework

Introduction and background

1. The One Devon Integrated Care System (ICS) is currently in Segment 4 of the National Oversight Framework (NOF) and in receipt of mandated support from NHS England (NHSE) as set out in the national Recovery Support Programme (RSP). The criteria to move from Segment 4 to Segment 3 have been agreed and delivery against these monitored by NHS system partners through the One Devon System Leadership Group (SLG) and by NHSE through the System Integrated Assurance Group (SIAG).

2. The expectation is that when NHS Devon's Board considers that the NOF4 exit criteria have been met, with the associated evidence, a proposal will be presented for evaluation by the NHSE South West Regional Team, and a recommendation made to the national team for a change in segmentation. The same applies to all NHS provider trusts within Devon, who would also require NHS Devon's support of their assessment.

3. This report sets out a self-assessment by Royal Devon University Healthcare NHS Foundation Trust with regards to the Trust's own progress against the NOF4 exit criteria themes and includes the following areas of focus
    - Position in relation to the NOF in July 2022
    - Improvements made since July 2022
    - Current position against the NOF
    - Further support required to ensure sustained improvement

Progress against individual exit criteria themes - Leadership

Exit Criteria Summary Requirement
Demonstrate collaborative decision-making in delivering all the RSP exit criteria at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system

Exit Measure
Review of the ICS strategy (developed by the ICS Board) and Joint Forward Plan (developed by the ICB) during 2024/25 and agree priorities and timelines for delivery
Revised NOF4 system architecture to reflect learning from 2023/24 RSP process. This will need to include effective governance arrangements for making collective decisions which have financial implications across organisational boundaries including control of workforce, service investments, cost reductions and productivity improvements.

Development and delivery of organisational and system improvement plans with clear trajectories aligned to the exit criteria and 2024/25 operational plan to include: ○ Named SROs for organisational and system programmes ○ Clear accountability and reporting arrangements
Agree which services will be delivered as part of a system-wide 'shared-services' programme and ensure realistic but stretching delivery plans are developed and progressed.
Review and adapt Devon Operating Model and Governance Architecture in response to ICB governance review and the restructure aligned to reduced management costs
Develop, agree and deliver specific improvement plans to address quality and performance issues raised by regulators. This will include any CQC notices and requirements of MSSP.

4. Following the integration of two predecessor NHS Trusts, the clinical and managerial teams of RDUH have been fully restructured, meaning that it has a settled and committed Executive Team with a commitment and drive to exiting NOF4 and to improve on its CQC rating of Requires Improvement. It has established an Executive Led Sexual Safety campaign and an It's Not OK campaign, as well as having made a significant investment in Violence and Aggression resources.

Progress against individual exit criteria themes - Strategy

Exit Criteria Summary Requirement

- Delivery of Phase 2 of the Acute Services Sustainability Programme
- Develop and commence implementation of a plan to eliminate unwarranted duplication of specialist DGH services across Devon

Exit Measure
Phase 2 to be launched in May 2024. Maternity services to be brought into the Programme with workshops complete before end July
Detailed modelling of the scenarios already developed for paediatric, medicine and surgical assessment services to be completed by September 2024 and Maternity by end November 2024
Draft Case for Change developed and socialised with key stakeholders during the summer of 2024
Final Case for Change agreed and signed off by Boards by November 2024
Options appraisal to be undertaken in advance of public consultation process being activated (date TBC before end Q4 2024/25)
Integrated solutions developed, agreed and in progress for a minimum 6 Fragile services
Proposal for elimination of unwarranted duplication of 'specialised services' agreed, and implementation plans underway
Public consultation process and timeline agreed with Region

5. RDUH has ensured the establishment and optimisation of the Exeter Nightingale, Centre for Excellence in Eyes, Community Diagnostic Centre and South West Ambulatory Orthopaedic Centre. It has also established the Biomedical Research

Centre; completed the double deployment of EPIC – within the Trust and now across Devon (all system collaborative commitments).

- Delivery and optimisation of the **Nightingale Hospital as a Community Diagnostic Centre, Centre of Excellence for Eyes, South West Ambulatory Orthopaedic Centre, Buttercup outpatients one stop shop provision (with European and World Class outcomes)**
- **Double deployment of EPIC** across the whole organisation and now driving **roll out across the entire Devon system**
- Establishment of **Virtual Ward and SDEC capabilities** – high utilisation and clinical expertise allowing significant integration with EPIC and wearable tech (Cardiology in particular)
- Establishment of **Cardiac Day Case Unit, Vascular hybrid theatre, Tiverton Endoscopy**
- Development of **University Partnership** and **Biomedical Research Centre** and **Health Technology Centre**
- **IR integration with Taunton** and **Pathology integration across Devon**
- **Outpatient transformation programme** driving top quartile DNA and PIFU performance, now focusing on ambient deployment (AI note capture and immediate transcription into EPR) – also very powerful advice and guidance programme (benchmarking very well)
- Establishment of **People Digital for Devon**

Progress against individual exit criteria themes – Urgent and Emergency Care (UEC)

Exit Criteria Summary Requirement
Make demonstrable progress towards achieving national UEC objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement.

Exit Measure
Improvements in line with agreed baseline and plan, over two quarters, in ambulance handover delays (>15 minutes & > 3 hours)
Improvements in line with agreed baseline and plan, over two quarters, in ambulance response times for Category 2 incidents to 30 minutes on average
Improvements in line with agreed baseline and plan, over two quarters, in 4 hour performance & 12-hour breaches
Month on month improvements, over one quarter, in pre-midday Discharges against agreed baseline and trajectories
Achieve and sustain a reduction in number of patients who no longer meet the “criteria to reside in hospital"
CQC confirmation of UHP compliance with Conditions on the trust’s Licence
Meet and maintain the exit criteria for national Tier 1 for UEC.

6. RDUH has ensured stable performance and a demonstrable response to national sprints to deliver top ten performance; currently in top ten for 12 hour absolute and improved performance; new Children's ED first class.

    - Consistently delivered timely **ambulance handover performance at top five in the region**
    - Supported the stabilisation of UEC flow across the Devon System and **maintenance of performance at or above national average for both type 1 and all types**
    - **Currently positioned in top 15 Trusts nationwide for 12 hour performance** (both absolute performance and improvement on 2023/24)
    - Implemented the March (2024) UEC Challenge – gaining national recognition and resulting in the award of £2m capital funding for being **one of the top ten Trusts nationally for greatest improvement in 4 hour performance (between January and March 2024)**
    - Against a challenging backdrop, **improved 4 hour performance from 58.99% in November 2022 to 67.3% in January 2025 (70.2% including Tiverton)**
    - Maintenance of **+ 30% discharges by 12pm every day for several months**.

A formal assessment of current position against each of the exit criteria measures is included in **Appendix 1**.

Progress against individual exit criteria themes – Elective Care

Exit Criteria Summary Requirement
Make demonstrable progress towards achieving national elective and cancer objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement

Exit Measure
Elimination of waits over 104 weeks and 78 weeks, in line with agreed plan and operational planning guidance.
Virtually eliminate waits over 65 weeks for elective care in line with agreed plan and operational planning guidance.
Meet and maintain the exit criteria for national Tier 1 for Elective, by all trusts

7. RDUH has demonstrated one of the fastest elective care recoveries in the country from one of the largest waiting lists to now in the NHSE pack (close to sub 70k from 85k patients), essentially clear at 104 and 78 week waits, sub 200 patients for 65 weeks waiting and a proven optimiser of Elective Recovery Fund (ERF) incentives (resulting in a drop to tier 2).

8. In terms of cancer recovery, RDUH has moved from significant concern Tier 1 to removal from all tiering inside a year; and now stabilisation against all statutory targets alongside restoration of quality focus through COSD et al.

- **Ten thousand fewer patients on the Trust's Waiting List -** a 12% reduction from 80398 at the end of November 2022, to 70390 at the end of January 2025
- **Eliminated 104week waits in Northern Services by March 2023, and eliminated them Trustwide by the end of Q2 23/24**
- **Virtually eliminated patients waiting longer than 78 weeks for treatment** (only 22 Trustwide at the end of January 2025, compared to 1451 patients in November 2022)
- **On track to have reduced by over 85% in just two years the volume of patients waiting longer than 65 weeks for treatment,** from over 2650 patients in April 2023, to a forecast of fewer than 200 patients at the end of March 2025
- **Delivered a 40% reduction in the number of patients on an open cancer pathway for longer than 62 days** - from 303 patients in April 2023 (equivalent to 8.8% of all open cancer pathways) to 177 (6.6%) at the end of January 2025.
- **Reduced by more than 55% the number of patients on an open cancer pathway for longer than 104 days** - from 84 patients in April 2023 to 37 patients in January 2025
- **Exited Tier 1 for both Elective Care and Diagnostics, and Exited All Tiering for Cancer**
- **Achieved third highest weighted productivity in the country**, remaining top quartile, and one of the fastest month on month clearance rates in the country over the last two years.

A formal assessment of current position against each of the exit criteria measures is included in **Appendix 2**.

Progress against individual exit criteria themes – Finance

Exit Criteria Summary Requirement

- Develop and deliver a short-term financial plan (2024/25) that is signed off regionally and nationally
- Deliver reductions in the run rate for each consecutive quarter
- To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones

Exit Measure
Develop and deliver a financial plan for 2024/25 that is signed off regionally and nationally. This will include, but not limited to: • Confirmation of the exit underlying run rate from 2023/24 and an improvement in the actual recurrent run rate in the 2024/25 plan (Q1 24/25) • The 2024/25 plan shows an improvement in productivity compared to 2023/24 (Q1 24/25) as agreed with NHS England • A system-wide shared services programme is developed that has all appropriate back-office functions within scope and includes accompanying timelines and delivery plans

• The system delivers the financial plan for 2024/25 recurrently for two successive quarters (Q4 24/25) • The system delivers improvements in productivity for two successive quarters compared to [baseline year to be determined] (Q4 24/25).
To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones
Develop and agree a Capital Plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.
Develop and agree a workforce plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.

9. RDUH has been successful in the Delivering Best Value (DBV) programme that's delivered close to break even for 2024/5 after receipt of a share of ICS deficit support funding and would have generated growth in all three of the next years, CIP delivery above target and generated leadership headroom to generate the Corporate Shared Services Business Case

    - Delivering **a £2.8m deficit in 24/25** from a c. £30m deficit in 2023/4
    - **Delivering our financial plan 24/25**
    - **Introducing whole organisation Delivering Best Value programme** – Executive, Clinical and Operational leadership across multiple workstreams
    - **Delivered CIP in excess of 5% in 24/25**
    - Developed the model for **Corporate Shared Services System Business Case**
    - Delivering **positive implied productivity vs 19/20** (upper quartile).

The Medium-Term Financial Plan (MTFP) for RDUH demonstrated a return to financial sustainability under the financial regime for 2024/25 reflecting the success of bringing elective and financial recovery together under the DBV programme. With the capping of the elective recovery fund and additional tariff efficiency the MTFP will need to be rest with a change in approach on financial recovery to mitigate the progress lost through a change in funding envelope. Whilst confident that a change of approach can be formulated the scale of turnaround whilst maintaining an RTT position remains challenging and will require a significant reset.

A formal assessment of current position against each of the exit criteria measures is included **in Appendix 3**.

Further support required to ensure sustained improvement

Maintaining and sustaining position against Financial Exit Criteria

The Trust has benefitted from resource which has allowed us to have an Improvement Director across the last two financial years, which given the planned level of productivity challenge in 2025/26 would be helpful to be able to continue so as to support driving delivery of this programme.

Maintaining and sustaining position against UEC and Elective Exit Criteria
The Trust has well explained positions in relation to NCTR and Winter Plan laid out in its financial and operational plan that show that an additional £2.8m of P1 pathway resource fully commissioned for the year would balance its demand and capacity and make a healthy impact on the Winter bed gap (which was 70 beds in 2024/5).

Developing a population health approach that sustains exit and moves towards sustainability
In addition the Trust has the following three public health improvement programmes planned in 2025/26 for which we would like to access funding so as to support prototyping their implementation, and to maintain a focus on population health in support of sustaining the Trust's improvement position:

(a) Buurtzorg Community Nursing;
(b) Prison Leavers in North Devon; and
(c) Homelessness in East Devon.

Recommendations

The Trust's Board of Directors is asked to consider and to agree the following recommendations

- to note the improvements outlined within the report as made by the Trust
- to formally approve the Trust's self-assessment against each of the agreed NOF4 exit criteria
- to endorse the request for further support outlined within this report.

List of Appendices
Appendix 1 – Self Assessment against Exit Criteria Measures – UEC
Appendix 2 – Self Assessment against Exit Criteria Measures – Elective
Appendix 3 – Self Assessment against Exit Criteria Measures – Finance

Appendix 1: Exit Criteria Measures – UEC

Exit Measure	RDUH update	
Improvements in line with agreed baseline and plan, over two quarters, in ambulance handover delays (>15 minutes & > 3 hours)	Pressures upon patient flow in quarters 3 and 4 at both Northern and Eastern sites illustrated by increase in ambulance handover delays, particularly those in excess of 60 minutes on the Eastern site. Actions to help restore flow anticipated to have attendant impact upon ambulance handover delays.	
Improvements in line with agreed baseline and plan, over two quarters, in ambulance response times for Category 2 incidents to 30 minutes on average	[N/A – criteria for SWAST]	
Improvements in line with agreed baseline and plan, over two quarters, in 4 hour performance & 12-hour breaches	Marked increase in 12 hour breaches across quarter 3 and January 2025 reflecting associated pressures upon patient flow arising from both increased demand and increased delays in discharge. Extended waits often (although not exclusively) linked with mental health patients. Mental Health Workshop with Devon Partnership NHS Trust and Devon ICB on 27/01, with further workshop held on 18/03. Exec to Exec escalation meetings with CEOs & COOs being arranged.	
Month on month improvements, over one quarter, in pre-midday Discharges against agreed baseline and trajectories	Increased emphasis upon actions to improve discharge including use of discharge lounges helping to routinely support discharge earlier in the day. This includes both improved performance in respect of pre-12noon discharge, as well as bringing forward of morning discharges to the day before.	
Achieve and sustain a reduction in number of patients who no longer meet the “criteria to reside in hospital"	Improvement in NCTR position observed in quarters 1 and 2 has reversed in Quarter 3 and 4, with performance of 140 vs trajectory of 97 in February 2025. Divergence from NCTR trajectory most acutely felt in Eastern services, with attendant impact upon patient flow.	
CQC confirmation of UHP compliance with Conditions on the trust’s Licence	[N/A – criteria for UHP]	
Meet and maintain the exit criteria for national Tier 1 for UEC.	[as referenced above]	
Summary rating		

Appendix 2 – Exit Criteria Measures – Elective Care

Exit Measure	RDUH Progress update	
Elimination of waits over 104 weeks and 78 weeks, in line with agreed plan and operational planning guidance.	**104 weeks:** **Performance – 0 patients waiting longer than 104 weeks at the end of month 11 vs trajectory of 0** **78 weeks:** **Performance - 15 patients waiting longer than 78 weeks at the end of month 11 vs trajectory of 0**	
Virtually eliminate waits over 65 weeks for elective care in line with agreed plan and operational planning guidance.	**65 weeks:** **Performance – 333 patients waiting longer than 65 weeks at the end of month 11 vs trajectory of 0**	
Meet and maintain the exit criteria for national Tier 1 for Elective, by all trusts	**[as referenced above]**	
Summary rating		

Appendix 3 – Exit Criteria Measures – Finance

Exit Measure	RDUH Progress update	
Develop and deliver a financial plan for 2024/25 that is signed off regionally and nationally. This will include, but not limited to: • Confirmation of the exit underlying run rate from 2023/24 and an improvement in the actual recurrent run rate in the 2024/25 plan (Q1 24/25) • The 2024/25 plan shows an improvement in productivity compared to 2023/24 (Q1 24/25) as agreed with NHS England • A system-wide shared services programme is developed that has all appropriate back-office functions within scope and includes accompanying timelines and delivery plans • The system delivers the financial plan for 2024/25 recurrently for two successive quarters (Q4 24/25) • The system delivers improvements in productivity for two successive quarters compared to [baseline year to be determined] (Q4 24/25).	• RDUH 2024/25 plan approved • Exit run-rate forecasting improvement form 2023/24 • Implied productivity improved qtr on qtr plus now in positive position against 2019/20 baseline • One Devon Finance Shared service FBC currently going through approvals process. Business case for overarching collaborative corporate services end state for all corporate services in progress • On track to deliver the finance plan	
To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones	Trajectory agreed in principle but as guidance now changing this will need to be reviewed. Tougher financial settlement expected that will adversely impact.	
Develop and agree a Capital Plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.	Strategic capital plan development is hampered by shortfall of BAU capital to address day to day running of estate and services and therefore restricting ability to carve out strategic capital. Uncertainty over national hospital program also contributing.	
Develop and agree a workforce plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.	Work on going internally on developing workforce trajectories and ways of meeting growth demands. Will need refresh in line with challenging financial settlement anticipated.	
Summary rating		

Torbay and South Devon NHS Foundation Trust

Trust Board

TSD Self assessment of progress against the requirements of Segment 4 of the NHS Oversight Framework

Date of meeting	Date report produced
26th March 2025	20th March 2025

Author(s)		Report approved by	
Name and title:	Adel Jones Deputy CEO and COO	**Name and title:**	Joe Teape Chief Executive
Phone:	01803 217382	**Date:**	21/03/2025
Email:	adeljones@nhs.net		

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

N/A

Executive summary

This report sets out a self-assessment by Torbay and South Devon NHS Foundation Trust against the organisation's progress against the NOF4 individual exit criteria themes and includes the following areas of focus:

- Position in relation to the NOF in July 2022
- Improvements made since July 2002
- Current position against the NOF
- Further support required to ensure sustained improvement

The assurance ratings in this report are based on the outcomes of the review meetings and are as follows:

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Leadership	Limited	Improved
Strategy	Limited	
Urgent and Emergency Care	Limited	Improving trajectories
Elective Care	Limited	Improving trajectories
Finance	Limited	

Committees that have previously discussed/agreed the report, and outcomes of that discussion
Finance and Performance Committee 25th March 2025

Key recommendations and actions requested
The Board is asked to accept the overarching assurance recommendations: • **Approve the recommendation that there is limited assurance** that the year-end delivery of the NOF4 criteria is achievable, noting that key financial and strategy criteria do not meet NOF4 exit criteria. • **Note the improvement** in Urgent and Emergency Care, Elective Care trajectories and leadership transitional arrangements are in place, but not sufficient to meet NOF4 exit.

How does this report further our purpose to 'support the people of Torbay and South Devon to live well'?
Good governance drives operational performance and accountability, ensuring we deliver a safe and quality service

How does the report support the Triple Aim	
Aim	**Impact**
Population Health and Wellbeing	
Quality of services provided	Good governance drives delivery & quality
Sustainable and efficient use of resources	Best use of resources to delivery services to local population

Impact on BAF Objectives	
BAF Objective	**Impact**
Quality and Patient Experience: Personalised Care	
People	
Financial Sustainability and Productivity	
Estates	
Operations and Performance Standards	
Strategy and Transformation	
Equality, Diversity and Inclusion	
Provision of Community and Care Services Delivered in Partnership	

Risk: Risk ID (as appropriate)	
Risk	**Risk ID**
N/A	Overarching legal and regulatory risk theme.

External Standards affected by this report and associated risks
Laws or regulations Care Quality Commission Terms of authorisation, NHS England licence and regulations National policy, guidance

Overall Assurance Opinion Definition The overall assurance opinion assigned to this report is based on the following definitions:

Significant	Delivery of core metrics evidenced and ahead of plan. Controls are well designed and are applied consistently. The level of risk carried is below the agreed risk appetite. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Delivery of core metrics evidenced and on plan. Controls are generally sound and operating effectively. The level of risk carried is in line with the agreed risk appetite. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	Delayed-delivery of core metrics, delivery cannot be fully evidenced. The organisation is exposed to a level of risk due to this performance position and/or exceeds the agreed risk appetite. There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	Non-delivery of core metrics, delivery cannot be evidenced and/or is behind plan. The organisation is exposed to significant risk (due to non-compliance).There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

Self assessment of progress against the requirements of Segment 4 of the NHS Oversight Framework

Introduction and background

1. The One Devon Integrated Care System (ICS) is currently in Segment 4 of the National Oversight Framework (NOF) and in receipt of mandated support from NHS England (NHSE) as set out in the national Recovery Support Programme (RSP). The criteria to move from Segment 4 to Segment 3 have been agreed and delivery against these monitored by NHS system partners through the One Devon System Leadership Group (SLG) and by NHSE through the System Integrated Assurance Group (SIAG).

2. The expectation is that when NHS Devon's Board considers that the NOF4 exit criteria have been met, with the associated evidence, a proposal will be presented for evaluation by the NHSE Southwest Regional Team, and a recommendation made to the national team for a change in segmentation. The same applies to all NHS provider trusts within Devon, who would also require NHS Devon's support of their assessment.

3. This report sets out a self-assessment by Torbay and South Devon NHS Foundation Trust against the organisation's progress against the NOF4 individual exit criteria themes and includes the following areas of focus:
    - Position in relation to the NOF in July 2022
    - Improvements made since July 2002
    - Current position against the NOF
    - Further support required to ensure sustained improvement

Progress against individual exit criteria themes – Leadership

Exit Criteria Theme Summary Requirement- Demonstrate collaborative decision-making in delivering all the RSP exit criteria at both system and organisational levels, based on the principle of delivering the best, most sustainable and most equitable solutions for the whole population served by the system.

Exit Measure
Review of the ICS strategy (developed by the ICS Board) and Joint Forward Plan (developed by the ICB) during 2024/25 and agree priorities and timelines for delivery
Revised NOF4 system architecture to reflect learning from 2023/24 RSP process. This will need to include effective governance arrangements for making collective decisions which have financial implications across organisational boundaries including control of workforce, service investments, cost reductions and productivity improvements.
Development and delivery of organisational and system improvement plans with clear trajectories aligned to the exit criteria and 2024/25 operational plan to include: ○ Named SROs for organisational and system programmes ○ Clear accountability and reporting arrangements
Agree which services will be delivered as part of a system-wide 'shared-services' programme and ensure realistic but stretching delivery plans are developed and progressed.
Review and adapt Devon Operating Model and Governance Architecture in response to ICB governance review and the restructure aligned to reduced management costs
Develop, agree and deliver specific improvement plans to address quality and performance issues raised by regulators. This will include any CQC notices and requirements of MSSP.

4. The Trust has been through a significant period of change and is receiving focussed support from the RSP team as part of the Trust turnaround. A new CEO commenced in March 2025 and restructures of the executive team have progressed with the appointment of a new Chief Operating Officer and Chief Strategy and Planning Officer. The Trust has developed an integrated improvement plan, to deliver improved governance oversight, financial recovery, performance improvement and leadership capability building to drive the exit from NOF4. This work builds on some of the positive strategic changes Trust has embedded, including the Compassionate leadership framework.

Progress against individual exit criteria themes - Strategy

Exit Criteria Theme Summary Requirement-

- Delivery of Phase 2 of the Acute Services Sustainability Programme
- Develop and commence implementation of a plan to eliminate unwarranted duplication of specialist DGH services across Devon

Exit Measure
Phase 2 to be launched in May 2024. Maternity services to be brought into the Programme with workshops complete before end July
Detailed modelling of the scenarios already developed for paediatric, medicine and surgical assessment services to be completed by September 2024 and Maternity by end November 2024
Draft Case for Change developed and socialised with key stakeholders during the summer of 2024
Final Case for Change agreed and signed off by Boards by November 2024
Options appraisal to be undertaken in advance of public consultation process being activated (date TBC before end Q4 2024/25)
Integrated solutions developed, agreed and in progress for a minimum 6 Fragile services
Proposal for elimination of unwarranted duplication of ‘specialised services’ agreed, and implementation plans underway
Public consultation process and timeline agreed with Region

5. The Trust is committed to system working and has provided significant leadership capacity into the delivery of key strategic programmes in the Acute Sustainability Programme.
   - Urology networked emergency care solution delivered between RDUH and TSD
   - Collaborative working with RDUH providing additional in-patient and elective cases being seen by TSD to support reductions in waiting times for Devon.
   - Establishment of the Surgical Hub for day surgery and ophthalmology services, optimisation is in progress which will position this facility to provide greater capacity for Devon.
   - Successful approval of the EPR business case collaboratively for Devon to underpin transformation of clinical and operational pathways

Progress against individual exit criteria themes – Urgent and Emergency Care (UEC)

Exit Criteria Theme Summary Requirement- Make demonstrable progress towards achieving national UEC objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement

Exit Measure
Improvements in line with agreed baseline and plan, over two quarters, in ambulance handover delays (>15 minutes & > 3 hours)
Improvements in line with agreed baseline and plan, over two quarters, in ambulance response times for Category 2 incidents to 30 minutes on average
Improvements in line with agreed baseline and plan, over two quarters, in 4 hour performance & 12-hour breaches
Month on month improvements, over one quarter, in pre-midday Discharges against agreed baseline and trajectories
Achieve and sustain a reduction in number of patients who no longer meet the “criteria to reside in hospital"
CQC confirmation of UHP compliance with Conditions on the trust’s Licence
Meet and maintain the exit criteria for national Tier 1 for UEC.

RAG rated against monthly Operational Plan trajectory	Target March 2025	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Operational Plan trajectory Feb 2025
NATIONAL OVERSIGHT FRAMEWORK EXIT CRITERIA															
Urgent and Emergency Care															
Ambulance handovers - time lost over 15 mins - Actual (hours)	1808	3217	3867	2846	3249	2488	2248	1576	3330	4343	3275	3108	2532	1625	2030
Percentage of Ambulance handovers greater than 3 hours	8%	20.0%	24.4%	16.6%	20.2%	14.7%	9.8%	6.7%	21.0%	31.2%	22.3%	18.5%	14.7%	7.6%	9%
Total average time in ED (hours/minutes)		06:39	06:33	06:04	06:00	05:43	05:34	05:25	06:20	06:44	06:18	06:17	06:20	05:53	No trajectory
ED attendances visit time over 12 hours (minor/major/spec/paeds)	0	836	861	722	800	672	588	525	779	979	854	793	818	677	No trajectory
UEC 4-hour target (RAG against local trajectory to national target)	78%	63.2%	65.7%	67.7%	71.6%	70.8%	70.3%	70.7%	65.5%	68.7%	67.3%	65.0%	66.7%	68.8%	75%
% patient discharges pre-noon	33%	23.3%	24.0%	22.3%	22.1%	21.3%	19.4%	18.9%	20.8%	21.5%	22.3%	20.4%	19.9%	21.2%	33%
Percentage of inpatients with No Criteria to Reside (acute)	<5%	4.9%	4.8%	4.9%	5.6%	7.8%	6.5%	6.0%	6.9%	5.9%	9.5%	6.6%	8.3%	9.1%	5%

6. The Trust met two of the UEC NOF 4 exit criteria in February 2024 centred on ambulance handovers. Of note there was significant progress in the percentage of ambulance handovers greater than 3hrs. Improvements have been made in total average time in ED, ED attendance visit time over 12 hours, UEC 4hr Target (highest performance in the past 6 months) and % of patient discharges pre-noon
7. 4hr Performance for the month stands at 68.8% and the focus on improving the non-admitted pathway has demonstrated daily performance of more than 80% at times in month. Daily huddles and PDSA change cycles have now been introduced within the Emergency Department to support improved performance
8. 12-hour wait times in the Emergency Department have improved, reaching the best position in the past 6 months.
9. Ambulance handover delay reduction continues to improve with the implementation of the cohort area, which is reviewed regularly to ensure safety and quality standards are maintained.

Progress against individual exit criteria themes – Elective Care

Exit Criteria Theme Summary Requirement- Make demonstrable progress towards achieving national elective and cancer objectives, in line with agreed trajectories, sustained over two consecutive quarters and have in place an agreed system plan to sustain this improvement

Exit Measure
Elimination of waits over 104 weeks and 78 weeks, in line with agreed plan and operational planning guidance.
Virtually eliminate waits over 65 weeks for elective care in line with agreed plan and operational planning guidance.
Meet and maintain the exit criteria for national Tier 1 for Elective, by all trusts

10. TSD has maintained its eliminated 104ww position throughout 24/25 having eliminated 104ww during FY23/24

11. TSD met the national requirement to eliminate 78ww by end of December 24. However there have been subsequent patients that will have breached by the end of March 25.The primary issues are specialty capacity, complex cases e.g. tandem cases in T&O, or patient choice in ENT. Work continues to address this.
12. TSD has maintained a month on month improvement against the 65ww standard, recording an improved position in all ten months of 24/25 so far.
13. In February there are 215 patients who have been waiting over 65 weeks for treatment which is not meeting the Trusts trajectory. There is a risk of delivery against 65-week waits for the end of March 2025. H&N incident has significant impacted on recovery plans. There is also a focus on prioritising cancer pathways.
14. TSD has exceeded its internal targets for both the cancer 62 day treatment trajectory and the 28 day cancer diagnosis standard.
15. In February 25 the Trusts theatre utilisation reached 85% which hits the national standard.

Progress against individual exit criteria themes – Finance

Exit Criteria Theme Summary Requirement-

- Develop and deliver a short-term financial plan (2024/25) that is signed off regionally and nationally
- Deliver reductions in the run rate for each consecutive quarter
- To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones

Exit Measure
Develop and deliver a financial plan for 2024/25 that is signed off regionally and nationally. This will include, but not limited to: • Confirmation of the exit underlying run rate from 2023/24 and an improvement in the actual recurrent run rate in the 2024/25 plan (Q1 24/25) • The 2024/25 plan shows an improvement in productivity compared to 2023/24 (Q1 24/25) as agreed with NHS England • A system-wide shared services programme is developed that has all appropriate back-office functions within scope and includes accompanying timelines and delivery plans • The system delivers the financial plan for 2024/25 recurrently for two successive quarters (Q4 24/25) • The system delivers improvements in productivity for two successive quarters compared to [baseline year to be determined] (Q4 24/25).
To agree a financial recovery trajectory with NHSE, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones
Develop and agree a Capital Plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.
Develop and agree a workforce plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.

16. The Trust continues to work with NHSE Recovery Support Team to address the financial challenges.

- The Trust's financial position at the end of February shows a year-to-date deficit of
  £26.1m, £12.9m higher than planned.

- The Trust is forecasting a **£33.6m** deficit for 2024/25, **£20.0m** higher than plan and **£5m** worse than previously forecast following review of the required level of accruals and provisions as we approach year end. The ICB/NHSE have been fully engaged and are aware of the planned deterioration.
- The financial gap cannot be addressed by control measures alone and it is recognised that workforce remodelling will be required. This will have associated financial support for the costs of change i.e. MARS and the infrastructure to deliver it.
- The Corporate Shared Services model is dependent on costs of change being funded centrally, and a decision is awaited e.g. Procurement, People Digital etc. It is essential that financial support is provided to enable these changes

Assurance and Recommendations

The Board is asked to accept the overarching assurance recommendations:

- **Approve the recommendation that there is limited assurance** that the year-end delivery of the NOF4 criteria can be achieved noting the improvement in leadership assurance rating
- **Note the improving trajectories** in Urgent and Emergency Care and Elective Care

Section	Assurance (Limited/Satisfactory/ Significant)	Trend from previous report
Leadership	Limited	Improved
Strategy	Limited	
Urgent and Emergency Care	Limited	Improving trajectories
Elective Care	Limited	Improving trajectories
Finance	Limited	

University Hospitals Plymouth NHS Trust

Self-assessment of progress against the requirements of Segment 4 of the NHS Oversight Framework

Leadership

Exit Measure
Review of the Integrated Care System (ICS) strategy (developed by the ICS Board) and Joint Forward Plan (developed by the ICB) during 2024/25 and agree priorities and timelines for delivery
Revised NOF4 system architecture to reflect learning from 2023/24 RSP process. This will need to include effective governance arrangements for making collective decisions which have financial implications across organisational boundaries including control of workforce, service investments, cost reductions and productivity improvements.
Development and delivery of organisational and system improvement plans with clear trajectories aligned to the exit criteria and 2024/25 operational plan to include: o Named Senior Responsible Officer (SROs) for organisational and system programmes o Clear accountability and reporting arrangements
Agree which services will be delivered as part of a system-wide 'shared-services' programme and ensure realistic but stretching delivery plans are developed and progressed.
Review and adapt Devon Operating Model and Governance Architecture in response to ICB governance review and the restructure aligned to reduced management costs
Develop, agree and deliver specific improvement plans to address quality and performance issues raised by regulators. This will include any CQC notices and requirements of MSSP.

The Trust continues to work with system partners to improve the NOF4 position for Devon. An interim Chief Executive Officer (CEO) was appointed in April 2024 and a new Trust Management Board (TMB) was established to involve with senior clinical leaders included in its membership along with Executive Directors. The TMB has oversight of all operational matters and is important decision-making forum in identifying quality priorities and improvement activity to deliver better outcomes for patients. As outlined below, the urgent and emergency care (UEC) One Plan has led to significant improvement for patients accessing care via our emergency pathway.

During the year the leadership team has focused on people and cultural issues in response to staff survey indicators and poor behavioural issues referred to the Freedom to Speak Up Guardian. The leadership team is committed to setting high standards of behaviour, and to holding all to account when behaviour falls short of what is expected. Our Trust values were refreshed and a new Staff Charter was published outlining what good behaviours look like in practice.

Additionally, respect and civility training has been launched for all senior executive and clinical leaders, and leading with compassion for all line managers.

Throughout the year the Trust has dedicated clinical leadership time to the PAPC work programme and engaged with Devon and Cornwall partners to ensure strategic alignment and sustainable healthcare service provision.

The UEC developed in year, specifically addresses the Care Quality Commission (CQC) actions raised in previous UEC inspections. A Maternity and Neonatal Improvement plan is in place as part of maternity safety support programme (MSSP) requirements and progress is monitored within the Trust's corporate governance structure.

Strategy

Exit Measure
Phase 2 to be launched in May 2024. Maternity services to be brought into the Programme with workshops complete before end July
Detailed modelling of the scenarios already developed for paediatric, medicine and surgical assessment services to be completed by September 2024 and Maternity by end November 2024
Draft Case for Change developed and socialised with key stakeholders during the summer of 2024
Final Case for Change agreed and signed off by Boards by November 2024
Options appraisal to be undertaken in advance of public consultation process being activated (date TBC before end Q4 2024/25)
Integrated solutions developed, agreed and in progress for a minimum 6 Fragile services
Proposal for elimination of unwarranted duplication of 'specialised services' agreed, and implementation plans underway
Public consultation process and timeline agreed with Region

University Hospitals Plymouth NHS Trust (UHP) continues to work collaboratively with system partners to realise strategic goals for Devon ICS.

During 2024/25 UHP has:

a) Published its clinical strategy setting out the clinical transformation and clinical priorities for the next 10 years.
b) Initiated an internal 'Big Conversation' to codesign with staff how we become a high quality organisation and what that means in how we live our values, behaviours and our leadership approaches to enable accountability, belonging and compassion. The outputs will feed into our overarching corporate strategy refresh for 25/26
c) Opened a new major trauma ward in January 2025. This is one of only 27 Major Trauma Centres in the country, and this is a really important step forward for the population we serve.
d) Started construction on the new Dartmoor Building which will be home to the Urgent Treatment Centre and Fracture Clinic at the Derriford Hospital site.
e) Received confirmation of funding from the Secretary of State to build a new emergency care facility as part of the New Hospital Programme.
f) Signed a contract for an electronic patient record (EPR) with Epic, following national approval of the business case. The signing of the contract signifies a major step forward in the shared vision to implement a single EPR across Devon, and by investing in a system from the same supplier, the three acute NHS trusts in Devon will be making the most of digital transformation.

Urgent and emergency care (UEC)

Exit Measure
Improvements in line with agreed baseline and plan, over two quarters, in ambulance handover delays (>15 minutes & > 3 hours)
Improvements in line with agreed baseline and plan, over two quarters, in ambulance response times for Category 2 incidents to 30 minutes on average
Improvements in line with agreed baseline and plan, over two quarters, in 4 hour performance & 12-hour breaches
Month on month improvements, over one quarter, in pre-midday Discharges against agreed baseline and trajectories
Achieve and sustain a reduction in number of patients who no longer meet the "criteria to reside in hospital"
CQC confirmation of UHP compliance with Conditions on the trust's Licence
Meet and maintain the exit criteria for national Tier 1 for UEC.

One Plan is UHP's single plan for improving access, quality of care and patient experience in our UEC service offer and pathways. The plan was co-designed with senior clinical leaders and has three improvement pillars – Admission Avoidance, Dynamic Flow and Timely Discharge to deliver resilient, consistent and long-lasting improvement in UEC quality and operational outcomes.

The One Plan has led to significant UEC improvements which include:

- UHP has been rated the most improved Trust in England in relation to the 4-hour target despite increased demand for the Emergency Department.
- UHP is recognised as one of top ten most improved in decreasing 12-hour length of stay (LoS), currently at 1402 patients from 1707.
- We are also the 12th most improved Trust for ambulance handover times in December, with a huge reduction in ambulances waiting to handover for more than 6 hours.
- Ambulance hours lost in February were 3,076, a 45% reduction from January (6,919) and a difference of a 35% reduction compared to February 2024 (8,671).
- Have worked collaboratively with South Western Ambulance Service NHS Foundation Trust (SWAST), Integrated Care Board (ICB) and community colleagues to maximise the use of our community capacity; test the care coordination spoke model and reduce ambulance dispatches; conveyances and handovers.
- The launch of 'Release to Rescue' timely handover plan in March 2025 with the aim of reducing handovers to less than 90 minutes
- Pre-midday discharges improvement target of 25% continues to improve at 22.1% from 19% with further work underway to improve.

The no criteria to reside (NCTR) has remained above target (9%) throughout the year. We have further work to do with Cornwall, to reduce the disproportionate number of patients delayed in receiving care in the right place.

Conditions placed on the Trust's licence in May 2021 remain. These require the Trust to take action with the health and social care system to improve patient safety and experience in urgent and emergency care. The conditions were not reissued following the last inspection in 2024, and we continue to report against compliance. The CQC will review UHP compliance with the conditions at the next UEC inspection.

Elective Recovery

Exit Measure
Elimination of waits over 104 weeks and 78 weeks, in line with agreed plan and operational planning guidance.
Virtually eliminate waits over 65 weeks for elective care in line with agreed plan and operational planning guidance.
Meet and maintain the exit criteria for national Tier 1 for Elective, by all trusts

During 2024/25 we have improved on our elective performance through consistent grip and control and improvement in our processes plus the addition of some new capacity as a result of capital projects completing in year (e.g. Royal Eye Infirmary (REI) hospital, Orthopaedic theatres and ward plus Endoscopy refurbishment). In November 2024, we moved from Tier 1 to Tier 2 for Elective and Diagnostics as a result of the improved position.

We continue to focus on reducing waits for our patients and our in year achievements are:

- All waits over 104 weeks have been eliminated and we are on track to eliminate waits over 78 weeks by the end of March 2025, except for some patient choice delays.
- Significant improvement in the number of 65 week waits, which has reduced by 65% since the end of March 2024. We forecast to have less than 100 at the end of March 2025 with

approx. 30% of those due to patient choice delays.
- Cancer performance remains strong for the Faster Diagnosis standard; we are the top performing Trust in the Southwest of England.
- Our Diagnostic waiting times performance (DM01) has improved from 25.2% seen outside of the 6 week wait standard in April 2024 down to 11.5% in February 2025, which is within our submitted operating plan trajectory.
- We have seen a huge improvement in our Histopathology turnaround times, achieving 85% within 10 days in February 2025.

Our waiting lists are subject to continuous scrutiny at specialty level to ensure patients are not harmed through long waiting times. Our crude mortality rate demonstrates a sustained, statistically significant reduction.

Finance

Exit Measure
Develop and deliver a financial plan for 2024/25 that is signed off regionally and nationally. This will include, but not limited to: • Confirmation of the exit underlying run rate from 2023/24 and an improvement in the actual recurrent run rate in the 2024/25 plan (Q1 24/25) • The 2024/25 plan shows an improvement in productivity compared to 2023/24 (Q1 24/25) as agreed with NHS England • A system-wide shared services programme is developed that has all appropriate back-office functions within scope and includes accompanying timelines and delivery plans • The system delivers the financial plan for 2024/25 recurrently for two successive quarters (Q4 24/25) • The system delivers improvements in productivity for two successive quarters compared to [baseline year to be determined] (Q4 24/25).
To agree a financial recovery trajectory with NHS England, which includes specific dates for the achievement of non-recurrent and recurrent balance with clear milestones, and the confidence from NHSE as to the deliverability of the plan. This deliverability will be demonstrated through the achievement of key (materially significant) milestones
Develop and agree a Capital Plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.
Develop and agree a workforce plan that is clearly aligned to System strategic priorities and supports long term financial sustainability.

As described in the above table the Trust has an adverse forecast outturn against plan of £5.5m. These reflects costs pressures on a short fall in pay awards inflation and non-pay cost pressures. Demand pressures have also impacted on pay budgets.

UHP has been delivering a Financial Improvement Programme that's delivered £40m (4%) or recurrent savings with a further £17m found non-recurrently. Through the work of the UEC One Plan, the full £57m improvements were identified. These are currently in implementation and have enabled the Trust to deal with the increased demand and NcTR position that has been significantly above plan. Were this not the case, we would expect the recurrent cost improvement programme (CIPs) delivery to be above plan.

UHP has also created leadership headroom to lead the Procurement Shared Service for the System and delivered a positive implied productivity

NHS Devon Integrated Care Board

Delivering the NHS Devon 2025/26 Operational Plan

Date of meeting	Date report produced
29 May 2025	15 May 2025

Author(s)		Report approved by	
Name and title:	Toby Hewlett, Transforming Devon Programme Director	**Name and title:**	Libby Ryan-Davies, Chief Strategic Commissioning & Planning Officer,
Phone:	07970590967	**Date:**	01 May 2025
Email:	toby.hewlett@nhs.net		

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

Executive summary
On 29 April 2025 the NHS Devon Board approved the System Operational Plan for 2025/26 for submission to NHS England, though limited assurance was taken on the deliverability of the plan due to the high risk contained within it. This report sets out a new approach to Performance Management that will oversee and assure delivery of the 2025/26 Operational Plan.

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Additionally, the Operational Plan will be underpinned by a Commissioning Plan that details NHS Devon's key commissioning priorities in 2025/26. This is also appended to this report.

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

Reviewed by the NHS Devon Executive at its meeting on 20 May 2025.

Key recommendations and actions requested

NOTE the level of ambition and risk within the submitted Operational Plan for 2025/26

TAKE SATISFACTORY ASURANCE from the proposed approach to Performance Management in 2025/26, including confirmation of the metrics that will be included within the Performance Management Dashboard

ENDORSE the NHS Devon Commissioning Plan for delivery in 2025/26

Impact on NHS Devon objectives

Objective	Impact
Improve population health	Delivery of operational plans will improve population health.
Improve services and reduced unwarranted variation	Delivery of the operational plans will improve services and reduce unwarranted variation.
Make more efficient use of our resources	Delivery of operational plans will support more efficient use of our resources.
Develop our culture and how we operate	This approach demonstrates a shift in culture and accountability within how we operate

Outline the implications of matters covered in this report for the following areas (if none, please state)

Area	
Quality of services	Positive if delivered.
Health inequalities	Positive if delivered.
Workforce	Positive if delivered.
Resources and finance	Positive if delivered.
Legal	None
Digital and Data	Positive if delivered.
Involvement, Engagement and consultation	None

Delivering the NHS Devon 2025/26 Operational Plan

Background

1. As part of the National Planning process Integrated Care Boards (ICBs) were required to submit a system Operational Plan to NHS England (NHSE) that delivered the expectations of the NHSE Planning Guidance.

2. On 29 April 2025 the NHS Devon Board approved the System Operational Plan for 2025/26 for submission to NHS England, though limited assurance was taken on the deliverability of the plan due to the high risk contained within it.

3. Given the level of risk contained within the plan, NHS Devon is proposing a new approach to Performance Management that will oversee and assure delivery of the 2025/26 Operational Plan

4. Additionally, the Operational Plan will be underpinned by a Commissioning Plan that details the key commissioning priorities of NHS Devon in 2025/26

5. It should be noted that the Operational Plan does not cover the full range of activity delivered by NHS Devon as described in the 2025/26 Annual Plan that was approved by the NHS Devon Board at its meeting on 27 March 2035.

Operational Plan compliance with NHSE requirements

6. The 2025/26 One Devon Integrated Care System Operational Plan submitted to NHSE in April 2025 was materially compliant with regional expectations.

7. It sets out the expectation that all performance measures will be hit, with the exception of Referral to Treatment (RTT) waits of over 52 weeks, which slightly exceeds the national target; this is being driven by performance challenges within University Hospitals Plymouth NHS Trust (UHP)

	Total A&E within 4 Hours	Type 1 A&E over 12 Hours	RTT within 18 Weeks Waiting	RTT over 52 Weeks Waiting	18 Week for First Attendance	28 Day Performance	62 Day Performance
System March 2026 Position	78.1%	4.9%	64.4%	1.3%	72.8%	82.0%	75.2%
National Targets	>78%	<2024/25	minimum 64.4%	<1%	minimum 72.4%	>80%	>75%

8. The System Financial Plan has now reached breakeven, though it should be noted that this has been delivered with the support of £63.8m deficit funding from NHS England and in the context that, in 2025/26, NHS Devon receives an allocation that is £163.3m (4.81%) above the level which it should receive according to need, also known as its 'fair share' target.

9. Despite deficit support, Torbay and South Devon NHS Foundation Trust has submitted a plan with a forecast deficit of c.£8m. At a system level this is offset by a forecast surplus of c.£8m within NHS Devon. All other organisations are forecasting a breakeven position.

10. The System Workforce Plan shows a gross reduction in workforce of 1390 whole time equivalents (wte), once planned recruitment due to investment is taken into account this is a net 849 wte reduction.

Risks to Operational Plan delivery

11. Though the Operational Plan that has been submitted is materially compliant, it remains high risk and challenging to deliver.

12. Cost Improvement Programme (CIP) levels across the system are at £256.7m; this represents a 7.8% CIP (using the blended approach) and exceeds 2024/25 CIP delivery by £33.7m. At the point of submission:

    a. 61% of CIP were either fully developed or have plans in progress.
    b. 50% of CIP were high risk or unidentified
    c. 65% of CIP were recurrent (against a 70% target)

13. The plan contains a gross financial risk of £157.0m, with mitigations of £57.7m leaving a net risk of £99.3m.

14. Performance trajectories will likewise be challenging to deliver, and will be underpinned by a number of NHS Devon led interventions that are detailed within the NHS Devon Commissioning Plan, which is summarised below (the detailed Commissioning Plan can be found at Appendix A to this report)

NHS Devon Commissioning Plan

15. The NHS Devon Commissioning Plan has been developed to detail the Commissioning actions that the ICB will progress to deliver its annual plan.

16. It will be delivered through four key priority areas

    a. **Delivering equitable services** – where the system is performing at a high level, describing the approach to move resource to support challenged areas of delivery in a cost neutral manner
    b. **Delivering best value, within allocation** – how NHS Devon will approach review of existing contracted provision to deliver efficiencies, or disinvest in services where they may not be viable or are not delivering value for money
    c. **Delivering Strategic Change** – taking a system wide approach to significant change to ensure alignment cross organisations
    d. **Delivering support for in year pressures**– when the system is under pressure and needs to refocus investment describing the approach to rebalancing investment against risk

17. To support delivery of the plan and ensure that organisation-wide commissioning activity is aligned a co-ordinating “Commissioning Hub” will be established, with oversight of the plan coming through Commissioning Group, a sub-group of the NHS Devon Executive.

18. Given the future focus on Strategic Commissioning, alongside in year delivery there will be a focus on building Strategic Commissioning organisational capability and approach

Performance Management

19. To ensure delivery of the 2025/26 Operational Plan, a new approach to Performance Management has been developed.

20. Underpinned by a performance dashboard (Appendix B to this report) detailing key performance metrics, trajectories and tolerances across Operational Performance, Workforce, Finance and Quality there will be a structured approach to reviewing against plan and identifying mitigating actions to manage risk.

Delivery Review
The **Tactical Cell** will review the performance dashboard and agree actions against any metrics rated Amber or Red. It will produce a report to the Strategic Cell detailing areas off track and mitigating actions.

Assessing Residual Risk
The **Strategic Cell** will review the Tactical Cell report and assess whether performance risk is fully mitigated by actions and therefore make a recommendation on any escalation or additional strategic actions that need to be taken.

Agreeing Escalations
The **System Leadership Group** will review the Strategic Cell recommendations and approve the escalation of any organisation as per the escalation framework (see below). It will also agree any interventions that will accompany the escalation.

Process Assurance
NHS Devon Board will receive a report at each meeting on the process and decisions made. This report will also be submitted for detailed discussion at the relevant Board Assurance Committees. When the Board is not assured that organisations have been escalated in line with the framework they the System leadership Group will be instructed to review decisions.

21. There will be a weekly tactical rhythm to reviewing performance against plan and mitigating actions where organisations are off plan, which will report to a monthly Strategic Cell who will advise CEOs (through System Leadership Group) on required escalation and intervention as per the Performance Management Escalation Framework:

	Level Criteria	Expected governance and range of interventions
Level 6*	Significant variance to organisational plan; risk to National plan delivery	TBC
Level 5*	Significant variance to organisational plan; risk to Regional plan delivery	TBC
Level 4	Significant variance to organisational plan; risks are not mitigated and pose significant risk to System plan delivery	Board to Board review and follow up process established until de-escalated; ICB Committee chairs invited to organisational committees, Chair/CEO Bilateral review
Level 3	Variance to organisational plan; risks may not be fully mitigated but will impact on System plan delivery	Exec to Exec review and follow up process established until de-escalated; Consideration of external Deep dive
Level 2	Variance to organisational plan; risks may not currently be fully mitigated but system plan is not impacted	Increased organisational governance and oversight; including greater Board scrutiny. Conduct peer review and ensure Recovery Action Plans in place
Level 1	Minimal variance to organisational plan; recoverable with mitigations; Organisational risk	Managed within routine organisational governance processes

* Regional and National Intervention layers to be designed and will need to informed by NHSE approach

22. Ultimate assurance of the process will fall to the NHS Devon Board who will be provided monthly reports on plan variance, actions taken and escalation decisions made.

23. Regional and National Performance oversight is being developed and will be aligned to this framework in negotiation with NHS England colleagues

24. This performance framework is, by design, to drive delivery of the Operational Plan for 2025/26 and does not reflect the full range of performance metrics expected as part of the NHS England's Performance Assessment Framework (PAF).

25. As the PAF is developed, a wider performance dashboard will be created as a replacement to the Integrated Quality Performance Report (IQPR) and used to routinely monitor System Performance through existing governance routes. The process described here should be seen as an enhanced level of performance management given the specific risks to the delivery of the operational plan and can be stood down should delivery to plan be maintained with minimal risk.

26. Similarly, where organisational delivery is to plan it is proposed that Locality Planning and Delivery Meetings are suspended, with the option of standing them back up to fulfil the Exec to Exec or Board to Board review functions in Levels 3 and 4 of the escalation framework.

NHS Devon Annual Plan delivery

27. NHS Devon is unique across system organisations in its role in overseeing both the system level performance and the performance of its own organisation.

28. To deliver the 2025/26 NHS Devon Operational Plan, all organisations will need to deliver their organisational plans – for NHS Devon this is its Annual Plan.

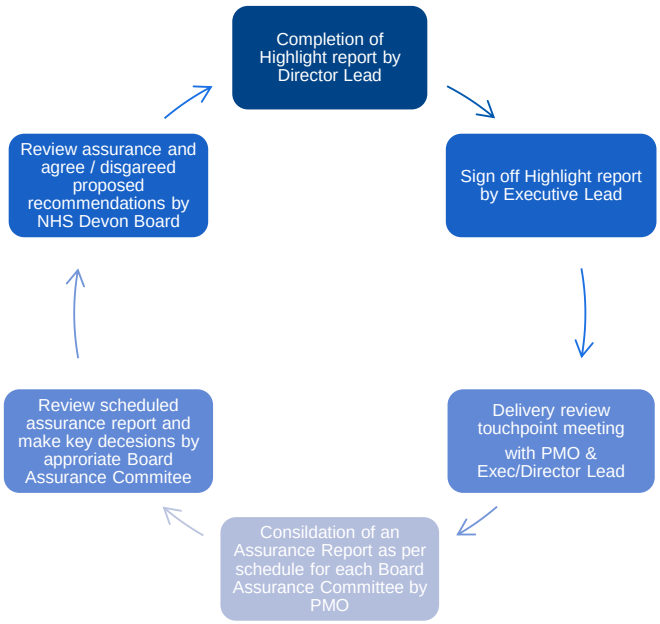
29. The process to deliver this plan will need to be cognisant of the requirements of the System Performance Framework, especially at levels 1 and 2 of the escalation framework.

30. This year's Annual Plan was shaped by rapid organisational development work undertaken with the NHS Devon Executive and Board, to review and refine NHS Devon's role and purpose within the evolving NHS landscape. The plan is built around 17 overarching objectives agreed by the Board for 2025/26

31. Each of the 17 objectives have been assigned an Executive and Director lead who will lead the delivery of the Annual Plan, drawing on subject matter expertise and leadership from across the organisation. This matrix approach will ensure that cross-cutting themes and interdependencies are managed effectively.

32. To support this, the Programme Management Office (PMO) will oversee the internal process, ensuring progress is monitored and issues are escalated through the appropriate governance structure. The focus will be on delivering the 2025/26 Annual Plan objectives, using high-level delivery plans to track progress against agreed milestones and metrics using monthly highlight report and delivery review meetings. The reporting cycle is described in Figure 1 below:

Figure 1 – Overview of Reporting & Assurance Process



33. Director leads, with support from subject matter experts from across the organisation, will be required to complete a monthly highlight report. Highlight reports will enable progress to be monitored against Key Performance Indicators (KPIs) and agreed impact metrics which will provide assurance of delivery milestones whilst highlighting risks and upcoming actions and progress made. PMO leads will support the collation of these reports and will make connections within the internal governance of the objective delivery structure.

34. Executive leads will be required to sign off the monthly highlight report prior to submission to the PMO.

35. The PMO will review highlight reports and agree with Executives and Directors at a touchpoint monthly meeting. These monthly touchpoints will focus on the delivery of our 2025/26 Annual Plan. They will also provide oversight of the Board Assurance Framework (BAF), track performance improvements against NOF4, and support the identification of risks that need to be included on corporate and programme risk registers.

36. The outputs from both the highlight reports and monthly touch point meetings will be collated into reports for the NHS Devon Executive and shared with Executives and Directors. This will enhance matrix working, allowing all objectives progress against delivery to be understood across the organisation, thus continuing to reduce the risk of silo working.

37. The consolidated reports will then be submitted to the NHS Devon Executive for sign-off / agreement ahead of the assigned Board Assurance Committee as per agreed the schedule.

38. The role of the agreed Board Assurance Committee is to ensure assurance of progress and delivery and to support and approve key decisions as required for the appropriate assigned planning objective. This will enable a more formal review of progress and key risks linked to each objective, improving delivery oversight and improving visibility of progress and barriers to delivery at Board level.

39. Board Assurance Committees may also conduct deep dives into areas of concern and scrutinise detailed programme plans as needed and request that objectives of higher / lower risk of delivery are reviewed more / less frequently by the Board Assurance Committee. Where planning objectives span the remit of multiple Committees, more than one Committee may work together to undertake more holistic deep dives.

40. Reports shared with Board Assurance Committees will also be shared with NHS Devon Board members in line with the schedule as well as results of any deep dives directed by Committees.

41. This process is detailed in full in the Annual Plan 2025/26 Next Steps paper

Recommendations

42. The Board is asked to

- **NOTE** the level of ambition and risk within the submitted Operational Plan for 2025/26
- **TAKE SATISFACTORY ASURANCE** from the proposed approach to Performance Management in 2025/26, including confirmation of the metrics that will be included within the Performance Management Dashboard
- **ENDORSE** the NHS Devon Commissioning Plan for delivery in 2025/26

Appendices

Appendix A – NHS Devon Commissioning Plan 2025/26
Appendix B – Draft Performance Management dashboard

NHS Devon

NHS Devon Commissioning Plan 2025/26

One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Contents

Contents 2
Introduction 3
Strategic context 4
Priorities for 2025/26 5
Update on Primary Care Collective Action and impact on commissioning plan 11
Continuous review of Devon ICB contracted activity with view to supporting Devon ICB financial position ..... **Error! Bookmark not defined.**
Delivery of the plan 11
Building the strategic commissioning function 15
Appendix 1 - NHS Devon contracts: by name/type 17

Introduction

NHS Devon has recently approved its annual plan, detailing 17 key priorities that it hopes to achieve in 2025/26. Many of these will require commissioning actions to achieve the expected outcomes, which, if done in a siloed manner, may lead to unintended consequences or gaps in provision.

This commissioning plan describes the key commissioning actions that the organisation will take in 2025/26 to deliver on the plan and the 17 priorities contained within. Setting out the actions in this way will provide numerous benefits, in particular:

1. Clarity for system partners on commissioning intentions on which to base their own plans.
2. Confirmation of commissioning priorities for the organisation to inform decision making and resource allocation in-year.

This is the first version of a commissioning plan for NHS Devon and as such there will be areas of priority that have not been initially considered. As important as the contents of this document will be the approach to making commissioning decisions in-year to ensure that unintended consequences are managed and oversights rectified.

With that in mind, this document will cover four key areas.

1. Delivering equitable services
2. Delivering best value, within allocation
3. Delivering strategic change
4. Delivering support for in-year pressures

In addition, the plan will describe the approach to developing strategic commissioning expertise to further refine the commissioning approach from 2026/27 onwards.

All commissioning intentions detailed in the plan have been subject to an Equality and Quality Impact Assessment (EQIA) and the outputs of these will be reported to the NHS Devon Quality and Patient Experience Committee (QPEC).

Strategic context

National context

1. The development of the commissioning plan for NHS Devon occurs at a time of great uncertainty around the future landscape in the way the NHS services are commissioned and delivered. At the time of development of this plan, the NHS 10 Year Plan being developed nationally has not yet been issued, however, it is clear, through the Darzi report and subsequent government response that this plan needs to address the Secretary of State for Health and Social Care's three shifts:

    - Moving care from hospitals to communities
    - Making better use of technology
    - Focussing on preventing sickness, not just treating it.

2. Similarly, this plan has been developed as significant organisational change has been announced, with the merger between NHS England (NHSE) and the Department of Health and Social Care (DHSC) expected as well as changes to the form and function of Integrated Care Boards (ICBs). The full impact of this is unknown, though it is apparent that a core role for ICBs will be to deliver a strategic commissioning function.

Local context

3. Devon remains a challenged system with the ICB and three acute providers currently subject to National Oversight Framework Segment 4 (NOF4). The system is under oversight for five areas:

    1. Leadership
    2. Strategy
    3. Elective care
    4. Urgent and emergency care
    5. Finance.

4. The oversight approach requires an element of prioritisation of each of these areas.

Financial challenge

5. NHS Devon receives an allocation in 2025/26 that is £163.3 million (4.81%) above that level which it should receive according to need, also known as its 'fair share' target. This target is based on a national formula that uses population demographics and needs factors, such as age, sex, and deprivation, to identify what a fair share of the NHS resource should be.

6. The financial plan as it currently stands for 2025/26 requires additional deficit funding of £63.8m. In total therefore, the financial plan requires funding totalling up to £227.1 million above the 'fair share' formula level.

7. This level of financial challenge will not be resolved in year, however all actions taken need to be cognisant of the need to improve this position rapidly.

Priorities for 2025/26

Delivering equitable services

8. NHS Devon is committed to allocating resources fairly to deal with need in an equitable manner. To do so, we will review where we are performing ahead of peers or significantly better than national standards to establish opportunities to rebalance investment into areas that are more challenged.

9. ***Example*** – Devon currently delivers access to Improving Access to Psychological Therapies (IAPT) services significantly ahead of national targets, by commissioning a reduced level of activity (which still allows national targets to be met) this will release resource that can either improve financial position or be reallocated to support an area that is more challenged (for instance mental health pressure in emergency departments).

10. A full review of opportunity will be established by the system business intelligence team using national tools such as Model Health System with commissioning actions taken in-year dependent on the outcome of this review.

11. Although the full set of opportunities may not yet be known, it is expected that there will be opportunity related to:

    - Implementation of National Institute for Health and Care Excellence (NICE) technology appraisals (TAs)
    - Implementation of high-cost drugs
    - Elective care pathways

Delivering best value, within allocation

12. NHS Devon is committed to getting best value for its investment, ensuring that the money that it spends on services is delivering the expected outcomes in a productive and efficient manner. To ensure that we have full grip on the investments made, we will be reviewing our contracts through three key actions:

    1. Routine due diligence
    2. Proactive investment:- review & re-procurement and decommissioning
    3. Efficiency factors
    4. Revise to the mean:- the vast majority of the opportunity will be in reviewing pathways against NICE guidance in acute trusts but there also will be some opportunity within Right to Choose contracts

5. Opportunity to review for decommissioning to mitigate ED demand over 2% if required

13. Appendix 1 details contracts for which Devon ICB Contracting and Commissioning teams have a process of continual review and oversight in support of the ICBs financial position.

14. This list has been RAG rated to indicate where there might be an opportunity to proactively review and look at further efficiency factors / test discretionary spend etc. The list also indicates those contracts where there is an opportunity for cost saving by revision to the mean for service provision. It also covers areas of focus if there is a requirement to decommission services to support failure to manage ED demand at 2% in line with the operational plan.

15. The RAG rating is - Red – contractually not viable, Amber contractually theoretically possible and Green contractually possible. Where there is opportunity for potential decommissioning / investment review (e.g. community diagnostics, GPwER services, MIUs etc) these schemes have already been identified through TDP.

16. It covers clinical services however only a small amount of (health-adjacent) non-clinical contracts.

17. It should be noted that there is no practical ability (without significant legal/financial/reputational risk), to apply efficiency factors to a number of services where those contracts are under block arrangements / multi-year terms (and have been procured and contracted on that basis), or where there are national unit prices or contract defined prices. This is also true of patient choice services in scope of right-to-choose legislation, where there is no practical ability to cap activity or place restriction on the number of commissioned providers.

18. SCW CSU manage the majority of non-clinical contracts on behalf of the ICB. BCF monies are excluded as they are managed under separate pooled funding and S75 agreements and to avoid duplication, no other partnership agreements (e.g. s 75 children's services) where that spend is covered under another contract.

19. All Age Continuing Care (AACC) contracts are also not included in the list as we do not currently have these on Atamis, Devon ICB contract management platform. We currently have 454 contracts (at annual spend of £87,248,000) under this area. This includes specialist hospitals, long-term live-in-care and Plymouth supports living contracts

20. The Contracting team are still reviewing all areas of spend since picking up market development as part of ICB Phase 2 process (Plymouth care homes, OOA 117 aftercare). A number of Right to choose services show as zero value as they are newly commissioned services and have no guaranteed volumes / values.

Routine due diligence

21. All low value contracts coming to an end will be reviewed on a monthly basis. These contracts will only renew where they align with strategic priorities and delivery of outcomes can be demonstrated. The agreed board position of a minimum of six-month notice needs to be followed.

Proactive investment review

22. A full review of contracted spend has identified two (to date) higher value contracts that could be disinvested with performance or quality impact that can be mitigated.

    - Independent Sector Community Diagnostics
    - GP with Extended Responsibility/Special Interest contracts

23. Additionally, as part of a review of planned investments for 2025/26 a number will now no longer be progressed including.

    - Digital Triage and streaming in ED, UTC an MIUs (University Hospitals Plymouth)
    - Medicine weekend ward clerks and DCMs (University Hospitals Plymouth)
    - Hybrid Closed Loop (ICB)
    - Annual Staffing Review – other (Royal Devon University Healthcare)

24. Further opportunities may be established as part of a review into increased urgent and emergency care spend.

Efficiency factors

25. As part of the development of 2025/26 plans for acute providers, each were expected to deliver 4% minimum productivity improvements in year for 2025/26. NHS Devon intends to create a parity of approach across all commissioned services.

26. As such, NHS Devon will immediately enter negotiations with all commissioned services to deliver 4% cost saving in year. Where a service is provided by a Voluntary, Community, and Social Enterprise (VCSE) organisation, this cost saving will be reduced to 2%.

27. All negotiations will be subject to EQIAs to ensure any risks can be mitigated.

Delivering strategic change

28. NHS Devon is committed to using a commissioning approach to ensure significant service changes within the system are aligned and are not driving

unwarranted variation for the population of Devon. To do so, as part of the plan, we will define Devon's approach in five key areas:

1. Minor Injuries Units (MIUs)
2. Community hospitals
3. Maximising the use of NHS elective care fixed assets.
4. Children and young people
5. Mental health

Minor Injuries Units (MIUs)

29. The Nationally promoted model for urgent and emergency care no longer includes Minor Injuries Units, with urgent care instead being delivered through Urgent Treatment Centres (UTCs).

30. The commissioned model for Devon will look to reflect the national position with action in 2025/26 to ensure sufficient UTC coverage across the county to meet modelled need.

31. Where appropriate this may be by ensuring MIUs are supported to deliver to a UTC specification, without the input of additional resource. Where this is not possible, there exists sufficient existing UTC coverage, or the MIU is no longer viable, the system will consult on the closure of an MIU.

Community hospitals

32. At an organisational level, there already exist plans to review community hospital provision. In order to ensure equitable access across the county and for the avoidance of increasing unwarranted variation in 2025/26 NHS Devon will develop a system wide approach to a strategic review of community hospital services and consolidation which will look to

- Consolidate services on existing estate wherever possible.
- Dispose of unneeded estate following consolidation

Maximising the use of NHS elective care fixed assets

33. There has been significant investment in NHS fixed assets in recent years to deliver Elective Care recovery. With the current levels of provision within the Independent Sector (IS) a proportion of these assets are at risk of being underutilised.

34. NHS Devon intends to commission activity across all providers (NHS and IS) that maximises the use of NHS assets, this will be done without capping activity.

Children's and women's services

Production of strategic plan for recommissioning and re-procurement of children and young people community health services.

35. This will deliver a plan with Vision, Principles, Outcomes for Invitation to tender with a preferred option of services in scope. Timeline agreed for procurement including stakeholder engagement and service user co production and develop and establish agreed joint commissioning process for individual children with all Local Authorities

Mental Health and Neurodiversity transformation – intention to align to National Tier 4 transformation through specialised commissioning.

36. This will optimise for Children and Young People Mental Health needs existing provision whilst continuing to expand access and inclusivity of the offer aligned to national developments of the Tier 4 offer. Neurodiversity transformation will improve integration and flow through diagnostic pathways whilst supporting transformation to reduce need for diagnostic assessment through a broader support offer for individuals, parents and carers and schools.

Implement agreed Devon wide plan for Children's waiting list recovery.

37. This will set measurable trajectories with providers for longest waits i.e. Speech and Language; Autism assessment; Occupational Therapy; Community Paediatrics and meet RTT requirements and ensure Providers do not exceed these limits.

Deliver the perinatal programme within PASP.

38. This will provide commissioning expertise to the medium-term transformation priorities identified through the Peninsula Acute Sustainability Programme (PASP) for maternity and neonates by March 2026 and deliver a Devon wide approach to nationally mandated specialist functions with Low Volume High Complexity consolidation of very specialist care. This will align protocols, policies and guidelines and a single employer for trainee doctors. This will also provide Commissioning and Clinical Leadership to the remodelling of maternity and neonatal services for longer term change.

Deliver the strategic alignment of women's health commissioning with core ICB responsibilities.

39. This will align Women's Health commissioning to ensure that services are delivered in the right setting to meet need and achieve greatest impact and efficiency.

Mental health services

40. Undertake a whole system review of the mental health program impact on the delivery of safe ED services.

Delivering support for in-year pressures

41. NHS Devon is committed to taking an agile approach to commissioning in 2025/26. Plans do not always deliver as expected and should unforeseen circumstances place additional pressure within the system in-year, we will refocus investment to support where the pressure is being seen.

42. This will mean disinvesting in one part of the system to support another area. In the first instance, opportunities to disinvest will be sought within acute provider contracts, focusing on those that are delivering under commissioned capacity.

43. This methodology for decommissioning will follow:

- **Assessment of need:** Evaluate the need for decommissioning the service. This includes looking at factors like changes in population health needs, advances in medical technology, financial constraints, and evolving healthcare policies.
- **Stakeholder engagement**: Engage with key stakeholders, including healthcare professionals, patients, unions, policymakers, and the public, to gather input and ensure that the decision to decommission is well-informed and transparent.
- **Impact assessment**: Conduct a thorough impact assessment of the service's closure, considering the potential effects on patients, staff, healthcare outcomes, and local communities.
- **Regulatory and legal review:** Ensure that all legal and regulatory requirements are met, including compliance with labour laws, contractual obligations, and health and safety standards.
- **Reallocation of resources:** Determine how to best reallocate resources, including funding, staff, and equipment, to other areas within the healthcare system that may be experiencing higher demand.
- **Ongoing monitoring:** After decommissioning, establish a monitoring system to ensure that patients and staff are not adversely affected. Regular reviews can help identify issues that need to be addressed, such as delays in patient referrals or issues with staff redeployment.
- **Feedback mechanisms:** Set up mechanisms for feedback from patients, staff, and other stakeholders to ensure any concerns or problems are quickly identified and addressed.
- **Post-decommissioning evaluation:** Conduct a final evaluation to determine the effectiveness of the decommissioning process, whether patient care was maintained, and the overall success of the transition.

44. By following this structured methodology, NHS Devon can ensure that decommissioning services for this purpose is done efficiently, responsibly, and with minimal negative impact on patients, staff, and the community.

Primary Care Collective Action and impact on commissioning plan

Background

45. During 24/5 General Practice and Community Pharmacy initiated 'Collective Action' in line with advice and direction from their national professional representatives.

46. Community Pharmacy Collective Action (CPCA) has had negligible actual impact, with the focus being on awareness generating actions. Therefore, this section focuses on General Practice Collective Action (GPCA).

47. General Practitioners Committee (GPC) England's advice to General Practice remains clear in early 25/6: although the national dispute between General Practice and the government is no longer active, practices and Local Medical Committees (LMCs) should maintain collective action locally, in particular through cessation of non-commissioned activity or areas of activity where the commissioned status is disputed. GPCA is therefore not a transient response but a sustained change in how general practice is prepared to interact with ICBs and wider system.

48. General practice activity in Devon remains up by 16% compared to pre-pandemic levels and 26.4% (March 2025) above national average. However, this masks substantial pressures being managed below the surface, with many practices withdrawing from historical informal or activity they identify as being unfunded. This has a direct impact on patients, pathways, provider workload, and ICB reputational and operational risk.

49. The ICB's Primary Care Medical Director continues to chair a bi-weekly meeting with providers in order to identify issues from the ongoing action and identify mitigations for consideration. Additionally, the ICB liaises with NHSE and other ICBs in the South West Region. Each ICB has its unique set of issues and risks but many of the issues, for example the pressure on resources and unmitigated issues and risks, are common.

Examples

50. A non-exhaustive list of GPCA-related delivery changes/commissioning gaps (and actual or potential mitigations) includes:

- **Anti-psychotic prescribing**: Two practices have already ceased all prescribing of anti-psychotic medications; circa 20 others advise intentions to act similarly. An options appraisal seeking investment has recently been taken to ExCo with a potential solution to this, efforts to mitigate at no cost having identified no viable option.
- **Secondary care phlebotomy**: Circa 40 practices are not signed up to the local enhanced service (LES), returning blood-taking demand back into

secondary care. More practices are considering withdrawal from this LES. Most viable mitigation is to return funding made available by secondary care providers to fund the LES. This is expected to realise service and patient efficiency gain of reduced blood taking as thresholds shift to need based.

- **Nebido (testosterone) injections**: Several practices, mainly in South Devon, have withdrawn provision of nebido injections. Director of Primary Care has substantively agreed a LES specification with LMC for consideration when 25/6 funding position is known.
- **PSA monitoring**: For non-cancer patients requiring regular PSA checks (6–12 monthly), several practices are handing this back to urology. Development of a LES is being investigated. This will be dependent on urologists committing to agreeing evidence based (and reduced) frequency of check to ensure system efficiency.
- **Prescribing on behalf of other professionals**: Practices are withdrawing from issuing prescriptions initiated by midwives, bladder and bowel nurses, dieticians, and heart failure nurses where historically issuance of scripts was undertaken by those services. Largely this is being picked up in acute/community providers.
- **Safe working guidance**: Some practices are enforcing a cap of 25 patient contacts/day per GP in line with BMA guidance. When ‘full’, the practice should continue triaging to assess the urgency of each case and signpost appropriately. Thus far given comparatively high GP team contact rates in Devon impact has been minimal.
- **Monitoring in specialist cohorts**: Some practices are withdrawing from checks for:
    - Eating disorder patients - mental health services taking on this work
    - Haematological diagnoses e.g. CLL, MGUS — secondary care providers are managing this.
    - Coeliac disease annual reviews — no mitigation currently in place
- **Spirometry** – no mitigation in place (note local commissioning priorities / decisions regarding spirometry mean variation in delivery is often linked to suitably qualified workforce seeking to maintain their skillset)
- **Bariatric patient monitoring –** system wide work is being undertaken to prepare a business case as some mitigations are currently believed to require investment.

51. Each of these changes carries a combination of clinical risk, reputational risk to the ICB, and may move activity into / back into other providers/departments, some of whom may already be under some degree of strain.

Delivery of the plan

52. Accountability for the delivery of the commissioning plan will sit with the Chief Strategic Commissioning and Planning Officer for NHS Devon and operationally overseen by the NHS Devon Commissioning Group.

Role of Provider Collaboratives

53. Delivery of the Commissioning plan is the core business of NHS Devon, and the activity will sit with the organisation. As part of the commissioning response and aligned to the delivery of the ICB Annual Plan, the Commissioning Group should consider and agree what key objectives should be commissioned from Provider Collaboratives. Wherever possible, any newly commissioned piece of work should first be considered for delivery through a Provider Collaborative before consideration of externally commissioning work. Each commissioning intention will need to be agreed at the Commissioning group and their implementation assured in line with the agree Devon ICB commissioning cycle.

In-year decision making and management

54. There are a number of items within the NHS Devon Annual Plan for which the required commissioning response is not yet known, for this reason, and to remain appropriately agile, there will need to be further commissioning decisions beyond this plan made in-year.

55. All commissioning decisions should be agreed through the NHS Devon Commissioning group to ensure consistency with strategic priorities or evidenced need due to risk.

56. As part of the oversight of the commissioning process, the NHS Devon Commissioning Group will assure itself of the appropriate commissioning processes, for instance use of single tender actions – none of which should progress without Commissioning Group review (virtually if required) and support from both the Chief Finance Officer and Chief Strategic Commissioning Officer (or nominated deputies).

The Devon Commissioning Hub

57. As described the ambitious programme of delivery that we will be progressing this year is going to require far greater levels of collaboration between senior managers and teams operating across the ICB. In order to ensure we succeed in an agile and responsive way we will establish a Devon Commissioning Hub that will enable collective ownership of development and realisation of the plans.

58. The Commissioning Hub will be made up of leadership across the following teams and functions:

    i. Localities
    ii. Mental Health
    iii. Neuro Diversity
    iv. Primary Care
    v. Community Services, Urgent & Emergency Care
    vi. Elective & Cancer Care
    vii. Diagnostics
    viii. Prevention and Population Health Management
    ix. Children and young people
    x. Womens health

59. It will include representation from the Strategic Planning, Contracting and Business Intelligence teams to ensure alignment of plans and embed a data-driven approach using population health data, demand forecasting, and performance analytics to inform commissioning decisions and improve outcomes. We will embed a continuous learning methodology to monitor impact of plans and through cross specialism working ensure we maximise opportunities for refinement and improvement of plans. The Hub will design and implement a framework/toolkit for decision making to ensure consistency.

60. The Commissioning Hub will embed matrix working across the existing teams and ensure close alignment of commissioning intentions. The Hub will meet on a weekly basis, be led by the Interim Chief Operating Officer and report to the Commissioning Group.

61. The Hub will operate under existing delegated authority of its Officers and Directors, but enable a collaborative approach to ensure these are discharged in a cohesive way across annual plan priorities. Where a decision exceeds the delegated approval limit then commissioning decisions will be referred to the Commissioning Group in line with the principals set out in this paper and the ICB's Scheme of Delegation.

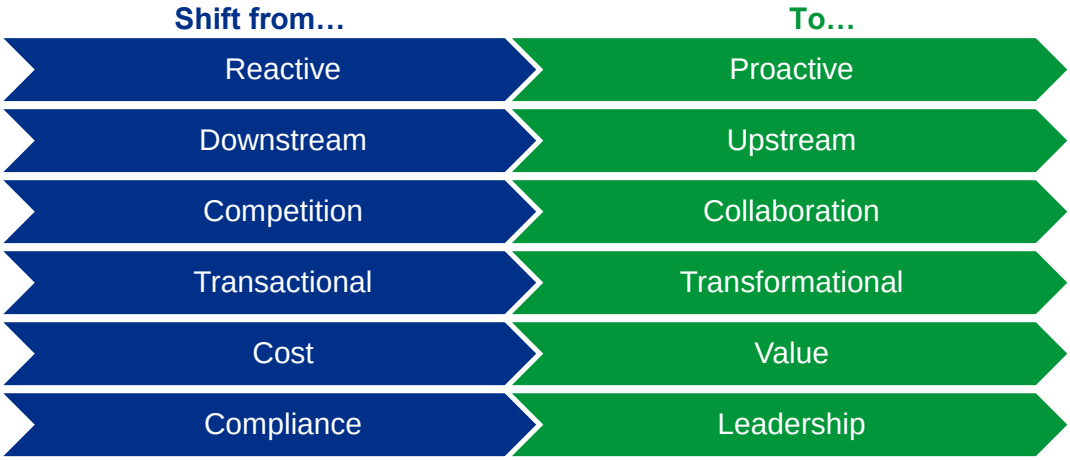
62. The Hub will take a lead in coordinating input across system partners, including providers and local authorities and coordinate updates at appropriate points through system boards, working groups and Health and Wellbeing Boards. It will ensure plans are developed in line with the People and Communities Framework, embedding engagement across patients, carers, and clinicians at appropriate points through the commissioning cycle.

63. The Hub will have responsibility for overseeing the execution of the commissioning aspects of the in-year requirements in the Annual Plan along with the development of the commissioning responses for those areas of the plan that are still yet to be determined. Actions will be driven forwards whilst ensuring work programmes are strategically aligned, services are efficiently commissioned, and plans are effectively delivered to meet the needs of the population, improve outcomes, and optimize resources.

64. We will move at pace to establish the Commissioning Hub by June to achieve the necessary pace of delivery, but ensure we monitor its impact and evolve our thinking to respond to the organisation and broader systems needs. By its nature it will manage the transactional work necessary to meet the ICB's objectives, but the approach will support the ICB in developing an increasing strategic focus in our commissioning approach.

Building the strategic commissioning function

65. The commissioning actions described within this plan are relatively transactional in nature, as the Health and Care strategy for the system is developed and the function of ICBs moves towards strategic commissioning NHS Devon will need to build the capability and structures to deliver a Strategic Commissioning response to the System strategy. This will be informed by the NHS Confed 6 shifts in commissioning.



Setting out the vision and establishing support infrastructure (0-6 months)

66. Informed by NHS Confed's Pioneers of Reform report and as part of the establishment of the strategic commissioning function in a model ICB, capability and structure will be built within the organisation over the first six months of 2025/26.

Reforming planning and performance systems (6-12 months)

67. Once the infrastructure is in place, at the same time the system's Health and Care Strategy has been developed, this will allow for a reformed process for planning and performance for the years 2026/27 and beyond that delivers on the 6 shifts.

Beyond 2026/27

68. In the following year the focus will be on ensuring the full implementation of the systems and processes designed in 2025/26 and delivering a programme of culture change to support the process

- Phase 3 Implementing new ways of working (12-24 months)
- Phase 4 Embedding cultural change (ongoing)

Appendix 1 - NHS Devon contracts:

RAG rated to indicate where there is an opportunity to proactively review and look at further efficiency factors/test discretionary spend etc

Contract name	Revise to the mean	If required to decommission for 2% ED demand	Amber Contractually theoretically possible	Green Contractually possible	Red Contractually not viable	Grand Total
999 Emergency Ambulance Services					£ 82,541,639	£ 82,541,639
Acute Services	x				£ 982,308,428	£ 982,308,428
Acute Services (Planned)					£ 6,791,315	£ 6,791,315
Acute services Out of Area					£ 7,089,889	£ 7,089,889
Acute, Community and CHC Services		x			£ 399,440,000	£ 399,440,000
Additional Services - Falls Prevention and Anticipatory Care		x		£ 170,060		£ 170,060
Additional Services - Special Allocation Service				£ 220,000		£ 220,000
ADHD Assessment Adult & CYP	x				£ -	£ -
ADHD Assessment Adults	x				£ -	£ -
ADHD Assessment and Treatment Service for Adults - Waiting List Initiative	x				£ 250,000	£ 250,000
Adult & CYP Autism Assessment	x				£ -	£ -
Adult ADHD & ASD Assessment	x				£ -	£ -
Adult ADHD Assessment & Titration	x				£ -	£ -

Adult ASD RTC	×				£ -	£ -
Advocate role - Torridge - addressing inequalities in health outcomes				£ 40,000		£ 40,000
All age ASD Assessment RTC					£ -	£ -
Alternative Place of Safety - AMPH				£ 153,741		£ 153,741
APMS - Bow Medical practice.					£ 645,852	£ 645,852
APMS - Core & Enhanced Services					£ 451,742	£ 451,742
APMS - Homeless Services (Exeter & Barnstaple)					£ 536,000	£ 536,000
AQP Routine Adult Audiology			£ 477,083			£ 477,083
ASD and ADHD RTC provision					£ -	£ -
ASD Assessment Adult & CYP	×				£ -	£ -
Assisted Conception					£ 484,800	£ 484,800
Audit of LD Annual Health Checks					£ 10,000	£ 10,000
Care (Education) Treatment Review Plans				£ 21,709		£ 21,709
Care (Education) Treatment Review Support - C(E)TR				£ 17,096		£ 17,096
Care co-ordination hub					£ 372,252	£ 372,252
Care Provision - Short Term Care Centre			£ 1,482,695			£ 1,482,695
Cataract Surgery Service					£ 15,026,985	£ 15,026,985
Children's Services					£ 57,949,849	£ 57,949,849
Community Based Triage and Elective Services		×	£ 1,190,590			£ 1,190,590
Community Eating Disorder Service			£ 784,383			£ 784,383
Community Services		×			£ 103,047,000	£ 103,047,000
Continuing Healthcare Services (including continuing care for children) (CHC)					£ -	£ -
CYP ASD Assessment					£ -	£ -
CYP In Reach Discharge Service			£ 423,000			£ 423,000
Delivery of children, young people and family mental health support						
Dental Service for Complex Needs				£ 100,763		£ 100,763
Dental Services Plymouth Homeless				£ 67,175		£ 67,175
Diagnostics- NOUS (Peninsula Ultrasound)				£ 588,000		£ 588,000

Discharge to Assess Bed Primary Care Cover Service in Plymouth			£ 371,504			£ 371,504
DLMNS Digital Scoping Project				£ 32,918		£ 32,918
Echocardiography (direct access)				£ 204,802		£ 204,802
EIP & Complex Emotional Needs Service					£ 954,660	£ 954,660
Elective Services					£ 11,137,307	£ 11,137,307
Employee Assist Service				£ 17,536		£ 17,536
End of Life Services					£ 8,799,916	£ 8,799,916
Fall Management Exercise (FaME) Service			£ -			£ -
General Medical Services (GMS)					£ 31,629,957	£ 31,629,957
GMS Core & Enhanced Services					£ 4,908,548	£ 4,908,548
GP Clinical Waste Services						
GPwER Service (Minor Skin Surgery)				£ 28,253		£ 28,253
HCQ Retinopathy Screening				£ 199,280		£ 199,280
Health Inequalities GP Fellowship				£ 170,000		£ 170,000
Health Inequality GP Fellows				£ 22,500		£ 22,500
High Flow, Low Complexity Cataract Services					£ 302,199	£ 302,199
Home Enteral Feeding & Ancilliaries			£ 1,703,526			£ 1,703,526
Home Oxygen Services for South-West Region					£ 2,198,902	£ 2,198,902
Identification of most appropriate peer support mechanisms across the Western LCP area						
Improving health and care outcomes for people experiencing homelessness						
Independent Prescribing Pathfinder Programme				£ -		£ -
Integrated Care Partnership					£ 107,229,000	£ 107,229,000
Integrated urgent care services in Devon					£ 20,548,400	£ 20,548,400
Interpersonal Trauma Response Service			£ 689,590			£ 689,590
Language and Translation Services for Primary Care			£ 10,000			£ 10,000
LGBTQ+ Support Services			£ 65,817			£ 65,817
Local Enhanced Services				£ 9,128,870		£ 9,128,870
Local Enhanced Services & GPwER services				£ 1,490,492		£ 1,490,492
Long Term Conditions Self-Management						

Lot 2: Strategy, System Leadership, Governance, & Integrated Assurance						
Maternity and Neo-natal Voices Partnership			£ 90,000			£ 90,000
Medicines Optimisation Subscription				£ 37,603		£ 37,603
Mental Health	x				£ 190,907,000	£ 190,907,000
Minor Ailment Service				£ -		£ -
Minor Ailment Service & Inhaler Service				£ -		£ -
Minor Injury Service - Axminster				£ 36,000		£ 36,000
Minor Injury Service - Honiton				£ 396,483		£ 396,483
Minor Injury Service - Okehampton				£ 107,079		£ 107,079
Minor Injury Service - Sidmouth				£ 118,208		£ 118,208
MIU Services (weekends only)				£ 130,000		£ 130,000
Non-emergency patient transport services in Devon		x	£ 6,503,000			£ 6,503,000
Occupational Health for Devon ICB			£ 36,233			£ 36,233
Oliver McGowan Mandatory Training - Train the Trainer				£ 48,000		£ 48,000
Online Counselling and Platform for Self-management.					£ 87,360	£ 87,360
P2 bedded care			£ 521,488		£ 156,000	£ 677,488
Parent Carer Forum Devon				£ 15,368		£ 15,368
Peripatetic Care				£ 1,200,000		£ 1,200,000
Personal Medical Services (PMS)					£ 94,929,504	£ 94,929,504
Pharmacy Unwanted Medicines Waste				£ 250,000		£ 250,000
Planned Services (Acute)					£ 1,368,720	£ 1,368,720
Podiatry Services				£ 45,060		£ 45,060
Primary Care Medical Services - Core and Enhanced Services					£ 9,768,946	£ 9,768,946
Routine adult audiology						
Routine Adult Audiology & Cardiology			£ 416,168			£ 416,168
Routine Age-related hearing loss			£ 2,065,968			£ 2,065,968
Routine Community Adult Audiology			£ 68,929			£ 68,929
RTC Adult ADHD	x				£ -	£ -

RTC Adult Autism	×					
RTC CYP ASD and ADHD	×				£ -	£ -
Safebus provision for Torbay and Plymouth		×		£ 236,095		£ 236,095
Self-neglect service				£ 86,250		£ 86,250
Short Term Care Centre - Support/Facilities		×		£ 209,542		£ 209,542
Short-term Live in domiciliary care						
Sign Language Services for Primary Care					£ 85,000	£ 85,000
South HIU Service				£ 154,994		£ 154,994
Specialist Audiology Services					£ 9,760,236	£ 9,760,236
Specialist Community Paediatric Services			£ 1,126,400			£ 1,126,400
Staff Training in LD and Autism					£ 249,000	£ 249,000
Step Up / Down Mental Health Beds and Crisis service						
Suicide Postvention support				£ 203,000		£ 203,000
Support for patients with Huntington's Disease					£ 4,999	£ 4,999
Systemic Family Therapy Service in Plymouth					£ 61,500	£ 61,500
Termination of Pregnancy Services			£ 1,120,717			£ 1,120,717
Urgent Treatment Centre - Tiverton			£ 1,097,759			£ 1,097,759
Walk In Centre - Sidwell Street				£ 400,700		£ 400,700
Weekend Care Home support pilot and Bank Holiday Dressing Service						
Western Wheelchair Services			£ 1,574,997			£ 1,574,997
Grand Total			£ 21,819,846	£ 16,347,577	£ 2,152,032,904	£ 2,190,200,327

ICS

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Finance	CIP Delivery	CIP scheme identification - Percentage of CIP schemes unidentified	Monthly			5%											
		CIP forecast risk rating - Percentage of CIP schemes assessed as high risk	Monthly			27%											
		CIP profile - Percentage of efficiencies forecast to deliver in Q1 and Q2	Monthly			39%											
		CIP forecast recurrent delivery - Variance (Plan v Forecast)	Monthly			0%											
	Revenue Plan Delivery	YTD Variance to plan	Monthly			0%											
		Forecast Variance to plan	Monthly			0%											
		Recurrent Forecast Variance (Variance to ULP)	Monthly			0%											
	Productivity	YTD Productivity metrics	Monthly			N/A											
	Cash Management	Cash Support Requirement	Monthly			Permanent											
	Capital	YTD Capital Financing (Use of Cash Reserves)	Monthly			N/A											
		Forecast Capital Financing (Use of Cash Reserves)	Monthly			0.0%											
		YTD System CDEL Variance to Plan	Monthly			N/A											
		Forecast System CDEL Variance to Plan	Monthly			0.0%											
Performance	RTT	RTT within 18 weeks	Monthly/Weekly			-0.1%											
		RTT over 52 weeks	Monthly/Weekly			13.6%											
	Cancer	Cancer 28 day performance	Monthly	Mar-25	3.0%												
		Cancer 62 day performance	Monthly	Mar-25	2.6%												
	Diagnostics	Diagnostic performance	Monthly	Mar-25	-17.4%												
	Ambulance	30 min Cat 2 response	Monthly			6.7											
		Maximum 45 min handover	Monthly			2,658											
	A&E	78% 4hr A&E	Monthly/Weekly			2%											
		95% 4hr A&E for children	Weekly			-15%											
		Maximum 10% 12hrs A&E	Weekly			-1%											
		No +24hr MH in ED	Weekly			32											
	Discharges	Reduce discharge delays NCTR	Weekly			6%											

ICS

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Workforce	WTE	Substantive WTE – track and measure against plan.	Monthly			-125											
		Agency WTE - track and measure against plan	Monthly			-185											
		Bank WTE - track and measure against plan	Monthly			291											
		Infrastructure WTE - track and measure against plan	Monthly	Mar-25	89												
	Substantive spend	Substantive Spend - track and measure against plan (£'000)	Monthly			£2,481											
	Bank and agency spend	Agency Spend - track and measure against plan (£'000)	Monthly			£250											
		Bank Spend – Track and measure against plan (£'000)	Monthly			£885											
UEC Demand management	A&E	A&E attendances	Monthly/Weekly			0.35%											
		Type 1 Respiratory attendances	Monthly/Weekly														
		Total number of 111 calls resulting in ETC outcome post validation	Monthly/Weekly			2%											
	Emergency admissions	Emergency admissions	Weekly			2%											
Elective Demand Management	Referrals	GP referrals	Monthly			0.36%											
	Activity	Total Non Elective spells	Monthly			6%											
		Total Elective spells	Monthly			-7%											
		Total Outpatient	Monthly			9%											
	Cost	Total IS Cost	Monthly			8%											
Primary Care and Dentistry	Primary care activity	Primary care appointments	Monthly	Mar-25	-0.07%												
		Primary care appointment same day	Monthly	Mar-25	9.44%												
		Primary care appointment within two weeks	Monthly	Mar-25	-5.10%												
	Dentistry activity	Dentistry activity	Monthly	Feb-25	-58.1%												
	Patient experience	GP Patient survery	Annual	2024	78%												

ICS

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Quality	Patient experience	GP continuity of care :Percentage of patients able to see their preferred primary care professional	Annual	2024	48%												
		Percentage of standard Continuing Healthcare referrals complete within 28 days	Monthly			-38%											
		Friends & Family Test (FFT) Inpatients - % positive responses	Monthly	Jan-25	96%												
		Number of contacts to patient experience team (concerns & complaints)	Monthly														
		CQC community mental health survey satisfaction rate	Monthly	Mar-25	6.067												
	Patient safety	NHS Staff Survey safety culture score	Annual	2024	69.85%												
		Learn from patient safety events (LFPSE) service	Monthly			7881											
		Total number of Patient safety incident investigations	Monthly			18											
		MH Rate of restrictive intervention use	Monthly	Feb-25	15.5												
	Effectiveness of care	New urgent referrals to Crisis teams in the reporting period with first face to face contace within 24 hours of referral	Monthly	Feb-25	58%												
		New VERY urgent referrals to Crisis teams in the reporting period with first face to face contace within 4 hours of referral	Monthly	Feb-25	100%												
		Urgent Community Response two-hour performance	Monthly	Jan-25	83%												
	Workforce	Staff survey engagement score	Annual	2024	5.73												
		Leaver rate	Monthly	Feb-25	8.03%												
		Sickness rate - Actuals	Monthly	Feb-25	5.30%												
		Percentage of GPs to leave in the last 12 months	Monthly	Mar-25	7.99%												

ICB

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Finance	CIP Delivery	CIP scheme identification - Percentage of CIP schemes unidentified	Monthly			7%											
		CIP forecast risk rating - Percentage of CIP schemes assessed as high risk	Monthly			17%											
		CIP profile - Percentage of efficiencies forecast to deliver in Q1 and Q2	Monthly			33%											
		CIP forecast recurrent delivery - Variance (Plan v Forecast)	Monthly			0%											
	Revenue Plan Delivery	YTD Variance to plan	Monthly			0%											
		Forecast Variance to plan	Monthly			0%											
		Recurrent Forecast Variance (Variance to ULP)	Monthly			0%											
	Productivity	YTD Productivity metrics	Monthly			N/A											
	Cash Management	Cash Support Requirement	Monthly			None											
	Capital	YTD Capital Financing (Use of Cash Reserves)	Monthly			0%											
		Forecast Capital Financing (Use of Cash Reserves)	Monthly			0%											
		YTD System CDEL Variance to Plan	Monthly			-100%											
		Forecast System CDEL Variance to Plan	Monthly			0%											
Workforce	WTE	Substantive WTE – track and measure against plan.	Monthly			-59											
		Agency WTE - track and measure against plan	Monthly			1.80											
		Bank WTE - track and measure against plan	Monthly			-											
		Infrastructure WTE - track and measure against plan	Monthly	Mar-25	89												
	Substantive spend	Substantive Spend - track and measure against plan	Monthly			£229											
	Bank and agency spend	Agency Spend - track and measure against plan	Monthly			£15											
		Bank Spend – Track and measure against plan	Monthly			£0											
UEC Demand Management	A&E	A&E attendances	Monthly/Weekly			0.4%											
		Type 1 Respiratory attendances	Monthly/Weekly														
		Total number of 111 calls resulting in ETC outcome post validation	Monthly/Weekly			2%											
	Emergency admissions	Emergency admissions	Weekly			-2%											

ICB

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Elective Demand Management	Referrals	GP referrals	Monthly			-1%											
	Activity	Total Non Elective spells	Monthly			6%											
		Total Elective spells	Monthly			-7%											
		Total Outpatient	Monthly			9%											
	Cost	Total IS Cost	Monthly			8%											
Primary Care and Dentistry	Primary care activity	Primary care appointments	Monthly	Mar-25	-0.07%												
		Primary care appointment same day	Monthly	Mar-25	44.44%												
		Primary care appointment within two weeks	Monthly	Mar-25	80.66%												
	Dentistry activity	Dentistry activity	Monthly	Feb-25	-58.1%												
		Urgent dental apointments place holder	Monthly														
	Patient experience	GP Patient survery	Annual	2024	78%												
Quality	Patient experience	GP continuity of care :Percentage of patients able to see their preferred primary care professional	Annual	2024	48%												
		Percentage of standard Continuing Healthcare referrals complete within 28 days	Monthly														
		Friends & Family Test (FFT) Inpatients - % positive responses	Monthly	Jan-25	96%												
		Number of contacts to patient experience team (concerns & complaints)	Monthly														
		CQC community mental health survey satisfaction rate	Monthly	Mar-25	6.067												
	Patient safety	NHS Staff Survey safety culture score	Annual	2024	69.85%												
		Learn from patient safety events (LFPSE) service	Monthly			7881											
		Total number of Patient safety incident investigations	Monthly			18											
		MH Rate of restrictive intervention use	Monthly	Feb-25	15.5												
	Effectiveness of care	Average number of days between planned and actual discharge date															
		New urgent referrals to Crisis teams in the reporting period with first face to face contace within 24 hours of referral	Monthly	Feb-25	58%												
		New VERY urgent referrals to Crisis teams in the reporting period with first face to face contace within 4 hours of referral	Monthly	Feb-25	100%												
		Urgent Community Response two-hour performance	Monthly	Jan-25	83%												

ICB

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
	Workforce	Staff survey engagement score	Annual	2024	4.50%												
		Leaver rate	Monthly	Feb-25	8.03%												
		Sickness rate - Actuals	Monthly	Feb-25	5.30%												
		Percentage of GPs to leave in the last 12 months	Monthly	Mar-25	7.99%												

RDUH

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Finance	CIP Delivery	CIP scheme identification - Percentage of CIP schemes unidentified	Monthly			1%											
		CIP forecast risk rating - Percentage of CIP schemes assessed as high risk	Monthly			34%											
		CIP profile - Percentage of efficiencies forecast to deliver in Q1 and Q2	Monthly			43%											
		CIP forecast recurrent delivery - Variance (Plan v Forecast)	Monthly			0%											
	Revenue Plan Delivery	YTD Variance to plan	Monthly			2%											
		Forecast Variance to plan	Monthly			0%											
		Recurrent Forecast Variance (Variance to ULP)	Monthly			0%											
	Productivity	YTD Productivity metrics	Monthly			N/A											
	Cash Management	Cash Support Requirement	Monthly			Permanent											
	Capital	YTD Capital Financing (Use of Cash Reserves)	Monthly			0%											
		Forecast Capital Financing (Use of Cash Reserves)	Monthly			11%											
		YTD System CDEL Variance to Plan	Monthly			-100%											
		Forecast System CDEL Variance to Plan	Monthly			0%											
Performance	RTT	RTT within 18 weeks	Monthly/Weekly			0.1%											
		RTT over 52 weeks	Monthly/Weekly			18%											
	Cancer	Cancer 28 day performance	Monthly	Mar-25	4.3%												
		Cancer 62 day performance	Monthly	Mar-25	3.4%												
	Diagnostics	Diagnostic performance	Monthly	Mar-25	-18.5%												
	Ambulance	Maximum 45 min handover	Monthly			826											
	A&E	78% 4hr A&E	Monthly/Weekly			-3%											
		95% 4hr A&E for children	Weekly			-15%											
		Maximum 10% 12hrs A&E	Weekly			3.42%											
		No +24hr MH in ED	Weekly			10											
	Discharges	Reduce discharge delays NCTR	Weekly			9%											

RDUH

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Workforce	WTE	Substantive WTE – track and measure against plan.	Monthly			54											
		Agency WTE - track and measure against plan	Monthly			-190											
		Bank WTE - track and measure against plan	Monthly			320											
		Infrastructure WTE - track and measure against plan	Monthly	Mar-25	-109												
	Substantive spend	Substantive Spend - track and measure against plan	Monthly			£870											
	Bank and agency spend	Agency Spend - track and measure against plan	Monthly			-£382											
		Bank Spend – Track and measure against plan	Monthly			-£738											
UEC Demand Management	A&E	A&E attendances	Monthly/Weekly			-1%											
		Type 1 Respiratory attendances	Monthly/Weekly														
	Emergency admissions	Emergency admissions	Weekly			-2%											
Elective Demand Management	Referrals	GP referrals	Monthly			0%											
	Activity	Total Non Elective spells	Monthly			12%											
		Total Elective spells	Monthly			-11%											
		Total Outpatient	Monthly			15%											

RDUH

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Quality	Patient experience	CQC inpatient survey satisfaction rate	Annual	2023	8.6 / 10 Better than expected												
		Friends & Family Test (FFT) Inpatients - % positive responses	Annual	Jan-25	99%												
		Number of contacts to patient experience team (concerns & complaints)	Monthly														
	Patient safety	NHS Staff Survey safety culture score	Annual	2024	73.24%												
		Rate of neonatal deaths 1,000 total births	Annual	2023	0.94												
		Rate of stillbirths per 1,000 total births	Annual	2023	3.00												
		Learn from patient safety events (LFPSE) service	Monthly			2603											
		Total number of Patient safety incident investigations	Monthly			2											
		CQC safe inspection score	Annual	Nov-23	Requires improvement												
	Effectiveness of care	Average number of days between planned and actual discharge date	Monthly														
		Standardised Hospital Mortality Index (SHMI)	Monthly	Nov-24	0.96												
	Workforce	Staff survey engagement score	Annual	2024	6.96												
		Leaver rate	Monthly	Feb-25	7.27%												
		Sickness rate - Variance to plan	Monthly	Feb-25	-0.33%												

UHP

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Finance	CIP Delivery	CIP scheme identification - Percentage of CIP schemes unidentified	Monthly			9%											
		CIP forecast risk rating - Percentage of CIP schemes assessed as high risk	Monthly			9%											
		CIP profile - Percentage of efficiencies forecast to deliver in Q1 and Q2	Monthly			28%											
		CIP forecast recurrent delivery - Variance (Plan v Forecast)	Monthly			0%											
	Revenue Plan Delivery	YTD Variance to plan	Monthly			0%											
		Forecast Variance to plan	Monthly			0%											
		Recurrent Forecast Variance (Variance to ULP)	Monthly			0%											
	Productivity	YTD Productivity metrics	Monthly			N/A											
	Cash Management	Cash Support Requirement	Monthly			None											
	Capital	YTD Capital Financing (Use of Cash Reserves)	Monthly			0%											
		Forecast Capital Financing (Use of Cash Reserves)	Monthly			0%											
		YTD System CDEL Variance to Plan	Monthly			-100%											
		Forecast System CDEL Variance to Plan	Monthly			0%											
Performance	RTT	RTT within 18 weeks	Monthly/Weekly			0.8%											
		RTT over 52 weeks	Monthly/Weekly			14%											
	Cancer	Cancer 28 day performance	Monthly	Mar-25	3.9%												
		Cancer 62 day performance	Monthly	Mar-25	5.6%												
	Diagnostics	Diagnostic performance	Monthly	Mar-25	-30.9%												
	Ambulance	Maximum 45 min handover	Monthly			1,401											
	A&E	78% 4hr A&E	Monthly/Weekly			0.89%											
		95% 4hr A&E for children	Weekly			13%											
		Maximum 10% 12hrs A&E	Weekly			-0.6%											
		No +24hr MH in ED	Weekly			15											
	Discharges	Reduce discharge delays NCTR	Weekly			5%											
Workforce	WTE	Substantive WTE – track and measure against plan.	Monthly			-62											
		Agency WTE - track and measure against plan	Monthly			-9											
		Bank WTE - track and measure against plan	Monthly			-21											
		Infrastructure WTE - track and measure against plan	Monthly	Mar-25	99												
	Substantive spend	Substantive Spend - track and measure against plan	Monthly			£1,095											
	Bank and agency spend	Agency Spend - track and measure against plan	Monthly			-£129											
		Bank Spend – Track and measure against plan	Monthly			£17											

UHP

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
UEC Demand Management	A&E	A&E attendances	Monthly/Weekly			6%											
		Type 1 Respiratory attendances	Monthly/Weekly			-47.6%											
	Emergency admissions	Emergency admissions	Weekly			-1%											
Elective Demand Management	Referrals	GP referrals	Monthly			3%											
	Activity	Total Non Elective spells	Monthly			1%											
		Total Elective spells	Monthly			-3%											
		Total Outpatient	Monthly			4%											
Quality	Patient experience	CQC inpatient survey satisfaction rate	Annual	2023	8.0 / 10 About the same												
		Friends & Family Test (FFT) Inpatients - % positive responses	Annual	Jan-25	95%												
		Number of contacts to patient experience team (concerns & complaints)	Monthly														
	Patient safety	NHS Staff Survey safety culture score	Annual	2024	70.66%												
		Rate of neonatal deaths 1,000 total births	Annual	2023	2.04												
		Rate of stillbirths per 1,000 total births	Annual	2023	3.53												
		Learn from patient safety events (LFPSE) service	Monthly			1602											
		Total number of Patient safety incident investigations	Monthly			2											
		CQC safe inspection score	Annual	Oct-21	Requires improvement												
	Effectiveness of care	Average number of days between planned and actual discharge date	Monthly														
		Standardised Hospital Mortality Index (SHMI)	Monthly	Nov-24	0.96												
	Workforce	Staff survey engagement score	Annual	2024	6.74												
		Leaver rate	Monthly	Feb-25	6.60%												
		Sickness rate - Variance to plan	Monthly	Feb-25	1.38%												

TSD

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Finance	CIP Delivery	CIP scheme identification - Percentage of CIP schemes unidentified	Monthly			0%											
		CIP forecast risk rating - Percentage of CIP schemes assessed as high risk	Monthly			30%											
		CIP profile - Percentage of efficiencies forecast to deliver in Q1 and Q2	Monthly			32%											
		CIP forecast recurrent delivery - Variance (Plan v Forecast)	Monthly			0%											
	Revenue Plan Delivery	YTD Variance to plan	Monthly			0%											
		Forecast Variance to plan	Monthly			0%											
		Recurrent Forecast Variance (Variance to ULP)	Monthly			0%											
	Productivity	YTD Productivity metrics	Monthly			N/A											
	Cash Management	Cash Support Requirement	Monthly			Permanent											
	Capital	YTD Capital Financing (Use of Cash Reserves)	Monthly			0%											
		Forecast Capital Financing (Use of Cash Reserves)	Monthly			-10%											
		YTD System CDEL Variance to Plan	Monthly			-100%											
		Forecast System CDEL Variance to Plan	Monthly			0%											
Performance	RTT	RTT within 18 weeks	Monthly/Weekly			0.6%											
		RTT over 52 weeks	Monthly/Weekly			4%											
	Cancer	Cancer 28 day performance	Monthly	Mar-25	0.9%												
		Cancer 62 day performance	Monthly	Mar-25	1.9%												
	Diagnostics	Diagnostic performance	Monthly	Mar-25	-27.3%												
	Ambulance	Maximum 45 min handover	Monthly			431											
	A&E	78% 4hr A&E	Monthly/Weekly			2.4%											
		95% 4hr A&E for children	Weekly			-17%											
		Maximum 10% 12hrs A&E	Weekly			-3%											
		No +24hr MH in ED	Weekly			7											
	Discharges	Reduce discharge delays NCTR	Weekly			1%											

TSD

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Workforce	WTE	Substantive WTE – track and measure against plan.	Monthly			-113											
		Agency WTE - track and measure against plan	Monthly			26											
		Bank WTE - track and measure against plan	Monthly			-9											
		Infrastructure WTE - track and measure against plan	Monthly	Mar-25	114												
	Substantive spend	Substantive Spend - track and measure against plan	Monthly			£370											
	Bank and agency spend	Agency Spend - track and measure against plan	Monthly			-£28											
		Bank Spend – Track and measure against plan	Monthly			£113											
UEC Demand Management	A&E	A&E attendances	Monthly/Weekly			-4.8%											
		Type 1 Respiratory attendances	Monthly/Weekly			-21%											
	Emergency admissions	Emergency admissions	Weekly			-5%											
Elective Demand Management	Referrals	GP referrals	Monthly			-5%											
	Activity	Total Non Elective spells	Monthly			6%											
		Total Elective spells	Monthly			-5%											
		Total Outpatient	Monthly			2%											
Quality	Patient experience	CQC inpatient survey satisfaction rate	Annual	2023	8.3 /10 about the same												
		Friends & Family Test (FFT) Inpatients - % positive responses	Annual	Jan-25	92%												
		Number of contacts to patient experience team (concerns & complaints)	Monthly														
	Patient safety	NHS Staff Survey safety culture score	Annual	2024	69.09%												
		Rate of neonatal deaths 1,000 total births	Annual	2023	1.02												
		Rate of stillbirths per 1,000 total births	Annual	2023	2.52												
		Learn from patient safety events (LFPSE) service	Monthly			1602											
		Total number of Patient safety incident investigations	Monthly			2											
		CQC safe inspection score	Annual	Oct-21	Requires improvement												
	Effectiveness of care	Average number of days between planned and actual discharge date	Monthly														
		Standardised Hospital Mortality Index (SHMI)	Monthly	Nov-24	0.95												

TSD

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
	Workforce	Staff survey engagement score	Annual	2024	6.68												
		Leaver rate	Monthly	Feb-25	11.69%												
		Sickness rate - Variance to plan	Monthly	Feb-25	0.03%												

DPT

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Finance	CIP Delivery	CIP scheme identification - Percentage of CIP schemes unidentified	Monthly			0%											
		CIP forecast risk rating - Percentage of CIP schemes assessed as high risk	Monthly			37%											
		CIP profile - Percentage of efficiencies forecast to deliver in Q1 and Q2	Monthly			48%											
		CIP forecast recurrent delivery - Variance (Plan v Forecast)	Monthly			0%											
	Revenue Plan Delivery	YTD Variance to plan	Monthly			0%											
		Forecast Variance to plan	Monthly			0%											
		Recurrent Forecast Variance (Variance to ULP)	Monthly			0%											
	Productivity	YTD Productivity metrics	Monthly			N/A											
	Cash Management	Cash Support Requirement	Monthly			None											
	Capital	YTD Capital Financing (Use of Cash Reserves)	Monthly			0%											
		Forecast Capital Financing (Use of Cash Reserves)	Monthly			-25%											
		YTD System CDEL Variance to Plan	Monthly			-100%											
		Forecast System CDEL Variance to Plan	Monthly			0%											
Workforce	WTE	Substantive WTE – track and measure against plan.	Monthly			-4											
		Agency WTE - track and measure against plan	Monthly			-11											
		Bank WTE - track and measure against plan	Monthly			1											
		Infrastructure WTE - track and measure against plan	Monthly	Mar-25	-16												
	Substantive spend	Substantive Spend - track and measure against plan	Monthly			£146											
	Bank and agency spend	Agency Spend - track and measure against plan	Monthly			£25											
		Bank Spend – Track and measure against plan	Monthly			£17											

DPT

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Quality	Patient experience	CQC MH survey satisfaction rate	Annual	2024	5.9 /10 Worse than expected												
		Friends & Family Test (FFT) Mental Health - % positive responses	Annual	Jan-25	91%												
		Number of contacts to patient experience team (concerns & complaints)															
	Patient safety	NHS Staff Survey safety culture score	Annual	2024	76.43%												
		Total number of incidents reported															
		CQC safe inspection score	Annual	Jun-21	Good												
		MH Rate per 1000 of restrictive intervention use	Monthly	Feb-25	19												
	Effectiveness of care	New urgent referrals to Crisis teams in the reporting period with first face to face contace within 24 hours of referral	Monthly	Jan-25	33%												
		New VERY urgent referrals to Crisis teams in the reporting period with first face to face contace within 4 hours of referral	Monthly	Jan-25	100%												
	Workforce	Staff survey engagement score	Monthly	2024	6.95												
		Leaver rate	Monthly	Feb-25	7.51%												
		Sickness rate - Variance to Plan	Monthly	Feb-25	-0.33%												

Livewell

Performance Framework Dashboard

Area	Dimension	Measure	Frequency	Date of latest available	Latest Available	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Workforce	WTE	Substantive WTE – track and measure against plan.	Monthly														
		Agency WTE - track and measure against plan	Monthly														
		Bank WTE - track and measure against plan	Monthly														
		Infrastructure WTE - track and measure against plan	Monthly														
	Substantive spend	Substantive Spend - track and measure against plan	Monthly														
	Bank and agency spend	Agency Spend - track and measure against plan	Monthly														
		Bank Spend – Track and measure against plan	Monthly														
Quality	Patient experience	CQC MH survey satisfaction rate	Annual	2024	6.3 / 10 About the same												
		Friends & Family Test (FFT) Mental Health - % positive responses	Annual	Jan-25	84%												
		Number of contacts to patient experience team (concerns & complaints)															
	Patient safety	NHS Staff Survey safety culture score	Annual	2024	78.86%												
		Total number of incidents reported															
		CQC safe inspection score	Annual	Oct-19	Good												
		MH Rate per 1000 of restrictive intervention use	Monthly	Feb-25	12												
	Effectiveness of care	New urgent referrals to Crisis teams in the reporting period with first face to face contace within 24 hours of referral	Monthly	Jan-25	73%												
		New VERY urgent referrals to Crisis teams in the reporting period with first face to face contace within 4 hours of referral	Monthly	Jan-25	100%												
	Workforce	Staff survey engagement score	Annual	2024	6.121												
		Leaver rate	Monthly	Feb-25	7.82%												
		Sickness rate - Actuals	Monthly	Feb-25	5.80%												

NHS Devon Integrated Care Board

Annual Plan 2025/26 Next Steps

Date of Meeting	Date Report Produced
29 May 2025	16 April 2025

Author(s)		Report Approved By	
Name and title:	Lucy Pare Deputy Director of Performance, Planning & PMO	**Name and title:**	Libby Ryan-Davis Transformation Director
Phone:	01752 398741	**Date:**	01 May 2025
Email:	Lucy.pare@nhs.net		

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

Executive Summary

NHS Devon's 2025/26 Annual Plan was approved by the Board at its meeting in public on 27 March 2025. It outlines the work that NHS Devon will undertake over the coming year to meet strategic and operational objectives, fulfil its statutory duties, and deliver key operational planning requirements. It also includes the actions we need to take as an organisation to exit Segment four of the NHS Oversight Framework (NOF4).

This report provides an overview of the reporting process, schedule and next steps for this plan. Additionally, it proposes an approach to support delivery and assurance, monitor progress and key risks, and support formal assurance by maximising visibility at the Board level.

Committees that have previously discussed / agreed the report, and outcomes of that discussion
Reviewed by the NHS Devon Executive at its meeting on 06 May 2025. Reviewed by the Population Health Improvement Committee at its meeting on 08 May 2025. Reviewed by the Finance and Performance Committee at its meeting on 08 May 2025.

Key recommendations and actions requested
TAKE SATISFACTORY ASSURANCE from the approach to delivering the 2025/26 NHS Devon Annual Plan described in this report.

Impact on NHS Devon Objectives	
Objective	**Impact**
Improve Population Health	All
Improve Services and Reduce Unwarranted Variation	
Make More Efficient Use of Our Resources	
Develop Our Culture and How We Operate	

Outline the implications of matters covered in this report for the following areas	
Area	
Quality of Services	All
Health Inequalities	
Workforce	
Resources and Finance	
Legal	
Digital and Data	
Engagement and Consultation	

2025/26 Annual Plan Next Steps

Introduction

1. NHS Devon's 2025/26 Annual Plan was approved by the Board at its meeting in public on 27 March 2025. This report provides an overview of the reporting process, schedule and next steps to support the delivery of this plan.

2. This year's Annual Plan comes at a time of transition for the NHS. NHS Devon, along with the wider NHS, is navigating significant changes in national policy and strategy, and changes to organisational structures. With a new government in place, we expect the NHS 10-Year Plan to be published soon, which will have a major impact on how we plan and deliver services from 2025/26 onwards.

3. As a result, alongside delivering our core planning requirements, this year's Annual Plan is focused on preparing for the future. A key part of this will be the development of a new Health and Care Strategy, which will form the basis of our 5-Year Joint Forward Plan next year, setting out how we will deliver the priorities set out in the NHS 10-Year Plan.

4. This year's Annual Plan was shaped by rapid organisational development work undertaken with the NHS Devon Executive and Board, to review and refine NHS Devon's role and purpose within the evolving NHS landscape. The plan is built around 17 overarching objectives agreed by the Board for 2025/26. These can be found in Appendix 1 to this report.

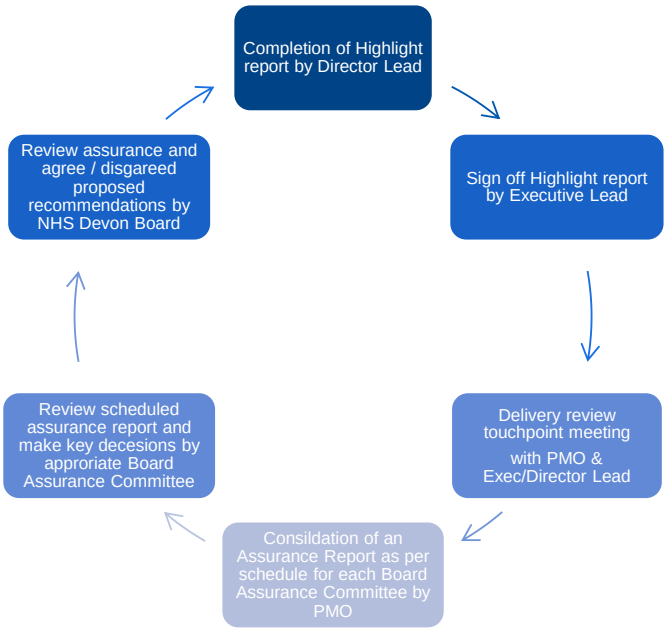
5. As per the feedback during the development of Annual Plan 2025/26, our high-level delivery plans for this year have been informed by insights from the Darzi Review, which has provided an early indication of the themes likely to feature in the NHS 10-Year Plan. The relationship between the 17 overarching objectives and each of the 3 key shifts identified in the Darzi Review can also be found in Appendix 1.

Delivery Approach

6. Each of the 17 objectives have been assigned an Executive and Director lead who will lead the delivery of the Annual Plan, drawing on subject matter expertise and leadership from across the organisation. This matrix approach will ensure that cross-cutting themes and interdependencies are managed effectively.

7. To support this, the Programme Management Office (PMO) will oversee the internal process, ensuring progress is monitored and issues are escalated through the appropriate governance structure (Appendix 3). The focus will be on delivering the 2025/26 Annual Plan objectives, using high-level delivery plans to track progress against agreed milestones and metrics using monthly highlight report and delivery review meetings. The reporting cycle is described in Figure 1 below:

Figure 1 – Overview of Reporting & Assurance Process



8. Director leads, with support from subject matter experts from across the organisation, will be required to complete a monthly highlight report. Highlight reports will enable progress to be monitored against Key Performance Indicators (KPIs) and agreed impact metrics which will provide assurance of delivery milestones whilst highlighting risks and upcoming actions and progress made. PMO leads will support the collation of these reports and will make connections within the internal governance of the objective delivery structure.

9. Executive leads will be required to sign off the monthly highlight report prior to submission to the PMO.

10. The PMO will review highlight reports and agree with Executives and Directors at a touchpoint monthly meeting. These monthly touchpoints will focus on the delivery of our 2025/26 Annual Plan. They will also provide oversight of the Board Assurance Framework (BAF), track performance improvements against NOF4, and support the identification of risks that need to be included on corporate and programme risk registers.

11. The outputs from both the highlight reports and monthly touch point meetings will be collated into reports for the NHS Devon Executive and shared with Executives and Directors. This will enhance matrix working, allowing all objectives progress against delivery to be understood across the organisation, thus continuing to reduce the risk of silo working.

12. The consolidated reports will then be submitted to the NHS Devon Executive for sign-off / agreement ahead of the assigned Board Assurance Committee as per the schedule in Appendix 2.

13. The role of the agreed Board Assurance Committee is to ensure assurance of progress and delivery and to support and approve key decisions as required for the appropriate assigned planning objective. This will enable a more formal review of progress and key risks linked to each objective, improving delivery oversight and improving visibility of progress and barriers to delivery at Board level.

14. Board Assurance Committees may also conduct deep dives into areas of concern and scrutinise detailed programme plans as needed and request that objectives of higher / lower risk of delivery are reviewed more / less frequently by the Board Assurance Committee. Where planning objectives span the remit of multiple Committees, more than one Committee may work together to undertake more holistic deep dives.

15. Reports shared with Board Assurance Committees will also be shared with NHS Devon Board members in line with the schedule in Appendix 2 as well as results of any deep dives directed by Committees.

Update on Detailed Delivery Plans

16. Since the Board approved the 2025/26 Annual Plan in March 2025, PMO leads have been working with Executive and Director leads and wider directorate teams to develop detailed delivery and enabling plans for each of the 17 overarching objectives. These plans set out:

    a. The scope of work;
    b. Key actions and the decisions required to deliver key actions;
    c. Milestones and metrics to enable the PMO and assurance committees to monitor progress;
    d. Expected outcomes; and
    e. Key risks to delivery (which will be managed through the risk management and BAF process).

17. These detailed plans will now guide implementation, forming the basis for Board Assurance Committee oversight. Where needed, they will be supported by more detailed project and programme plans.

18. As previously agreed, Executives and Directors will lead delivery, drawing on subject matter expertise from across the organisation. This matrix working approach will help ensure that cross-cutting themes and interdependencies are effectively managed.

19. The PMO will continue to oversee internal delivery, monitoring progress and escalating issues through established routes as described within Figure 1 and Appendix 3.

Model Integrated Care Board – Blueprint

20. Subsequent to the approval of the 2025/26 Annual Plan, has been the publication of the Model ICB Blueprint document. The model outlines changes to a variety of functions and others of which are new.

21. The document states it is intended to provide an indication of the future state, with the detail and implementation depending on multiple factors, including engagement and refinement with partners, the parallel development of provider and regional models, readiness to transfer and receive across different parts of the system and, in some cases, legislative change.

22. NHS Devon will, therefore, be undertaking a review of the 17 planning objectives and their alignment to the Model ICB Blueprint in light of this new guidance. The outcomes of this review will be presented to the Board for approval in July 2025.

Development of Health and Care Strategy

23. NHS Devon is also developing a Health and Care Strategy that will be presented to the Board for approval in September 2025. This will include the key strategic actions that the system will need to take to become financially sustainable as part of the refreshed Medium Term Financial Plan. This Strategy will then inform the development of the 2026/27 Annual Plan. The Discovery phase for the strategy is currently underway and it is expected that the outputs of this will be shared in the summer.

Conclusion

24. The Board is asked to **TAKE SATISFACTORY ASSURANCE** from the approach to delivering the 2025/26 NHS Devon Annual Plan described in this report.

Appendix 1 – Annual Plan 2025/26 alignment to the Darzi 3 key shifts

NHS Devon ICB Annual Plan 25/26 Planning Objective	Hospital to Community	Analogue to Digital	Sickness to Prevention
1. **Population Health and Prevention Focused Commissioning** Develop capacity capability and processes to enable the ICB to reduce inequalities and shift focus from treatment to prevention. This will result in an improvement in Healthy Life Expectancy and a reduction in the gap in life expectancy between advantaged and disadvantaged populations.			✓
2. **Enhance Primary Care Outcomes** Work with the emerging Primary Care Provider Collaborative and Primary Care Networks (PCNs) to design, commission and implement new models of care, which ensures patients can access the right services at the right time, improving patient experience and workforce productivity.	✓		
3. **Strengthen Community-Based Care and Support** Design, commission and implement community-based care models and strengthen health and care services, at 'place' and neighbourhood, actively supporting the voluntary, community, and social enterprise (VCSE) sector, and delivering initiatives to address health inequalities.	✓		✓
4. **Improve Services for Adults with Mental Health Disorders, Learning Disabilities, Autism, and Neurodiversity** Commission, monitor and drive targeted improvements to services for mental health, learning disabilities, autism, and neurodiversity, ensuring timely access to services, a positive patient experience, and improved outcomes for the population.	✓	✓	✓
5. **Improve Services for Children and Young People** Design, commission and implement a new care model in Devon which addresses long community waiting lists, delivers SEND (Special Educational	✓	✓	✓

NHS Devon ICB Annual Plan 25/26 Planning Objective	Hospital to Community	Analogue to Digital	Sickness to Prevention
Needs and Disabilities) improvements, reduces inequalities, and better supports children and young people with long-term conditions, including those with mental health issues, learning disabilities, autism, and neurodiversity.			
6. **Maternity and Neonatal Improvements and Women's Health** Oversee the delivery of neonatal improvement programmes in each Trust ensuring alignment with the national Maternity Safety Support Programme (MSSP). By overseeing delivery of the programme, NHS Devon will drive and monitor the required improvements to meet the national compliance agenda for maternity and neonatal care.	Linked to other key policy objectives which include financial recovery, improving healthcare outcomes, and addressing patient safety issues.		
7. **Health Protection and Prevention of Infectious Diseases** Take a lead role in outbreak planning and prevention working with primary care and community providers to drive vaccination uptake for preventable diseases.			✓
8. **Proactive, Preventative, Personalised Care at Home** Design, commission and implement integrated care models to provide proactive, personalised support at home for those with long-term conditions and those approaching End of Life (EoL), focused on reducing emergency hospital admissions, empowering patients, and improving overall outcomes.	✓	✓	✓
9. **Improve Quality and Safety** Lead the development and delivery of a co-produced five-year Quality Framework, to support the delivery of local and national quality objectives.	✓	✓	✓
10. **Strengthen Safeguarding Across the System** Lead system-wide safeguarding initiatives with a focus on improving service commissioning for vulnerable populations and embedding adult and children's safeguarding requirements into provider contracts and partnership arrangements.			✓
11. **Clinical Service Change and Transformation** Support the development and stabilisation of acute services in Devon by addressing secondary care fragility and delivering new models of acute care.	Linked to other key policy objectives which include financial recovery, improving healthcare outcomes, and addressing patient safety issues.		

NHS Devon ICB Annual Plan 25/26 Planning Objective	Hospital to Community	Analogue to Digital	Sickness to Prevention
This will include leading engagement and consultation in relation to significant service change and commissioning and overseeing the implementation of new models of acute care.			
12. **Support 'In-Hospital' Productivity Improvement** Work with Acute care providers to reduce elective waiting lists and improve urgent care flow, by driving productivity improvements. This will include optimising care pathways, encouraging and supporting collaboration across providers, securing capital investment in modern buildings and equipment, and supporting the development of a flexible workforce to increase service stability and resilience.	✓	✓	
13. **System Productivity and Efficiency** Lead collaborative financial planning and resource allocation to maximise economies of scale and increase value for money, with a focus on high-cost and high-impact services, making best use of system assets and capacity.		✓	
14. **Shared Clinical and Non-Clinical Support Services** Work with system partners to deliver at scale to maximise efficiency and effectiveness, and reduce costs through the design, development and commissioning of new, and better use of existing, shared service models for corporate back-office functions and clinical support services.	✓	✓	
15. **Digital Systems and Technology** Lead the implementation of a shared digital care record to enable real-time information sharing and reduce duplication for clinicians and patients, and maximise the benefits of digital systems, automation, and AI while addressing digital exclusion		✓	
16. **Workforce Productivity and Transformation** Develop and deliver a system-wide plan to improve staff wellbeing, workforce productivity and efficiency, by increasing our focus on inclusion, coordinating training pathways, supporting recruitment and retention initiatives, and ensuring sustainability through workforce transformation.	✓	✓	✓

NHS Devon ICB Annual Plan 25/26 Planning Objective	Hospital to Community	Analogue to Digital	Sickness to Prevention
17. **Social and Economic Development** NHS Devon will play a full an active role working with partners to address social, economic and environmental priorities identified by the One Devon Integrated Care Partnership to reduce health inequalities and improve population health and wellbeing.			✓

Appendix 2 - Reporting Schedule

Month	Meeting	Meeting Date	Objective (O) for Review
July	Population Health Improvement Committee	09/07/2025	O1: Population Health & Prevention Focused Commissioning
	Finance and Performance Committee	10/07/2025	O11: Clinical Service Change & Transformation
			O12: Support In-Hospital Productivity Improvements
			O13: System Productivity & Efficiency
	NHS Devon Integrated Care Board	31/07/2025	O1: Population Health & Prevention Focused Commissioning
			O2: Enhance Primary Care Outcomes
			O3: Community Based Care & Support
			O4: Improve Services for Adults with MHLDAN
			O5: Improve Services for Children & Young People
			O6: Maternity & Neonatal Improvements and Women's Health
			O8: Proactive, Preventative, Personalised Care at Home
			O11: Clinical Service Change & Transformation
			O12: Support In-Hospital Productivity Improvements
			O13: System Productivity & Efficiency
			O16: Workforce Productivity & Transformation
August	People and Organisational Development Committee	13/08/2025	N/A
	Finance and Performance Committee	14/08/2025	O14: Shared Clinical & Non-Clinical Support Services
			O15: Digital Systems & Technology
	NHS Devon Integrated Care Board		

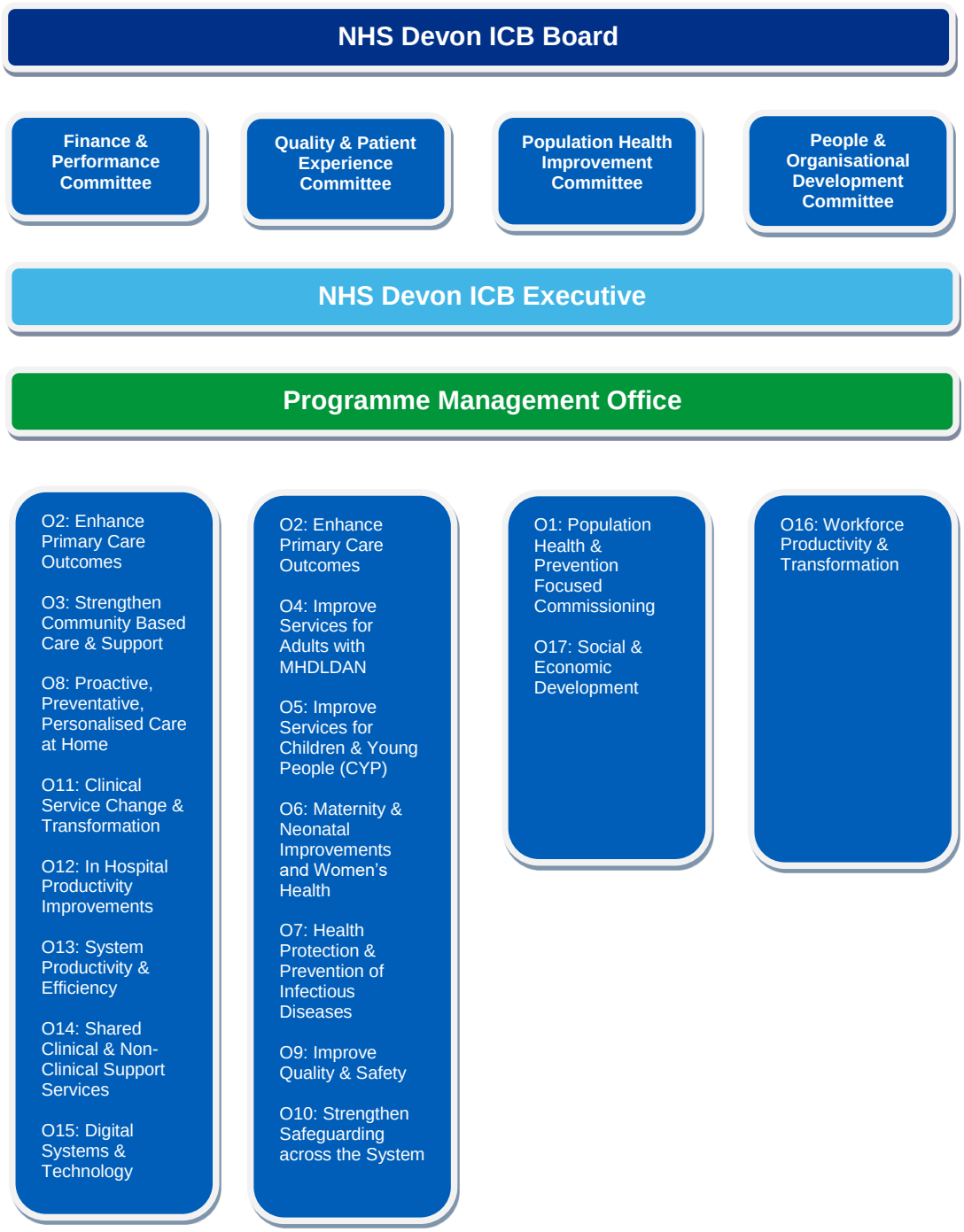
Month	Meeting	Meeting Date	Objective (O) for Review
September	Public Health Improvement Committee	10/09/2025	O17: Social & Economic Development
	Quality and Patient Experience Committee	11/09/2025	O7: Health Protection & Prevention of Infectious Diseases
			O9: Improve Quality & Safety
			O10: Safeguarding across the System
	Finance and Performance Committee	11/09/2025	O2: Enhance Primary Care Outcomes
			O3: Community Based Care & Support
			O8: Proactive, Preventative, Personalised Care at Home
	NHS Devon Integrated Care Board	25/09/2025	O2: Enhance Primary Care Outcomes
			O3: Community Based Care & Support
			O7: Health Protection & Prevention of Infectious Diseases
			O8: Proactive, Preventative, Personalised Care at Home
			O9: Improve Quality & Safety
			O10: Safeguarding across the System
			O14: Shared Clinical & Non-Clinical Support Services
			O15: Digital Systems & Technology
			O17: Social & Economic Development
October	People and Organisational Development Committee	08/10/2025	O16: Workforce Productivity & Transformation
	Finance and Performance Committee	09/10/2025	O11: Clinical Service Change & Transformation
			O12: Support In-Hospital Productivity Improvements
			O13: System Productivity & Efficiency
	NHS Devon Integrated Care Board		

Month	Meeting	Meeting Date	Objective (O) for Review
November	Public Health Improvement Committee	12/11/2025	N/A
	Quality and Patient Experience Committee	13/11/2025	N/A
	Finance and Performance Committee	13/11/2025	O14: Shared Clinical & Non-Clinical Support Services
			O15: Digital Systems & Technology
	NHS Devon Integrated Care Board	27/11/2025	O11: Clinical Service Change & Transformation
			O12: Support In-Hospital Productivity Improvements
			O13: System Productivity & Efficiency
			O14: Shared Clinical & Non-Clinical Support Services
			O15: Digital Systems & Technology
			O16: Workforce Productivity & Transformation
December	People and Organisational Development Committee	10/12/2025	N/A
	Finance and Performance Committee	11/12/2025	O2: Enhance Primary Care Outcomes
			O3: Community Based Care & Support
			O8: Proactive, Preventative, Personalised Care at Home
	NHS Devon Integrated Care Board		
January	Public Health Improvement Committee	14/01/2026	O1: Population Health and Prevention Focused Commissioning
	Quality and Patient Experience Committee	15/01/2026	O2: Enhance Primary Care Outcomes
			O4: Improve Services for Adults with MHLDAN
			O5: Improve Services for Children & Young People
			O6: Maternity & Neonatal Improvements and Women's Health
	Finance and Performance Committee	15/01/2026	O11: Clinical Service Change & Transformation
			O12: Support In-Hospital Productivity Improvements

Month	Meeting	Meeting Date	Objective (O) for Review
			O13: System Productivity & Efficiency
	NHS Devon Integrated Care Board	29/01/2026	O1: Population Health and Prevention Focused Commissioning
			O2: Enhance Primary Care Outcomes
			O3: Community Based Care & Support
			O4: Improve Services for Adults with MHLDAN
			O5: Improve Services for Children & Young People
			O6: Maternity & Neonatal Improvements and Women's Health
			O8: Proactive, Preventative, Personalised Care at Home
			O11: Clinical Service Change & Transformation
			O12: Support In-Hospital Productivity Improvements
			O13: System Productivity & Efficiency
February	People and Organisational Development Committee	11/02/2026	O16: Workforce Productivity & Transformation
	Finance and Performance Committee	12/02/2026	O14: Shared Clinical & Non-Clinical Support Services
			O15: Digital Systems & Technology
	NHS Devon Integrated Care Board		
March	Public Health Improvement Committee	11/03/2026	O17: Social & Economic Development
	Quality and Patient Experience Committee	12/03/2025	O7: Health Protection & Prevention of Infectious Diseases
			O9: Improve Quality & Safety
			O10: Safeguarding across the System
	Finance and Performance Committee	12/03/2026	O2: Enhance Primary Care Outcomes
			O3: Community Based Care & Support

Month	Meeting	Meeting Date	Objective (O) for Review
			O8: Proactive, Preventative, Personalised Care at Home
	NHS Devon Integrated Care Board	26/03/2026	O2: Enhance Primary Care Outcomes
			O3: Community Based Care & Support
			O7: Health Protection & Prevention of Infectious Diseases
			O8: Proactive, Preventative, Personalised Care at Home
			O9: Improve Quality & Safety
			O10: Safeguarding across the System
			O14: Shared Clinical & Non-Clinical Support Services
			O15: Digital Systems & Technology
			O16: Workforce Productivity & Transformation

Appendix 3 - Annual Plan 2025/26 Delivery Structure



*N.B. some objectives may be allocated to alternative or multiple Committees following their review at the beginning of June 2025.

NHS Devon Integrated Care Board

Developing NHS Devon's Health Care Strategy

Date of Meeting	Date Report Produced
29 May 2025	20 May 2025

Author(s)		Report Approved By	
Name and title:	Toby Hewlett, Transforming Devon Programme Devon Programme Director	**Name and title:**	Libby Ryan-Davis Transformation Director
Phone:	07970 590967	**Date:**	01 May 2025
Email:	Toby.hewlett@nhs.net		

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

Executive Summary
As an Integrated Care Board (ICB), our core responsibility is to plan, fund, and oversee NHS services within our local footprint. We are tasked with developing and implementing strategies that improve local health outcomes, reduce health inequalities, and coordinate care across multiple organisations. In fulfilling this duty, NHS Devon has committed to the development of a comprehensive Health and Care Strategy, to be completed by September 2025. This ambitious strategy will outline our operational vision for delivering improved, financially sustainable health outcomes for our local population.

Committees that have previously discussed / agreed the report, and outcomes of that discussion
Reviewed by the NHS Devon Executive at its meeting on 06 May 2025.

Key recommendations and actions requested
NOTE the urgency and need for rapid strategy development
TAKE SATISFACTORY ASSURANCE from the proposed timeline and governance as outlined in the report

Impact on NHS Devon Objectives	
Objective	**Impact**
Improve Population Health	All
Improve Services and Reduce Unwarranted Variation	
Make More Efficient Use of Our Resources	
Develop Our Culture and How We Operate	

Outline the implications of matters covered in this report for the following areas	
Area	
Quality of Services	All
Health Inequalities	
Workforce	
Resources and Finance	
Legal	
Digital and Data	
Engagement and Consultation	

Developing NHS Devon's Health Care Strategy

Introduction

1. As an Integrated Care Board (ICB), our core responsibility is to plan, fund, and oversee NHS services within our local footprint. We are tasked with developing and implementing strategies that improve local health outcomes, reduce health inequalities, and coordinate care across multiple organisations. In fulfilling this duty, NHS Devon has committed to the development of a comprehensive Health and Care Strategy, to be completed by September 2025. This ambitious strategy will outline our operational vision for delivering improved, financially sustainable health outcomes for our local population.

2. The Health and Care Strategy will form the cornerstone of our Joint Forward Plan (JFP) for 2026–31, aligning our priorities with the NHS Long Term Plan, the Integrated Care Partnership's Integrated Care Strategy, and local Joint Local Health and Wellbeing Strategies (JLHWS). It will also integrate and align the Medium-Term Financial Plan (MTFP) to ensure both operational and financial sustainability. Central to the strategy is a pathway approach to service transformation across all age groups, focusing on key areas such as population health and prevention, out-of-hospital and community care, primary care, mental health, acute services (including maternity), and the Better Care Fund (BCF).

3. It is imperative that this Strategy also delivers on the MTFP with timelines and process to do so currently being aligned

4. Our strategic direction builds on national policies emphasising greater integration across services. Initiatives such as the NHS Long Term Plan and the Fuller Stocktake stress the importance of dissolving traditional divides between primary and community health services. Current government priorities further reinforce this, calling for three strategic shifts:

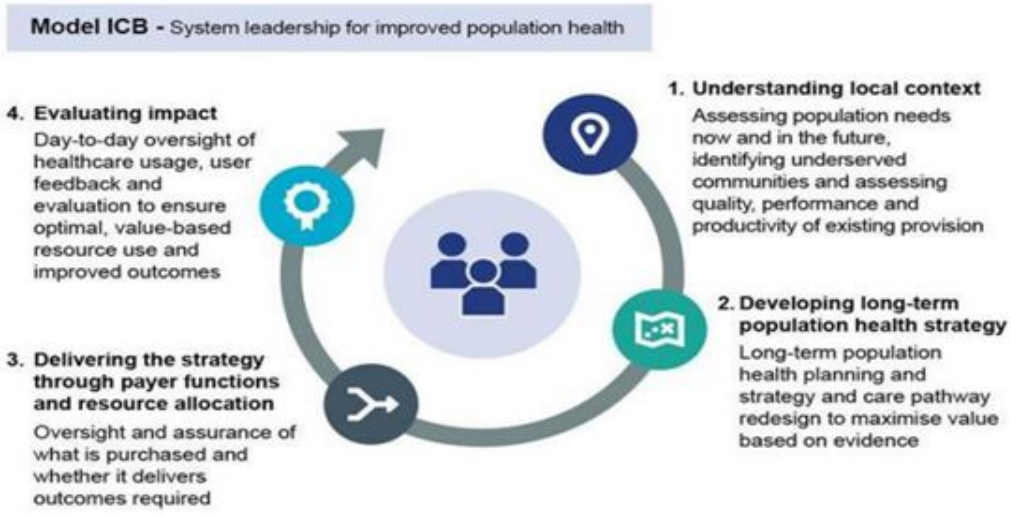
    a. from hospitals to community and primary care,
    b. from analogue to digital services,
    c. and from treatment to prevention.

5. Further, the vision for a Neighbourhood Health Service—delivering more care within communities—is a crucial element of this transformation, supported by growing evidence that integrated, locally based services deliver better outcomes and reduce health inequalities.

6. Commissioning practices are also evolving. NHS England, alongside system leaders, recognises that to manage rising demand sustainably, commissioning must shift from transactional contracting to strategic reform. ICBs have been charged with leading this change—moving from reactive to proactive care, focusing resources upstream, fostering collaboration, transforming care pathways, ensuring value over cost, and empowering local leadership.

National Policy Framework and Alignment

6. NHS Devon's Health and Care Strategy will need full alignment to the Model ICB Blueprint Framework recently published. ICBs are asked to focus on the following core functions:



7. The development of the Health and Care strategy will be underpinned by our response to the core functions as follows:

- **Understanding Local Needs & Reviewing Provision**
  NHS Devon will:

  - Use population segmentation and stratification to identify risk and unmet need.
  - Apply real-time data, public health insight, and user feedback to inform service design.
  - Leverage forecasting and demand modelling to plan sustainable future services.
  - Disaggregate data to surface inequalities and monitor equity outcomes.
  - Conduct performance, quality, and productivity reviews across all providers.
  - This data-driven understanding will underpin all commissioning and transformation efforts, ensuring **allocative efficiency** and tailoring investment to areas of highest impact.

- **Developing Long-Term Health Strategy**
  The strategy will:

  - Develop **care pathways across the life course** through co-design, evidence, and local engagement.
  - Apply **value-based healthcare** principles to prioritise high-impact interventions.
  - Align funding to need using **actuarial modelling** and "should-cost" analysis.

- Set system-level strategy to improve **access, experience, and outcomes** while addressing health inequalities.

- **Delivering the Strategy: Payer Functions and Market Oversight**
  NHS Devon aims to shift from transactional contracting to **strategic commissioning**, by:

  - Setting **outcome-linked service specifications** and priorities for quality improvement.
  - Deploying **payment mechanisms** such as gainshare, blended payments, and shared savings to drive equity and productivity.
  - Undertaking **market shaping**, introducing new models of care (e.g. frailty pathways) where gaps exist.
  - Managing **contracts for outcomes**, not activity, with robust provider performance monitoring and financial stewardship tools.
  - Prioritising commissioning to **reduce unwarranted variation** and deliver person-centred care.

- **Evaluation, User Feedback and Continuous Learning**
  NHS Devon will ensure real-time oversight and adaptability through:

  - Monitoring **utilisation via dashboards and benchmarking** to identify and eliminate unwarranted variation.
  - Embedding **feedback loops** for patients, clinicians, and communities into planning and redesign processes.
  - Undertaking **return-on-investment evaluation** for all major interventions.
  - Enabling **co-design and community participation** through deliberative engagement approaches and inclusive design thinking.

Development of the NHS Devon Health and Care Strategy

8. As outlined, the goal is to develop a comprehensive, inclusive, and future-focused health and care strategy for Devon that ensures safe, effective, and sustainable care for all residents. This includes children and young people, adults, older people, and those with specific needs such as mental health conditions, long-term conditions, or complex care requirements.

9. Devon, like many health and care systems across England, faces significant financial and operational pressures. Rising demand for services, increasing complexity of care, workforce challenges, and the need to recover from the impact of the COVID-19 pandemic have all contributed to a system under strain. Financial deficits, long waiting times, and variation in access and outcomes across the county highlight the urgent need for a strategic approach that ensures better value, reduces unwarranted variation, and prioritises population health. A well-developed strategy will support the difficult choices ahead by ensuring they are evidence-based, equitable, and aligned with a shared system vision. A strategic, system-wide roadmap for improvement and transformation is essential.

10. This strategy will therefore focus not only on stabilising the system, but on driving meaningful and lasting change—by redesigning pathways, embracing innovation

and digital tools, supporting prevention and population health, and making best use of our collective workforce and estate, within a set financial envelop. It will set out a phased and realistic plan to transform how care is delivered, reduce variation, and ensure high-quality services are available equitably across urban, rural, and coastal communities in Devon.

11. Learning from other Integrated Care Systems that have developed integrated strategies grounded in local engagement, Devon's strategy will be co-produced with patients, staff, clinicians, and community partners. This will ensure that services are not only clinically effective and financially sustainable, but also reflect the needs, aspirations, and lived experiences of local people.

12. Ultimately, this strategy is about developing a credible and shared roadmap that delivers better health and wellbeing, reduces inequalities, and builds a health and care system that works for everyone—now and for future generations.

Case for Change

13. Devon's health and care system is at a critical point. Despite the hard work and dedication of staff across NHS and care services, the system is under intense and growing pressure. Rising demand, an ageing population with increasingly complex needs, and persistent health inequalities are placing significant strain on already stretched services. At the same time, the financial position across the Devon system is unsustainable, with recurrent deficits and cost pressures affecting the ability to invest in new models of care or fully meet population needs.

14. Performance across key areas of care reflects these challenges. Devon continues to experience long waits for elective treatment, pressure on urgent and emergency care services, and delays in mental health and community-based support. People often struggle to navigate the system, which can feel fragmented and inconsistent. Services don't always follow the patient — care can be disjointed, access can depend on where someone lives, and support often arrives too late, leading to avoidable deterioration or hospital admissions.

15. This strategy is needed to confront these issues head-on. Without a clear and united plan for improvement and transformation, the gap between demand and capacity will widen, outcomes will worsen, and financial sustainability will remain out of reach. The current system is not designed to meet the modern needs of Devon's diverse communities — from rural and coastal populations with limited access to services, to children and young people needing better mental health support, to older adults living with multiple conditions who require more joined-up, personalised care.

16. The strategy will help shift the system away from reactive and siloed responses, toward a more proactive, preventative, and integrated model of care that places people at the centre. It will support a new way of working across organisations, ensuring that care follows the patient — not the other way around — and that people receive timely, coordinated support close to home wherever possible.

17. Devon must also make tough but necessary decisions to secure long-term sustainability. This means redesigning care pathways, reducing duplication, tackling unwarranted variation, and focusing resources where they will deliver the greatest impact. The strategy will help create a roadmap to achieve this — balancing immediate recovery needs with long-term transformation and ensuring Devon can deliver high-quality care within the resources available.

18. This local need for transformation also aligns with wider national health priorities. The government's policy direction continues to emphasise population health, prevention, recovery of core NHS services, improving access, and reducing health inequalities. There is also a growing national push for care integration through place-based partnerships, digital innovation, and greater collaboration between the NHS, local government, and the voluntary sector. The strategy for Devon will reflect these priorities while translating them into real, practical improvements for local communities — ensuring that national expectations are met in ways that are tailored to Devon's unique geography, demography, and needs.

Process for Strategy Development

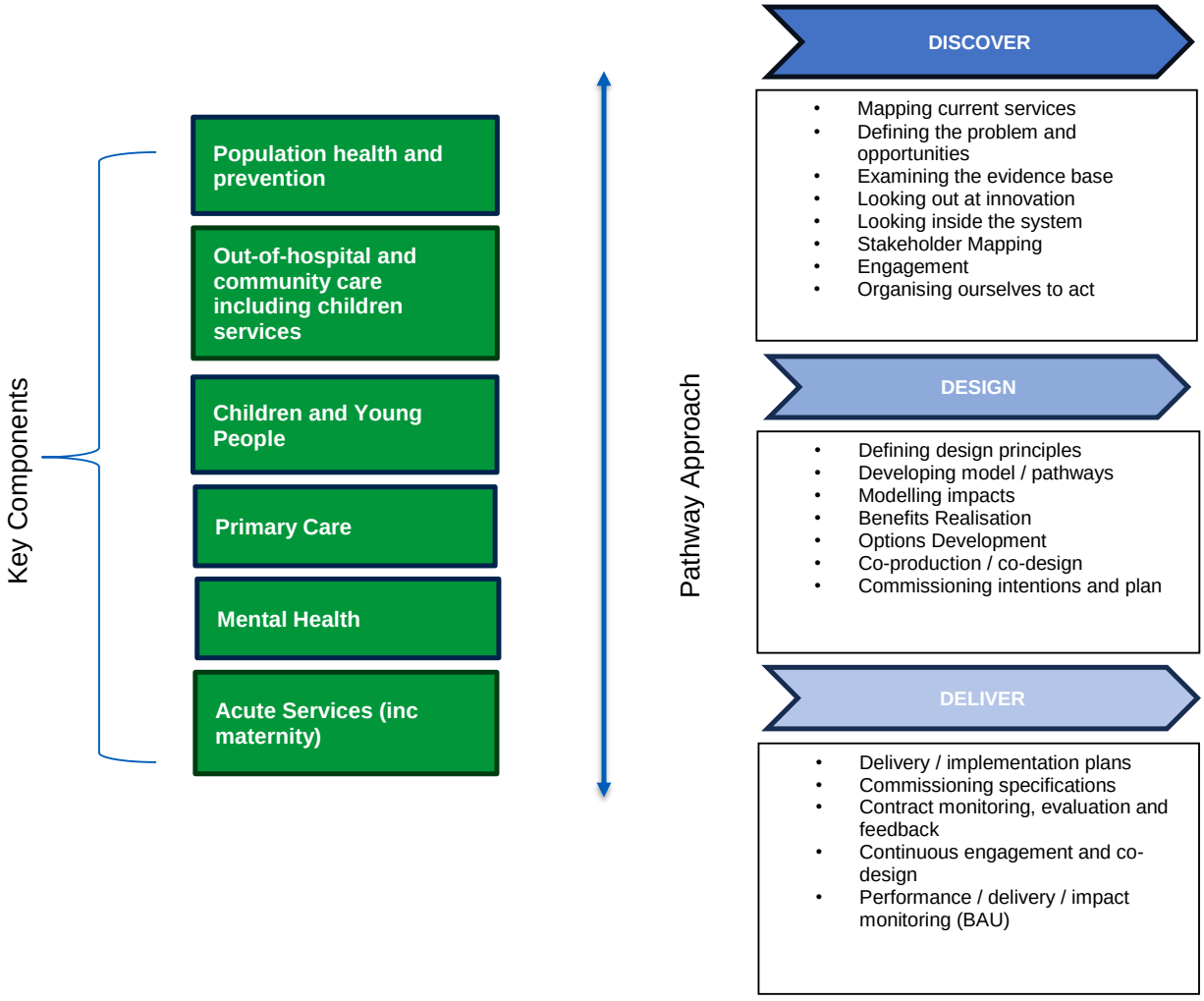
19. Delivering the vision set out in this strategy will require a coordinated, phased, and pathway-driven approach. Through these reforms, and underpinned by a strong strategic framework, NHS Devon is committed to creating a health and care system that is sustainable, integrated, and focused on delivering better outcomes for all the communities we serve—across all ages and areas of need.

20. These pathways will serve as the building blocks for change, ensuring that services are redesigned in ways that are person-centred, joined-up, and responsive to the needs of different population groups. The key components of this pathway approach include:

- **Population Health and Prevention** – Shifting the focus from treatment to prevention by addressing the wider determinants of health, supporting healthier lifestyles, and tackling inequalities at source.
- **Out-of-Hospital and Community Care** – Strengthening community-based services, including community nursing, reablement, adult social care, and integrated children's services to ensure more care is delivered closer to home.
- **Children and Young People** – Developing more proactive and joined-up support for children and young people, including mental health, special educational needs and disabilities (SEND), and early intervention services.
- **Primary Care** – Supporting and evolving general practice and primary care networks to meet rising demand, deliver population health approaches, and improve access and continuity of care.
- **Mental Health** – Transforming mental health pathways across the life course to ensure timely, accessible, and recovery-focused care in both community and inpatient settings.
- **Acute Services (including Maternity)** – Redesigning acute and specialist pathways to improve outcomes, reduce variation, and ensure clinically and financially sustainable hospital services.

- **Better Care Fund (BCF)** – Strengthening integration across health and social care, particularly for older adults and those with complex needs, through the effective use of pooled budgets and shared outcomes.

21. The development and implementation of NHS Devon's Health and Care Strategy will focus on transforming care pathways across the system, and follow a Discover, Design and Deliver Methodology.



Phased Implementation

22. To manage complexity and ensure sustainable change, the strategy will be delivered through a phased implementation approach:

Phase 1: Discover (June 2025)

- Establish strategic governance, leadership, and programme infrastructure.
- Engage system partners, clinicians, staff, and the public to co-design pathway priorities.
- Begin immediate improvement actions in areas of greatest need

- Align existing programmes and resources with the emerging strategic framework.

Phase 2: Transformation Design (Sept 2025)
- Co-produce detailed transformation plans for each priority pathway.
- Implement early-stage integrated models of care across communities and places.
- Strengthen workforce, digital infrastructure, and population health management capabilities.
- Embed prevention, equity, and patient experience as core drivers in all service redesign.

Phase 3: Deliver (Years 1-3)
- Scale successful models of care across Devon.
- Deliver measurable improvements in health outcomes, care experience, workforce wellbeing, and financial performance.
- Continuously review and adapt the strategy based on real-time data, system learning, and feedback from communities.

23. This structured and collaborative approach will ensure that Devon's health and care system does not just respond to short-term pressures but is fundamentally transformed to meet the needs of the future. It recognises the urgency for change while also acknowledging the importance of doing it in a way that is inclusive, evidence-based, and sustainable.

Communication and Engagement

24. Working together across the system widens the opportunity of engagement to the whole population, ensuring that the voices of those who experience health inequalities, or those who live in rural, coastal or remote locations have an equal chance to be heard and influence decision-making. As such:

- We will enact the **people and community's framework** and ensure that:
  - ✓ The Devon Engagement Partnership help co-design an involvement approach to support the strategy development and will have a rep from this group as part of the steering group
  - ✓ Use the insights library to support the discovery stage. This would be a separate piece of work to the engagement, as per page 9 of the attached. The first thing we do before we ask the DEP for a view on an approach is establish what we already know.
  - ✓ Ensure the Involvement Platform supports continuance engagement as the strategy develops, and

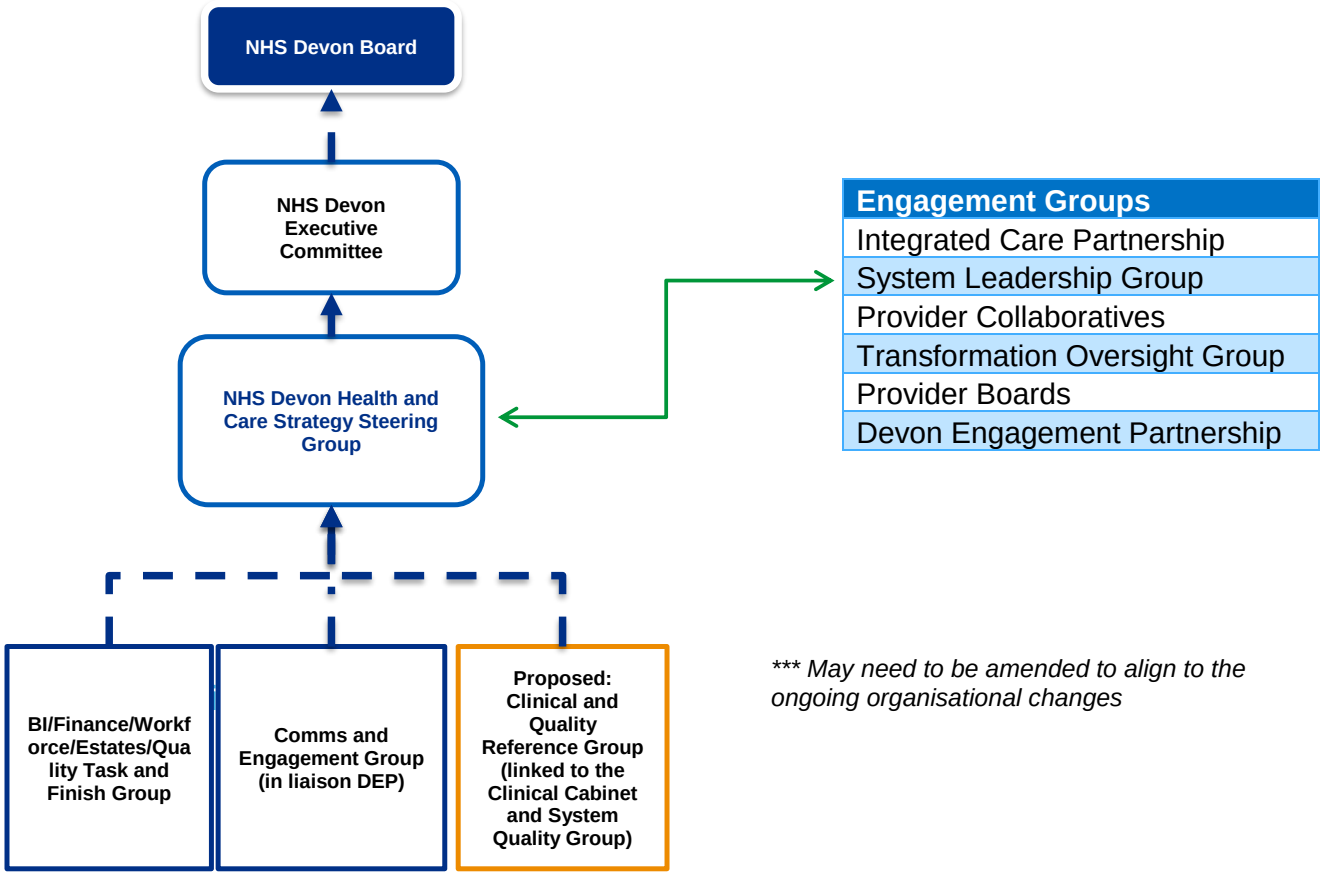
- Use the findings from the **10 Year Plan engagement** to support development of the strategy around the three shifts – hospital to community, sickness to prevention, analogue to digital. As part of the evaluation, we will be able to draw on feedback from over 3400 people (see graphic below). We also have 200 people signed up to work with us on an on-going basis as part of developing the strategy and plans for Devon. There is an opportunity to create

a citizens panel or bespoke reference groups with this cohort and we will look to see which model best suits.

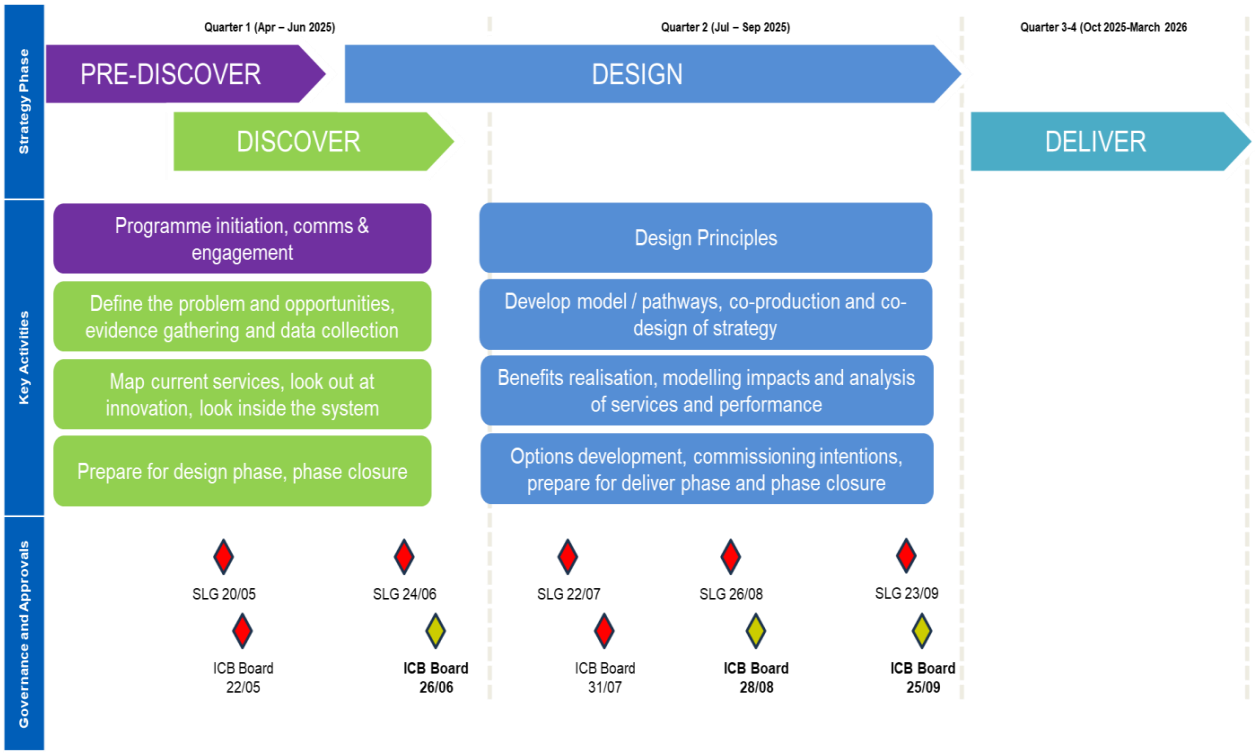
- **Personas** – we have developed a set of personas that can be used as part of the strategy development. These will be tested and agreed ahead of the strategy development.
- **Stakeholder map** – we have created a stakeholder map for NHS Devon which can be used as part of the strategy to ensure we have good visibility of our stakeholders and how they should be involved in the strategy
- During the **Discover Phase**, we will design specific activities through focus groups/targeted meeting and engagement activities to test and co-produce ideas & models including the Collaboratives and VCSE academy in the development of the strategy

Governance

25. The development of NHS Devon's Health and Care Strategy is crucial to developing a roadmap to transformation towards operational and financial sustainability. As such, the Health and Care Strategy development will be led by the NHS Devon Chief Strategic Commissioning and Planning Officer and Deputy Chief Executive. Two task and finish group groups have been established, with a further Clinical and Quality Reference Group being proposed to support the development of the technical requirements for the strategy, and will report into the wider steering group. Overall accountability of the plan will sit with the NHS Devon Board, though System groups and individual providers and wider partners will be engaged as part of the development process.



*** *May need to be amended to align to the ongoing organisational changes*



Recommendations

26. The NHS Devon Board is asked to:

- **NOTE** the urgency and need for rapid strategy development
- **TAKE SATISFACTORY ASSURANCE** from the proposed timeline and governance as outlined in the report

NHS Devon

NHS Devon Integrated Care Board

Consolidation of Primary Percutaneous Coronary Intervention (pPCI) services in Devon

Date of meeting	Date report produced
29 May 2025	12 May 2025

Author(s)		Report approved by	
Name and title:	Peter Collins, Chief Medical Officer Libby Ryan-Davies, Chief Strategic Commissioning & Planning Officer John Finn, Interim Chief Operating Officer	**Name and title:**	Peter Collins Chief Medical Officer
Phone:		**Date:**	21 May 2025
Email:			

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

Executive summary
This report provides the Board with a briefing on the evidence which indicates that consideration should be given to a future change to commissioning arrangements in relation to Primary Percutaneous Coronary Intervention (pPCI) services in Devon. It proposes an approach to evaluating the options available in terms of

service change and sets out how this will be used, alongside stakeholder engagement to inform a final decision on this issue.

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

An oral update on the subject of this report was discussed by the NHS Devon Executive at its meeting on 13 May 2025.

Key recommendations and actions requested

AGREE, subject to ratification by the South West Joint Specialised Services Commissioning Committee, to commission a "test and learn" process to inform a future decision on service change alongside other appropriate engagement activities **(Appendix 1)**

NOTE that the evaluation of the "test and learn" process will be presented to the Board alongside a detailed options appraisal. These will both inform the decision on which service change options are to be engaged upon before a final decision is taken on the change to be implemented.

Impact on NHS Devon objectives

Objective	Impact
Improve population health	Allows resources to be redirected to reduce elective backlog
Improve services and reduced unwarranted variation	
Make more efficient use of our resources	Reduces costs associated with the delivery of primary Percutaneous Coronary Intervention services. This proposal would release consultant capacity to deliver improvements in the significant elective backlog in cardiology.
Develop our culture and how we operate	

Outline the implications of matters covered in this report for the following areas (if none, please state)

Area	
Quality of services	The impact of consolidating pPCI services in Devon on the whole population and the specific segments of it
Health inequalities	Consolidating services may carry inherent risks of widening inequity of access as well as providing mechanisms to reduce inequities.

	Consideration is given to this within the paper and the associated Equality and Quality Impact Assessment (EQIA).
Workforce	
Resources and finance	The recommendation outlined in the paper could allow more efficient use of resources to deliver greater value to the Devon population.
Legal	
Digital and Data	
Involvement, Engagement and consultation	

Consolidation of Primary Percutaneous Coronary Intervention (pPCI) services in Devon

Introduction

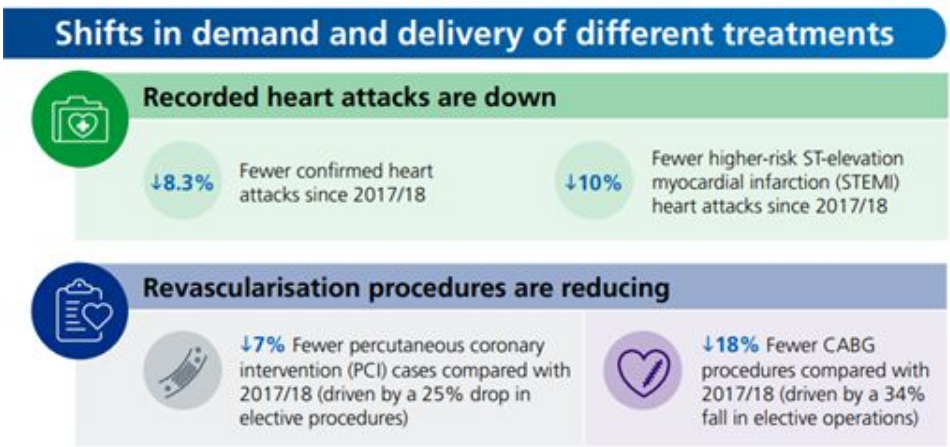
1. NHS Devon has reviewed the current service for the provision of primary Percutaneous Coronary Intervention (pPCI) and has noted that evidence indicates that consideration should be given to a future change to commissioning arrangements.

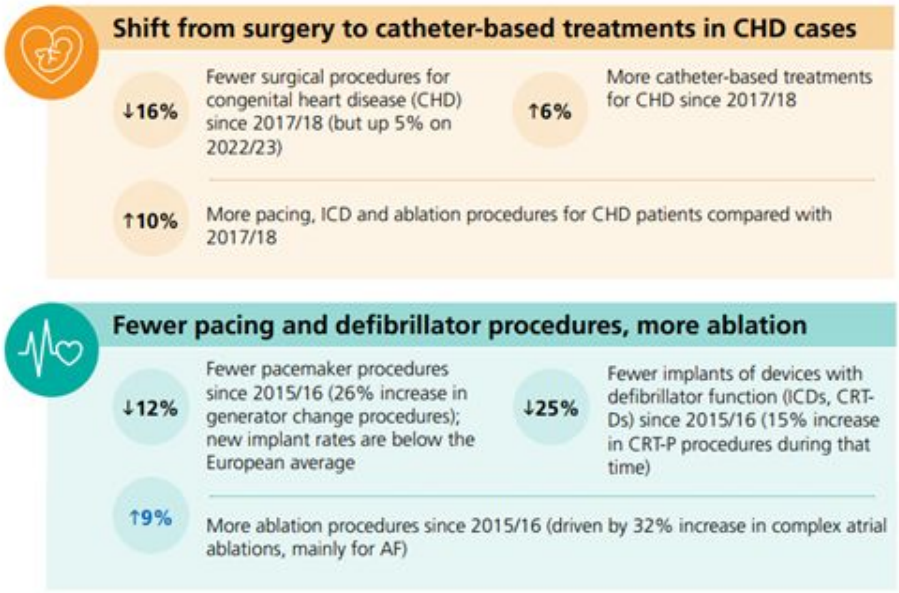
2. pPCI, also known as angioplasty or coronary angioplasty is a procedure used to treat narrowed or blocked coronary arteries, often as an emergency treatment for heart attack (STEMI), by opening the artery with a balloon and placing a stent to keep it open.

3. Most patients receiving pPCI are transferred to these locations by ambulance, some will self-present at the emergency department, and some will be hospital inpatients.

4. Low-volume, high-complexity interventions are considered to deliver best value to a population where they are delivered in a small number of sites allowing for economies of scale, clinical and operational pathway standardisation.

5. While Devon's demographics show a rising population of older people, data suggests that for cardiovascular disease the demand for pPCI is reducing and the demand for elective interventional procedures is rising.





6. Currently, pPCI services are provided in three sites in the county (University Hospitals Plymouth NHS Trust (UHP), Royal Devon University Healthcare (RDUH) (in Exeter) and Torbay and South Devon NHS Foundation Trust (TSDFT).

7. Providing highly complex interventions 24/7 is associated with high infrastructural and workforce costs despite low, and falling numbers being treated. British Cardiovascular Intervention Society (BCIS) guidance suggests that where centres are performing low volumes of pPCI consideration should be made to a networked model of delivery to maximise value and allow for long term resilience.

8. Evidence indicates that consideration should be given to consolidation to two sites for delivery, which could provide better value for the population, while continuing to be clinically safe and effective, and in line with BCIS guidance. Continuing to staff multiple rotas across Devon may impact the available elective capacity provided to meet current and future patient need. This could result in a decreased ability to reduce the already significant waits over 8 weeks, and for P2 patients (clinical priority to be treated withing 4 weeks), which are associated with patient harm (see below table).

Subject: Cardiology waiting lists for RDUH and TSDFT as of 21/5.2025

	RDUH		TSDFT	
	all	P2	all	P2
78+	1	0	0	0
65-77 wks	36	0	2	0
52-64 wks	309	7	81	0
40-51 wks	513	25	278	0
26-39 wks	1015	61	691	0
18-25 wks	863	46	707	0
<18 wks	3247	197	2468	0

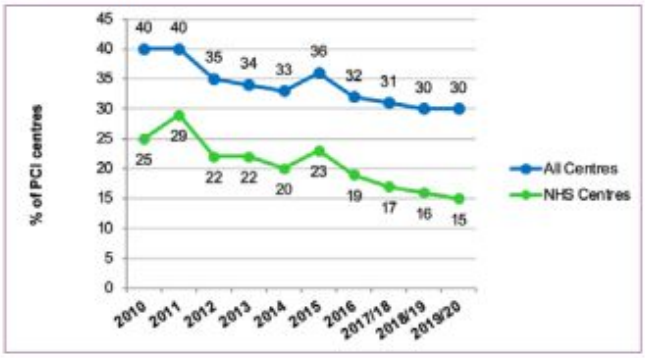
P2 activity defined as the clinical prioritisation of elective care patents to be treated within 4 weeks after coding assigned .

9. Current guidance from the BCIS supports the exploration of a networked model of delivery for pPCI if centres perform less than 200 procedures per year. TSDFT performed a total of 123 Primary PCIs in 2023/24 (National Institute for Cardiovascular Outcomes Research (NICOR) data).

10. A report written by the South West Strategic Clinical Network in 2016 (Bigger Better Faster) looking at optimal configurations of interventional cardiology and stroke services across the Southwest suggested that there is a marginal negative impact of moving for the population between 7 and 6 pPCI centres for the population in terms of safety efficacy for the specific patient cohort affected whilst providing other, wider benefits as summarised in paragraph 14 below.

11. The stand-alone centres providing smaller volumes of pPCI (<400 per annum) are reducing year on year according to National Institute for Cardiovascular Outcomes Research (NICOR) data with moves towards consolidation via networks or changes in organisational form (see table below)

Figure 2.1: Number of PCIs per centre: trend in % of centres doing <400 procedures per year, 2010 – 2019/20



12. Whilst reaching the minimum recommended by BCIS, the number of clinicians on the pPCI rota at TSDFT may limit the opportunity to provide a resilient rota that is fully compliant with current BCIS guidance, considering the necessary reduction of out of hours working from clinicians over 50 yrs of age.

13. Waiting times for elective cardiology assessment and treatment are excessive in parts of the county, with patients waiting in excess of 65 weeks for some elective interventions (including P2). Patients waiting on the list are at risk of harm from complications of cardiovascular disease such as stroke, heart failure and arrythmia further impacted by these extended waits. Safely managing excessive waits currently involves the use of the independent sector, which consumes additional NHS resource that could be invested in local NHS provision. Consolidation of resources in terms of consultant and other clinical time could mean that these are available for release to support NHS activity to reduce the elective backlog and the associated risk of harm. This view is supported by past and current evidence and recommendations, as well as advice from independent subject matter experts (Getting it Right First Time (GIRFT) Cardiology team, peer review by UHP and Royal Cornwall Hospital NHS Trust (RCH) clinicians).

14. Consolidating rotas could:

- Allow the provision of a pPCI service delivering outcomes that are in line with national benchmarks and guidance.
- Allow a rota that is fully compliant with the current BCIS guidelines.
- Release resource and redirect to reducing excessive waits for elective cardiology assessment and treatment
- Release the infrastructural and staffing costs associated with maintaining 24/7 pPCI rooms (cath labs) on multiple sites.

- Allow a volume of demand that supports excellent training opportunities and an ability to optimise internal processes to minimise door-to-balloon time which partially or fully mitigate increases in travel time (see below).

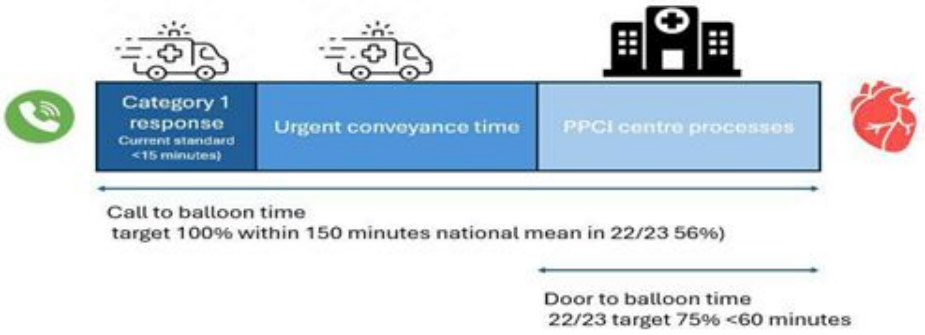
- Provide workforce retention and recruitment benefits associated with a larger centre.

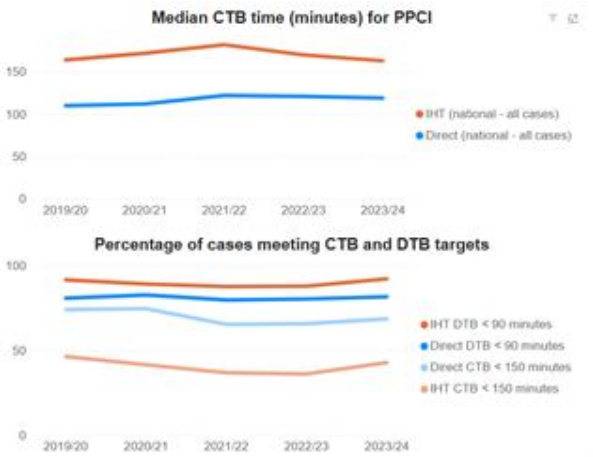
Impact of a change to pPCI centres in Devon

15. pPCI is a time sensitive intervention where timely access to treatment can reduce the risks of mortality and morbidity from acute myocardial infarction.

16. Efficiency and value must be balanced against the need to deliver a safe and effective service. Defined national measures of an effective service include (see tables below):

    - mortality within 30 days of the procedure,
    - Door-to-balloon time (a measure of internal processes within the control of the cardiology team and hosting site)
    - Call-to-balloon time (a measure transport services and geography)





17. Consolidating pPCI centres in Devon could increase travel times for some of the population, but analysis provided both in the 2016 South West Cardiovascular

Strategic Clinical Network (SWSCN) report and a recent 2024 South West Ambulance Service evaluation suggest that there will be only a modest increase in travel time.

18. As this is primarily a 999 service with no proposed change to the mode of access (i.e. patients with myocardial infarction suitable for pPCI would be conveyed direct to the single site) differential impacts on individual cohorts of patients are less likely (see below tables). Specific cohorts of patients have been identified that may be differentially affected and have been considered in the initial Equality and Quality Impact assessment (EQIA) attached to this paper (Appendix 2).

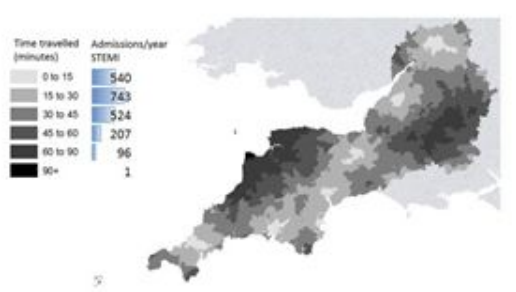


Figure 5.20 Modelled ambulance travel times: 7 Heart Attack Centres

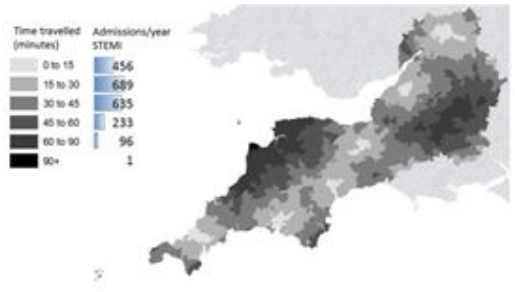


Figure 5.21 Modelled ambulance travel times: 6 Heart Attack Centres

Modelled impact on ambulance travel moving from 7 to 6 pPCI centres demonstrating no impact on patients travelling >60 minutes: Bigger Better Faster report 2016.

Patient Location	Average Current Travel Time	Average New Travel Time (RDUH)	Change (Average)
East and Mid Devon	19 minutes	19 minutes	No change
North Devon	89 minutes	89 minutes	No change
South Devon	15 minutes	43 minutes	+28 minutes

Devon Cardiology collaborative travel analysis 2024

3.2.3 Table 1: Model outputs: travel time results (mins)

	Basecase scenario	All STEMI Patients diverted to Wonford site	Increased travel time	STEMI patients diverted to nearest pPCI site (includes Derriford)	Increased travel time
Weighted average travel time	16	35	**+19**	34	**+18**
Min travel time	4	22	**+18**	22	**+18**
Max travel time	47	65	**+18**	59	**+12**

South Western Ambulance Service NHS Foundation Tryst (SWASFT) Travel analysis 2025

Conclusion

19. NHS Devon believes that consolidating pPCI centres for the Devon population, may provide increased value for the population of Devon with minimal and clinically acceptable impact on safety and quality.

20. This view is supported by past and current evidence as referenced in this paper, and recommendations as well as advice from independent subject matter experts (GIRFT Cardiology team, peer review by UHP and RCH clinicians).

21. NHS Devon is working with the Peninsula Acute Provider Collaborative to ensure that a detailed options appraisal is undertaken alongside a “test and learn” process to inform any future decision on service change. Further information about the “test and learn” process can be found in Appendix 1.

22. To support the “test and learn” process, NHS Devon will implement a clear, inclusive, and responsive engagement approach that involves NHS staff, patients, carers, local communities, Healthwatch, Overview and Scrutiny Committees, and voluntary, community and social enterprise (VCSE).

23. Prior to the launch of the “test and learn” process, the provider organisations across Devon and their clinical bodies will be asked by NHS Devon to collaborate to further define its scope, structure, timeframe and evaluation measures.

24. NHS Devon will also engage key stakeholders, such as local MPs, to enable them to support their constituents with any questions or queries they may receive during the process.

25. Once the “test and learn” process is live, ongoing engagement will take place with staff (including clinicians), public, patients and their carers on the rationale, the process and the impacts, to gather their experiences and insights of being involved. Regular updates to all stakeholders will form part of a communications plan, which will support the test and learn, and the associated engagement process.

26. Once complete, insights from all stakeholders will be collated and shared with all Overview and Scrutiny Committees (OSC). This will also support further engagement with the OSCs about how they should be involved in any future change programmes. We will discuss the outcomes of the “test and learn” process and the options appraisal fully with the OSCs, who would ultimately make a decision about the level of involvement if required for any new future model.

27. The “test and learn” process will be evaluated in terms of the impacts of any new proposed models and assess the practicalities of such an approach. This would be a temporary change to help us learn and to inform a future decision and will initially include extra measures to ensure patient safety during the transition to the new rota, such as the continuation of any shadow rota arrangements. It

would not lead to a permanent change without wider involvement and a robust decision-making process.

Recommendations for Board

28. The Board is asked to:

- **AGREE**, subject to ratification by the South West Joint Specialised Services Commissioning Committee, to commission a “test and learn” process to inform a future decision on service change alongside other appropriate engagement activities (Appendix 1)
- **NOTE** that the evaluation of the “test and learn” process will be presented to the Board alongside a detailed options appraisal. These will both inform the decision on which service change options are to be engaged upon before a final decision is taken on the change to be implemented.

Appendices

Appendix 1 – Test and learn scope

Appendix 2 - EQiA

Appendix 1

Key elements of the test and learn proposal scope

- All patients calling an ambulance with a ST-elevation myocardial infarction (STEMI) heart attack in the Torbay and South Devon NHS Foundation Trust (TSDFT) catchment would be conveyed to the designated pPCI centre (Royal Devon University Healthcare NHS Foundation Trust (RDUH))
- Inpatients and patients self-presenting to the TSDFT emergency department with a STEMI in hours (Monday to Friday 9am – 5pm) would be treated on site (Torbay and South Devon Foundation Trust (TSDFT)) (in-line with British Cardiovascular Intervention Society guidance)
- Patients presenting to the TSDFT emergency department out of hours would be transferred to the designated pPCI centre.
- Patients within the TSDFT who experienced a STEMI out of hours whilst receiving other care (for example after an operation) would be transferred to the designated pPCI centre if pPCI was required.
- TSDFT site will maintain their out of hours (OOH) rota as a "shadow rota" during the test and learn process, and may initially include extra measures to ensure patient safety during the transition to the new rota.
- A non-interventionalist on-call rota will be provided to support increased demand at the base site during the test and learn period.

Key operational requirements to be explicit in the test and learn process

- Clear processes to ensure all patients who present to South Western Ambulance Service NHS Foundation Trust (SWASFT) with ST-elevation myocardial infarction (STEMI) are conveyed directly to their nearest pPCI centre (UHP or TSDFT)
- Clear processes to identify self-presenting patients at TSDFT with STEMI who are suitable for pPCI can be rapidly transferred directly to a pPCI laboratory
- Clear processes to repatriate patients requiring post-procedural care.
- Clear processes to provide acceptable levels of cardiology advice out of hours (OOH) across all 3 acute sites.
- Externally validated model of care/job plans to ensure resource optimisation.
- External evaluation of outcomes in terms of safety/adverse events and acceptable call-to-balloon times

Roles and Responsibilities

- The acute providers will collaborate to define the detail of the test and learn structure, timescale, evaluation criteria in order to deliver the high level scope set out.
- An independent party will be identified to undertake the formal evaluation of the test and learn process and outcomes

Peter Collins

DevonNHS Devon Patient Safety compliance

FOR EQIA SCHEMES PLEASE COMPLETE THE EQIA FORM FOUND ON THE LEFT HAD SIDE COLOURED GREEN.

EQIA SCHEMES APPROVAL STATUS NEEDS TO BE:"IN HOLDING AREA, AWAITING REVIEW".

ONCE YOU HAVE SAVED YOUR RECORD, YOU WILL BE ABLE TO UPLOAD DOCUMENTS.

If you need support with the completion of the EQIA form, please contact the EQIA Team on d-icb.qeia@nhs.net

Case management Fields

ID	**13758**
Reference (Datix generated)	
Case Handler/Scheme Author	**Collins, Peter**
Directorate Lead	**Collins, Peter**

Type of form

Type	**EQIA**

Progress notes Relating to the incident

No progress notes.

Linked records

No Linked Records.

Actions

No actions

EQIA Part One

EQIA: Title	**Combined Primary PCI rota**
Scheme Lead Name:	**Arshiya KHan**
Directorate Lead:	**Peter Collins**
Organisation that is completing the scheme:	**TSD and RDUH**
Directorate:	**Chief Medical**
Date scheme started:	**30/06/2025**
Version of impact assessment:	**1.0**
Has a previous EQIA tool been submitted:	**No**
What was the previous reference:	
Stage of scheme:	**Progress**
Reason for change:	**System remodelling and redesign**
EQIA: Review/Oversight Meeting/Committee:	

Financial Impact?

Please indicate the financial implications for the scheme (£ savings or £ required)

If unknown at this stage at least indicate if the impact will be negative or positive

Summary of scheme:	**Proposal to commission a test and Learn process to evaluate the impact of moving from the current model of 2 designated pPCI centres in TSDFT and RDUH to a single designated pPCI centre at the Exeter provided by clinicinas form both cardiology services. The combined services currently deliver @400 activations per year with an estimated 60% (240 patients) treated out of hours**
1. Does the scheme affect patient safety or clinical effectiveness:	**Partly**
Impact:	**Negative and positive**
Please can you explain your reasoning for impact selected:	**The Test and Learn proposal would increase travel times for some patients in the current Torbay catchment area. Detailed travel analysis completed form the Bigger Better Faster Report into cardiology and Stroke interventional services demonstrated no change to the number of patients travelling >60 mins to the proposed single centre which sits within an acceptable timeframe for the national target of call to balloon time of <120 minutes. Evidence suggests that shorter call to balloon times have a positive impact on mortality and morbidity. Current data shows that HSMR for TSD and RDUH (which already provides pPCI the north Devon population _ are within the expected range RR 117.1 and 90.7 respectively) Patients at the Torbay site may not have access to onsite consultant cardiology expertise although 24/7 telephone support would be available from the pPCI site Patients who self-present to Torbay Hospital out of hours would require transfer to the Exeter site before receiving pPCI Combining an out of hours rota allows a more sustainable model of care with a larger pool of consultants contributing to a rota that would meet all BCIS recommendations. Job Planned activity released by reorganisation of the rota could be redirected to address other known areas of risk of harm for patients (elective waiting list, inpatient urgent angiography for acute coronary syndromes. The resource freed up is estimated to be at least 8 sessions per week**
2. Does the scheme affect patient, carers or service user experience:	**Partly**
Impact:	**Negative and positive**
Please can you explain your reasoning for impact selected:	**The negative impact of patients travelling further for life saving treatment and the further travel time for them and their family/carers would be mitigated in part by early repatriation protocols (patients discharged or transferred back to TSDFT the following day). Benefits to patients in Devon of shorter waits for elective or urgent cardiology interventions**
3. Does the scheme affect staff experience:	**Yes**
Impact:	**Negative and positive**

Please can you explain your reasoning for impact selected:	**TSDFT staff would have to travel or be resident when contributing to the pPCI rota (estimated frequency 1 in 10 to 1 in 14 patients per year)** **A larger more resilient rota affords the opportunity to adopt BCIS recommendations for compensatory rest times and reduction in out of hours work for consultants over 55 years of age**
4. Does the scheme affect access to services:	**Yes**
Impact:	**Negative and positive**
Please can you explain your reasoning for impact selected:	**As mentioned above pPCI access times for the population currently served by TSD would increase but analysis suggests this would not impact on ability to meet current NHSEngland access standards** **Increased elective capacity would improve access standards for patients awaiting elective and urgent cardiac assessment or intervention. 8 sessions of elective activity (using GIRFT recommended procedural/clinic times)equates to aprox 3300 new outpatient appointments or 750 ablation procedures or 1100 pacemaker placements**
5. Does the scheme affect people with health inequalities/population health/protected characteristics:	**No**
What data and evidence has been used to inform this scheme:	**GIRFT: Getting it right first time** **Mortality and morbidity** **NICE: National Institute for Health and Care Excellence** **Other** **Subject matter specific metrics**
EQIA Other Data:	**Bigger, Better, Faster? An options appraisal for the reconfiguration of emergency heart attack and stroke services for the** **South West of England South West Cardiovascular Strategic Clinical Network on behalf of NHS South April 2016**
What subject matter experts have you engaged with: **Please select all subject matter experts you have engaged with. Ideally you will have reached out and engaged with most of them.**	**Chief Officer** **Members of subject matter experts** **Members of the Clinical Effectiveness Team** **Members of the Commissioning Team** **Other**
Known gaps in your evidence?	
What governance/decision making group will this scheme be taken to for approval:	**PASP board (including CMOs of RDUH. UHP and TSD)** **GIRFT Cardiology Lead** **Author of Bigger, Better, Faster? options appraisal**
EQIA has been approved to progress:	
Date reviewed:	
EQIA Part two	
What communication and engagement with the population of Devon will there be:	**Briefings to politicians and members of the public will be ongoing once agreement to proceed to the test of operational readiness is complete**
Who else has been involved:	**PASP board** **On Devon Elective Programme (led by Prof Tim Briggs)** **GIRFT** **Operational teams from three acute providers**

What communication and engagement with Health and Social Care organisations will there be:	**Healthwatch Local Authority MP's NHS England**
Please detail the impact the change will have on the health and care system and organisations within in: [Impact could be local, peninsular, or regionally]	**Impact on RDUH in terms of increased pPCI patents (approximately 1.6 patients per week) Impact on SWAST in terms of TSDFT bypass for patents with STEMI and inter-hospital transport for patients requiring repatriation (self presenters to TSDFT ED and post-procedural)**

Quality impacts (Safety, effectiveness, and experience)

Group impacted:	**Population**
Description of impact:	**Improved waiting times for elective and urgent cardiology and assessment due to reallocation of job planned resource Current OOH cardiology support to facilitate OOH pPCI rotas require 43.68 Programmed Activities per week a combined service (also providing in hours cardiology support 7/7 at TSD and telephone advice OOH) would require a maximum of 37.68 PAs which would release at least 6 PAS of activity (equivalent to 2500 new outpatient appointments or 3750 follow up appointments or 832 pacemeker placements per year)**
Type of impact:	**Positive**
Workforce impacts:	**TSDFT consultants may need to travel further TSDFT and Exeter consultants contribute to a less frequent unpredictable OOH rota) Overnight Cath lab support staff no longer required at TSDFT Increased support staff to (radiographer) to RDUH as current model does not provide recommended AHP support**
Add another Group impacted:	**Yes**

Group impacted:	**Population**
Description of impact:	**Some of the 137 patients currently receiving pPCI at TSDFT will need to travel further with an possible increase in call to balloon time. Whilst the expectation is that the majority will still receives pPCI within the recommended time frame (current NICOR England average 0f 56% patients with Call to Balloon time <150 minutes TSD 62% RDUH 35%) Note door to balloon times (the time within the centres direct control) are comparable with % less than recommended 60 minutes for TSD 68% and RDHU 72%) Update 06/05/25 data supplied by SWAST modelling team looking at data from 1/1/24 to 31.12/24 show 51 patients conveyed between the hours of 19:00-07:00 and at weekends (of 99 in total) show weighted average travel time to be 34 minutes (min 22-max 59 minutes) an increase of 18 minutes The SWAST modelling did suggest an impact on Call to Balloon time with percentage of patients achieving a CTB time <150 minutes falling from 74.4% to 62.8% (this equates to 5 patients per annum) of note the national average last reported by NICOR was 56% and the 18 minute increase in travel time could be partially or fully offset by improvements to internal processes in a singe pPCI centre SWAST guidance (Acute Coronary Syndromes and Stable Angina, 2021) states that patients who are eligible for pPCI but are likely to face a travel to hospital time of over 75 mins should receive pre-hospital thrombolysis. This modelling did not find any incidents in the sample to be 75 mins or more from the nearest available CCU. Only two incidents (Stoke Fleming and Strete in TQ6) were modelled as 60 minutes or more from act on Call to Balloon time RD&E, and at least 56 mins from Derriford.**
Type of impact:	**Negative**
Add another Group impacted:	**Yes**

Group impacted:	**Staff**
Description of impact:	**TSD consultants may need to travel further** **TSD and Exeter consultants contribute to a less frequent unpredictable OOH rota)** **Overnight Cath lab support staff no longer required at TSDFT** **Increased support staff to (radiographer) to RDUH as current model does not provide recommended AHP support** **Increased volume allows concentration of expertise and maximisation of training potential**
Type of impact:	**Negative and positive**

Equality (Population impact)

Please use the links below to support you with completing this section of the form

Plymouth Joint Strategic Needs Assessment

Devon Joint Strategic Needs Assessment

Torbay Joint Strategic Needs Assessment

How will the scheme support a shift from treatment to prevention:	**Resource diversion to elective interventional activity will contribute to secondary prevention of IHD and arrhythmia**
How will the scheme affect population health outcomes:	**Resource diversion to elective interventional activity will contribute to secondary prevention of IHD and arrhythmia** **Increased call to balloon time has the potential to increase mortality and morbidity from IHD for a proportion of the approx. 140 patients per year who receive primary PCI at TSDFt (@ 83 patients would need transfer to RDUH)**
How will the scheme ensure that people who are digitally excluded will have access:	**no relevant issues**
Core 20 **[20% Most deprived population]**	**Income deprivation 22.5%**
Impact:	**Negative**
How was this group impacted:	**risk of reduced access for family/carers due to cost of travel to RDUH**
What actions are being taken to improve the impact:	**mitigations to be considered by implementation group ahead of eth Test and Learn**
Core PLUS **[ICB chosen populations]**	**Rural or coastal deprivation**
Impact:	**Negative**
How are these people impacted:	**coastal population around South Devon will need to travel further for PPCI with risk to mortality and morbidity outcomes** **Wider eastern Devon rural population may benefit from improved access to elective cardiology services**
How are these people impacted: **Adversely affected by wider determinants:** **Consider impact on those who are homeless, rough sleeping or whose**	**no significant impact anticipated as this is a change to an existing emergency service which will still be available to the whole Devon population through existing access routes (999 or presentation to ED)**

accommodation is insecure. Those with a history of trauma, mental illness, drug, or alcohol dependency. Consider poverty and resources, transport and environment, education, employment.	
Identity:	
Impact:	
How are these people impacted:	**no significant impact anticipated as this is a change to an existing emergency service which will still be available to the whole Devon population through existing access routes (999 or presentation to ED)**
What actions are being taken to improve the impact:	
Age:	
Impact:	
How are these people impacted:	**no significant impact anticipated as this is a change to an existing emergency service which will still be available to the whole Devon population through existing access routes (999 or presentation to ED)**
What actions are being taken to improve the impact:	
Sexual orientation:	
Impact:	
How are these people impacted:	**no significant impact anticipated as this is a change to an existing emergency service which will still be available to the whole Devon population through existing access routes (999 or presentation to ED)**
What actions are being taken to improve the impact:	
Impact:	
How are these people impacted:	**no significant impact anticipated as this is a change to an existing emergency service which will still be available to the whole Devon population through existing access routes (999 or presentation to ED)**
What actions are being taken to improve the impact:	
Ethnicity: **Consider ethnicity pay gap, diseases, and different ethnicity groups.**	
Impact:	
How are these people impacted:	**no significant impact anticipated as this is a change to an existing emergency service which will still be available to the whole Devon population through existing access routes (999 or presentation to ED)**
What actions are being taken to improve the impact:	
Disability:	
Impact:	

How are these people impacted:	**no significant impact anticipated as this is a change to an existing emergency service which will still be available to the whole Devon population through existing access routes (999 or presentation to ED)**
What actions are being taken to improve the impact:	
Additional equality groups:	
Impact:	
How are these people impacted:	**no significant impact anticipated as this is a change to an existing emergency service which will still be available to the whole Devon population through existing access routes (999 or presentation to ED)**
What actions are being taken to improve the impact:	
Religion: **Religion: Consider time required for praying and fasting periods.** **NICE guidance changes that impact medication decisions based on religious beliefs.**	

Risk and mitigation actions

How will impacts be improved or reduced:	**The EQIA recognises the potential impact on travel times and associated risk of mortality and morbidity on the population who currently could receive pPCI at TSDFT and would have to travel to either Exeter or Plymouth. This is balanced against the impact of reduction in the waiting times for patients currently waiting for elective assessment or intervention** **The EQIA and the information that informs it recognises areas of South Devon where travel times would be expected to increase above 60 minutes (TQ6 postcodes) and also identifies two cohorts of patients that maybe differentially affected (self-presenting patients to TSDFT with STEMI suitable for PPCI, and patients who develop STEMI whilst an inpatient at TSDFT for another reason).** **Monitoring of the impact on these cohorts would be a stipulation of the independent assessment of the Test and Learn process** **The operational requirements of the Test and Learn process will include the following requirement designed to mitigate the excess travel time as much as possible and to maximise the expected benefits.** **• Clear processes (providers in conjunction with SWAST) to for early identification of patients with STEMI suitable for pPCI and to ensure rapid transportation, if possible directly to the catheter laboratory** **• Exploration of a model allowing self-presenting patients or existing patients at TSDFT to undergo pPCI within core hours if there is expertise on site to carry this out safely** **• Description of new operating model and job plans for Cardiologists within RD&E and TSDFT that demonstrate release of resource that can be redirected to reduce the elective backlog (working across both sites to optimise expertise and infrastructure)**
Type of mitigation:	
What action will you take to mitigate the impact:	**Monitoring of the impact on these cohorts would be a stipulation of the independent assessment of the Test and Learn process** **The operational requirements of the Test and Learn process will include the following requirement designed to mitigate the excess travel time as much as possible and to maximise the expected benefits.** **• Clear processes (providers in conjunction with SWAST) to for early identification of patients with STEMI suitable for pPCI and to ensure rapid transportation, if possible directly to the catheter laboratory** **• Exploration of a model allowing self-presenting patients or existing patients**

at TSDFT to undergo pPCI within core hours if there is expertise on site to carry this out safely
• Description of new operating model and job plans for Cardiologists within RD&E and TSDFT that demonstrate release of resource that can be redirected to reduce the elective backlog (working across both sites to optimise expertise and infrastructure)

Timeframe to complete action:	
Action Owner:	**provider implementation team**
Describe how the action will be monitored:	**monitored by implementation team and subject to independent analysis**

Add a new risk:

Add a new risk:

Overall risk score based on identified impacts:

	Consequence				
Likelihood of recurrence	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Almost certain	○	○	○	○	○
Likely	○	○	○	○	○
Possible	○	○	○	○	○
Unlikely	○	○	○	○	◉
Rare	○	○	○	○	○
	Grade: High Risk (8-12)				

Is there an open risk regarding the scheme?	**No**
Referred to clinical cabinet:	**Yes**
Date sent to clinical cabinet:	**27/05/2025**
Executive summary and EQIA approval:	
Date reviewed by Executive:	**23/04/2025**
Executive Approval status:	**Final Approval of scheme**
Summary of impact: **To include the overall impact identified as being either neutral, positive or negative.**	**Following detailed discussion at ICB Executive meeting and Commissioning Group, consideration of the evidence suggests that the impact on mortality and morbidity of the change would be small and still allow outcomes to be comparable with national benchmarking. Mitigations in terms of optimising operational model ahead of any Test and Learn process should ensure impacts of increase travel on certain cohorts are minimised.** **Given the public and clinical concern around the decision the EQIA will also be considered at System clinical cabinet and System quality group and a formal decision on the proposal will be taken at ICB board and subject to the approval of Joint South West Joint Specialised services Commissioning Committee**
Which governance/decision making groups has this scheme be taken to for approval:	

Executive agreement with the scheme summary and actions identified:

- ○ None
- ◉ Yes
- ○ No

Documents

Created	Type	Description	ID
06/05/2025	Document	SWAST impact analysis	95876
23/04/2025	Document	current PASP case for change document (April 2025	95638
23/04/2025	Report	One Devon Cardiology Capacity and demand analysis	95637
23/04/2025	Report	Bigger better faster Report	95636
23/04/2025	E_Mail	BCIS recommendations link	95635
23/04/2025	Document	NICOR data	95634

Approval Status and Closed Date

Current approval status	**Being reviewed**
Closed (dd/MM/yyyy)	

Additional Information

Are there any documents to be attached to this record?	**No**

NHS Devon

NHS Devon Integrated Care Board

Board Assurance Framework

Date of Meeting	Date Report Produced
29 May 2025	15 May 2025

Author(s)		Report Approved By	
Name and title:	Victoria Williams, Senior Governance and Assurance Specialist	**Name and title:**	Philippa Harding, Director of Governance and Interim Chief Communications and Corporate Affairs Officer
Phone:	01392 675 101	**Date:**	15 May 2025
Email:	victoria.williams80@nhs.net		

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

Executive Summary
This report provides the NHS Devon Integrated Care Board with information about the high-level strategic risks that might impact on the achievement of NHS Devon's strategic objectives in the current financial year. In light of recent changes to the operating context for Integrated Care Boards (ICBs), the report proposes an alternative approach to the Board Assurance Framework in 2025/26 to that which was agreed by the Board at its meeting in public on 27 March 2025. It also proposes the addition of two risks in relation to ICB recent requirements to reduce ICB running costs by 50%.

Committees that have previously discussed / agreed the report, and outcomes of that discussion
The revised approach to the BAF was reviewed by the NHS Devon Executive at its meeting on 06 May 2025 and by the Audit and Risk Committee meeting on 06 May 2025.

Key recommendations and actions requested
APPROVE the revised proposed approach to the Board Assurance Framework for the first 2 quarters of 2025/26
APPROVE the addition of two new risks in relation to ICB transition to the Board Assurance Framework
APPROVE the 2025/26 Board Assurance Framework risks to achieving the strategic objectives of NHS Devon.

Impact on NHS Devon Objectives	
Objective	**Impact**
Improve Population Health	**All**
Improve Services and Reduce Unwarranted Variation	
Make More Efficient Use of Resources	
Develop Our Culture and How We Operate	

Outline the implications of matters covered in this report for the following areas	
Area	
Quality of Services	Risk management systems and processes do not in themselves present any quality or safety implications. They capture and report the risks relating to population health outcomes and patient experience in the One Devon Integrated Care System, in order to ensure that they are appropriately mitigated / controlled.
Health Inequalities	None
Workforce	None
Resources and Finance	Risk management systems and processes do not present in themselves any financial implications. They capture and report the strategic financial risks faced by NHS Devon in order to ensure that they are appropriately mitigated / controlled.

Legal	Sound control and assurance mechanisms, including risk management systems are an essential component of internal control processes. NHS organisations are required to sign an annual governance statement to provide reasonable assurance that they have been properly informed about the totality of their risks and can evidence that they have identified the organisational objectives and managed the principal risks to them. There is a mandatory annual internal audit review into aspects of risk management and the BAF each year.
Digital and Data	None
Engagement and Consultation	This is an internal control process, and no patient engagement has taken place with respect to it.

Board Assurance Framework

Introduction and Background

1. NHS Devon is required to prepare public statements to confirm that it has done its reasonable best to maintain a sound system of internal control to manage the risks to achieving its objectives. This is achieved by the Chief Executive providing a signed Annual Governance Statement, which covers the risk management and review processes within the organisation. The evidence to support this Statement is supported by the Board Assurance Framework, referred to hereafter as the BAF.

2. NHS Devon's BAF is based upon the identification of its strategic objectives (in essence, its strategic aims and goals), the principal risks to delivering them, the key controls to minimise these risks, with the key assurances of these controls identified. These are monitored by the NHS Devon Executive to resolve issues or concerns and to improve control mechanisms.

Board Assurance Framework in 2024/25

Greater alignment to NHS Oversight Framework

3. In light of the importance of exiting Segment 4 of the NHS Oversight Framework (NOF4), it was agreed at the NHS Devon Board meeting in public on 27 March 2024 that the BAF in 2024/25 should be aligned to the six themes set out in the NHS Oversight Framework:

    - Quality of care, access and outcomes
    - Preventing ill-health and reducing inequalities
    - Finance and use of resources
    - People
    - Leadership & capability
    - Local strategic priorities

4. The BAF risks have, therefore, were articulated in 2024/25 as follows:

    Quality of care, access and outcomes
    If NHS Devon does not work with system partners to deliver NHS service performance in line with national standards, then we will fail to deliver on one of our key statutory purposes (improve outcomes in population health and healthcare), resulting in patients across the One Devon Health and Care System not receiving the services that they need.

    Preventing Ill-health and reducing inequalities
    If NHS Devon is unable to embed a focus on population health management across all of its own activities and those of its partners, then we will fail to deliver on of our key statutory purposes (tackle inequalities in outcomes, experience, and access), resulting in patients across the One Devon Health and Care

System potentially continuing to suffer health inequalities.

Finance and use of resources
If NHS Devon does not work with system partners to deliver financial recovery plans, then we will fail to deliver on one of our key statutory purposes (enhance productivity and value for money), resulting in patients across the One Devon Health and Care System potentially not receiving the services that they need.

People
If NHS Devon does not work with system partners to grow and develop the NHS workforce, then we will fail to deliver the priorities set out in the NHS People Plan, resulting in patients across the One Devon Health and Care System not receiving the services that they need.

Leadership and capability
If NHS Devon does not sufficiently develop its own leadership capability and that within system partners (particularly clinical leadership), then we will fail to deliver transformational change in relation to service delivery, resulting in patients across the One Devon Health and Care System not receiving the services that they need.

Board Assurance Framework in 2025/26

Reflecting the strategic objectives set out in the 2025/26 Annual Plan

5. The 2025/26 Annual Plan approved by the Board at its meeting in public on 27 March 2025 consists of 17 overarching objectives, addressing the following areas:

- Population Health and Prevention Focused Commissioning
- Enhance Primary Care Outcomes
- Strengthen Community-Based Care and Support
- Improve Services for Adults with Mental Health Disorders, Learning Disabilities, Autism, and Neurodiversity
- Improve Services for Children and Young People
- Maternity and Neonatal Improvements and Women's Health
- Health Protection and Prevention of Infectious Diseases
- Proactive, Preventative, Personalised Care at Home
- Improve Quality and Safety
- Strengthen Safeguarding Across the System
- Clinical Service Change and Transformation
- Support 'In-Hospital' Productivity Improvement
- System Productivity and Efficiency
- Shared Clinical and Non-Clinical Support Services
- Digital Systems and Technology
- Workforce Productivity and Transformation
- Social and Economic Development

6. It was agreed by the Board at its meeting in public on 27 March 2025 that the 2025/26 BAF should focus on providing assurance with regard to the risks to each of the 17 Annual Plan objectives.

7. In light of this reports were taken to the following Board Assurance Committees in April 2025:

    - People and Organisational Development Committee;
    - Finance and Performance Committee
    - Quality and Patient Experience Committee

8. These reports included proposed initial articulations of the risks to the achievement of each of the 17 Annual Plan objectives. However, the Board Assurance Committees, did not consider that the risks as articulated captured the strategic risks faced by the organisation.

9. It was noted that the operational context of the organisation had changed significantly since work had been undertaken on the Annual Plan, and that further work was likely to be required on the articulation of the Annual Plan objectives to reflect this.

10. It was also noted that, once delivery had commenced on the 2025/26 Operational Plan the planning team would immediately commence on the development of a Health and Care Strategy (Joint Forward Plan) that would describe the strategic change required alongside a refreshed Medium Term Financial Plan (MTFP), for presentation to the Board for approval by September 2025.

11. In light of these observations, it is now proposed that the BAF risks in 2025/26 should continue to remain aligned to the NOF themes as articulated under paragraph 4 above, rather than being aligned to the 2025/26 Annual Plan objectives. This would be until the approval of the Health and Care Strategy (Joint Forward Plan) in September, at which point the risks to the strategic objectives identified within the strategy would be articulated for a further iteration of the BAF.

The Board is asked to approve the revised proposed approach to the Board Assurance Framework for the first 2 quarters of 2025/26.

Proposed new BAF Risk

12. In light of the changing operational context for ICBs, the requirement to consider organisational change in order to significantly reduce running costs by Q3 2025/26 and the publication of the “ICB Blueprint”, it is proposed that two additional risks should be added to the BAF in relation to transition.

13. These risks have been articulated as follows:

    Reducing ICB running costs
    If the appropriate systems and processes are not in place to support the

implementation of ICB transition activities
then we may fail to deliver the reduction of running costs by Q3 2025/26 as required
resulting regulatory action being taken

Delivering business as usual in 2025/26
If the appropriate systems and processes are not in place to support the delivery of business as usual activities whilst transition activities are being undertaken
then we may fail to deliver our 2025/26 Operational Plan
resulting in patients across the One Devon Health and Care System potentially not receiving the services that they need

14. Once the risks have been approved, the detailed BAF template identifying controls, assurances and mitigating actions will be completed.

The Board is asked to approve the addition of two new risks in relation to ICB transition to the Board Assurance Framework

Risk Appetite Statement for 2025/26

15. Risk appetite is defined as 'the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic objectives' and is key to achieving effective risk management. It represents a balance between the potential benefits of innovation and the threats that change, and improvement inevitably bring. It should be at the heart of the systems and processes in place to manage risk within NHS Devon, as well as how decisions are taken.

16. The NHS Devon Board has previously agreed to articulate its risk appetite using the following Corporate Governance Institute Framework:

Avoid	Avoidance of risk and uncertainty is a key organisational objective
Minimal	(ALARP) (as little as reasonably possible). Preference for ultra-safe delivery options that have a low degree of inherent risk and only limited reward potential
Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward and Value for Money (VfM)
Seek	Eager to be innovative and choose options offering potentially higher business rewards despite greater inherent risk
Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

17. The agreed risk appetite, that is, the levels and types of risk that the Board is prepared to accept (and not accept) in pursuance of the strategic goals of NHS Devon, will be used to inform the agendas for meetings of the Board and its Committees, as well as to ensure that the mitigations controls being put in place for risks are appropriate.

18. Set out below is the risk appetite statement that was agreed by the Board for the 2024/25 financial year:

NHS Oversight Framework Theme	Risk Appetite	Tolerance Level for Residual Risk
Quality of Care, Access and Outcomes	AVOID	8-12
Preventing Ill-health and Reducing Inequalities	AVOID	8-12
Finance and Use of Resources	OPEN	15
People	SEEK	20-25
Leadership & Capability	SEEK	20-25
Local Strategic Priorities	OPEN	15

19. This has been maintained for the latest iteration of the BAF presented with this report. The Board is due to give more detailed consideration to whether the risk appetite statement should be amended for 2025/26 over the next month.

Current Risk Position

20. Updates by Chief Officers / Director Leads for individual BAF risks at this latest iteration, have been via High Light Report submissions provided via the Delivery Room process. The details for each risk are attached at **Annex A** and the scoring methodology at **Annex B** of this report.

21. The table below provides a high-level summary of the current risk position for the 5 strategic risks for the current financial year:

Committee Abbreviations	
ExCo	Executive
QPEC	Quality and Patient Experience Committee
FPC	Finance and Performance Committee
PHIC	Population Health Improvement Committee
ODC	Organisational Development Committee

Key - Movement in Risk Scores		
↑	↔	↓
Increased	No Change	Decreased

NHS Oversight Framework Theme – Risk Entry	Board Committee	Inherent Risk Score	Historical and Current Risk Scores: April 2024 Residual Risk Score	June 2024 Residual Risk Score	August 2024 Residual Risk Score	October 2024 Residual Risk Score	December 2024 Residual Risk Score	January 2025 Residual Risk Score	March 2025 Residual Risk Score	Risk Movement (Residual Risk Score)	Risk Appetite	Target / Tolerance Level (Residual Risk Score)	Last Reviewed
1. Quality of Care, Access and Outcomes	QPEC & FPC	25	12	12	12	12	12	12	12	↔	AVOID	8 - 12	Apr-25
2. Preventing Ill-health and Reducing Health Inequalities	PHIC	25	12	16	16	16	16	16	16	↔	AVOID	8 - 12	Apr-25
3. Finance and Use of Resources	FPC	20	12	12	12	12	12	12	12	↔	OPEN	15	Apr-25
4. People	PODC & FPC	20	12	12	12	12	12	12	12	↔	SEEK	20 - 25	Apr-25
5. Leadership and Capability	EXCO	20	16	12	12	12	12	12	12	↔	SEEK	20 - 25	Apr-25

Heat Map Showing Current Risk Scores

22. The heatmap provides a comprehensive view of the likelihood and impact of NHS Devon's strategic risks. It shows that of the five BAF risks, four are within or below the agreed target / tolerance level in terms of their residual risk score. One risk has a residual risk rating in excess of the target / tolerance level.

Board Assurance Framework Heatmap – Status as at April 2025:

NHS Oversight Framework Theme - Risk Entry	Chief Officer	Assigned Board Committee	Risk Appetite	1-3	4-6	8	9	10	12	15	16	20	25
1. Quality of Care, Access and Outcomes	CNO	QPEC & FPC	AVOID										
2. Preventing Ill-health and Reducing Health Inequalities	CMO	PHIC	AVOID										
3. Finance and Use of Resources	CFO	FPC	OPEN										
4. People	CPO	PODC & FPC	SEEK										
5. Leadership and Capability	CCA & CO	EXCO	SEEK										

Chief Officer Abbreviations:	
CNO	Chief Nursing Officer
CMO	Chief Medical Officer
CFO	Chief Finance Officer
CPO	Chief People Officer
CCA&CO	Chief Corporate Affairs & Communications Officer

Key – Risk Score Symbols and Shapes	
▭	Tolerance Level – Residual Risk
●	Current Residual Risk Score

Conclusion

23. The Board is asked to

- **APPROVE** the revised proposed approach to the Board Assurance Framework for the first 2 quarters of 2025/26
- **APPROVE** the addition of two new risks in relation to ICB transition to the Board Assurance Framework
- **APPROVE** the 2025/26 Board Assurance Framework risks to achieving the strategic objectives of NHS Devon.

Annex A

NHS Oversight Framework Theme	Chief Officer	Assigned Board Committee	Review Date
1. Quality of Care, Access and Outcomes	Penny Smith - Chief Nursing Officer	Quality & Patient Experience Committee; and Finance & Performance Committee	April 2025

Principal Risk

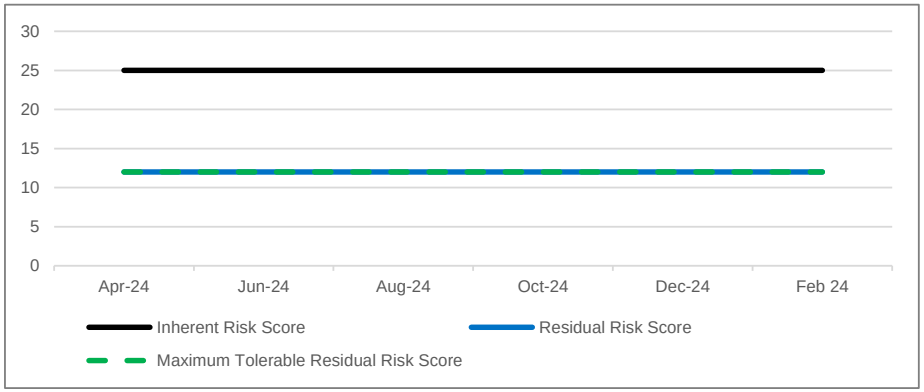
IF NHS Devon does not work with system partners to deliver NHS service performance for 'All Age' services in line with national standards and quality requirements, **THEN** we will fail to deliver on one of our key statutory purposes (improve outcomes in population health and healthcare), **RESULTING IN** patients across the One Devon Integrated Care System not receiving the services that they need.

Risk Appetite	AVOID	Risk Tolerance	8 - 12

Risk Scoring	Likelihood	Impact	Total	Movement
Inherent Risk Score	5	5	25	-
Current Residual Risk Score	3	4	12	↔

Rationale for Amendment to Residual Risk Score:

N/A



Current Key Controls (what do we have, or what should we have in place to mitigate the risk?)		In Place?
1.	**Quality Strategy** in place articulating current and future ambitions for delivering high quality healthcare aligned to national standards, in line with the needs of the Devon population.	Not in Place
2.	**Quality Management System (QMS)** in place to support delivery of high quality healthcare.	Partially
3.	**2024/25 Annual Plan** priorities agreed and delivery plan in place to ensure achievement of these.	Partially
4.	**NHSE Quality and Accountability Framework** implementation.	Fully

Current Key Control Gaps	
CG1	**Quality Strategy** needs to be developed, in line with proposed priorities set out in the 2024/25 Annual Plan.
CG2	**QMS** – monitoring systems need refinement to include improved visibility of system risks where NHS Devon oversight is required.
CG3	**2024/25 Annual Plan** priorities agreed by the Board at its meeting on 30 May 2024; final iteration approved by the Board on 25 July 2024. Ongoing development / changes to be approved by the Board throughout 2024/25.

Annex A

5.	**Equality and Quality Impact Assessment (EQIA)** framework in place to help inform commissioning decision-making processes, business cases, projects and other business plans.	Fully			
6.	**Mental Health Strategy** in place to ensure delivery of high quality, safe, effective and well commissioned Mental Health Services. This is supported by a Delivery Plan.	Partially		CG6	**Mental Health Strategy and Delivery Plan** needs to be developed, in line with proposed priorities set out in the 2024/25 Annual Plan.
7.	**Dementia Strategy** in place to ensure high quality, safe and effective delivery of Dementia Services. This is supported by a Delivery Plan.	Partially		CG7	**Dementia Strategy and Delivery Plan** needs to be developed, in line with proposed priorities set out in the 2024/25 Annual Plan.
8.	**Eating Disorders and Disordered Eating Strategy** in place to ensure high quality, safe and effective delivery of Eating Disorders and Disordered Eating Services. This is supported by a Delivery Plan.	Partially		CG8	**Eating Disorders and Disordered Eating Strategy and Delivery Plan** needs to be developed, in line with proposed priorities set out in the 2024/25 Annual Plan.
9.	**LD & Neurodiversity Services Strategy** in place to ensure high quality, safe and effective delivery of LD & Neurodiversity Services. This is supported by a Delivery Plan.	Partially		CG9	**LD & Neurodiversity Services Strategy and Delivery Plan** needs to be developed, in line with proposed priorities set out in the 2024/25 Annual Plan.
10.	**Sustainable Acute Hospital Service Delivery Strategy** - The system has a clear strategy for sustainable acute hospital service delivery in the long-term.	Partially		CG10	**Sustainable Acute Hospital Service Delivery Strategy** – NHS Devon needs to ensure that the system has a clear strategy for sustainable hospital service delivery in the long-term.
11.	Fulfilling **Operational Plan Requirements, NOF4 and National Standards** as set by NHSE.	Partially		CG11	**Operational Plan Requirements, NOF4 and National Standards** – Trajectories need to be put in place as not currently addressing Operational Plan requirements and complying with national standards.
12.	**Urgent and Emergency Care (UEC) Strategy and Policy** has been fully and appropriately implemented.	Partially		CG12	**Urgent and Emergency Care (UEC) Strategy and Policy** needs to be fully and appropriately implemented.
13.	**GIRFT** is an enabler to delivery of the Elective Care and UEC strategies.	Partially		CG13	**GIRFT** – Implementation of the GIRFT programme / recommendations to reduce unwarranted variations in services and practices to bring about higher-quality care in hospitals, at lower cost.
14.	**Specialised Commissioning** – There is a clearly defined and agreed approach in place for the formal delegation of specialised commissioning functions from NHSE to NHS Devon.	Partially		CG14	**Specialised Commissioning** – Clarification is needed about the approach to formal delegation of specialised commissioning functions from NHSE to NHS Devon.
15.	**Levelling Up Services Across Devon** – There are consistent service level provided across the One Devon ICS.	Partially		CG15	**Levelling Up Services Across Devon -** Certain services require amendment to ensure that a consistent service level is provided across the One Devon ICS.
16.	Fulfilling statutory obligations under **Working Together Safeguarding Children (2023) and the Care Act (2014)**.	Partially		CG16	**Working Together Safeguarding Children (2023) and the Care Act (2014)** – need to ensure full implementation of the Joint Targeted Area Inspection Plan (JTAI).

Annex A

17.	Fully functional **CHC Function** in place to deliver NHS Devon's statutory responsibilities in relation to this service, to deliver value and improve efficiency.	Partially		CG17	**CHC Function** – Organisational change, Phase 2.2 (CHC) requires completion, including the need to recruit to key business critical posts. Digital business case requires discussion at DIG.
18.	There is a clear strategy and plan in place for the system to enable successful delivery and exit from the national **Maternity Safety Improvement Programme**.	Partially		CG18	**Maternity Safety Improvement Programme** – action plan needs to be fully implemented in order to enable successful delivery and exit from the programme.
19.	Fulfilling **Special Educational Needs and Disabilities (SEND) and Wider National Requirements**.	Partially		CG19	**(SEND) and Wider National Requirements** - Trajectories need to be put in place as not currently addressing SEND requirements and complying with national standards.
20.	Effective commissioning of **Child and Adolescent Mental Health Services (CAMHS)** is in place across the One Devon system.	Partially		CG20	**CAMHS** – There is potentially a lack of effective commissioned intermediate care across the One Devon system to meet the need of children and young people (under 18).

Current Assurances **(how do we know that the controls in place are working effectively?)**			**Current Assurance Gaps**	
1.	**System Quality Group (SQG)** in place focused on enabling quality improvement across the One Devon Integrated Care System.			
2.	**Quality & Patient Experience Committee (QPEC)** in place providing oversight and assurance to the NHS Devon Integrated Care Board that it is delivering its functions in a way that secures continuous improvement in the quality of services.		AG2	**QPEC** forward plan needs to be informed by 2024/25 Annual Plan priorities once approved.
3.	**Quality Report** is received by the NHS Devon Executive, QPEC and the NHS Devon Board at agreed intervals throughout the year.			
4.	**Provider Quality Committees** are in place and attended by representatives of NHS Devon, ensuring that providers have appropriate assurance and oversight mechanisms with regard to quality.			
5.	**National and NOF4 Reporting Requirements** ensure that all partners within the One Devon Integrated Care System provide assurance about quality metrics to appropriate national bodies.			
6.	**System planning and delivery assurance structures** are clear and in place to ensure oversight of key risks and issues.			

Mitigating Actions **(what do we plan to do to address the control gaps / assurance gaps identified above?)**	**Action Owner**	**Planned Completion Date**	**Assurance Level**	**Update Since Last Review** **(only applicable where assurance level is 'partially assured / 'limited assurance')**
CG1: Quality Strategy needs to be developed.	CNO	Start of Q1 2025/26	Not Yet Due	N/A
CG2: Quality Management System Improvement Process Implementation *(Annual Plan Ref. CNO 001)*	John Trevains	End Q4 2024/25	Fully Assured	N/A

Annex A

CG3: 2024/25 Annual Plan to be approved by the Board *(Annual Plan Ref. DECO 001)*	Sam Wadham-Sharpe	Start Q2 2024/25 / Ongoing	Fully Assured	N/A
CG6: Perinatal Mental Health *(Annual Plan Ref. CMO 002)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG6: Transformed Models of Community Mental Services *(Annual Plan Ref. CMO 003)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG6: Adults and Older Adults with Severe Mental Illness and Support with Health and Social Care Needs *(Annual Plan Ref. CMO 004)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG6: Mental Health Crisis and access to necessary help without the need to visit A&E *(Annual Plan Ref. CMO 005)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG6: High Quality, Safe, Effective and Well Led Commissioned Mental Health Services *(Annual Plan Ref. CMO 013)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG7: More timely **Dementia Diagnosis** *(Annual Plan Ref. CMO 008)*	CMO	End Q4 2024/25	Partially Assured	Partial assurance but improving and well versed. As of December 2024 the estimated diagnosis rate is 58.8%, the national average is 65.6%. This is an improvement from December 2023 position which was 57.7%. January 2025 position not yet available.
CG7: Development of a **Devon Health and Social Care Dementia Strategy** *(Annual Plan Ref. CMO 009)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG8: Develop alternative **Community Physical Health Monitoring Services** for eating disorder patients *(Annual Plan Ref. CMO 011)* *NB: Previously aligned to BAF Risk 2 (Preventing Ill-health and Reducing Inequalities)*	CMO	End Q2 2024/25	Fully Assured	N/A
CG9: Reliance on Mental Health Inpatient Care (LDA) *(Annual Plan Ref. CMO 017)* *NB: Moved from BAF Risk 2 (Preventing Ill-health and Reducing Inequalities)*	CMO	Ongoing (Previously End Q3 2024/25)	Partially Assured	Over target, counting currency changed, now including ASC on Acute MH wards. We have reduced numbers this reporting period.
CG9: Test and implement improvements in **Autism Diagnostic Assessment Pathways** *(Annual Plan Ref. CMO 018)* *NB: Moved from BAF Risk 2 (Preventing Ill-health and Reducing Inequalities)*	CMO	Ongoing (Previously End Q3 2024/25)	Fully Assured	N/A
CG9: Develop **Governance and Due Diligence with Contracting for the ADHD Patient Choice Pathway** *(Annual Plan Ref. CMO 023)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG9: ADHD Pathway and Models of Care *(Annual Plan Ref. CMO 024)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG9: Oliver McGowen Mandatory Training (OMMT) *(Annual Plan Ref. CMO 025)*	CMO	End Q4 2024/25	Fully Assured	N/A

Annex A

CG10: Stabilisation of Fragile Acute Services *(Annual Plan Ref. CMO 042)*	CMO	Start Q1 2025/26 (Previously End Q3 2024/25)	Fully Assured	N/A
CG11: Hospital Admissions (Adults and Older Adults) Mental Health *(Annual Plan Ref. CMO 001)*	CMO	End Q4 2024/25	Fully Assured	
CG11: Clinical Pharmacy Services Expansion *(Annual Plan Ref. COO 001)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG11: Improve **Access to Primary Care Facilities** to enhance patient experience *(Annual Plan Ref. DCEO 009)*	DCEO	Ongoing	Fully Assured	N/A
CG11: Plan for Recovery and Reform of NHS Dentistry *(Annual Plan Ref. COO 002)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG11: Integrated Approach to Care and Support *(Annual Plan Ref. COO 003)*	Deputy COO	-	Partially Assured	This objective will remain partially assured for the remainder of the 2024/25 financial year.
CG11: Implement **Personalised Care** across integrated teams *(Annual Plan Ref. COO 004)*	Deputy COO	-	Partially Assured	This objective will remain partially assured for the remainder of the 2024/25. Work is happening across Devon, for example, EoL and Frailty in place as part of the wider plan and Dementia sits within the mental health workstream with a primary care element.
CG11: Expand and invocate the **Independent Prescribing Programme (IP)** *(Annual Plan Ref. COO 005)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG11: Improve the sustainability of **General Practice Sustainability** *(Annual Plan Ref. COO 006)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG11: A&E Response Times *(Annual Plan Ref. COO 009)*	Deputy COO	End Q4 2024/25	Partially Assured	Off track and partially assured . Unlikely to be met and will remain partially assured for the remainder of the 2024/25 financial year. A&E performance remains volatile and despite seeing marginal improvements overall, this has proven difficult to sustain.
CG11: Category 2 Ambulance Response Times *(Annual Plan Ref. COO 010)*	Deputy COO	End Q4 2024/25	Partially Assured	Off track and partially assured . Unlikely to be met and will remain partial for the remainder of the 2024/25 financial year.
CG11: Eliminate **Elective Care Waits** >65 weeks *(Annual Plan Ref. COO 021)*	Deputy COO	End Q4 2024/25	Partially Assured	Mitigations in place. Partially assured as we are slightly behind the initial plan but on a downward trend. All actions at an ICB level are in place; remaining recovery actions sit with providers.
CG11: Delivery or exceed **System Specific Activity Targets** *(Annual Plan Ref. COO 022)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG11: Outpatient Attendances *(Annual Plan Ref. COO 023)*	Deputy COO	End Q4 2024/25	Partially Assured	Off track but the position is recoverable. System – 40.2% as at January 2025.
CG11: Improve Patient Experience of Choice at Point of Referral *(Annual Plan Ref. COO 024)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A

Annex A

CG11: Improve performance against **62 Day Cancer Treatment Standard** *(Annual Plan Ref. COO 025)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG11: Increase **Cancer Diagnosis %** *(Annual Plan Ref. COO 026)*	Deputy COO	No Fixed Milestones Set	Fully Assured	N/A
CG11: Increase **Diagnostic Tests %** *(Annual Plan Ref. COO 027)*	Deputy COO	End Q4 2024/25	Partially Assured	November 2024 position is: System (73.8%), RDUH (69.4%), TSD (66.8%) and UHP (86.5%). Refreshed data has been delayed due to SUS availability.
CG11: Improve **Patient and List Management** *(Annual Plan Ref. COO 028)*	Deputy COO	Ongoing (Monitor and Mitigate Against Any Deviation from Plan)	Partially Assured	Off track but improving. Significant improvements in validation volumes at TSDFT and RDUH. NHS Devon now at 75% of 12ww validated (against a target of 90%).
CG11: Appropriateness of **Referrals to Secondary Care** *(Annual Plan Ref. COO 031)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG11: Increase **Diagnostic Capacity** *(Annual Plan Ref. COO 033)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG11: Complete **Contract Reviews** *(Annual Plan Ref. COO 034)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG11: Reduce **Children and Young People Long Waits** *(Annual Plan Ref. CNO 007)*	CNO	End Q4 2024/25	Fully Assured	N/A
CG12: Standardise UTC Provision Across Devon *(Annual Plan Ref. COO 011)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG12: Establishment and Delivery of a **Care Coordination Hub** *(Annual Plan Ref. COO 012)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG12: Standardise **Same Day Emergency Care (SDEC)** across One Devon *(Annual Plan Ref. COO 013)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG12: Consistent delivery of **Virtual Wards** across Devon *(Annual Plan Ref. COO 014)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG12: Implementation of **Acute Frailty Services** across the 4 acute trusts *(Annual Plan Ref. COO 015)*	Deputy COO	End Q4 2024/25	Partially Assured	Rapid assessment of progress against service specifications have identified gaps. Working with COO and team to agree what can and cannot be achieved.
CG12: Standardise **Urgent Community Response (UCR)** operations *(Annual Plan Ref. COO 016)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG12: Establish consistent proactive clinical care in Care Homes *(Annual Plan Ref. COO 017)*	Deputy COO	End Q4 2024/25	Partially Assured	Rapid assessment of progress against service specifications have identified gaps. Working with COO and team to agree what can and cannot be achieved.
CG12: Reduce **Acute Bed Occupancy and Length of Stay** *(Annual Plan Ref. COO 018)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG12: Children and Young People Inclusion in UEC Recovery Plans *(Annual Plan Ref. COO 019)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A

Annex A

CG12: Expand and develop **High Intensity User (HIU) Services** *(Annual Plan Ref. CMO 032)*	CMO	End Q4 2024/25	Limited Assurance	This will need to form part of the ongoing conversations about service provision for 2025/26.
CG13: Theatre Utilisation using GIRFT *(Annual Plan Ref. COO 030)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG14: Specialised Commissioning *(Annual Plan Ref. COO 035)*	Deputy COO	Not Stated	Fully Assured	N/A
CG15: Review of Neurology Headache Clinics *(Annual Plan Ref. COO 032)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG16: Safeguarding Improvement – Working Together Safeguard Children (2023) and The Care Act (2014) *(Annual Plan Ref. CNO 002)*	CNO	End Q4 2024/25	Partially Assured	"360" degree survey to be shared with ICB safeguarding partners . Feedback analysed and report for QPEC. Learning from feedback to inform 2025/26 plan. All other elements are on track.
CG17: Review and enhance the **Continuing Health Care (CHC) Function** *(Annual Plan Ref. CNO 003)*	CNO	End Q4 2024/25	Fully Assured	N/A
CG18: System collaboration and implementation of **Maternity, Neonatal and Women's Health (3 Year Delivery Plan)** *(Annual Plan Ref. CNO 004)*	CNO	End Q4 2024/25	Fully Assured	N/A
CG18: System collaboration and implementation of **10 Year National Women's Health Strategy** *(Annual Plan Ref. CNO 005)*	CNO	End Q4 2024/25	Fully Assured	N/A
CG19: Implementation of **Neurodiversity Offer for Children and Families** *(Annual Plan Ref. CNO 008)*	CNO	End Q4 2024/25	Fully Assured	N/A
CG19: Improve outcomes for **Children and Young People with Long Term Conditions** *(Annual Plan Ref. CNO 009)*	CNO	End Q4 2024/25	Fully Assured	N/A
CG19: Prioritise the **Special Education Needs and Disabilities (SEND)** of children and young families across the Devon ICS *(Annual Plan Ref. CNO 010)*	CNO	End Q4 2024/25	Partially Assured	Objective will need to continue be delivered in 2025/26. Local offer videos are currently on hold due to capacity within the ICB but due to be completed by end March 2025. Details of sub actions and reasons are largely due to re prioritisation and capacity.
CG19: Support **Children and Young People Community Services Recovery** *(Annual Plan Ref. CNO 011)*	CNO	-	Partially Assured	This objective has been noted as delayed due to issues with funding of the advice line. This will not be completed within 2024/25 and so will continue into 2025/26.
CG20: Children and Young People's Timely, Co-ordinated Access to NHS Funded Mental Health Support, and Treatment *(Annual Plan Ref. CMO 010)*	CMO	End Q4 2024/25	Fully Assured	N/A
AG2: QPEC forward plan to be informed by 2024/25 Annual Plan.	CCCAO	End Q2 2024/25	Partially Assured	-

Annex A

NHS Oversight Framework Theme	Chief Officer	Assigned Board Committee	Review Date
2. Preventing Ill-Health and Reducing Inequalities	Chief Medical Officer	Population Health Improvement Committee	April 2025

Principal Risk

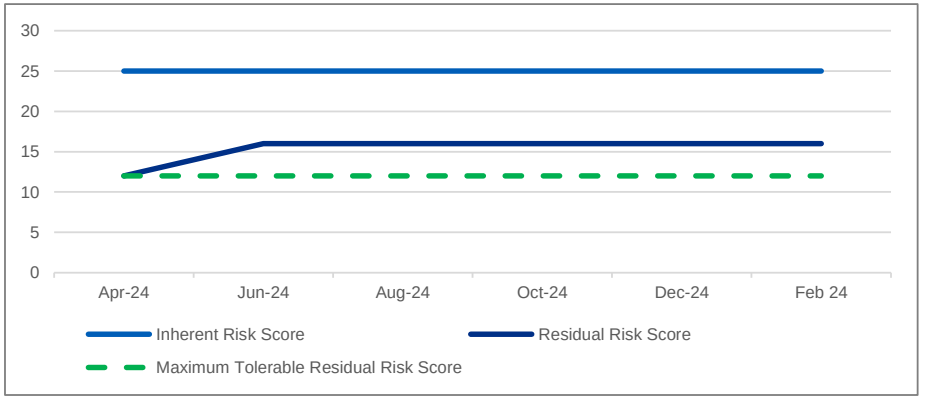
IF NHS Devon is unable to embed a focus on population health management across all of its 'All Age' services and activities and those of its partners, **THEN** we will fail to deliver on our key statutory purposes (improve outcomes in population health and healthcare, tackle inequalities in outcomes, experience and access, and help the NHS support broader social and economic development) **RESULTING IN** patients across the One Devon Integrated Care System potentially continuing to suffer health inequalities.

Risk Appetite	AVOID	Risk Tolerance	8 - 12

Risk Scoring	Likelihood	Impact	Total	Movement
Inherent Risk Score	5	5	25	-
Current Residual Risk Score	4	4	16	↔

Rationale for Amendment to Residual Risk Score:

N/A



Current Key Controls (what do we have, or what should we have in place to mitigate the risk?)		In Place?
1.	**Population Health Objectives** are set out within the Joint Forward Plan (JFP).	Fully
2.	**Funding for Population Health** agreed at a level that enables a full programme of work to be established.	Not in Place
3.	**Population Health Programme of Work** agreed and in place in line with available funding.	Not in Place
4.	**Quality and Equality Impact Assessments (QEIAs)** in place to help inform commissioning decision-making processes, business cases, projects and other business plans.	Partially

Current Key Control Gaps	
CG1	**Funding for Population Health** agreed but at a significantly reduced level (£3.7m from national Health Inequalities budget has been put in bottom line).
CG2	**Population Health Programme of Work** – 2024/25 Annual Plan priorities have been agreed in principle, but the reduction in funding means that they are not fully resourced.
CG3	**Quality and Equality Impact Assessments (QEIAs)** may not be fully effective and / or being monitored.

Annex A

	(Links to NHS Oversight Theme 1: Quality of Care, Access and Outcomes)				
5.	**Clear One Devon PHM Dataset** to which all Primary Care and Voluntary Community and Social Enterprise Sector (VCSE) are signed up to.	Partially		CG4	**Clear One Devon PHM Dataset** - Access to data for PHM limited. Not all of Primary Care and the Voluntary Community and Social Enterprise Sector (VCSE) are signed up to this.
6.	**Health Inequalities Actions** are incorporated into all key service strategies.	Partially		CG6	**Health Inequalities Actions** are not incorporated into all key service strategies.
7.	**Evidence Based Interventions.**	Partially		CG7	**Evidence Based Interventions** – Need to ensure that our intervention are evidence based.
8.	**Infection Control** action plan fully implemented to improve infection prevention and control.	Partially		CG8	**Infection Control** action plan needs to be fully implemented to improve infection prevention and control.
9.	Agreed plan in place and being successfully delivered in order to tackle health inequalities experienced by care experience **Children & Young People**.	Partially		CG9	**Children & Young People Plan** to be implemented and successfully delivered in order to tackle health inequalities of experienced by care CYP.

Current Assurances **(how do we know that the controls in place are working effectively?)**			**Current Assurance Gaps**	
1.	**System Governance and Assurance Structures** are focused on Population Health.		AG1	**System Governance and Assurance Structures** are not fully informed by Population Health perspectives.
2.	**One Devon Population Health Steering Group** in place which is comprised of system partners. This group provides assurance that work is on-going within the system in relation to Population Health.			
3.	**Population Health Improvement (Board Assurance) Committee** in place to provide assurance to the Board that NHS Devon is fulfilling its role to improve outcomes in population health and healthcare and to tackle inequalities in outcomes, experience and access. Provides oversight and challenge.			
4.	**NHS Devon Annual Report** demonstrates how it has discharged its functions in the previous financial year. NHS England (NHSE) Core20PLUS5 relates specifically to those duties in relation to health inequalities.			

Mitigating Actions **(what do we plan to do to address the control gaps / assurance gaps identified above?)**	**Action Owner**	**Planned Completion Date**	**Assurance Level**	**Update Since Last Review** **(only applicable where assurance level is 'partially assured / 'limited assurance')**
CG1 Funding for Population Health to be explored with the Finance team.	CMO	TBC	TBC	-
CG2 Population Health Programme of Work - Capacity to deliver the agreed Population Health programme of work to be considered through Phase 2 of the organisational change programme.	CMO	TBC	TBC	-

Annex A

CG3: Develop and implement a **Population Health Charter** *(Annual Plan Ref. CMO 029)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG4 One Devon Dataset to be improved with access to Primary Care and VCSE data.	Kelvin Grabham	End Q4 2024/25	Partially Assured	Primary care data from both SystmOne and Emis practices is now being received into the One Devon Dataset (SystmOne data has been available for around 2 years, Emis from 2025). Although there are no regular VCSE data flows into ODD these are handled on a case-by-case basis depending on the data requirements of individual ODD Use Requests, which are considered monthly by the ODD Use Request Board. Where specific VCSE datasets are required there is a mechanism for linking these to the other data held in ODD. However, whilst the BI action has been completed, not all practices have signed up to sharing their data with ODD. Currently around 70% of practices share data but further engagement work is required to increase this number.
CG6: Mental Health Annual Physical Health Checks *(Annual Plan Ref. CMO 007)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG6: Learning Disability and Autism (LDA) Annual Health Checks *(Annual Plan Ref. CMO 016)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG6: Reduce over-medications through the **STOMP and STAMP** programmes *(Annual Plan Ref. CMO 020)*	CMO	Ongoing (Previously End Q3 2024/25)	Fully Assured	N/A
CG6: LeDeR Programme Implementation *(Annual Plan Ref. CMO 021)*	CMO	End Q4 2024/25 (Previously End Q3 2024/25)	Partially Assured	More scrutiny being undertaken and reviewers now in place so reviews will be undertaken. LeDeR lead commences in post in February 2025.
CG6: Support delivery and use of the **LDA Reasonable Adjustment Digital Flag** *(Annual Plan Ref. CMO 022)*	CMO	Ongoing (Previously End Q3 2024/25)	Partially Assured	Partially assured with mitigations in place. Clear plan for the programme being developed and supported by the Business Intelligence team.
CG6: Support LCPs and Provider Collaboratives with **Population Health and Evidence Based Resources** *(Annual Plan Ref. CMO 027)*	CMO	Q4 2024/25 (Previously End Q3 2024/25)	Fully Assured	N/A
CG6: Implement the **National Inclusion Health Framework** *(Annual Plan Ref. CMO 028)*	CMO	End Q4 2024/25	Partially Assured	Limited progress in 2024/25 but staff now appointed to take forward in 2025/26.
CG7: Continue to contribute to the **Peninsula Research and Innovation Programme (PRIP)** *(Annual Plan Ref. CMO 038)*	CMO	End Q4 2024/25	Fully Assured	N/A

Annex A

CG7: Implement deliverables in the **Peninsula Research and Innovation Strategy (PRIS)** *(Annual Plan Ref. CMO 039)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG7: Support the development of the **Research Engagement Network (REN)** *(Annual Plan Ref. CMO 040)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG8: Infection Management System *(Annual Plan Ref. CNO 013)*	CNO	End Q4 2024/25	Fully Assured	N/A
CG9: Address significantly poorer outcomes for care experienced **Children & Young People** *(Annual Plan Ref. CNO 012)*	CNO	End Q4 2024/25	Fully Assured	N/A
AG1 System Governance and Assurance Structures to be reviewed once established to determine the most appropriate method of ensuring that they are appropriately informed by Population Health perspectives.	CCCAO	End Q4 2024/25	Fully Assured	Systems reviewed in December 2024 and amended structures and terms of reference agreed by the SLG in January 2025.

Annex A

NHS Oversight Framework Theme	Chief Officer	Assigned Board Committee	Review Date
3. Finance and Use of Resources	Kirsty Denwood – Acting Chief Finance Officer	Finance and Performance Committee	April 2025

Principal Risk

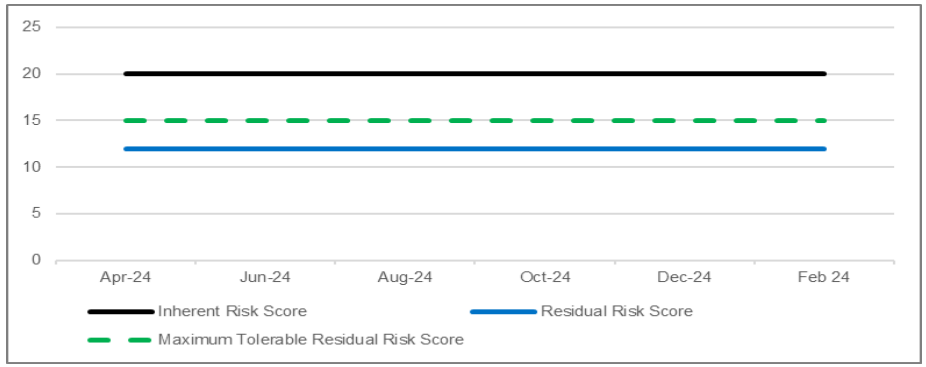
IF NHS Devon does not work effectively with system partners to deliver financial recovery plans, **THEN** we will fail to deliver on one of our key statutory purposes (enhance productivity and value for money), **RESULTING IN** patients across the One Devon Integrated Care System potentially not receiving the services that they need.

Risk Appetite	OPEN	Risk Tolerance	15

Risk Scoring	Likelihood	Impact	Total	Movement
Inherent Risk Score	5	4	20	-
Current Residual Risk Score	4	3	12	↔

Rationale for Amendment to Residual Risk Score:

N/A



Current Key Controls (what do we have, or what should we have in place to mitigate the risk?)		In Place?	Current Key Control Gaps	
1.	**Financial Plans** in place that underpin the Operating Plan for 2024/25.	Fully		
2.	**Medium-Term Financial Plan** in place setting out the scope and scale of challenge to deliver financial balance during the strategic medium-term. MTFP developed locally and understood and owned by all system partners.	Fully		
3.	**System Recovery Plan** (which is encapsulated in the 2024/25 operational and financial plans) in place. This is a dynamic plan that continually assesses progress against system-wide savings, identification of new schemes and performance against key finance and performance trajectories.	Fully		

Annex A

4.	**Devon Investment Group (DIG)** in place and responsible for ensuring the adoption and application of best practice governance and decision-making for investments by NHS Devon.	Fully			
5.	**Triple Lock Sign-Off Process** in place for all revenue investments above £100k, with sign-off required by the organisation, system and NHS England (NHSE) regional team.	Fully			
6.	**System Vacancy Control Panel (VCP)** in place to prevent an increase in workforce growth and to support a reduction in running costs.	Partially			
7.	**Cost Improvement Programmes (CIPs)** in place that contains cost reduction strategies that aim to identify and implement measures to achieve cost savings and efficiency improvements while maintaining or enhancing the quality of healthcare services provided to patients. *(Annual Plan Ref. CMO 036, DECO 008, CFO 005 & CFO 010)*	Fully			
8.	**ICB Programme Management Office (PMO)** established.	Partially		CG4	**ICB PMO** needs to be adequately resourced.
9.	**Information Systems and System Processes** facilitate decisions with respect to the most effective use of resources.	Partially		CG5	**Information Systems and System Processes** need improvement to facilitate decisions with respect to the most effective use of resources.
10.	**Infrastructure Strategy** enables most effective use of resources.	Partially		CG6	**Infrastructure Strategy** - Further work required to ensure Infrastructure Strategy enables most effective use of resources.
11.	**Systems Medicines Strategy** is an enabler to deliver financial savings.	Partially		CG7	**Systems Medicines Strategy** – Further work required to ensure Systems Medicines Strategy enables delivery of financial savings.
12.	**Infrastructure Innovations** enable delivery of financial savings.	Partially		CG8	**Infrastructure Innovations** – Further work required to ensure infrastructure innovations enable delivery of financial savings.
13.	**Service Resilience** is aligned to fragile services.	Partially		CG9	**Service Resilience** needs to be aligned to fragile services.
14.	Fulfilling **Operational Plan Requirements, NOF4 and National Standards** as set by NHSE.	Partially		CG10	**Operational Plan Requirements, NOF4 and National Standards** – Trajectories need to be put in place as not currently addressing Operational Plan requirements and complying with National Standards.
15.	**30% Running Cost Reduction –** Fulfilling the 30% reduction in running costs as set by NHSE.	Partially		CG11	**30% Running Cost Reduction** – Organisational Change Programme to be completed in order to enable the 30% reduction in running costs to be realised.

Current Assurances **(how do we know that the controls in place are working effectively?)**		**Current Assurance Gaps**	
1.	**Weekly Chief Finance Officer (CFO) meetings** take place in relation to system working arrangements. Issues for resolution are discussed and proposals agreed as appropriate.	AG1	**More closely aligned reporting to system financial plans** is needed.

Annex A

2.	**Fortnightly reporting to the Finance and Planning Board (FPB)**. Matters that cannot be resolved here are escalated to the System Recovery Board (SRB).		AG2	**Assurance needed that system level CIPs are being delivered** in provider financial plans.
3.	**NHS Devon Finance and Performance Committee (FPC)** receives system finance reports; these flag issues for escalation to the Board.			
4.	**Additional mandated support** is provided by NHS England (NHSE).			

Mitigating Actions (what do we plan to do to address the control gaps / assurance gaps identified above?)	Action Owner	Planned Completion Date	Assurance Level	Update Since Last Review (only applicable where assurance level is 'partially assured / 'limited assurance')
CG1: Progress **Shared Service Arrangements** *(Annual Plan Ref. CFO 009)*	Acting CFO	End Q4 2024/25	Fully Assured	N/A
CG1: Produce **Long Term Financial Plan** *(Annual Plan Ref. CFO 012)*	Acting CFO	End Q4 2024/25 (Previously End Q3 2024/25)	Fully Assured	N/A
CG1: Efficiencies and Consistency in Business Processes *(Annual Plan Ref. CPO 002)*	CPO	End Q4 2024/25	Partially Assured	The position is off-track but recoverable. Employee portal is to 'go live' 01 April 2025. The programme is an enabler of system transformation in 2025/26 and therefore has low impact on delivery of the ICB 2024/25 Annual Plan.
CG1: Implement **One Devon Workforce Strategy** *(Annual Plan Ref. CPO 003)*	CPO	End Q4 2024/25	Fully Assured	N/A
CG4: Resourcing of ICB PMO to be considered through Phase 2 of the organisational change programme	Libby Ryan-Davies	Start Q2 2024/25	TBC	-
CG5: Strategic Client Function for Business Intelligence (BI) *(Annual Plan Ref. DCEO 004)*	DCEO	Discharged Reactively Through 2024/25	Fully Assured	N/A
CG5: Support implementation of **Devon and Cornwall Care Record (DCCR)** *(Annual Plan Ref. CFO 003)*	Acting CFO	Ongoing (Previously End Q4 2024/25)	Partially Assured	The core NHS organisations are on target for connection by the end of March 2025. Care homes and social care will be connected by the end of March 2029.
CG5: Rationalise **Data Centres** *(Annual Plan Ref. CFO 004)*	Acting CFO	End Q4 2024/25	Fully Assured	N/A
CG6: Estates – deliver collaboration between provider service departments *(Annual Plan Ref. DCEO 006)*	DCEO	End Q4 2024/25	On Hold	-

Annex A

CG6: Implement **Estates Strategy** *(Annual Plan Ref. DCEO 007)*	DCEO	End Q4 2024/25	Fully Assured	N/A
CG7: Delivery of 16 National Medicines Optimisation Opportunities *(Annual Plan Ref. CMO 033)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG7: Develop **Integrated Medicines Optimisation Committee (IMOC)** *(Annual Plan Ref. CMO 037)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG8: Develop **Peninsula Aseptic Hub (PAH)** *(Annual Plan Ref. CMO 034)*	CMO	End Q4 2024/25	Partially Assured	All actions have been satisfactorily answered but waiting for regional approval prior to national review.
CG9: Develop **Peninsula Radiopharmacy Strategy (PRS)** *(Annual Plan Ref. CMO 035)*	CMO	End Q4 2024/25	Partially Assured	Updated PenRAD board and the appraisal process has been extended.
(Control 13) CG9: Acute Services Transformation *(Annual Plan Ref. CMO 043)*	CMO	End Q4 2024/25	Partially Assured	Clinical scenarios are currently being modelled to describe the implications for activity, travel, workforce, finance, and estates - to be completed by April 2025. Evaluation criteria to be developed for appraisal of scenarios by April 2025.
CG10: Develop **Community Pharmacy** *(Annual Plan Ref. COO 008)*	Deputy COO	End Q4 2024/25	Fully Assured	N/A
CG10: Improving management and productivity of **System Workforce Resources** *(Annual Plan Ref. CPO 001)* *NB: Moved from BAF Risk 4 (People)*	CPO	End Q4 2024/25	Partially Assured	All supporting workstreams are on track, however, there is an overspend on the Operating Plan. A review of dashboard and finance has identified areas for focus in Quarter 4 to reduce overspend.
CG11: 30% Running Cost Reduction *(Annual Plan Ref. CPO 004 & CFO 011)*	CPO	End Q4 2024/25	Fully Assured	N/A
AG1: Closer Aligned Reporting to System Financial Plans	Acting CFO	Start Q3 2024/25	TBC	
AG2: Assurance on Delivery of System Level CIPs Reporting of progress of CIP workstreams to FPB to provide assurance that system CIPs are being identified and delivered in accordance with submitted provider annual financial plans.	Libby Ryan-Davies	On-going Through 2024/25	TBC	

Annex A

NHS Oversight Framework Theme	Chief Officer	Assigned Board Committee	Review Date
4. People	Piers Tetley – Chief People Officer	People and Organisational Development Committee Finance and Performance Committee	April 2025

Principal Risk

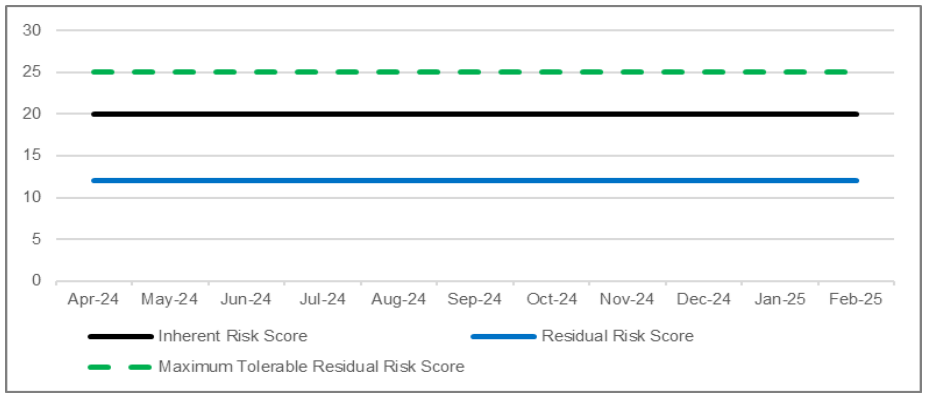
IF NHS Devon does not work with system partners to ensure an appropriate NHS workforce, **THEN** we will not be appropriately resourced to deliver safe and effective services, **RESULTING IN** patients across the One Devon Integrated Care System not receiving the services that they need.

Risk Appetite	SEEK	Risk Tolerance	20 - 25

Risk Scoring	Likelihood	Impact	Total	Movement
Inherent Risk Score	5	4	20	-
Current Residual Risk Score	3	4	12	↔

Rationale for Amendment to Residual Risk Score:

N/A



Current Key Controls (what do we have, or what should we have in place to mitigate the risk?)		In Place?	Current Key Control Gaps	
1.	**Workforce Recovery Programme** - Robust and deliverable workforce recovery programme approved and in place. Workforce controls (including those covering temporary and agency staff, rostering for clinical staff) are part of this.	Partially		
2.	**System Workforce Strategy** designed, approved and in place.	Fully		
3.	**5 Year Workforce Numerical Plan** outlining the size and skill mix of the NHS provider workforce required to meet population demand.	Partially	CG2	**5 Year Workforce Numerical Plan** not yet agreed by System Partners.
4.	**Workforce Programmes** in place to support wider service transformation. These focus on specific services / areas of greatest concern e.g. Urgent & Emergency	Fully		

Annex A

	Care (UEC) improvement and Peninsula Acute Sustainability Programme (PASP) etc.				
5.	**NHS Devon's Ability to Lead System Partners** – NHS Devon has the required workforce and skill sets in place to lead the work of system partners in ensuring an appropriate NHS workforce to deliver safe and effective services across Devon.	Partially		CG3	**NHS Devon's ability to lead system partners** – Phase 2 of the NHS Devon organisational change process yet to be completed.
6.	**NHS Roles and Careers** are shaped to reflect the future needs and priorities in the NHS Long Term Plan (LTP).	Partially		CG4	**NHS Roles and Careers** need to be shaped to reflect LTP requirements e.g. providing placements and apprenticeship opportunities in order to expand the clinical workforce, providing education and training opportunities, improving staff retention and attendance etc.

Current Assurances **(how do we know that the controls in place are working effectively?)**			**Current Assurance Gaps**	
1.	**Governance Architecture** – Appropriate governance architecture in place to manage delivery of this workstream.			
2.	**System Workforce Dashboard** in place and monitored on a monthly basis. The dashboard includes data relating to staff turnover, staff sickness absence rates etc.			
3.	**Workforce Delivery Group (WDG)** in place, with membership comprising of Chief People Officers (CPOs) and Chief Finance Officers (CFO) from across the Devon system. Considers matters such as plans for efficient use of workforce (e.g. job planning, staff rostering etc.) and work programmes in support of system transformation (e.g. UEC improvements and PASP), reporting to SRB on the latter.			
4.	**National People Plan** – A People Plan specifically for the Devon system has been established.			

Mitigating Actions **(what do we plan to do to address the control gaps / assurance gaps identified above?)**	**Action Owner**	**Planned Completion Date**	**Assurance Level**	**Update Since Last Review** **(only applicable where assurance level is 'partially assured / 'limited assurance')**
CG2: 5 Year Workforce Numerical Plan – Skill mix reviews to be completed to inform development of the programme	Mark Sowden	End Q4 2024/25 (Previously End Q3 2024/25)	Partially Assured	Workforce case for change completed and being presented to CPO this month prior to wider stakeholder sharing. 5 year workforce plan delivery carried over to 2025/26 annual plan deliverables. Workforce plan to be informed by TDP and wider workforce transformation program.
CG3: NHS Devon's ability to lead system partners – Phase 2 of the NHS Devon organisational change process to be completed	Steve Moore	End Q4 2024/25	Fully Assured	N/A

Annex A

CG4: Staff Retention and Attendance *(Annual Plan Ref. CPO 006)*	CPO	End Q4 2024/25	Fully Assured	N/A
CG4: Sufficient **Clinical Placements and Apprenticeship Pathways** *(Annual Plan Ref. CPO 007)*	CPO	End Q4 2024/25	Fully Assured	N/A
CG4: Increase **Advanced Practice Posts** *(Annual Plan Ref. CPO 008)*	CPO	End Q4 2024/25	Fully Assured	N/A
CG4: Increase **Placement Capacity** *(Annual Plan Ref. CPO 009)*	CPO	End Q4 2024/25	Partially Assurance	Partially assured and off track with mitigating actions in place. Unable to provide benchmark means full assurance cannot be given. Requires further detailed analysis to formulate a delivery plan across the system.

Annex A

NHS Oversight Framework Theme	Chief Officer	Assigned Board Committee	Review Date
5. Leadership and Capability	Philippa Harding, Interim Chief Communications & Corporate Affairs Officer	NHS Devon Executive	April 2025

Principal Risk

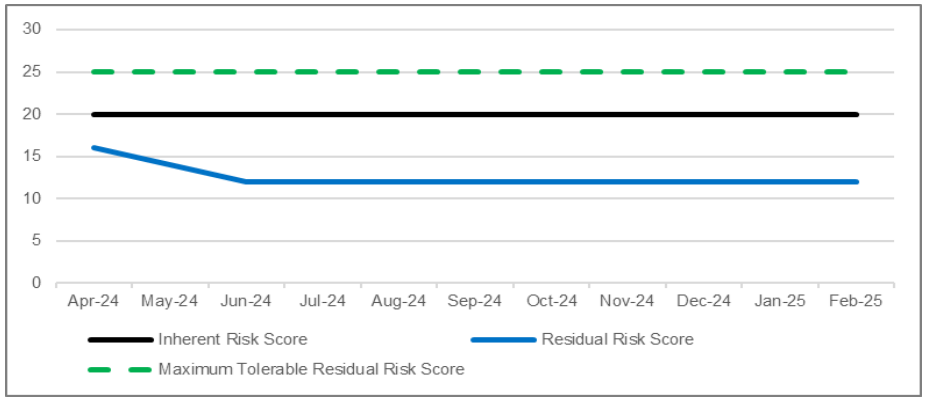
IF NHS Devon does not sufficiently develop its own leadership capability and that within system partners (particularly clinical leadership), **THEN** we will fail to deliver transformational change in relation to service delivery, **RESULTING IN** patients across the One Devon Integrated Care System not receiving the services that they need.

Risk Appetite	SEEK	Risk Tolerance	20 - 25

Risk Scoring	Likelihood	Impact	Total	Movement
Inherent Risk Score	4	5	20	-
Current Residual Risk Score	3	4	12	↔

Rationale for Amendment to Residual Risk Score:

N/A



Current Key Controls (what do we have, or what should we have in place to mitigate the risk?)		In Place?
1.	**Clear Leadership Structure within NHS Devon** with a coherent vision for the organisation.	Partially
2.	**NHS Devon Leadership to System Partners** – There is a clear vision for how NHS Devon will provide leadership to its system partners.	Partially
3.	**NHS Devon's Ability to Lead System Partners** – NHS Devon has the required workforce and skill sets	Partially

Current Key Control Gaps	
CG1	**NHS Devon Organisational Change Programme** – Phase 1 of the Organisational Change Programme has now been completed. However, there are a number of interim arrangements in place for Chief Officer roles and a number of vacancies amongst key Senior Leadership Team (SLT) roles. Phase 2 of the Organisational Change Programme is due to complete by the end of the 2024 calendar year.
CG2	**Compact and Articulation of Shared Vision for the System** – a Compact needs to be developed and agreed to provide formal articulation of the shared vision of system partners and an explicit set of reciprocal behaviours to deliver this.
CG3	**NHS Devon's ability to lead System partners** – Phase 2 of the NHS Devon organisational change process yet to be completed.

Annex A

	in place to lead the work of system partners in ensuring an appropriate NHS workforce to deliver safe and effective services across Devon.				
4.	**Annual Plan for 2024/25** developed and approved by the NHS Devon Board. This is an enabling function that will ensure the delivery of NHS Devon priorities. *(Annual Plan Ref. DECO 001)*	Fully			
5.	**ICB Governance Improvement Plan** in place and approved, ensuring governance structures are robust, up-to-date, and responsive to evolving organisational needs. *(Annual Plan Ref. CCO 001)*	Fully			
6.	**System Planning, Delivery and Assurance Structures** for the 2024/25 governance approach within the ICB now implemented. *(Annual Plan Ref. CCO 002)*	Fully			
7.	**NHS Devon Programme of Organisational Development Activities** – There is a clear programme of organisational development activities in place for NHS Devon.	Fully			
8.	**System Programme of Organisational Development Activities** – There is a clear programme of organisational development activities for the system.	Partially		CG5	**System Organisation Development Action Plan** – This needs to be developed for the system and signed off via the appropriate governance routes.
9.	**Patient and Public Engagement insights** inform the work of NHS Devon and its Board.	Partially		CG6	**Patient and Public Engagement insights** work programme to be confirmed
10.	**Equality, Diversity and Inclusion** considerations are embedded throughout the work of NHS Devon.	Partially		CG7	**Equality, Diversity and Inclusion** priorities to be identified, agreed and embedded.
11	**Clinical and Professional Leadership Framework** in place and operating effectively.	Partially		CG8	**One Devon Clinical and Care Professional Leadership Framework** to be developed
12	**Annual Planning approach for 2025/26 and beyond** to be agreed and implemented.	Partially		CG9	**Rolling Annual Planning** cycle to be developed and supported by System Delivery Governance PMO approach.

Current Assurances **(how do we know that the controls in place are working effectively?)**		**Current Assurance Gaps**	
1.	**NHS Devon Organisation Change Oversight Group** provides assurance on the organisational change process from a technical and procedural perspective and also touches on the wider determinants.		
2.	**NHS Devon Governance Structure** – Clear governance structure in place to provide robust assurance on the measures being taken to improve and develop leadership capability in NHS Devon.		

Annex A

3.	**System Planning and Delivery Assurance Structures** are clear and in place to ensure oversight of key risks and issues.			
4.	**NHS Oversight Framework (NOF)** – Ongoing work with NHSE regional colleagues to ensure that NHS Devon has the appropriate senior capacity and capability to deliver the priorities set out in NHS planning guidance, the overall aims of the NHS Long Term Plan (LTP), and the NHS People Plan, as well as the shared local ambitions and priorities of the One Devon Integrated Care System.			

Mitigating Actions (what do we plan to do to address the control gaps / assurance gaps identified above?)	**Action Owner**	**Planned Completion Date**	**Assurance Level**	**Update Since Last Review** (only applicable where assurance level is 'partially assured / 'limited assurance')
CG1: Organisation Change Programme and developing the workforce *(Annual Plan Ref. CPO 005)*	CPO	End Q4 2024/25	Fully Assured	N/A
CG2: Create a **Compact and Articulation of Shared Vision for the System** *(Annual Plan Ref. CCO 003)*	CCCAO	End Q4 2024/25 (Previously End Q2)	Fully Assured	N/A
CG5: Development of **System Organisation Development Action Plan** *(Annual Plan Ref. CCO 004)*	Katy Kerley	End Q4 2024/25 (Previously End Q3)	Fully Assured	N/A
CG6: Establishment of **One Devon Involvement Platform** *(Annual Plan Ref. CCO 005)*	Nicola Bonas	End Q4 2024/25 (Previously End Q3)	Fully Assured	N/A
CG6: Integrate Healthwatch into NHS Devon ICB Governance *(Annual Plan Ref. CCO 006)*	Nicola Bonas	End Q4 2024/25 (Previously End Q3)	Fully Assured	N/A
CG7: Agree on **Shared Equality, Diversity and Inclusion (EDI) Priorities** *(Annual Plan Ref. CCO 007 & CCO 008)*	CCCAO	End Q4 2024/25 (Previously End Q3)	Partially Assured	CCO 007 Off track. Resource acquired to support meeting arrangements. CCO 008 – Fully assured.
CG8: Development of **One Devon Clinical and Care Professional Leadership Framework** *(Annual Plan Ref. CMO 041)*	CMO	End Q4 2024/25	Fully Assured	N/A
CG9: Development of **Rolling Annual Planning Cycle** *(Annual Plan Ref. DCEO 002)*	DCEO	Q4 2024/25 ('Process Live')	Fully Assured	N/A

Annex A

CG9: Development of **System Delivery Governance PMO Approach** *(Annual Plan Ref. DCEO 003)*	DCEO	End Q4 2024/25	Fully Assured	N/A

Annex B

Assessing and Scoring Risks:

Current risks are scored using a combined assessment of both the likelihood and impact of the risk materialising, as summarised in the matrix below. Further information on the definition of the likelihood and impact categories can be found in NHS Devon's Risk Management Policy.

The inherent risk score is the rating assigned to a risk before any mitigations / controls are applied; the current risk score is the rating assigned to a risk that takes account of the mitigations / controls applied to it.

Risk Scoring Approach = Impact / Consequence x Likelihood (I x L)						
		Likelihood				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Almost Certain
Impact / Consequence	5 Catastrophic	**5**	**10**	**15**	**20**	**25**
	4 Major	**4**	**8**	**12**	**16**	**20**
	3 Moderate	**3**	**6**	**9**	**12**	**15**
	2 Minor	**2**	**4**	**6**	**8**	**10**
	1 Negligible	**1**	**2**	**3**	**4**	**5**

For grading risk, the scores obtained from the risk matrix are assigned as follows:

Colour	Risk Score Range	Risk Grading
	1 to 6	Low Risk
	8 to 10	Moderate Risk
	12	High Risk
	15 to 25	Extreme Risk

BAF Controls and Mitigating Action Status - Colour Keys:

Annex B

Control - In Place?
Not in Place *(No Control)*
Partially *(Control in Place BUT Concerns Over Effectiveness of Control)*
Fully *(Control In Place)*

Assurance Levels	
Limited Assurance	• **A significant delay in schedule** • **Metrics are falling below acceptable thresholds**
Partially Assured	• **Some delay in schedule** • **Metrics that are borderline or trending negatively**
Fully Assured	▪ **Project is on schedule** ▪ **Metrics that meet or exceed expectations**

Risk Appetite:

Risk appetite is defined as “the amount and type of risk that an organisation is prepared to pursue, retain or take in pursuit of its strategic aims and objectives” and is key to achieving effective risk management.

Good Governance Institutes Framework Definitions:

Risk Appetite	Risk Appetite Level Description
Avoid	The avoidance and uncertainty is a key organisational objective
Minimal	(ALARP - As Little As Reasonably Possible) - The preference for ultra-safe delivery options that have a low degree of inherent risk and only for a limited reward potential
Cautious	The preference for safe delivery options that have a low degree of inherent risk and may only have a limited potential for reward
Open	Willing to consider all potential delivery options and chose while also providing an acceptable level of reward and Value for Money (VfM)
Seek	Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk
Mature	Confident in setting higher levels of risk appetite because controls, forward scanning and responsiveness systems are robust

Annex B

NHS Devon's Risk Appetite Statement (Board Approved: 26 March 2024):

NHS Devon's Risk Appetite Statement documents the delegation of risk taking from the Board to senior management. It specifies the overall risk levels that the Board is willing to accept whilst operating in full compliance with regulatory and legal requirements:

NHS Oversight Framework Theme	Risk Appetite	Tolerance Level for Residual Risk
Quality of Care, Access and Outcomes	AVOID	8 to 12
Preventing Ill-health and Reducing Inequalities	AVOID	8 to 12
Finance and Use of Resources	OPEN	15
People	SEEK	20 to 25
Leadership and Capability	SEEK	20 to 25
Local Strategic Priorities	OPEN	15

NHS Devon Integrated Care Board

NHS Devon 2024/25 Annual Plan – Delivery Assurance Close Down Report

Date of Meeting	Date Report Produced
29 May 2025	15 April 2025

Author(s)		Report Approved By	
Name and title:	Mark Elster Senior Programme Specialist Performance and Planning	**Name and title:**	Libby Ryan-Davies Chief Strategic Commissioning and Planning Officer
Phone:		**Date:**	30 April 2025
Email:	Mark.elster@nhs.net		

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

Executive Summary

The Annual Plan is a comprehensive set of corporate objectives designed to address NHS Devon's response to all relevant local and national requirements (internal and external). It directly addresses local needs outlined in the One Devon Integrated Care Strategy, as well as national policy objectives in the NHS Long Term Plan, NHS England's operational planning guidance, and the NHS Oversight Framework.

By supporting the delivery of our Annual Plan at a Directorate level, our assurance processes at Executive and Board level, and by the strengthening our central Programme Management Office (PMO) function throughout NHS Devon during 2024/25 we have been able to demonstrate NHS Devon's ability to meet relevant

priorities and requirements, including our performance, oversight, and commissioning responsibilities in relation to NHS providers in Devon.

This report provides a year-end update to the Board on the implementation of the 2024/25 Annual Plan, the development of NHS Devon's Performance and Planning Team and the implementation of the new Annual Plan assurance and review process.

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

Reviewed by the NHS Devon Executive at its meeting on 06 May 2025.
Reviewed by the Population Health Improvement Committee at its meeting on 08 May 2025.
Reviewed by the Finance and Performance Committee at its meeting on 08 May 2025.

Key recommendations and actions requested

AGREE the final positions of assurance for each directorate at 2024/25 year end.

Impact on NHS Devon Objectives

Objective	Impact
Improve Population Health	All
Improve Services and Reduce Unwarranted Variation	
Make More Efficient Use of Our Resources	
Develop Our Culture and How We Operate	

Outline the implications of matters covered in this report for the following areas

Area	
Quality of Services	All
Health Inequalities	
Workforce	
Resources and Finance	
Legal	
Digital and Data	
Engagement and Consultation	

NHS Devon 2024/25 Annual Plan – Delivery Assurance Close Down Report

Introduction

1. The Annual Plan is a comprehensive set of corporate objectives designed to address NHS Devon's response to all relevant local and national requirements, both internal and external. The Annual Plan aimed to detail the actions to be undertaken within the 2024/25 financial year and to that end, what NHS Devon needed to have in place to achieve these actions by 31 March 2025 and the process by which it intended to do this.

2. The Annual Plan for Devon was built on objectives that had been identified for 2024/25 in response to requirements in the NHS Long Term Plan (LTP), the NHS Oversight Framework (NOF), NHS England's 2024/25 operational planning guidance and One Devon's Integrated Care Strategy.

3. The NOF outlines NHS England's approach to NHS oversight of NHS provider organisations, (trusts, foundation trusts) Integrated Care Boards (ICBs) and is aligned with the ambitions set out in the NHS LTP and the 2022/23 NHS operational planning and contracting guidance.

4. Organisations in Segment 4 of the NOF (NOF4) need the highest level of mandated support. From a Devon perspective, all our system NHS acute providers and NHS Devon are in NOF4. Exiting NOF4 requires demonstratable improvements in leadership, strategy, urgent and emergency care (UEC) and elective care performance as well as financial grip and control to be made over a continued period during the current financial year. The Annual Plan therefore included the corporate objectives that NHS Devon planed to deliver to support system recovery in 2024/25 and beyond

NHS Devon Board Oversight

5. During 2023/24, it was identified that there was limited evidence demonstrating the delivery of NHS Devon's Annual Plan and its impact on the Board Assurance Framework (BAF), as well as performance against the expectations set out in the NOF. The following areas were identified as priorities for improvement in 2024/25:

    - Performance against key performance indicators was not able to be consistently measured, nor assurance to NHSE that appropriate progression was being undertaken. This led to further NHSE and regional scrutiny, oversight of the Board Assurance Framework, performance improvements against the NOF, identification of risks on the corporate and programme risk registers had in previous years had also proved challenging.

- Directorates needed to be more joined up in their approach, as limited recognition of interdependencies led to fragmented efforts. As a result, objectives often lacked momentum or failed to progress, providing only partial assurance and reducing overall confidence in delivery.

- Risks were not always appropriately captured and, as a result, mitigation actions could not be fully demonstrated and progress, ownership and management of risk was not able to be consistently evidenced.

NHS Devon 2024/25 Annual Plan

6. By tracking delivery of the Annual Plan at a Directorate level and working with partners at place, NHS Devon aimed to demonstrate the activity required to meet all relevant priorities and requirements, including performance, oversight, and commissioning responsibilities in relation to NHS providers in Devon.

Delivery Room / Highlight Report Review:

7. The development of the Annual Plan was led by the Director for Planning and Performance, supported by NHS Devon's Programme Management Office (PMO).

8. All directorates were supported in engaging with the Delivery Room review meeting process, implemented by the Director of Planning and Performance.

9. The aims of the monthly Delivery Room Process were as follows:

    - Provide enhanced assurance regarding system recovery.
    - Provide a check-and-challenge to programme Senior Responsible Officers (SROs) and Chief Officers ahead of formal assurance processes, such as committee reviews.
    - Support the rapid identification and escalation of key risks.
    - Check that Equality, Quality Impact Assessments (EQIAs) are undertaken to examine the quality, and equality impacts of plan / programme delivery.
    - Agree on key actions for the following month to meet the monthly and quarterly milestones set out in NHS Devon's Annual Plan, recovery plans, or PMO workbooks.
    - Agree highlight reports (HLRs) and escalations to support formal assurance processes.

10. To support the Delivery Room approach, the PMO developed a highlight report template.

11. This supported the establishment of Key Performance Indicators (KPIs) for each directorate based on available data sources to monitor progress and support escalation. The draft highlight reports are circulated monthly to be considered ahead of, and to inform, the agenda, discussion and focus of the Delivery Review Meetings and Key Lines of Enquiry (KLOEs) agreed and shared with SROs.

12. By ensuring a comprehensive and disciplined approach to programme management and delivery, the Delivery Room supported NHS Devon's ability to demonstrate achievement against national and local policy objectives and external regulatory requirements, such the required improvements required for exiting NOF4.

13. The output from the monthly highlight reports and delivery review meetings were collated into a monthly assurance report for the NHS Devon Executive and the NHS Devon Board. This has supported all directorates in understanding corporate delivery against NHS Devon and system priorities and improving collaborative planning.

In Year Annual Plan Objective Reviews

14. During the development of NHS Devon's Annual Plan, it was recognised that emerging priorities throughout the year may necessitate further objective review, inclusion, removal or significant changes to current ones.

15. To maintain both flexibility and agility in responding to new priorities, while staying focused on the delivery of core objectives agreed annually, a change process was essential. The process ensures that any changes to the plan—whether adding or removing objectives—are managed effectively.

16. During the year, it was recognised that the responsibilities of individual Chief Officers change, which could involve adjustments to portfolios and subsequently alter the SRO for specific Annual Plan objectives. If objectives needed to be transferred between directorates during the year, and there was a change in Chief Officer responsibility, these transfers have been made visible to the Board through the Annual Plan Delivery Assurance report, to ensure that the Board is fully informed of the SRO changes.

17. For new priorities that may arise for the NHS (requiring NHS Devon to incorporate additional objectives into its annual plan), proposed new objectives have been presented to the Board via the Annual Plan Delivery Assurance report, ensuring the Board is fully informed of any additions.

18. It was also recognised that, in certain circumstances, an objective agreed at the start of the year may become obsolete, irrelevant, de-prioritised, or unachievable due to resource or financial constraints. Where this has been identified by a Chief Officer and they can present a clear rationale, this has been proposed to the Board via the Annual Plan Delivery Assurance Report. Before Board approval is sought, an impact assessment is to be completed, and any risks recorded in the relevant risk registers.

19. As part of the assurance process, any updates, additions, closed or reassigned objectives are noted or approved by the Board. Upon Board approval, amendments are updated within the Annual Plan and change log, with a clear rationale provided by the Performance, Planning & PMO Team.

Risk and Assurance: Executive and Board

20. In order to ensure appropriate communication of the Annual Plan monthly status, the NHS Devon Annual Plan – Delivery Assurance Report was further developed covering each Directorate's objectives against their agreed Annual Plan.

21. The report provides detailed of the objectives by exception which the NHS Devon Programme Management Office (PMO) and Performance team had limited or only partial assurance on the progress being made to deliver NHS Devon's Annual Plan.

22. The content of the report was generated through the information and assurance given by each directorate in their respective highlight reports and from the outputs of the Delivery Room review and assurance process chaired by the Deputy Director of Performance and Planning.

Reflections on 2024/25 Delivery / Lessons and Achievements

23. The 2024/25 Annual Plan marked a significant change in the ability of NHS Devon to take control and grip of the process. This included:

- The development and relaunch of the PMO function within NHS Devon and the significant levels of engagement and support provided have helped to move the organisation into one that can robustly demonstrate its achievements, be aware of the risks it faces and be confident in the actions being taken to address those risks to delivery.

- Standardised processes and reporting templates have supported the organisation in gaining a better understanding of the need to work differently.

- The relationships built between the Directorate teams and the PMO function have been fundamental to development cross-directorate engagement. This has helped to progress objectives, better recognise risks to delivery and demonstrate a higher level of assurance.

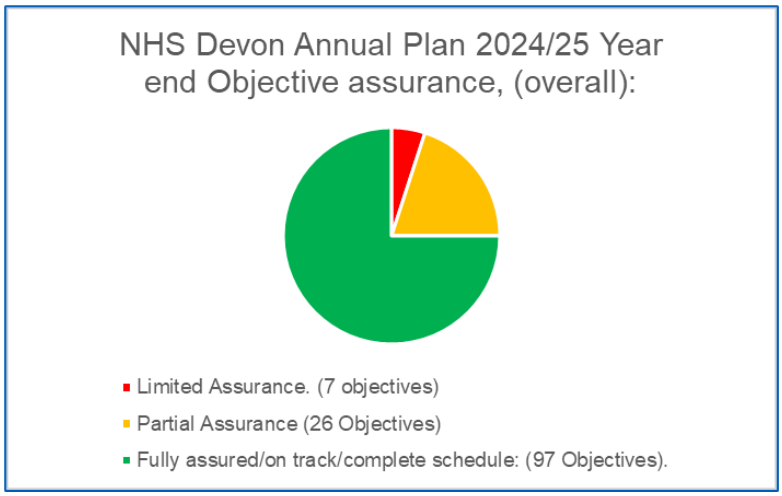
- Engagement of directorates through the implementation of the delivery review process has been extremely positive.

24. Key achievements noted by NHS Devon in respect to delivery of the 2024/25 Annual Plan can be seen below:

- Achieved the lowest level of Did Not Attend (DNA) rates for General Practice appointments of any ICB area in the country.
- Significant reduction in all long waiting patients including clearance of all 104ww patients.
- Achievement of cancer targets: the 28-day faster cancer diagnosis and the 62-day performance.

- Urgent care improvement - achieved a significant reduction in ambulance handover delays and improved performance in Emergency Departments and Category 2 response times.
- Multi Agency Safeguarding Hub (MASH) capacity increased improving our ability to meet statutory Safeguard Children responsibilities.
- Autism recovery programme implemented across the One Devon Integrated Care System (ICS) resulting in streamlined pathway of support, assessment and delivery models.
- Neurodiversity Hub established on MyHealth Devon providing support, information and resources for children, young people and families.
- Perinatal Pelvic Health Services (PPHS) have been implemented in all Trusts.
- Implementation of Real Birth Company antenatal education in all Trusts.
- Implementation of the Devon Menopause Service (DMS).
- Met the NHS Long-Term Plan target, ensuring 1,115 women have access to perinatal mental health support.
- £40 million in capital investment delivering care closer to home for patients with complex learning disabilities and mental health needs.
- Data sharing across the ICS is improving, helping to better target interventions through tools like the One Devon Dataset and Low-Income Family Tracker.
- More vulnerable people vaccinated and protected: Increased access to winter vaccinations through wider provision from Community Pharmacies and outreach teams.
- Delivered a range of vaccination campaigns targeting different groups, contributing to some of the highest vaccination uptake rates in the country.

Summary of Progress and Delivery of Assurance Against 2024/25 Objectives



97 Fully assured/on track/complete schedule.	75%
26 Partial Assurance.	20%

7 Limited Assurance.	5%

The definitions for assurance levels are as follows:

	• A significant delay in schedule • Metrics are falling below acceptable thresholds • Limited assurance	**Overall directorate status of assurance of delivery for 24/25:** **Fully Assured - over 75%,** **Partially Assured – between 50% and 75% and** **Not Assured – below 50% of directorate objectives are on track/fully assured.**
	• Some delay in schedule • Metrics that are borderline or trending negatively • Partially assured	
	• Project is on schedule • Metrics that meet or exceed expectations • Fully assured	

Directorate	**CNO**	**CMO**	**COO**	**CPO**	**CFO**	**DCEO**	**CCO**
Total objectives	14	39	39	10	10	9	8
Fully Assured	12	31	26	6	-	7	5
Partially Assured	2	7	10	3	-	2	1
Limited Assurance	-	1	8	1	-	-	2
Outcomes:							
Directorate	**CNO**	**CMO**	**COO**	**CPO**	**CFO**	**DCEO**	**CCO**
Continuing to 25/26	13	29	32	4	10	4	-
Completed/Closed	-	-	-	1		-	5
Moved to BAU	1	9	4	5		4	1
Paused		-	1	0		1	2
Stopped/Will not continue	-	1	2	0		-	-

(Please see Appendix One: 24/25 Annual Plan Objectives end year position for a detailed position breakdown of achievements by Executive portfolio).

Informing the 2025/26 Annual Plan

25. Building on the organisational development and engagement work, which provided the foundation and parameters for the 2025/26 Annual Plan, the planning team worked with the NHS Devon Executive and Board to rapidly co-produce a set of cross-cutting, overarching objectives that:

- Clearly link to relevant published strategies, recognising that these will be updated in 2025/26 following the publication of the NHS 10-Year Plan.
- Recognises the need to restructure the objective oversight process and moves away from the Directorate based portfolios, to a more appropriate model that supports cross directorate working.
- Align directly with NHS Devon's purpose, maintaining a visible connection to the wider ICS vision and key strategic drivers.

- Reflect Darzi's three key shifts, as we expect these to feature significantly in the NHS 10-Year Plan expected later this year.
- Capture cross-directorate priorities, including population health and prevention.
- Balance 'in year' improvement work and longer-term transformation, with a greater focus on how NHS Devon and its partners will drive long-term change alongside short-term financial and performance recovery.

26. Alongside the work undertaken with the NHS Devon Executive and Board, Chief Officers worked with their teams to review existing workplans and identify directorate-level priorities and actions required to meet finance, quality, and performance requirements. This additional directorate-level review has ensured that critical business-as-usual, statutory, and commissioning responsibilities remain visible in our Annual Plan and are included for monitoring and assurance purposes.

27. The 17 overarching objectives agreed by the Board are supported by high-level delivery and enabling plans, which outline:

- The scope of work to be undertaken;
- The actions required to deliver on objectives;
- The milestones that need to be achieved; and
- The expected outcomes from delivering this work.

28. These high-level delivery plans will drive implementation, providing the focus for Board Assurance Committee oversight.

29. They will be underpinned by detailed project and programme plans, which will be available for in-depth committee review as needed.

Conclusion

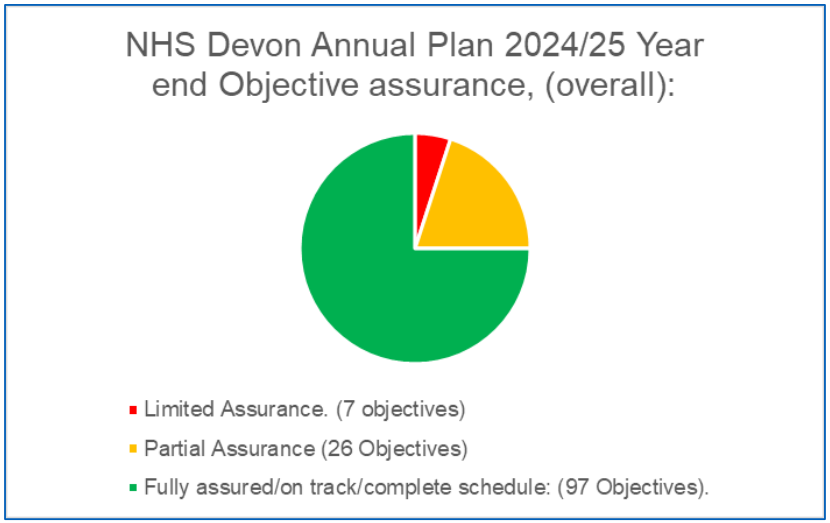
30. The Board is asked to **AGREE** the final positions of assurance for each directorate at 2024/25 year end.

Appendix 1: 2024/25 Annual Plan Objectives End Year Position

The definitions for assurance levels are as follows:

	• A significant delay in schedule • Metrics are falling below acceptable thresholds • Limited assurance	**Overall directorate status of assurance of delivery for 24/25:** **Fully Assured - over 75%,** **Partially Assured – between 50% and 75% and** **Not Assured – below 50% of directorate objectives are on track/fully assured.**
	• Some delay in schedule • Metrics that are borderline or trending negatively • Partially assured	
	• Project is on schedule • Metrics that meet or exceed expectations • Fully assured	

130 Active Objectives within the 2024/25 Annual Plan.



Chief Nursing Officer

Overview of Assurance – Fully Assured

There are a total of 14 objectives being actively monitored which fall within the CNO directorate of which 86% (12) are fully assured to deliver within the expected timescales and 14% (2) are partially assured.

CNO directorate staffing structure consists of **121.03 FTE** at a cost **£7.60m**.

Objective Dashboard

	Objective no.	Objective description	On Track?	Year End declared Position	Additional information relating to 2025/26	Outcome
Quality & Safety	CNO 001	Implement Quality Management System Improvement Process •To improve and develop the ICB's Quality processes, governance, and reporting •Alignment to NQB guidance/requirements •To support the JFP/Operational Plan/ ICB Annual Plan delivery	G	On Target 24/25 Positive feedback received from QPEC & Board. Recent Internal Audit of Patient Safety governance compliance assessed as "Satisfactory" by auditors.	Ongoing 25/26 QMS strategy planned for progression as part of the 17 Objectives for 25/26.	Continuing to 25/26 Objective 9.
	CNO 002	Safeguarding Improvement • Delivering high standard of compliance with Working Together Safeguard Children (2023) statutory guidance • Delivery of the ICB's duties under The Care Act (2014) regarding safeguarding adults	G	Assured 24/25 Improved reporting as per plan, established in Quality Report for QPEC updated report submitted as part of the March 2025 Quality Report. JTAI closure report also submitted to QPEC in March 2025	Planned developments for 25/26 included in POAPs. 360 review: in light of national strategic changes, this element will not be progressed at this time. Safeguarding objectives under the 25/26 Annual Plan development process at time of preparation have been developed and submitted as part of Executive status report. Aware that current National Strategic changes may impact on the deliverability of this element of the objective at ICB level.	Continuing to 25/26 Objective 7.

	CNO 003	Review and enhance the Continuing Health Care (CHC) function to deliver value and improve efficiency	G	↔	Recommendations of the AACC review are being implemented as part of the restructure and the digital transformation programme. National Strategic change may impact on the implementation of proposed actions for 25/26.	Continuing to 25/26 Part of Transforming Devon. BAU
	CNO 016	Establish a framework for quality assuring the standards expected of any digital services that children and young people can access; with a central resource that children and young people can be signposted to.	-	Action not progressed on transfer due to prioritisation of existing CNO Directorate objectives. Risks related to not progressing this objective are mitigated through EQIA and procurement processes for any new digital service being considered for implementation.	This objective will be reconsidered in future planning, noting revised system priorities in 25/26 plan.	-
Maternity, Neonatal and Women's Health	CNO 004	Collaborate with system partners to implement the three-year maternity and neonatal delivery plan, focusing on safety, personalisation, and workforce development. The Core20PLUS5 approach for women and birthing people will be implemented as part of the core programme.	A	Three-year plan (2023-2027): Partial Assurance: Process progress monitoring limited by ICB capacity to monitor. Targets/ Success measures: Off Track some individual objectives are on track or completed in year.	Ongoing 25/26.	Continuing to 25/26.Objective 6.
	CNO 005	Collaborate with system partners to implement the 10-year national Women's Health Strategy in Devon. This will include delivery of a Women's Health Hub model by March 2025.	G	Assurance: On track (part of a 10-year strategy implementation process within Devon).	Ongoing 25/26	Continuing to 25/26.Objective 6.
Children and Young People	CNO 007	Reduce the number of children and young people on long waiting lists for paediatrics acute and surgery procedures to eliminate waits of over 65 weeks for elective care	G	Assurance: On track Complete	GIRFT visiting UHP children's surgical unit in late March. Limited ability to progress within elective recovery priorities, due to funding availability. Reprioritisation being undertake in 25/26 workplan.	Continuing to 25/26.Objective 6.

	CNO 008	Implement a neurodiversity offer for children and families with neurodiverse, emotional and communication needs	G	On track The objectives for 2024/25 have been delivered.	Q4 milestone, which requires recurrent investment to ensure sustainable transformation, is subject to business case approval. This is because sustainable transformation requires recurrent investment. Business case for 25/26	Continuing to 25/26.Objective 6.
	CNO 009	Improve outcomes for CYP with long term conditions, focussing on a reduction in health inequalities	G	On track Asthma Complete: Diabetes: GIRFT completed in November – ICB adult lead now confirmed for HCL and GIRFT 19+ recommendations No current changes reported by NHSE for priority HCL groups for 25/26. NHSE reimbursement has been sent to providers. Epilepsy: CYP workplan currently in development for all programmes of work. To be agreed and signed off during Q1 25/26. Oral 25/26 CIC dental contract has been extended and is out to EOI for Torbay and Exeter areas to look to provide a more equitable offer across the county.	Ongoing 25/26	Continuing to 25/26. Objective 5.
	CNO 010	Prioritise the Special Education Needs and Disabilities (SEND) of children and families across Devon ICS, embedding SEND reforms in line with local inspection findings within mandated timeframes	A	Off track and partially assured. EHCP Sitrep Delayed: work underway new role within the team to support review and contracting support agreed but anticipate capacity will not be fully released until after Torbay and Plymouth SEND Local Area inspections. 2. Evaluate Autism in schools impact: Delayed until end 2025	Ongoing 25/26	Continuing to 25/26. Objective 5.

				due to significant capacity reduction, workload and time constraints of PINS project which superseded this work. 3. Evaluation of new EHCP process and timeliness: Delayed: until reconfiguration of, and additional capacity within the team, following restructure to support this is identified. Process will need to embed and timeliness to be measured post implementation.		
	CNO 011	Develop a comprehensive plan to support the recovery of community services, with a target to reduce the autism pathways waits over 52 weeks by April 2025.	G	On track Overall, the objectives for 2024/25 have been delivered.	Q4 milestone, which requires recurrent investment to ensure sustainable transformation, is subject to business case approval. This is because sustainable transformation requires recurrent investment. Programme workplan for 25/26 currently in development and will cover all community services recovery.	Continuing to 25/26. Objective 5.
	CNO 012	Address significantly poorer outcomes for care experienced children and young people by tackling access and equity issues in care delivery	G	On track	Ongoing 25/26 Trajectories have been identified for IHA and RHA performance across the ICS and will be monitored through Corporate Parenting Boards.	Continuing to 25/26 Objective 5.
	CNO 015	More children and young people will have timely, coordinated access to NHS-funded mental health support, care, and treatment, including through mental health support teams in schools. This will mean that at least 15 754 CYPS will access NHS services.	G	On Track Fully assured	Ongoing 25/26	Continuing to 25/26 Objective 5.
Health Protection	CNO 013	Infection Management System • ICBs are responsible for developing integration and collaboration, and for improving population health across the system.	G	Fully assured for 24/25	Infection Management Systems: objectives under the 25/26 Annual Plan development process at time of preparation have been developed and submitted as part of Executive status report.	Continuing to 25/26 Objective 7.

		• Under the Civil Contingencies Act 2004, NHS England and ICBs are identified as Category 1 responders.			Aware that current National Strategic changes may impact on the deliverability of this element of the objective at ICB level.	
	CNO 014	Vaccination Delivery – Develop reporting mechanisms	G	Fully Assured for 24/25	Completed: objectives under the 25/26 Annual Plan development process at time of preparation have been developed and submitted as part of Executive status report. Aware that current National Strategic changes may impact on the deliverability of this element of the objective at ICB level.	Continuing to 25/26 Objective 7.

Chief Medical Officer

Overview of Assurance – Fully Assured

(Currently awaiting final signoff from directorate Chief Officer on CMO032):

There are a total of 39 objectives being actively monitored within the CMO directorate of which 79% (31) are fully assured to deliver within the expected timescales, 18% (7) are partially assured with only one objective recorded as limited assurance.

CMO directorate staffing structure consists of **77.49 FTE** at a cost **£5.70m**.

Objective Dashboard

	Obj no.	Objective description	On Track?	Year End declared Position	Additional information relating to 2025/26	Outcome
Mental Health	CMO 001	Adults and older adults who need to be admitted to hospital for treatment of a mental illness will be treated in a hospital in Devon whenever it is clinically safe. By March 2025 there will be no more than 2 people inappropriately out of area, for acute care	G	Full assurance for 24/25 and will continue 2024/25 was the first year of the 3-year Mental health inpatient strategy, with the second year being 2025/26.	Work will progress in 2025/26 aligned to delivery of the Mental Health inpatient strategy and more widely ensuring that those, where it is clinically appropriate and safe, will be admitted to hospital as close to their home as possible. This is aligned to objective 4 for 25'26 "	Continuing to 25'26 Objective 4
	CMO 002	People and families to get help early in development of perinatal mental health need. A minimum of 1115 will access the service. System recommendations aligned to supporting infant -care giver relationships will be known.	G	Full assurance and will continue NHS devon achieved this target for 2024/25.	In line with Operating Plan for 2025/26, this target remains and plans are being finalised with providers to ensure delivery. This is aligned to objective 4 for 25'26	Continuing to 25'26 Objective 4
	CMO 003	As a minimum 8700 adults and older adults with Severe Mental Illness (on a rolling 12-month period) will have timely access to transformed models of community mental services.	G	Full assurance and will continue NHS Devon has exceeded this target for 2024/25.	It will continue to be monitored during 2025/26 with appropriate actions taken should performance become an area of concern. This is aligned to objective 4 for 2025/26	Continuing to 25'26 Objective 4
	CMO 004	Adults and older adults with Severe Mental Illness will get help with their health and social care needs including housing and physical health as close to home as possible.	G	Fully assured for 24/25	Ongoing 25/26 pending identifying leads within ICB The recommendations of the report have been reviewed and are being incorporated into a wider working group with a particular focus on the DCC footprint.	Continuing to 25'26 Objective 4

	Obj no.	Objective description	On Track?	Year End declared Position	Additional information relating to 2025/26	Outcome
					The MHLDN provider collaborative were leading this area of work and whilst it is a system piece of work, leads within the ICB to be part of this working group need to be identified to enable progress to maintain in 2025/26.	
	CMO 005	Enable people of all ages experiencing a mental health crisis to access the necessary help as early as possible without the need to visit A&E.	G	Actions identified in 2024/25 have been completed, with next steps from 2024/25 needing to be progressed in 20205/26.	A workplan aligned to this objective is in process of being finalised and this objective forms a key part of the operating plan for 25/26. This is part of objective 4.	Continuing to 25'26 Objective 4
	CMO 006	Enhance treatment outcomes for anxiety and depression through improved NHS Talking Therapies to 700,000, with at least 67% achieving reliable improvement and 48% reliable recovery.	G	2024/25 targets were achieved.	Talking therapies targets aligned to the operating plan 2025/26 have been agreed and will be appropriately monitored with commissioner – provider actions being taken as required in 20205/26. This is part of objective 4 in 2025/26.	Continuing to 25'26 Objective 4
	CMO 007	Reduce inequalities in mental health care by increasing the rate of annual physical health checks so that 75% of people with severe mental illness (SMI) are receiving a full annual physical health check, with at least 64% receiving one by March 2025 ensuring appropriate follow-up care for all those who need it.	G	On Target as of December 2024, NHS Devon were circa 300 people away from achieving the 2024/25 target. The final end position for 24/25 cannot yet be confirmed as data is not yet available.	Arrangements aligned to the LES will remain in 2025/26. It is anticipated that SMI physical health checks will form part of core 20 plus 5 monitoring and as such, performance and mitigations required will continue to form a focus in 2025/26. A paper aligned to drug safety monitoring for antipsychotics is due to Ex Co at the end of April and dependent upon the decision reached, actions will be implemented This is part of objective 4 in 2025/26.	Continuing to 25'26 Objective 4
	CMO 008	Provide more timely dementia diagnoses and coordinated care planning by increasing the dementia diagnosis rate to 65% by March 2025.	A	Partial Assurance. As of February 2025, NHS Devon achieved a 58.3% against a 67% target. Some of the actions planned for q4 could	Ongoing 25/26. Nationally, as part of the 25/26 operating plan, dementia diagnostic rates were not included as a 'must do.' However, the MH commissioning team will continue to maximise opportunities that will maintain	Continuing to 25'26 Objective 4

	Obj no.	Objective description	On Track?	Year End declared Position	Additional information relating to 2025/26	Outcome
				not be implemented due to a capacity challenge.	and/or improve dementia diagnosis rates. This is part of objective 4	
	CMO 009	Develop a Devon health and social care Dementia Strategy	G	Fully Assured for 24/25. The MHLDN PC drafted a strategy which is currently with Devon ICB for sign off.	Ongoing 25/26 Under the Transforming Devon Programme, the MHLDN PC will lead a programme of work aligned to reducing LOS for those with dementia in 25/26. This is part of objective 4.	Continuing to 25'26 Objective 4
	CMO 011	Develop alternative community physical health monitoring services for eating disorders patients to enhance outpatient support.	G	Fully Assured for 24/25	Focus of activity needed to be on responding to collective action and ensuring the physical health monitoring of high-risk patients was in place. A business case was successful and service specifications and delivery plans are being finalised for 25/26 delivery. Work aligned to developing a pathway continue in 25/26 and is part of objective 4.	Continuing to 25'26 Objective 4
	CMO 012/ 015	Develop a business case for a community-based alternative to hospital admission for individuals with severely disordered eating with atypical features or which is secondary to neurodiversity &/or trauma-based issues. Work to ensure that all acute hospital trusts across the ICB work to the same protocol of medical admissions for "Physiological rescue" admissions with rapid admission and rapid discharge within a 14-21 day time frame and similar criteria for NG feeding, enhanced nursing, restraint, sedation, use of legislation and working with liaison psychiatry.			*CMO 12 and CMO 15 Merged to this objective for 25'26:* Ensure we are commissioning a safe and effective service for people with severe eating disorders that require significant clinical input	Continue in 25/26 Objective 4

	CMO 013	Ensure that commissioned mental health services are of high quality, safe, effective and well led.	G	All necessary procurements were completed as per timelines in 2024/25.	Cost pressures from VCSE providers have been fed into operational planning for 25/26. Commissioned services will continue to be monitored and evaluated with regards to safety, quality and carer/service user experience and effectiveness. This is part of objective 4	Continuing to 25'26 Objective 4
Learning Disabilities	CMO 016	Ensure 75% of individuals aged 14 and over on GP learning disability registers receive an Annual Health Check (AHC) by 31 March 2025.	G	Full assurance for 24/25. Our end position on target and reached 75.2 % at the end of the year	Ongoing 25/26. This remains in the GP Qof and part of the Health Inequalities Core Plus 5. We will continue to support this objective in 2025/2026 as part of our annual plan BAU. "	Moving to BAU
	CMO 017	Reduce reliance on mental health inpatient care for people with learning disabilities and autistic individuals, achieving a target of no more than 30 adults and 12–15 under 18s per 1 million population.	A	Partial assurance for 24/25. We are not on target for as we come to year-end, but our position is well known and understood with NHSE and region.	Ongoing 25/26: This year's targets will be split between LD and ASC, and we start the new financial year in a poor position with a move to reduction by March 2026. It is in our annual plan (objective 4) and the new bed capacity in region and community pathway will support our ongoing position.	Continuing to 25'26 Objective 4
	CMO 018	Test and implement improvements in autism diagnostic assessment pathways, including actions to reduce waiting times by March 2028.	G	Fully Assured and will continue into 25/26.	Most of this work has sat in the Right to Choose pathway which we have created significant provision, in 25/26 the focus in our plan is the community offer so we will continue to focus on this agenda. "	Continuing to 25'26 Objective 4
	CMO 019	Develop integrated workforce plans for the learning disability and autism workforce to support the delivery of objectives outlined in national Workforce Plan.	G	Fully Assured for 24/25	Part of the commissioning strategy development in 25/26	Continuing to 25'26 Objective 4
	CMO 020	Reduce health inequalities by reducing over-medication through the STOMP and STAMP programmes and taking action to prevent overprescribing.	G	Fully Assured for 24/25	BAU into 25/26 community pathway work.	Moving to BAU
	CMO 021	Continue to implement the LeDeR programme to enhancing care, reducing health inequalities, and preventing premature deaths	A	Partial assurance for 24/25.	LeDeR is part of the 2025/2026 annual plan we have resource in place to manage the reviews and we are	Continuing to 25'26 Objective 4

		among individuals with learning disabilities and autism.			focussing this year (25'26) on actioning the learning.	
	CMO 022	Support the delivery and use of the reasonable adjustment digital flag to reduce health inequalities among people with learning disabilities and autistic individuals.	A	Partial assurance for 24/25.	Ongoing 25/26: objective 4 of annual plan. On going project that has made huge successes in several EPR areas across the county. It is ongoing work and part of next year's plan. To continue roll out across the system. The delivery sits within our IT team.	Continuing to 25'26 Objective 4
	CMO 023	Develop governance and due diligence with contracting for the Patient Choice pathway for ADHD. Compliant with "Patient Choice" Legislation whilst protecting local delivery and quality.	G	Fully Assured for 24/25	Will continue in Objective 4 of annual plan 25/26 We have come a long way in this area we have several new providers that are contracted, and our oversight and quality governance is of a much better standard. We have resource this year to triangulate the intelligence in the RtC pathway to support understanding of our financial position trajectories and out pouts and developments of this demographic. We are part of the national taskforce work and working with policy writers on specification and tariff work.	Continuing to 25'26 Objective 4
	CMO 024	ADHD Pathway develop access to support closer to home in models of care yet to be designed by clinical group, Engage with the national taskforce and GIRFT	G	Fully Assured for 24/25		Continuing to 25'26 Objective 4
	CMO 025	Oliver McGowan Mandatory Training (OMMT) Standardised training developed for the purpose of education health and social care staff on Learning Disability and Autism. Statutory requirement in the health and care Act 2022regulating service providers in compliance.	G	Fully Assured for 24/25.	We continue to support successful roll out of the OMMT training. Will continue as part of 25/26 plan. We have agreed a further year sustainability and procured the train the trainer model for the trusts to take forward for future delivery. There is another year's funding from the national team, and this will require an increase of	Continuing to 25'26 Objective 4

					compliance to 66% we work closely with the provider to increase flow and encourage take up.	
	CMO 026	REGIONAL CAPITAL INVESTMENT OF 20.5 million New MH LDA bed capacity for the treatment of our community closer to home of people who are intellectual, disabled or an Autistic Person.	G	Fully assured for 24/25	The next bed capacity has a delay on opening which has now moved to first bed day September. Bristol regional first bed day is in March 2026. Workforce and phased bed plan are in place, and we continue to work as a regional group to satisfy governance requirements. We remain as a lead SRO with the SWRFD being the admission criteria and oversight structure for the unit.	Continuing to 25'26 Objective 4
Population Health	CMO 027	Support Local Care Partnerships (LCPs) and Provider Collaboratives with evidence-based resources to empower them to make informed decisions and implement change at the local level.	G	Fully assured for 24/25	Plans in place across Devon and within localities. Funding needs to be confirmed. This work will be taken forward as part of Objective 1 in 25/26.	Continuing to 25'26 Objective 1
	CMO 028	Implement the national Inclusion Health Framework to ensure health equity and support the needs of the most vulnerable groups.	A	Partial Assurance: Good progress made with limited resources.	Plans in place for implementation in 25/26 as part of Objective 1	Continuing to 25'26 Objective 1
	CMO 029	Develop and implement a Population Health Charter to articulate and guide the collective health priorities and strategies across the system.	G	Fully assured. for 24/25	Plans in place for implementation in 25/26 as part of Objective 1	Continuing to 25'26 Objective 1
	CMO 032	Expand and develop High Intensity User (HIU) services and establish system working arrangements to support ongoing learning and development.	R	Limited assurance in 24/25	Work will be carried forward in 25/26 led by localities - Key task which needs to be picked up in the Annual Plan is the commissioning of the HIU services linked to EDs as per NHSE model ensuring we have equity across the county.	Continuing to 25'26 Objective 12
	CMO 044	Within the ICS '4th purpose' (to help the NHS support broader social and economic development), develop the ICB as an Anchor Organisation by March 2025 to strengthen community ties and improve those factors that	G	Fully assured for 24/25	Blueprint developed. Implementation in 25/26 as part of objective 17."	Continuing to 25'26 Objective 17

		contribute to improved prospects for local populations				
Medicines Optimisation	CMO 033	Delivery of the 16 National Medicines Optimisation Opportunities	G	Fully assured for 24/25 CIP achieved for 24/25.	CIP goal for 25/26 has not been finalised, although a £5M target has been suggested. Emerging plans exist which provide a medium level of confidence of £5.0M CIP 25/26 achievement. Other non-CIP workstreams will form part of MO workplan for 25/26.	Continuing to 25'26 Objectives (1,2,7,8,9,13)
	CMO 034	Develop the Peninsula Aseptic Hub to centralise and optimise the preparation of sterile medications	G	Fully assured for 24/25	Ongoing for 25/26. NHSE has agreed £11.5m capital for the Peninsula Hub. With that secured, the ICB will now discuss a managed handover from ICB leadership to Provider Collaborative leadership.	Moving to BAU
	CMO 035	Develop the Peninsula Radio pharmacy Strategy to enhance the provision and distribution of radiopharmaceuticals	G	Fully assured for 24/25	Ongoing for 25/26: Options appraisal completed and approved by PASP Board. To be presented to PAPC in May.	Moving to BAU
	CMO 036	Implement CIP projects in line with national best practice to improve the clinical and cost-effective use of medicines across all sectors in the Devon system.	G	Fully assured for 24/25	Provider High-Cost Drugs savings plans for 2025/26 shared and being collated to identify any additional opportunities.	Moving to BAU
	CMO 037	Develop the Integrated Medicines Optimisation Committee (IMOC) and associated work programme to oversee and enhance medicines use across the health system	G	Fully assured for 24/25	IMOC now well-established and work programme drafted up to end of 2025.	Moving to BAU
Research and Innovation	CMO 038	Continue to contribute to the Peninsula Research and Innovation Programme (PRIP) with partners across the Peninsula to foster collaborative improvements and innovation in healthcare	G	Fully assured for 24/25	Ongoing for 25/26: PRIP partnerships have been developed through 2024/25 and it has now been agreed to build on this with a 2025/26 PRIP reset plan which is being drafted for presentation to April PRIP Board	Moving to BAU
	CMO 039	Work with Cornwall and Somerset to implement key deliverables in the Peninsula Research and Innovation Strategy (PRIS),	G	Fully assured for 24/25	Ongoing for 25/26: PRIP partnerships have developed through 2024/25, and it has now been agreed to build on this with	Moving to BAU

		enhancing regional healthcare research and development			a 2025/26 PRIP reset plan which is being drafted for presentation to April PRIP Board. This will include the development of a shared RII strategy."	
	CMO 040	Continue to support the development of the Research Engagement Network (REN) to increase opportunities for people to participate in health and social care research, including those working in primary care	G	Fully assured for 24/25.	Ongoing 25/26: The ICB has continued to engage with the REN work and research participation is included in the PRIP reset plan which is being drafted for presentation to April PRIP Board.	Moving to BAU
System Development	CMO 041	Develop and implement the One Devon Clinical and Care Professional Leadership framework to enhance clinical and care professional leadership and involvement in strategy development and delivery across the system	G	Fully assured for 24/25. ICB Strategic Clinical Advisors in post following restructure. Regular meetings of the SCAs are now in place.	Decision to be taken in 2025/26 whether to update and implement the CCPL framework or to await the next restructure.	Stopped/will not continue
Acute Services Strategy	CMO 042	Transform acute services to ensure workforce, clinical and financial sustainability.	A	Partial Assurance achievement for 24/25	Work will continue into 25/26 within Objective 11: Clinical Service change and transformation.	Continuing to 25'26 Objective 11
	CMO 043	Stabilise acute services that are fragile	A	Partial Assurance achievement for 24/25	Work will continue into 25/26 within Objective 11: Clinical Service change and transformation.	Continuing to 25'26 Objective 11
	CMO 044	Develop plans to enhance the ICB's role as an Anchor Organisation by March 2025 to strengthen community ties and improve those factors that contribute to improved prospects for local populations. This is a 2024/25 step towards delivery of the ICS '4th purpose' (to help the NHS support broader social and economic development).	G	Fully assured for 24/25	Work going forward for 25/26 will fall within ICB Objective 17	Continuing to 25'26 Objective 17

Chief Communications and Corporate Affairs Officer

Overview of Assurance – Partially Assured

There are a total of 8 objectives being actively monitored within the CCO directorate of which 62% (5) are fully assured to deliver within the expected timescales and 12% (1) is partially assured and 25% (2) limited assurance.

CCO directorate staffing structure consists of **22.6 FTE** at a cost **£1.38m**.

Objective Dashboard

	Obj no.	Objective description	On Track?	Year End declared Position	Additional information relating to 2025/26	Outcome:
Governance	CCO 001	Develop an ICB governance improvement plan, secure approval by the July Board meeting, and make necessary amendments to constitutions, risk frameworks, and terms of reference based on agreed actions	G	Objective is complete for 24/25. ICB Governance Improvement Plan was presented and approved by the Board on 27th March 2025.		Completed / Closed
	CCO 002	Implement new System Planning, and Delivery & Assurance Structures for the 2024-25 governance approach within the ICB	G	Objective is complete. For 24/25. This was presented and approved by the Board on 27th March 2025.		Completed / Closed
System OD	CCO 003	Create a compact to formally articulate the shared vision of system partners and establish a set of reciprocal behaviours for effective delivery, supporting the Devon single operating model	Off track	CPOs recommendation to pause delivery of workshops following recent cost reduction announcement and this will be considered as part of 25/26 if appropriate.	Awaiting Penny Dash review.	Paused
	CCO 004	Develop a system Organisation Development (OD) plan focused on implementing high-impact actions to address challenges identified in ICS maturity assessments, supporting the development of a single operating model for Devon.	Off Track	CPOs recommendation to pause delivery of workshops following recent cost reduction announcement and this will be considered as part of 25/26 if appropriate.	Awaiting Penny Dash review.	Paused
Communications	CCO 005	Establish the One Devon Involvement Platform to enhance engagement and participation across the healthcare system	G	Objective is complete for 24/25.	One Devon Platform has been established and will develop further as part of the implementation of People and Communities Framework.	Completed / Closed
	CCO 006	Integrate Healthwatch into NHS Devon ICB Governance to enhance public accountability and consumer	G	Objective is complete for 24/25.	Healthwatch will form part of ICB Governance as we implement the People & Communities Framework.	Completed / Closed

		insight.				
Equality, Diversity and Inclusion	COO 007	Work with system partners to agree on shared Equality, Diversity, and Inclusion (EDI) priorities and initiate actions based on the NHS England EDI Improvement Plan's six high-impact areas	A	Partial Assurance for 24/25 There has been slight slippage in delivery.	This will be considered at the next EDI working group on 1st May to determine appropriate workplan for 25/26.	Moved to BAU
	CCO 008	Through the NHS Devon governance review, identify opportunities to incorporate the six high-impact actions from the NHS England EDI Improvement Plan	G	Objective is complete for 24/25. This was presented and approved by the Board on 27th March.		Completed / Closed

Chief People Officer

Overview of Assurance – Partially Assured

There are a total of 10 objectives being actively monitored which fall within the CPO directorate of which 60% (6) are fully assured to deliver within the expected timescales, 30% (3) are partially assured and 10% (1) with limited assurance.

CPO directorate staffing structure consists of **20.8 FTE** at a cost **£1.4m**.

Objective Dashboard

	Obj no.	Objective description	On Track?	Year End declared Position	Additional information relating to 2025/26	Outcome
System Workforce	CPO 001	Improve management and productivity of workforce resources (WTE and financial) across all System providers, delivering activities aligned with the 6 workforce Financial Recovery Programme (FRP) workstreams.	A	Majority (70%) of deliverables achieved. Financial savings partially realised. Dashboard in place and monitored by Workforce Delivery Group. 3 of 6 workstreams closed.	25/26 3x new/refreshed workstreams planned	Moved to BAU
	CPO 002	Deliver significant efficiencies and ensure consistency in business processes across Trusts and the ICB through technological and digital advancements, aiming to save £19 million over five years, contributing to system financial recovery	R	System enabler with low impact on delivery of the ICB 24/25 Annual Plan. ICB internal implementation is on track (see CPO 010)	User interface launch delayed to 30th May 2025. 25/26 People Digital is a project of the Shared Non-Clinical Support Services pillar of the Transforming Devon. Remedial actions for 25/26 overseen by System Provider Collaborative Board.	Moved to BAU
	CPO 003	Implement the One Devon Workforce Strategy and development of case for change to inform a new financially sustainable workforce model and plan to meet local and national objectives and comply with the 10 regulatory requirements of an Integrated Care System (ICS) People function.	A	Partial Assurance for 24/25: Outputs completed.	Sign off and roll out due to complete in Q1 25/26	Moved to BAU

HR	CPO 004	Reduce running costs by 30% while continuing to evolve the ICB's functions and form to effectively meet its strategic and statutory responsibilities	G	Savings target achieved for 24/25. Phase 2 90% completed Phase 2.2 CHC paused considering further cost reduction announcements.		Completed/Closed
	CPO 005	Develop a workforce with the skills and capability to fulfil the strategic and statutory responsibilities of the ICB in a sustainable and affordable manner	G	Achieved for 24/25 Delivered Board and Exec development programme and commenced work on Values and Behaviours framework.	25/26 deliverables will support staff through more organisational change and potential changes to role of ICBs.	Continuing to 25/26 – Objective 16
	CPO 006	Improve the working lives of all staff, thereby increasing staff retention and attendance at work -	G	Achieved for 24/25	Support for staff wellbeing to continue in 25/26 as HR BAU	Moved to BAU
	CPO 010	Implement People Digital for ICB staff	G	Achieved for 24/25	Next steps in ICB implementation to continue in 25/26.	Moved to BAU
System Learning and Education	CPO 007	Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan	G	Achieved annual process of planning with providers.	Deliverable transfers to 25/26 Annual Plan objective 16, action 2.	Continuing to 25/26 – Objective 16
	CPO 008	Increase the number of Advanced Practice posts across Devon by implementing a governance matrix and enhancing education and recruitment strategies, aiming to recruit 10% new trainees in new and emerging areas of advanced practice.	G	Achieved 24/25 Target reached.	Deliverable will continue for new academic year in 25/26 Annual Plan objective 16, action 3.	Continuing to 25/26 – Objective 16
	CPO 009	Increase placement capacity across the system to enable an increase of supply of domestic nursing and AHP. Specifically, the aim is to: •Reduce placement under-utilisation by 30% •Increase placement capacity by 20% •Increase range of placement experiences by 30%	A	Partially achieved. Baseline not in place.	Deliverable continues in 25/26 Annual Plan objective 16, action 1. High confidence to achieve measurement of baseline in Q1 25/26.	Continuing to 25/26 – Objective 16

Chief Finance Officer

Overview of Assurance – Fully Assured

There are a total of 10 objectives being actively monitored which fall within the CFO directorate of which 100% (10) are fully assured to deliver within the expected timescales.

CFO directorate staffing structure consists of **38.57 FTE** at a cost **£2.69m**.

Objective Dashboard

	Objective no.	Objective description	On Track?	Year End declared Position	Additional information relating to 2025/26	Outcome
Digital & Data	CFO 001	Support implementation of Electronic Patient Records (EPRs) in TSDFT and UHP by 2026.	G	**Complete** The ongoing management of the EPR will be via the EPR Programme Board which includes representation from the ICB.	Ongoing 25/26	Continuing to 25/26. Objective 15.
	CFO 002	Procure and implement the Peninsula Laboratory Information Management System (LIMS) solution for the clinical network by 2025.	G	**Complete** This is on track within Devon, and we will have a common LIMS as part of the Acute EPR Programme. Interoperability with Cornwall will be achieved by pulling all Pathology results into the DCCR.	HP are now planning to implement Beaker as part of their main EPR in July 2026.	Continuing to 25/26. Objective 15.
	CFO 003	Support core health and care organisations to implement the Devon and Cornwall Care Record by 2028.	G	On track and ongoing: RDUH to provide Admission, Discharge, Transfer and Outpatient information RDUH API for eTEP status in EPIC. NRL for eTEP dependent upon finance TSDFT are still to complete connection but are actively progressing.	Care homes and Social Care will be connected by the end of March 2029	Continuing to 25/26. Objective 15.
	CFO 004	Rationalise data centres subject to business case approval.	G	On Track and ongoing Data Centre Rationalisation across DPT/ICB and GP ICT has been achieved by DELT, with a single Cloud provider. Acute Hospitals are working with	Data centre rationalisation: centres have been reduced from 15 to 8. TSDFT to progress with data centre implementation by October 25.	Continuing to 25/26. Objective 15.

				Eviden to produce a "Roadmap to Cloud". Eviden has completed its report and the costs for full public cloud are substantially higher than options such as hybrid hosted cloud. TSDFT are progressing with an off premises hosted data centre solution	Once TSDFT move to an off-premises data centre this will reduce to 6.	
	CFO 005	Undertake contract reviews to achieve non-pay contract savings.	**G**	On Track Contract reviews on Cyber, Server Virtualisation, RIS/PACS, DCCR and soon EPR.	Final positions of partner sign-up have been determined and all partners are progressing with collaborative laptop procurement saving an estimated £9m over 5 years. 400k identified in mobile telephony savings and reported through CIP.	Continuing to 25/26. Objective 15.
	CFO 007	Implement the national Digital Inclusion Framework, working in partnership with the population health team, to increase accessibility to digital health resources among underserved populations	**-**	-	**No further action.** This action is not carried forward as a specific action for the 25/26 Annual Plan. Opportunities to promote digital inclusion will be integrated within other activity e.g. NHS App promotion	Moved to BAU
Finance and Use of Resources	CFO 008	Achieve a balanced net system financial position across all NHS organisations by the end of the 2024/25 financial year.	**G**	On track System has reported a deficit of £20m against plan which has been agreed by the system and NHSE	Ongoing: Core to 2025/26 delivery	Continuing to 25/26. Objective 15.
	CFO 009	Progress shared service arrangements within ICB and across system to increase efficiency and productivity and reduce costs.	**G**	On Track 24/25. Handover of reporting on Procurement Shared Service Transformation and procurement savings to Transformation Oversight Group.	Procurement re: shared service transformation to be undertaken by July 2025. Procurement cost savings delivery plan and savings projections in place for 25/26. Governance is through the Collaborative Corporate Services Board chaired by Angela Hibbard. Further shared service arrangements will	Continuing to 25/26. Objective 15.

					be managed under the Transforming Devon Programme. In scope are Finance & Accounting, Payroll, People Digital, EPR teams and helpdesk, BI and procurement. Further shared service transformations to be managed under the Transforming Devon Programme commencing 1st April 2025 and will include Payroll and People Digital.	
	CFO 010	Deliver NHS Devon's 2024/25 recovery and Cost Improvement Programmes (CIP) and performance manage delivery of provider CIPs	**G**	On Track This scheme is progressing as planned. Procurement shared service transformation due to complete July 25. 24/25 procurement savings £1.1M	Ongoing: Finance shared services being developed with target implementation of April 2026	Continuing to 25/26. Objective 15.
	CFO 011	Ensure ICB re-structure allows the organisation to operate within its agreed Running Cost Allowance (RCA)	**G**	On Track	Pause on external recruitment whilst new ICB running costs structure developed to deliver the required reductions.	Continuing to 25/26. Objective 15.
	CFO 012	Produce the long-term financial plan to achieve sustainable financial balance by system and by organisation.	**G**	On Track and ongoing	Long term financial plan to be updated once 25/26 operational plan is complete	Continuing to 25/26. Objective 15.

Deputy Chief Executive Officer

Overview of Assurance – Fully Assured

There are a total of 9 objectives being actively monitored which fall within the DCOE directorate of which 78% (7) are fully assured to deliver within the expected timescales. 22% (2) are partially assured.

DCEO directorate staffing structure consists of **28.85 FTE** at a cost **£2.03m**.

Objective Dashboard

	Objective no.	Objective description	On Track?	Year End declared Position	Additional information relating to 2025/26	Outcome
Performance and Planning	DCEO 001	Develop Annual Plan for 24/25	**G**	Fully Assured: Annual Plan 24/25 undertaken.	Ongoing 25/26 implementation.	Moved to BAU
	DCEO 002	Develop a rolling Annual Planning cycle to support the ongoing development, refresh, and alignment of key strategic and operational plans, including necessary annual updates to One Devon's Integrated Care Strategy and NHS Devon's 5-Year Joint Forward Plan, organisational-level Annual Plans, and NHS Operational Planning submissions	**G**	Fully Assured for 24/25: Process put in place to support year on year Annual Planning Cycle	JFP approved by NHS Devon Board on 27 March 2025 and submitted to NHS England ahead of publication. NHS Devon Annual Plan – Plan complete and approved by NHS Devon Board on 27 March 2025. Operational Plan – On track to submit final operational planning submissions on 30 April 2025 (if submissions approved by provider and ICB Boards)	Moved to BAU
	DCEO 003	Develop a System Delivery Governance PMO approach, including a PMO Delivery Room to support the delivery of corporate objectives.	**G**	Development of a System wide PMO delivery approach None as paused until 25/26. Delivery Governance and PMO delivery assurance process of ICB objectives.	Development of a System wide PMO delivery approach to be reconsidered as part of overall Nationally led organisational restructure.	Paused
	DCEO 004	Provide the Strategic Client function for Business Intelligence (BI), developing and agreeing on the ICB requirements of the external BI function	**G**	Fully Assured for 24/25	BAU, operational function that will be discharged reactively throughout the year.	Moved to BAU

	DCEO 005	Work collaboratively with regional ICS teams to develop a regional secure data environment to support future research	G	The ICB are actively involved in the SDE Leadership Board and have completed all required actions, including the sign-off of the initial IG agreements and contribution to the design and contractual process.	The ICB will continue to closely collaborate with regional SDE colleagues whilst in Continuing to 25/26 parallel developing the future data environment for Devon.	Moved to BAU
Estates and Green Plan	DCEO 007	Commence delivery of the implementation plans that will support each area of the Estates Strategy	-	On track limited assurance	On hold until ICB reorganisation undertaken.	
	DCEO 008	Deliver agreed Estates recovery and Cost Improvement Programmes (CIP)	A	On track limited assurance Three of the four remaining gen sets have been closed at community hospitals and mitigated against at least £650,000 spent this year and will make a revenue saving of around £7000 a year based on actions taken.	Community estate has four properties remaining from the initial tranche of void assets. These shall be progressed however future assets require service design and consultation prior to estates decisions being made.	Continuing to 25/26 Objective 17.
	DCEO 009	Enhance the patient experience by improving access to primary care facilities.	A	On track limited assurance All schemes are being progressed as best as possible that shall be subject to national funding offer for primary care estates developments. All the work surrounding primary care estate has been completed and signed off through the PCN strategy work.	We understand what credit or capital will be provided by NHSE to fund the programme.	Continuing to 25/26 Objective 17
	DCEO 010	Refresh the ICS Green Plan by 2025	G	On Track and ongoing	Refresh the ICS Green Plan by July 2025	Continuing to 25/26 Objective 17.
	DCEO 011	Draft ICB report and annual report with data base line collection.	G	Completed Submission of the Environmental element of the 24/25 Annual Report was made March 2025		Continuing to 25/26 Objective 17.

Objectives by Exception Partial and Limited Assurance:

	Objective no.	Objective description	On Track?	Year End declared Position	Additional information relating to 2025/26
Quality Improvement.	CNO 016	Establish a framework for quality assuring the standards expected of any digital services that children and young people can access; with a central resource that children and young people can be signposted too	-	Action not progressed on transfer due to prioritisation of existing CNO Directorate objectives. Risks related to not progressing this objective are mitigated through EQIA and procurement processes for any new digital service being considered for implementation.	This objective will be reconsidered in future planning, noting revised system priorities in 25/26 plan.
Maternity, Neonatal and Women's Health	CNO 004	Collaborate with system partners to implement the three-year maternity and neonatal delivery plan, focusing on safety, personalisation, and workforce development. The Core20PLUS5 approach for women and birthing people will be implemented as part of the core programme.	A	Three-year plan (2023-2027): Partial Assurance: Process progress monitoring limited by ICB capacity to monitor. Targets/ Success measures: Off Track some individual objectives are on track or completed in year	Ongoing 25/26.
	CNO 010	Prioritise the Special Education Needs and Disabilities (SEND) of children and families across Devon ICS, embedding SEND reforms in line with local inspection findings within mandated timeframes	A	Off track and partially assured. EHCP Sitrep Delayed: work underway new role within the team to support review and contracting support agreed but anticipate capacity will not be fully released until after Torbay and Plymouth SEND Local Area inspections. 2. Evaluate Autism in schools impact: Delayed until end 2025 due to significant capacity reduction, workload and time constraints of PINS project which superseded this work. 3. Evaluation of new EHCP process and timeliness: Delayed: until reconfiguration of, and additional capacity within the team, following restructure to support this is identified. Process will need to embed and timeliness to be measured post implementation.	Ongoing 25/26

	Obj no.	Objective description	On Track?	Year End declared Position	Additional information relating to 2025/26
	CMO 008	Provide more timely dementia diagnoses and coordinated care planning by increasing the dementia diagnosis rate to 65% by March 2025.	A	Partial Assurance. As of February 2025, NHS Devon achieved a 58.3% against a 67% target. Some of the actions	Ongoing 25/26. Nationally, as part of the 25/26 operating plan, dementia diagnostic rates were not included as a 'must do.' However, the MH commissioning

	Obj no.	Objective description	On Track?	Year End declared Position	Additional information relating to 2025/26
				planned for q4 could not be implemented due to a capacity challenge.	team will continue to maximise opportunities that will maintain and/or improve dementia diagnosis rates. This is part of objective 4
	CMO 012/ 015	Develop a business case for a community-based alternative to hospital admission for individuals with severely disordered eating with atypical features or which is secondary to neurodiversity &/or trauma-based issues. Work to ensure that all acute hospital trusts across the ICB work to the same protocol of medical admissions for "Physiological rescue" admissions with rapid admission and rapid discharge within a 14-21 day time frame and similar criteria for NG feeding, enhanced nursing, restraint, sedation, use of legislation and working with liaison psychiatry.			*CMO 12 and CMO 15 Merged to this objective for 25'26:* Ensure we are commissioning a safe and effective service for people with severe eating disorders that require significant clinical input Continue in 25/26 Objective 4
	CMO 017	Reduce reliance on mental health inpatient care for people with learning disabilities and autistic individuals, achieving a target of no more than 30 adults and 12–15 under 18s per 1 million population.	A	Partial assurance for 24/25. We are not on target for as we come to year-end, but our position is well known and understood with NHSE and region.	Ongoing 25/26: This year's targets will be split between LD and ASC, and we start the new financial year in a poor position with a move to reduction by March 2026. It is in our annual plan (objective 4) and the new bed capacity in region and community pathway will support our ongoing position.
	CMO 021	Continue to implement the LeDeR programme to enhancing care, reducing health inequalities, and preventing premature deaths	A	Partial assurance for 24/25.	LeDeR is part of the 2025/2026 annual plan we have resource in place to manage the reviews and we are focussing this year (25'26) on actioning the learning.

	Obj no.	Objective description	On Track?	Year End declared Position	Additional information relating to 2025/26
		among individuals with learning disabilities and autism.			
	CMO 022	Support the delivery and use of the reasonable adjustment digital flag to reduce health inequalities among people with learning disabilities and autistic individuals.	A	Partial assurance for 24/25.	Ongoing 25/26: objective 4 of annual plan. On going project that has made huge successes in several EPR areas across the county. It is ongoing work and part of next year's plan. To continue roll out across the system. The delivery sits within our IT team.
	CMO 028	Implement the national Inclusion Health Framework to ensure health equity and support the needs of the most vulnerable groups.	A	Partial Assurance: Good progress made with limited resources.	Plans in place for implementation in 25/26 as part of Objective 1
	CMO 032	Expand and develop High Intensity User (HIU) services and establish system working arrangements to support ongoing learning and development.	R	Limited Assurance for 24/25	Work will be carried forward in 25/26 led by localities - Key task which needs to be picked up in the Annual Plan is the commissioning of the HIU services linked to EDs as per NHSE model ensuring we have equity across the county.
Acute Services Strategy	CMO 042	Transform acute services to ensure workforce, clinical and financial sustainability.	A	Partial Assurance achievement for 24/25	Work will continue into 25/26 within Objective 11: Clinical Service change and transformation.
	CMO 043	Stabilise acute services that are fragile	A	Partial Assurance achievement for 24/25	Work will continue into 25/26 within Objective 11: Clinical Service change and transformation.

Chief Operating Officer

Overview of Assurance – Partially Assured

There are a total of 39 objectives being actively monitored within the COO directorate of which 67% (26) are fully assured to deliver within the expected timescales, 25% (10) are partially assured and 8% (3) limited assurance.

COO directorate staffing structure consists of **155.80 FTE** at a cost **£8.67m**.

Objective Dashboard

	Obj no.	Objective description	On Track?	Year End declared Position	Additional information relating to 2025/26
	COO 003	Support Devon Primary Care Network (PCNs) to adopt an integrated, proactive approach to care and support	A	Partially Assured for 24/25. .	Ongoing 25/26: For 25/26, this will form part of ICB Objective 8: Proactive, Preventative, Personalised Care at Home Delivery Plan
	COO 004	Implement personalised care across integrated teams, focusing on the most benefiting groups such as end-of-life, frailty, and dementia.	A	This objective will remain partially assured for remaining of FY24/25. Work is happening across Devon for example EoL and Frailty in place as part of the wider plan and Dementia sits within the mental health workstream with a primary care element.	Ongoing 25/26: Work is happening across Devon for example EoL and Frailty in place as part of the wider plan and Dementia sits within the mental health workstream with a primary care element. For 25/26, this will form part of ICB Objective 8: Proactive, Preventative, Personalised Care at Home Delivery Plan
Urgent and Emergency Care	COO 009	Increase the proportion of A&E patients seen within four hours to at least 78% by March 2025	A	Partial Assurance for 24/25. 4-hour performance improvement in year from 65% to 69%. However, this position has remained volatile and despite seeing marginal improvements overall, this has proven difficult to sustain.	Plans for 25/26 focus on demand management and supporting the mitigation of any demand over 2%, which will be absorbed within provider operational plans. NHS Devon actions include the development of a virtual ED model and providing Same Day Primary Care and ARI Hubs."
	COO 010	Achieve an average response time of 30 minutes for Category 2 ambulance calls during 2024/25	A	Partial Assurance for 24/25: CAT 2 performance has improved from 58 mins (23/24-year end to 39 mins 24/25-year end).	SWAST's system development and improvement plan focuses on releasing capacity by reducing sickness, sustaining higher levels of 'hear and treat', reducing the time vehicles are 'off the road' and better use of alternatives.

					(Note: Cat 2 performance is not an ICB target and the learning for 25/26 annual plan has ensured a greater focus on ICB objectives).
	COO 015	Implement Acute Frailty Services operating 70 hours per week (10 hours per day) at all three acute trust organisations, ensuring alignment with Virtual Wards and community-based services for individuals aged over 65.	A	Partial assurance for 24/25 All Acutes have developed frailty pathways over the course of the year, however, some are more developed than others.	Ongoing for 25/26: Frailty remains an area of focus through 25/26, recognising that Devon is an outlier with LOS for patients over 65. Furthermore, schemes are in place to support the redirection of frail patients to these alternatives, which include Frailty SDEC and virtual wards.
	COO 017	Establish consistent proactive clinical care in care homes, aiming for a 20% reduction in unplanned admissions for people aged 65+, 85% coverage of Electronic Treatment Escalation Plans, and improved pathways for End of Life and falls and frailty by 2025.	A	Partial assurance 24/25. Multiple programmes contributing to increased utilisation of eTEP. Acutes have onboarded or have plans to onboard and nearly all GP practices onboard.	Ongoing: In 25/26 we plan to continue to reduce demand from care home by embedding the 24/25 developments, retaining advice services to support decision making and working with SWAST to prevent conveyances where safe and appropriate.
Elective Care	COO 020	We aim to reduce waiting times for community services, focusing specifically on significant reductions in long waits	A	Partially assured for 24/25	Work to continue in 25/26 as per Operational plan Wait Management T&F Recovery Group now in place as a key deliverable to support 25/26 recovery. Neuro rehab scoping now complete. Gaps remain in general rehab and coding at capture.
	COO 021	Eliminate waits of over 65 weeks for elective care as soon as possible and by September 2024 at the latest (except where patients choose to wait longer or in specific specialties)	A	Partially assured for 24/25	Work to continue in 25/26 Significant work underway across the system to identify further productivity opportunities ahead of the April planning submission. Key to this is repatriation work from the IS which is currently going through check and challenge and sign off.

	COO 023	Increase the proportion of all outpatient attendances that are for first appointments or follow-up appointments attracting a procedure tariff to 46% across 2024/25	A	Partially assured for 24/25 target and anticipating this to be recoverable. System - 45.4% as at February 2025.	This metric will not be a formally tracked one by NHSE for 25/26
	COO 027	Increase the percentage of patients receiving a diagnostic test within six weeks to 95% by March 2025.	R	Not assured/Off track and not likely to recover for 24/25.	Opportunities for stretching CDC performance underway through Q1 of 25/26 and will continue throughout the year. Audiology backlog clearance plans being developed following mobilisation of new providers for 25/26 January validated position is as below against the 95% national target: System = 69.4% RDUH = 63.9% TSD = 59.2% UHP = 86.6%
	COO 028	Improve patient and list management, ensuring at least 90% of patients waiting over 12 weeks are validated at any time	R	Not assured/Off track and unlikely to hit target for 24/25. Stalled improvement from TSD, now at 44%, UHP - 99%, RDUH - 81%. NHS Devon now at 79% of 12ww validated (against a target of 90%)	All acute providers will be taking place in the national validation sprint through Q1 of 25/26 with an expectation of increased performance being maintained through the remainder of the year. The ICB is supporting TSD with some focused work on validation to increase the underperformance and support with the RTT recovery position.
	COO 032	Conduct a review of the neurology headache clinics	R	Off track - risk to delivery for 24/25 due to capacity challenges. Not assured for remainder of 24/25.	Review needs to take place if this will be picked up in 25/26 ICB Annual Plan. This is still pending and unlikely to be able to have capacity to continue, however, we will be managing the demobilisation of Exeter Headache Clinic through Q1 25/26
	COO 039	Establish an early screening, risk assessment and health	A	Off track and partially assured.	A case for funding for 25/26 has been submitted to the Population Health Team.

		optimisation programme for patients waiting extended periods and/or coming from demographics experiencing health inequalities		This will remain only partially assured for FY24/25. End 24/25 position: Service remained under-utilised through 24/25 due to lack of capacity within Trusts to screen and consent patients.	

NHS Devon

NHS Devon Integrated Care Board

Mental Health Assertive and Intensive Outreach Action Plan Update

Date of Meeting	Date Report Produced
29 May 2025	16 April 2025

Author(s)		Report approved by	
Name and title:	Louise Arrow Head of Adults/Older Adults Mental Health Commissioning	**Name and title:**	Peter Collins, Chief Medical Officer
Phone:		**Date:**	16 April 2025
Email:	l.arrow1@nhs.net		

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

Executive summary
Following the Valdo Calocane case, in September 2024 NHS England (NHSE) required Integrated Care Boards (ICBs) to coordinate an urgent assessment of the current provision of intensive and assertive outreach services with initial findings and anticipated actions being discussed at public board. For NHS Devon, this discussion took place at the meeting of the Board in public on 28 November 2024. Following the publication of the Independent Mental Health Homicide Investigation in February 2025 (aligned to the Valdo Calocane case), NHSE required ICBs to review progress against the previously identified actions, ensure alignment of actions to themes from this investigation and for this to be discussed at public board. This is the focus of this report.

One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

The immediate mitigating actions previously identified are aligned to the findings from the investigation namely personalised assessment of risk across community and inpatient teams; joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies); multi-agency working and information sharing; working closely with families; and eliminating Out of Area Placements in line with ICB 3-year plans.

Mental health providers having made steady progress against delivery and have executive governance arrangements in place.

The implementation of the longer term actions which require additional resource have been included within operational planning for 2025/26.

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

Reviewed by the NHS Devon Executive at its meeting on 29 April 2025.

Key recommendations and actions requested

NOTE the update on progress against the mental health assertive and intensive outreach action plan.

TAKE SATISFACTORY ASSURANCE from the establishment of Mental Health Planning and Delivery meetings

NOTE that, while the identified actions aim to reduce risks, some level of risk will remain, even with enhanced service delivery and workforce capacity aligned to this high risk group of individuals.

Impact on NHS Devon objectives

Objective	Impact
Improve population health	Enhanced wellbeing and health outcomes for individuals with severe mental illness, particularly those needing intensive and assertive community care. Early intervention and targeted support will reduce health inequalities and prevent deterioration of conditions.
Improve services and reduced unwarranted variation	Reducing variation in service delivery ensures equitable care for all patients, addressing regional disparities and enhancing access to appropriate support**.**
Make more efficient use of our resources	Optimised allocation of resources through workforce planning, integrated services, and targeted interventions. By improving operational efficiencies, we can reduce pressure on acute services and focus resources on prevention and early support**.**

Develop our culture and how we operate	A more collaborative, learning oriented culture that encourages cross-organisational cooperation. Improved staff engagement, training, and reflective practice will ensure a proactive, patient centred approach to delivering care, fostering innovation and continual service improvement

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	The review and subsequent progress against plans seek to address gaps in pathway provision will improve the quality of services received.
Health inequalities	The initial review (September 2024) identified that certain vulnerable populations, particularly those with complex needs like homelessness and substance misuse, are not receiving the level of support required. Addressing these gaps will reduce health inequalities and ensure equitable access to intensive community care. The report highlights progress made to address inequalities for this high risk cohort.
Workforce	The initial review highlighted workforce capacity required to meet capped caseloads numbers. The outcome from Operational Planning 2025/26 will determine any further risks or mitigations required.
Resources and finance	There are financial implications related to any expansion of workforce capacity, enhancing training, and integrating services. Addressing the demand-capacity gap will require additional funding, and NHSE support is likely needed for resource allocation (MHIS/SDF).
Legal	Ensuring compliance with national guidance and legal frameworks is essential, particularly in areas such as safeguarding, the Mental Capacity Act, and the Mental Health Act. Policies need to be continually reviewed to remain legally compliant.
Digital and Data	The initial review highlighted a need for improved data collection and integration across health and social care services. Enhanced data dashboards and analytics will help monitor patient outcomes, track service effectiveness, and align resources with demand. Progress is being made to address this.
Engagement and consultation	Continued engagement with VCSE partners, patients, and experts by experience is vital. Involvement of families and carers was a key action required following the initial review and a key theme from the independent investigation. Incorporating their insights into service design and delivery will ensure services are more person-centred and responsive to patient needs Both providers are progressing to enhance family/carer involvement in care planning and risk assessment.

Mental Health Assertive and Intensive Outreach Action Plan Update

Introduction and background

1. In September 2024, a review was undertaken of the provision for an intensive response for people with severe mental illnesses, such as psychotic illnesses and bipolar affective disorder. The review and subsequent report to the meeting of the NHS Devon Board meeting in public on 28 November 2024 were in response to a directive from NHS England (NHSE) following the Valdo Calocane case, which highlighted gaps in care for high-risk individuals who struggle to engage with traditional mental health services.

2. In February 2025, NHSE wrote to all Integrated Care Boards (ICBs) directing that previous action plans be reviewed and amended accordingly, paying due regard to the issues identified in the Independent Mental Health Homicide Investigation[1]. The investigation was commissioned by NHSE, aligned to the Valdo Calocane case, following the fatal stabbings of three people in Nottingham in June 2023, with three others sustaining serious injuries. The purpose of the investigation was to help the NHS and partners understand if there were lessons that could be learned that could prevent something similar happening in the future.

3. The key areas for particular attention from this investigation were detailed by NHSE as being:

    - personalised assessment of risk across community and inpatient teams
    - joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies)
    - multi-agency working and information sharing
    - working closely with families
    - eliminating Out of Area Placements in line with ICB 3-year plans

4. The scope of those included in the original review was defined by NHSE in September 2024 and is detailed below.

    Individuals who:
    - Are presenting with psychosis (but not necessarily given a diagnosis of psychotic illness)
    - May not respond to, want to or may struggle to access and use ‘routine’ monitoring, support and treatment
    - Lack insight into their condition and struggle to remain concordant with any treatment

[1] https://www.england.nhs.uk/midlands/wp-content/uploads/sites/46/2025/02/independent-investigation-into-the-care-and-treatment-provided-to-vc.pdf

- Are vulnerable to relapse and/or deterioration with the potential for serious subsequent harm (e.g. suicide, neglect, violence and aggression)
- Have multiple social needs (housing, finance, self-neglect, isolation etc)
- Likely present with co-occurring problems (e.g. drug and alcohol use/dependence)
- May have had negative (e.g. harmful and/or traumatic) experiences of mental health services or other functions of the state (e.g. the criminal justice systems)
- Concerns may have been raised by family / carers

Action: Progress

Governance and Oversight:

5. The original proposal was for the Mental Health, Learning Disability and Neurodiversity (MHLDN) Collaborative to hold responsibility for delivery of the recommendations and reporting back to NHS Devon.

6. Following the establishment of Mental Health Planning and Delivery Meetings at the end of 2024/25, oversight of this area of work will be overseen through this mechanism. These meetings are chaired by the Chief Executive of NHS Devon and attended by the Chief Executives from the Mental Health providers.

7. This governance structure ensures cross organisational coordination and regular updates on progress, risks, and resource needs, ensuring that the programme remains aligned with the ICB's strategic objectives and required response to NHSE. This would encompass all actions identified aligned to this area of work.

Immediate Actions - Providers (Minimal Cost):

8. Recommendations were aligned to the key findings of the Independent Review. It should be recognised that many of the actions taken will have an impact across the themes identified.

   Personalised assessment of risk across community and inpatient teams: Embed Did Not Attend (DNA) Policies

   Progress: Providers have strengthened policies to ensure that DNA is not used as a reason for discharge and non-attendance is discussed routinely within multi-disciplinary team meetings.
   Next steps: Monitoring and auditing of adherence to policy (provider led)

   <u>Working closely with families:</u>

   Strengthen family and carer involvement through family inclusive care plans and provide direct access to care coordinators for families to raise concerns.

Progress: Actions taken to date include implementation of a personalised risk assessment to include family/carer information/concerns, embedding Triangle of Care framework[2] and Trust Carer Strategy[3] specifically to those in scope of this review.
Next steps: auditing and monitoring of impact of actions taken (provider led)

Joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies)

Progress: Within the Devon and Torbay footprint, a discharge lead role has been created that will hold oversight of ensuring that coproduced (including family/carers), planned risk assessed discharge plans are in place. This role will cross inpatient and community services.
Within the Plymouth footprint, work is progressing in enhancing collaboration between internal teams through streamlining discharge processes and fostering seamless transitions.
Next steps: monitoring of impact of and sharing learning (provider led)

Multi-agency working and information sharing:

Providers to consider the establishment of a centralised register of high risk individuals, supported by regular daily huddle risk assessment meetings (or similar) across care teams to monitor engagement and follow up.

Progress: a quality improvement project aligned to this has been implemented by a community team in Torbay. Implementing and trialling changes within one local team, enables learning to be maximised before larger scale roll out. The evaluation of this project including patient/carer experience will enable proposals to be formalised in relation to the implementation of a distance monitoring approach, alongside a dynamic register
Next steps: The evaluation and learning from this project will be presented in May 2025 (provider led in first instance to draw evaluation together).

Eliminating Out of Area Placements in line with ICB 3-year plans

Progress: Devon Partnership Trust opened additional local beds; and both Devon Partnership Trust and Livewell Southwest have submitted capital bids to NHSE to further increase local bed capacity. NHS Devon is awaiting the outcome of these bids. Work is ongoing to eliminate out of area placements and continues to form a key part of operational plans between the ICB and mental health providers in 2025/2026.
Next steps: The operating plan for 2025/26, has reducing out of area placements as a priority area for focus. This plan is currently in process of being finalised. One area of focus during 2025/26 will be on enabling those, who due to the complexity of their needs, are experiencing a delay in their discharge/transfer back into community provision and require a bespoke community based

[2] https://carers.org/triangle-of-care/the-triangle-of-care
[3] https://www.dpt.nhs.uk/news/introducing-the-carers-strategy-2024-2027#:~:text=The%20strategy%20puts%20carers%20at,ensure%20carers%20are%20supported

provision. Through a focus on improving bed flow, the need to use out of area placements will reduce. (provider and ICB commissioning joint working).

Longer Term Actions as part of the developing programme of work Commissioners and Providers (High Cost)

9. Whilst it is vital that people have access to appropriate beds when required, NHS Devon with mental health providers, is working towards sustainable prevention and maintenance of wellbeing within the community. These plans align to the longer term actions identified following the initial audit in October 2024, namely workforce expansion and caseload management.

10. Plans include further investment to increase capacity within home treatment and community teams, as well as scoping plans for a 24/7 community based hub.

11. In relation to the recommendation aligned to addressing commissioning gaps, particularly in relation to substance misuse, discussions have commenced with local authority commissioning colleagues, with recommended actions to be agreed by end of May 2025.

Acknowledgement of Risk

12. As detailed in the previous report to the Board, the nature of the population that this report focuses upon, means that full risk mitigation is unlikely. While the identified actions aim to reduce risks and improve engagement, it is recommended that the Board continues to recognise that some level of risk will remain, even with enhanced service delivery and workforce capacity. This understanding should continue to be factored into governance and risk management framework aligned to this area of work.

South West Provider Collaborative (SWPC)

13. The SWPC are working across the region with providers around a clinical model aligned to Assertive Outreach to reduce variation, share best practice and develop shared protocol for joint working. Both mental health providers in Devon are involved in this work. The focus of this work has recently been defined. Further updates will be available once the work has progressed. Local providers and commissioners will continue to link with the work as appropriate.

Conclusion

14. The Valdo Calocane case and subsequent outcome from the Independent Mental Health Homicide Investigation highlights the need for a continuation of focus on ensuring that the intensive support and intervention for this high risk group of individuals is available.

15. The actions identified, following the audit in October 2024, align to the themes from the Independent Investigation.

16. Providers have made steady progress in the implementation of immediate actions identified, with the next phase being to monitor and understand the impact of the changes made. Both providers have executive oversight and reporting in place for their individual action plans.

17. The Board is asked to:

- **Note** the update on progress against the mental health assertive and intensive outreach action plan.
- **Take satisfactory assurance** from the establishment of Mental Health Planning and Delivery meetings
- **Note** that, while the identified actions aim to reduce risks, some level of risk will remain, even with enhanced service delivery and workforce capacity aligned to this high risk group of individuals.

NHS Devon Integrated Care Board

NHS Devon (ICB) Finance Report Month 12

Date of Meeting	Date Report Produced
29 May 2025	22 April 2025

Author(s)		Report Approved By	
Name and title:	Kevin Wheller Deputy Director of Finance	**Name and title:**	Kirsty Denwood Interim Chief Finance Officer
Phone:	07825 027569	**Date:**	22 April 2025
Email:	kevin.wheller@nhs.net		

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

Executive Summary
The presentation of the NHS Devon's (Integrated Care Board (ICBs)) Finance Report seeks to provide the necessary assurance to the Board on the financial position of NHS Devon for the year ended 31 March 2025. The assurance ratings in this report are based on an assessment of the key issues and risks identified and are as follows:

Section	Assurance	Trend from previous month
Overall assurance	**Satisfactory**	**No change**
Financial performance	Satisfactory	No change
Savings and efficiencies	Satisfactory	No change
Financial risks	Satisfactory	No change

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

NHS Devon Executive considered this report at its meeting on 29 April 2025.
The Finance and Performance Committee considered this report at its meeting on 08 May 2025.

Key recommendations and actions requested

TAKE SATISFACTORY ASSURANCE from the information provided with regard to the NHS Devon financial position as at the year ended 31 March 2025.

Impact on NHS Devon Objectives

Objective	Impact
Improve Population Health	All
Improve Services and Reduce Unwarranted Variation	
Make More Efficient Use of Our Resources	
Develop Our Culture and How We Operate	

Outline the implications of matters covered in this report for the following areas

Area	
Quality of Services	None
Health Inequalities	None
Workforce	None
Resources and Finance	Delivery of financial sustainability.
Legal	None
Digital and Data	None
Engagement and Consultation	None

NHS Devon (ICB) Finance Report Month 12

Executive Summary

1. The presentation of NHS Devon's (Integrated Care Board (ICB)) Finance Report seeks to provide the necessary assurance to the Board on the financial position for the year ended 31 March 2025.

2. NHS Devon's funding envelope includes allocations for Primary Medical Care Services, Elective Recovery, Ambulance capacity funding and Discharge funding as well as funding for Service Development.

3. The One Devon Integrated Care System (ICS) submitted an original deficit plan of £85.4m and an expectation that £207.9m of efficiency savings were needed to meet that plan. Within the plan, NHS Devon's financial position was an underspend of £23.0m with a requirement to deliver £74.7m of efficiency savings (£31.8m net of system provided embedded efficiency).

4. After the initial plan was submitted, NHS England (NHSE) required the One Devon ICS to revise its plan to a deficit of £80.0m. Consequently, the One Devon ICS efficiency savings target increased from £207.9m to £213.3m. NHS Devon's required underspend rose from £23.0m to £28.4m, resulting in a total efficiency savings requirement of £80.1m (£37.3m net of system-provided embedded efficiency).

5. At Month 6, NHSE provided the One Devon ICS with £80.0m in non-recurrent deficit support, with the expectation that the One Devon ICS would achieve financial balance by the end of the year. The deficit support would be repayable in subsequent years.

6. At Month 8, the forecast outturn (FOT) deficit for Torbay and South Devon NHS Foundation Trust (TSD) increased by £15.0m, while University Hospitals Plymouth NHS Trust (UHP) saw a rise of £5.5m. However, Royal Devon University Healthcare NHS Foundation Trust (RDUH) and NHS Devon offset these increases with FOT surplus improvements of £2.8m and £17.7m, respectively, enabling the One Devon ICS to maintain an overall balanced position.

7. At Month 11, cost pressures began to crystalise across the One Devon ICS. It was also apparent that further non recurrent allocations to support winter pressures were unlikely. In order to recognise and manage the pressures within TSD, NHS Devon felt it was appropriate to revert to the original plan of using the £17.7m M8 improvement within NHS Devon to support the One Devon ICS over winter and was therefore unable to deliver the additional surplus required to manage the M8 position.

8. As a consequence of the above, the changes in the financial performance of One Devon ICS organisations resulted in a deterioration of £5.0m for TSD, a deterioration of £2.8m for RDUHT and an improvement of £5.5m for UHP.

9. Having utilised it's M8 improvement to manage winter pressures, NHS Devon revised its FOT surplus from £46.1m, reported at Month 10, back to the originally planned surplus of £28.4m.

10. The combination of the above movements has resulted in the One Devon ICS position moving from an overall balanced position at Month 10 to a £20.0m deficit.

Financial Position

11. The following detailed report reflects the budget set compared with the actual commitments against that budget for the year ending 31 March 2025.

As at 31 March 2025	Year to date		
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000
Total Net Expenditure	3,172,206	3,172,206	(0)
Resource Allocation	3,200,625	3,200,625	0
Total Commissioned Services	**28,419**	**28,419**	**(0)**

12. NHS Devon's 2024/25 outturn is a £28.4m surplus.

13. At month 12, many of the service lines exceeded budget, including some acute services, community health, continuing healthcare individual placements and delegated primary care commissioning. These variances have been offset by underspends in running costs, other programme services and contingencies set aside at plan to manage variation.

14. Service line variances are detailed in the detailed financial performance section and appendix 3.

Savings Plan

15. At month 12, NHS Devon achieved savings of £97.9m, reflecting additional savings of £17.8m. These variances are attributable mainly to balance sheet flexibilities, reserves, projected in year underspends and slippage on investments.

16. Details are disclosed in the savings and efficiencies section.

Risks

17. All risks identified at plan and throughout the year have been mitigated as at 31 March 2025.

Conclusion

18. As at 31 March 2025, NHS Devon reported a surplus of £28.4m in line with the plan.

Detailed Financial Performance

19. The outturn by main service heading as at 31 March 2025 is as follows:

Service	Year to date		
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000
Acute	1,604,501	1,606,278	(1,777)
Mental Health	333,226	337,159	(3,933)
Community Health	359,607	363,175	(3,567)
Continuing Care	168,362	170,367	(2,005)
Primary Care	287,735	286,394	1,341
Delegated Primary Care	257,246	259,361	(2,115)
Delegated Dental	77,998	81,734	(3,736)
Delegated Pharmacy	33,061	31,900	1,161
Delegated Optometry	12,520	12,325	195
Other Programme Services	37,212	33,783	3,429
Total Commissioned Services	**3,171,468**	**3,182,475**	**(11,008)**
Running Costs	21,520	19,503	2,017
Net Expenditure	**3,192,988**	**3,201,978**	**(8,990)**
Reserves/Contingencies	(20,782)	(29,772)	8,990
Total Net Expenditure	**3,172,206**	**3,172,206**	**(0)**
Resource Allocation	3,200,625	3,200,625	0
Total Commissioned Services	**28,419**	**28,419**	**(0)**

20. Further detail of the budgets, actual spend and variances making up the main service areas above is provided in Appendix 3.

Acute Services

21. Acute services include contracts with our main system acute providers as well as contracts with acute providers in Cornwall, Somerset, Bristol and London. It also includes our contract with South Western Ambulance Service NHS Foundation Trust, contracts for patient transport and contracts for acute procedures undertaken in the independent sector and by other non-NHS providers.

22. NHS Devon and One Devon ICS providers have agreed a set of block contract payments that also include top-up payments and growth funding allocations. NHS Devon's budget under these financial arrangements has been set to match the payments.

23. At Month 12 there is a total overspend of £1.8m. This is mainly made up of overspends in acute NHS and independent sector contracts of £0.6m and £3.7m respectively. This overspend is partially offset by underspends in non-contracted acute activity (£1.8m) and patient transport (£0.7m).

Mental Health Services

24. The mental health budget commissions mental health, learning disability, autism and neurodiversity services for adult, children and young people. The main contracts for the services are with Devon Partnership NHS Trust (DPT) and Livewell Southwest, with the child and adolescent mental health service (CAMHS) for northern, eastern and southern localities being provided by Children and Families Health Devon through a contract with TSD. This section also includes spend relating to individual adult placements for mental health and learning disability services.

25. In 2024/25 NHS Devon planned to invest an additional £13.1m (4.46%) in mental health services based on the Mental Health Investment Standard target. In addition to this, NHS Devon has received £25.0m of Service Development Fund (SDF) Transformation funding for mental health, learning disability and autism services.

26. At Month 12, there is a £3.9m overspend, primarily driven by increased costs in right to choose attention deficit hyperactivity disorder (ADHD) and autism spectrum disorder (ASD) assessments (£3.1m), s117 learning disability and mental health (£1.0m), and individual patient placements (£1.2m). This is partially offset by a £1.4m underspend in other mental health areas.

27. There is a growing number of providers in the right to choose ADHD / ASD assessment pathway, with many of them now providing services under the NHS Devon right to choose ADHD / ASD assessment contract, which is providing more control and understanding of costs. However, these arrangements are not managing the level of referrals which is impacting on the overall increase in spend.

28. Plans are being developed to seek to address the backlog of children's assessments through a procured service with a single provider which will help reduce the growing right to choose activity. In addition to this, we have recently appointed a woman's and children's transformation director to focus, amongst other things, on improvements in children's services.

Community Health Services

29. Community healthcare services include contracts with One Devon ICS partners for the provision of community healthcare (including community hospitals and children's services) as well as minor injury units.

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

31. At month 12, community health services report an overspend of £3.6m. This comprises £1.1m relating to individual patient placements, £1.5m arising from the Better Care Fund agreement with Devon County Council, and £1.1m across other community services. These pressures are partially offset by small underspends in other areas.

Continuing Healthcare

32. Placements includes continuing care budgets comprising of continuing care administration, continuing healthcare (CHC), interim funding, joint funding, children's continuing care and funded nursing care (FNC).

33. The placements budget represents a particular risk to NHS Devon's financial position that requires robust financial management. The key risks relate to local authority disputes to the external provider review programme and breaches from the continuation of four-week hospital discharge programme.

34. Some examples of other risks include:

- Fluctuations in the number of clients eligible for financial support;
- Assessments exceeding 28 days;
- Unexpected exceptional levels of support required for some clients; and
- Responsible commissioner cases.

35. The Month 12 outturn position is £2.0m over budget, a deterioration of £0.8m compared to last month. The overspend is a result of greater than budgeted standard CHC and FNC clients for large periods of the year, unplanned high-cost clients and omission of pay award budget but off-set, in part, by an underspend in interim funding.

Other Programme

36. All other programme area picks up the remaining community-based provision of healthcare services including hospice care and other voluntary sector grant based commissioned services. This area also includes the element of our integrated urgent care contract that relates to NHS 111.

37. As at Month 12 there is an underspend of £3.4m, comprising of underspends across various services, including NHS 111 and medical and nursing team recharges.

Primary Care Services

38. Primary care includes expenditure on primary care prescribing, GP medical services, enhanced services, out-of-hours and other primary care related expenditure including GP IT.

Prescribing

39. Expenditure data for the first ten months of 2024/25 was available at the time of reporting and the national forecast now gives a position that is £3.3m lower than our prescribing budget. This feeds into our overall prescribing costs which contains recharges and other drug related spend to give a reported figure of £0.3m below plan.

40. There are multiple factors influencing our prescribing expenditure. This includes national price changes to Direct Oral Anticoagulant (DOAC) drugs, national changes to Category M, the phasing of flu vaccinations and uncertainty surrounding the usage of drugs that are coming off patent.

Delegated GP Commissioning

41. At the end of the year we are reporting an overspend of £2.1m across delegated primary medical care.

Other Primary Care

42. Other Primary Care services include contracts for Enhanced GP Services, Out of Hours GP services, Home Oxygen services and provision for GP IT costs.

43. At Month 12, we are reporting underspends within Out of Hours GP services of £0.1m, Home Oxygen services of £0.6m and Other Primary Care of £0.3m.

Delegated Pharmacy, Ophthalmic & Dental

44. At year end we are reporting an overspend position against delegated Dental services of £3.7m primarily as a result of increased secondary healthcare dental costs. Ophthalmic is now showing an underspend by £0.2m and pharmacy by £1.2m, both driven by lower than anticipated activity levels.

Running Costs

45. The pay and associated costs for NHS Devon are categorised into programme and administrative costs according to whether they relate to healthcare services and are solely concerned with management of the organisation. Variances relating to programme pay costs are reported within other earlier sections including acute services, placements and other programme costs.

46. Each year NHS Devon receives a specific allocation for its running costs and has an obligation to report against it separately and must not overspend against the limit set.

47. NHS Devon's annual allocation is £21.5m, including £1.9m for pension costs. At Month 12, NHS Devon underspent on running costs by £2.0m, primarily driven by the organisational restructure and delays in recruiting to the new structure.

Resource Allocation

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

Allocation Description	Year to date
	ICB
2024/25 Recurrent core allocation	2,337,140
2024/25 Additional discharge allocation	10,641
2024/25 Additional physical and virtual bed capacity fundin	41,869
2024/25 Allocation baseline reset (limited public health exe	859
2024/25 Ambulance capacity funding	7,545
Pay Award - Cost increases on initial allocations	6,743
Learning disability and autism FTA	(917)
Running Costs Allowance	19,461
Delegated Primary Medical Care Services	236,680
Delegated Dental/Optomotry/Pharmacy	122,144
M3 - 7 Recurrent Allocations	66,333
M8 Recurrent Allocations	(1,690)
M10 Recurrent Allocations	954
Recurrent Allocation	**2,847,762**
SDF Cancer	12,813
SDF Maternity	2,129
SDF LD and Autism	2,916
SDF CYP	710
SDF Mental Health	20,762
SDF Prevention and Long Term Conditions	1,808
SDF Primary Care	3,005
SDF Community Services	1,745
Other SDF	1,924
Elective Recovery Funding	45,437
Adult Long COVID	1,362
Charge exempt overseas visitor and UK cross border adju	(672)
COVID-19 Testing	1,801
Pay Award	800
Repayment of prior year deficit	(11,686)
Delegated ERF	1,808
Delegated Primary Care Allocation	(142)
Delegated Primary Care Allocation - RDUHFT contract	(1,103)
Pay Award - Cost increase on Secondary Dental plans	67
Pay Award - Cost increase on Secondary Dental ERF	8
M3 - 7 Non Recurrent Allocations	115,520
M8 Non Recurrent Allocations	36,599
M9 Non Recurrent Allocations	16,333
M10 Non Recurrent Allocations	28,771
M11 Non Recurrent Allocations	64,309
M12 Non Recurrent Allocations	5,839
Non-Recurrent Allocation	**352,863**
Total Allocation	**3,200,625**

Budget Reserves

49. To support NHS Devon in achieving its financial plan, budget reserves are maintained for both anticipated and unforeseen costs. These reserves currently include contingency funds, undistributed allocations, as well as, expected non-recurrent allocations.

50. The reserve position at Month 12 is as follows:

Reserve Description	Year to date		
	Budget £000	Committed £000	Variance Favourable/ (Adverse) £000
System Reserves	7,706	0	7,706
Service Development Funding	1,012	0	1,012
Investment Reserves	(7,455)	(4,647)	(2,808)
Allocation Reserves	(22,045)	(25,125)	3,080
Total	**(20,782)**	**(29,772)**	**8,990**

51. System reserves relate mainly to undistributed funds from the system plan.

52. Service development funds are those allocations yet to be delegated to budgets but that have expected commitments. The variance represents slippage in plans.

53. Investment reserves include recurrent budgets at plan that relate to NHS Devon commitments and efficiency savings (negative reserve) as well as a contingency. The variance represents a shortfall in planning expectations.

54. The allocation reserve includes in year allocations received that haven't been delegated to budgets as well as a provision (negative reserve) for allocations confirmed and distributed at the plan. The variance recognises a shortfall in planning expectations.

Conclusion

55. Based on the above reported position and detailed analysis, the assurance on the reported financial performance is considered **Satisfactory**.

Savings and Efficiencies

56. Delivery of the planned surplus of £28.4m required savings of £80.1m. The table below provides a summary of the Month 12 position against the £80.1m target. The target represents a 2.8% saving against NHS Devon's overall resource. If the embedded system provider efficiencies are excluded the remaining savings £37.3m target is 4% of NHS Devon's influenceable budget.

Scheme	Year to date		
	Plan Savings Delivery £000	Actual Savings Delivery £000	Variance Favourable / (Adverse) £000
Acute - System provider embedded efficiency	31,571	31,571	0
Community - System provider embedded efficiency	6,970	6,970	0
Mental Health - System provider embedded efficiency	4,308	4,308	0
	42,849	42,849	0
Non-System provider embedded efficiency	1,000	1,000	0
Prescribing - medicines management	2,732	2,732	0
- secondary care interface	560	560	0
- specific schemes	768	768	0
Continuing healthcare	3,000	3,079	79
Learning disabilities and autism placements	4,750	4,750	0
Commissioning	2,500	2,500	0
Digital	1,000	1,000	0
Hold back growth	3,829	3,829	0
Running cost reductions	4,177	4,177	0
In year allocations review	2,000	2,000	0
Primary care underspend	500	500	0
Primary Care	5,000	5,000	0
System risk share	5,412	5,412	0
Balance sheet flexibility, slippage, underspends and reserves	0	17,710	17,710
Unidentified	0	0	0
Total	**80,077**	**97,866**	**17,789**

57. Prescribing savings plans concentrated on the following schemes:

- Addressing Low Priority Prescribing: This includes medications with significant safety concerns, lack of robust evidence of clinical effectiveness, or those that are clinically effective but deemed a low priority for NHS funding.

- Improving Uptake of Clinically and Cost-Effective Medicines: Promoting the use of the most clinically effective and cost-efficient medications.
- Using Best Value Biologic Medicines: Adhering to NHS England commissioning recommendations to use biologic medicines that offer the best value.
- Appropriate Prescribing and Supply of Blood Glucose and Ketone Meters, and Testing Strips: Ensuring the correct prescribing and supply of these essential items.
- Identifying Patients with Atrial Fibrillation: Using best value direct-acting oral anticoagulants for patients with atrial fibrillation.

58. Continuing healthcare savings plans included the schemes below:

- Continued grip and control of front-end assessment threshold and reviews which will reduce client numbers.
- Ensure clients receiving 1:1/2:1 packages are regularly reviewed to determine if care is still appropriate.
- Assess short-term stay hospital discharge clients in a timely manner to determine their long-term funding stream (KPI for CHC Assessment 28 days).
- Review of s117 clients in a timely manner reducing unnecessary costs.

59. Based on the analysis above, the assurance level for the full delivery of NHS Devon's efficiency plan is **satisfactory.**

Risks

60. All risks identified at plan and throughout the year have been mitigated as at 31 March 2025.

61. Th management of NHS Devon's risks has been considered as **satisfactory.**

Other Financial Information

Statement of Financial Position

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

63. NHS Devon's position at 31 March 2025 is shown in Appendix 1.

Capital

64. NHSE have approved NHS Devon capital schemes totalling £2.15m. Schemes include £0.30m for primary care capital grants, £1.74m GP IT and just over £0.1m for NHS Devon's IT needs.

Better Payment Practice Code

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

66. NHS Devon's current performance against the target of 95% is detailed below:

Better Payment Practice Code	M12	
	Number	£000
Non NHS Creditors - % of bills paid within target	99.81	99.67
NHS Creditors - % of bills paid within target	99.61	100.00

Cash

67. There are several key cash performance targets that ICBs are measured against; these are set out in Appendix 2.

Assurance and Recommendations

68. Based on the assessment of the key issues and risks identified, the overall level of assurance that NHS Devon will achieve its planned forecast outturn is as follows:

Section	Assurance	Trend from previous month
Overall assurance	**Satisfactory**	**No change**
Financial performance	Satisfactory	No change
Savings and efficiencies	Satisfactory	No change
Financial risks	Satisfactory	No change

69. The Board is asked to **take satisfactory assurance** from the information provided with regard to the NHS Devon financial position as at the year ended 31 March 2025.

Appendix 1: Statement of Financial Position

Statement of Financial Position	M12
Property Plant & Equipment	4,593
Intangible Assets	0
Non Current Assest	**4,593**
Inventories	2,239
Trade & Other Receivables - NHS	4,511
Trade & Other Receivables - Non NHS	22,729
Cash & Cash Equivalents	643
Current Assets	**30,122**
Total Assests	**34,715**
Trade & Other Payables - NHS	(26,474)
Trade & Other Payables - Non NHS	(120,882)
Other Liabilities	(6,754)
Borrowings / Cash in Transit	(2,065)
Provisions	(397)
Current Liabilities	**(156,572)**
Total Assets Employed	**(121,857)**
General Fund	(121,857)
Total Taxpayers Equity	**(121,857)**

Appendix 2: Cash

There are several key cash performance targets that NHS Devon is measured against:

Measure	Month 12
ICBs must operate within their Cash Drawdown Requirement *The cash drawdown requirement is based on the revenue and capital resource limits, amended for various non-cash items like depreciation. At present NHS England has calculated this to equate to £3,231m for Devon ICB for the year ended 31st March 2025.*	100% of the Cash Drawdown Requirement has been utilised as at month 12.
ICBs daily and monthly forecasting accuracy and notional charges NHS England is working on implementing a regime of bank charges against ICBs based on the accuracy of daily and monthly cash forecasting*. The start date for any charges to flow through the scheme to the ICB has not yet been confirmed.	The calculations used for the notional charges are currently being reviewed by NHSE and Shared Business Services.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown.	NHS Devon has met the requirement to manage its cash balance at the bank on the last day of the month to be no greater than 1.25% of the drawdown for that month.

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

Appendix 3: Operating Expenditure

The detailed financial position as at 31 March 2025:

Service	Year to date		
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000
NHS Royal Devon & Exeter Foundation Trust	663,836	663,831	5
NHS University Hospitals Plymouth NHS Trust	420,494	420,343	151
NHS Torbay and South Devon NHS Foundatior	315,704	316,573	(869)
NHS South Western Ambulance Trust	86,315	86,315	0
NHS Taunton and Somerset	11,521	11,413	108
Independent Sector	47,340	50,996	(3,656)
Low Volume Activity	9,307	9,318	(11)
Non Contract Activity	3,118	1,317	1,801
AQP	2,110	1,824	287
Referrals Management	2,091	1,896	195
Patient Transport	12,601	11,913	688
Other Acute Services	30,063	30,539	(476)
Acute	**1,604,501**	**1,606,278**	**(1,777)**
Devon Partnership NHS Trust	198,853	198,851	2
Livewell MH Services	8,570	8,567	3
University Hospitals Plymouth MH	50,506	50,506	0
Children and Families Health Devon	22,489	22,488	1
Individual Patient Placements	13,438	14,640	(1,202)
Section 117	30,074	31,066	(991)
ADHD	1,541	4,643	(3,102)
MH Low Volume Activity and NCA	871	856	15
Other Mental Health	6,884	5,542	1,342
Mental Health	**333,226**	**337,159**	**(3,933)**
Livewell Southwest	708	709	(1)
Royal Devon and Exeter Community	103,150	103,150	(0)
Torbay and South Devon FT	74,358	74,358	(0)
University Hospitals Plymouth Community	64,662	64,664	(3)
Children and Families Health Devon	14,663	14,663	(0)
Individual Patient Placements	2,663	3,813	(1,149)
SWAST Tiverton MIU	1,666	1,666	(0)
MIU Contracts	382	376	5
Hospices	9,776	9,855	(80)
Better Care Fund_Plymouth CC	8,584	8,581	3
Better Care Fund_Devon CC	42,251	43,783	(1,532)
Better Care Fund Torbay	4,092	4,092	(0)
Demand and capacity	5,681	5,543	138
Prevention	3,261	3,089	172
Other Community Services	23,712	24,831	(1,120)
Community Health	**359,607**	**363,175**	**(3,567)**
Continuing Healthcare	149,515	151,267	(1,752)
Funded Nursing Care	18,847	19,099	(253)
Continuing Care	**168,362**	**170,367**	**(2,005)**

Service	Year to date		
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000
Prescribing	243,202	242,889	313
Enhanced Services	12,015	12,341	(326)
Delegated Commissioning - Co Commissionin	257,246	259,361	(2,115)
Delegated Commissioning - Optometry	12,520	12,325	195
Delegated Commissioning - Pharmacy	33,061	31,900	1,161
Delegated Commissioning - Dental	77,998	81,734	(3,736)
GP Out Of Hours	9,896	9,764	132
GP IT	5,632	5,556	76
Other Primary Care	16,991	15,845	1,146
Primary Care	**668,559**	**671,714**	**(3,154)**
NHS 111	10,353	10,234	119
Chime Audiology	4,432	4,603	(171)
All Other Commisionned Services	22,428	18,946	3,481
Other Programme	**37,212**	**33,783**	**3,429**
Total Commissioned Services	**3,171,468**	**3,182,475**	**(11,008)**
Pay	16,734	13,218	3,516
Non Pay	4,824	6,408	(1,584)
Income	(39)	(124)	85
Running Costs	**21,520**	**19,503**	**2,017**
Net Expenditure	**3,192,988**	**3,201,978**	**(8,990)**
System Reserves	7,706	0	7,706
SDF Reserves	1,012	0	1,012
Investment Reserves	(7,455)	(4,647)	(2,808)
Non Recurrent ICB Reserves	(22,045)	(25,125)	3,080
Total Net Expenditure	**3,172,206**	**3,172,206**	**(0)**
Resource Allocation	3,200,625	3,200,625	0
Total Surplus	**28,419**	**28,419**	**(0)**

NHS Devon Integrated Care Board

One Devon (ICS) Finance Report Month 12

Date of Meeting	Date Report Produced
29 May 2025	23 April 2025

Author(s)		Report Approved By	
Name and title:	Suzanne Pollard Head of Finance - System	**Name and title:**	Kirsty Denwood Interim Chief Finance Officer
Phone:		**Date:**	
Email:	SuzannePollard@nhs.net		

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

Executive Summary
The presentation of the One Devon Integrated Care System's (ICSs) Finance Report seeks to provide the necessary assurance on the financial position relating to the One Devon ICS financial plan for the year ending 31 March 2025. The report details the One Devon ICS financial position for the period ended 31 March 2025 against the finance plan submitted for the financial year 2024/25 on the 12 June 2024. NHS Devon carried out monthly financial assurance reviews with all Trusts.

The assurance ratings in this report are based on the reported outturn positions and are as follows:

Section	Assurance	Trend from previous month
Overall assurance	**Satisfactory**	**No change**
Financial performance	Satisfactory	No change
Savings and efficiencies	Limited	No change
Financial risks	N/A for M12 reporting	N/A
Workforce	Satisfactory	No change

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

NHS Devon Executive reviewed this report at its meeting on 29 April 2025.
The Finance and Performance Committee reviewed this report at its meeting on 08 May 2025.

Key recommendations and actions requested

TAKE SATISFACTORY ASSURANCE from the information provided within the report with regard to the financial position of the One Devon Integrated Care System and **NOTE** the financial outturn for the year 2024/25.

Impact on NHS Devon Objectives

Objective	Impact
Improve population health	
Improve services and reduced unwarranted variation	
Make more efficient use of our resources	Financial Recovery
Develop our culture and how we operate	

Outline the implications of matters covered in this report for the following areas

Area	
Quality of Services	None
Health Inequalities	None
Workforce	None
Resources and Finance	Delivery of financial sustainability
Legal	None
Digital and Data	None
Engagement and Consultation	None

One Devon (ICS) Finance Report Month 12

Executive Summary

1. In month 6 the receipt of £80m non-recurrent deficit funding phased in the second half of the year enabled the One Devon Integrated Care System (ICS) to forecast delivery of a balanced outturn for 2024/25.

2. At month 10 an assessment of the remaining unmitigated risk relating to winter pressures was undertaken for each organisation. The original deterioration reported in month 8 at University Hospitals Plymouth NHS Trust (UHP) and Torbay and South Devon NHS Foundation Trust (TSD) was largely offset by the utilisation of flexibility within NHS Devon to forecast a balanced year end revenue position. It has now been deemed necessary to use this flexibility for its original intention, which was to mitigate any winter pressure within the One Devon ICS. The net deterioration across the organisations has crystalised in TSD, therefore as at Month 12, the One Devon ICS has reported a deficit of £19.8m against a planned deficit of £0.

3. The One Devon ICS has reported £223.0m efficiency achievement for 2024/25; this is £9.7m above plan.

4. The Board can take **satisfactory assurance** that the agreed forecast was delivered.

5. The headline messages in the following sections are considered in further detail in the attached 'Integrated Care System Financial Performance and Assurance Review' slide pack (Appendix 1). This slide pack has been developed to support obtaining an increased in-depth financial assurance from the organisations within the One Devon ICS.

Financial Position

6. In Month 6 the receipt of £80m non-recurrent deficit funding phased in the second half of the year enabled the One Devon ICS to forecast delivery of a balanced outturn for 2024/25.

7. At Month 10 an assessment of the remaining unmitigated risk relating to winter pressures was undertaken for each organisation. The original deterioration reported in Month 8 at UHP and TSD was largely offset by the utilisation of flexibility within NHS Devon to forecast a balanced year end revenue position. It has now been deemed necessary to use this flexibility for its original intention, which was to mitigate any winter pressure within the One Devon ICS. The table below shows the revised year end forecast following the Month 10 risk review. The net deterioration across the organisations has crystalised in TSD.

8. As at the 2024/25 year end, the One Devon ICS has reported a deficit of £19.8m against the plan of breakeven after deficit support funding:

Organisation	Outturn		
	Plan surplus / (deficit) £000	Actual surplus / (deficit) £000	Variance favourable / (adverse) £000
Devon ICB	28,419	28,419	0
Devon Partnership NHS Trust	3,591	3,599	8
Royal Devon University NHS FT	(2,790)	(2,743)	47
Torbay and South Devon NHS FT	(13,624)	(33,538)	(19,914)
University Hospitals Plymouth NHST	(15,596)	(15,584)	12
Total	**(0)**	**(19,847)**	**(19,847)**

Efficiencies

9. The One Devon ICS has reported £223.0m efficiency achievement for the year 2024/25; this is £9.7m above plan:

Organisation	Outturn		
	Plan CIP delivery	Actual CIP delivery	Variance favourable / (adverse)
Devon ICB	37,228	55,017	17,789
Devon Partnership NHS Trust	15,739	15,799	60
Royal Devon University NHS FT	63,610	66,574	2,964
Torbay and South Devon NHS FT	39,900	27,889	(12,011)
University Hospitals Plymouth NHS Trust	56,801	57,732	931
Total	**213,278**	**223,011**	**9,733**

10. The 2024/25 plan states that 70% of savings are to be recurrent, however achievement of this was 58% for the year which was a shortfall of £20.2m. The reduction in recurrent efficiency delivery overall is as a result of the Month 8 re-forecast whereby NHS Devon has forecast to deliver additional non-recurrent CIP through balance sheet and reserves flexibility to ensure the overall One Devon ICS plan of breakeven is delivered.

	Outturn		
	24/25 plan	24/25 actual	Variance fav/(adv)
Recurrent Efficiencies	150,076	129,897	(20,178)
NR Efficiencies	63,202	93,114	29,912
Total efficiencies	**213,278**	**223,011**	**9,733**
Recurrent efficiencies	70%	58%	
NR efficiencies	30%	42%	

11. Based on the above there is **limited assurance** around delivering the full efficiency requirement particularly in relation to levels of recurrent delivery.

12. Proposed mitigations continuing into 2025/26:
    - NHS Devon's Chief Finance Officer continuing to hold monthly Financial Assurance Reviews with all providers where the recurrent vs non-recurrent delivery risk and underlying position is discussed.
    - Trusts will be expected to reduce unidentified efficiences to zero by the end of Month 4 and progress the scheme maturity monthly. The system is implementing a financial risk management framework.

Workforce, including agency

13. Due to the timing of provider returns at the year end, there is limited information available on workforce at the time of writing this report.

14. The reported Whole Time Equivalent (WTE) for Month 12 is 684 WTE above plan.

15. NHSE set a system level agency cap of £51.1m (2.9% of total pay) in 2024/25. The One Devon ICS has planned to restrict agency costs at a lower figure of £37.5m (2.1% of pay costs). The One Devon ICS has delivered a small overspend of £0.3m against the agency plan but significantly below the agency cap:

Organisation	Agency expenditure: Outturn		
	Plan £000	Actual £000	Variance favourable / (adverse) £000
Devon Partnership NHS Trust	8,506	10,740	(2,234)
Royal Devon University NHS FT	18,530	13,830	4,700
Torbay and South Devon NHS FT	5,657	9,144	(3,487)
University Hospitals Plymouth NHST	4,791	4,115	676
Total	**37,484**	**37,829**	**(345)**

16. The Board can take **satisfactory assurance** that the workforce controls and priority areas will deliver the workforce cost and WTE reductions.

Organisational Positions

17. Due to the timing of provider returns at the year end, the information for detailed positions is not available at the time of writing the report. Summary organisational outturn is set out in section 2 above.

Capital

System Capital (CDEL)

Trust	CDEL excl IFRS16				IFRS16			
	FY allocation £000	FY plan £000	Outturn £000	Variance fav/(adv)	FY allocation £000	FY plan £000	Outturn £000	Variance fav/(adv)
Devon Partnership NHS Trust	6,865	6,979	7,730	(751)	1,501	3,354	2,793	561
Royal Devon University NHSFT	42,082	31,324	46,277	(14,953)	4,503	19,204	5,006	14,198
Torbay and South Devon NHSFT	15,101	15,371	18,555	(3,184)	2,102	6,700	547	6,153
University Hospitals Plymouth NHST	31,270	31,690	33,270	(1,580)	24,261	22,706	24,999	(2,293)
Total	**95,318**	**85,364**	**105,832**	**(20,468)**	**32,367**	**51,964**	**33,345**	**18,619**

18. At the 2024/25 year end, providers have spent £1.8m above plan in relation to combined core and IFRS 16 system capital expenditure. This overspend and switch to more IFRS16 has been agreed with the NHSE regional team who are managing the overspend within the regional allocation envelope.

Productivity

From Month 8, NHSE have changed the methodology for measuring acute productivity by improving the granular detail of the activity by increasing coverage and recognising complexity. In the first iteration this has meant for the One Devon ICS, there has been a significant deterioration in productivity compared to the previous methodology. The table below shows Month 9 data with the new method productivity growth of 3.6% compared with the old method of 7.9% improvement on 2023/24:

	23/24 Comparison, unadjusted								
	Old Method			New Method			Variance		
	Inflation adj. expenditure growth	Cost weighted activity growth	Implied productivity growth	Inflation adj. expenditure growth	Cost weighted activity growth	Implied productivity growth	Inflation adj. expenditure growth	Cost weighted activity growth	Implied productivity growth
RDUH	1.8%	13.2%	11.2%	1.7%	6.6%	4.9%	-0.1%	-6.5%	-6.3%
T&SD	0.8%	4.9%	4.0%	1.6%	5.8%	4.1%	0.8%	1.0%	0.1%
UH Plymouth	6.5%	13.0%	6.2%	8.0%	9.7%	1.5%	1.5%	-3.4%	-4.6%
DEVON	3.2%	11.3%	**7.9%**	3.9%	7.7%	**3.6%**	0.8%	-3.6%	**-4.3%**

19. The One Devon ICS is waiting to receive a bridge analysis of the changes to further understand the new figures and areas of opportunity.

Assurance and Recommendations

20. Based on the outturn positions as reported throughout the report, the assurance ratings are as follows:

Section	Assurance	Trend from previous month
Overall assurance	**Satisfactory**	**No change**
Financial performance	Satisfactory	No change
Savings and efficiencies	Limited	No change
Financial risks	N/A (not required for M11)	N/A
Workforce	Satisfactory	No change

21. The Board is asked to **take satisfactory assurance** from the information provided within the report with regard to the financial position of the One Devon Integrated Care System and **note** the financial outturn for the year 2024/25.

NHS Devon Integrated Care Board

Committee Chair's Report – Finance and Performance Committee

Date of Meeting	Date of Committee Covered in this Report
29 April 2025	10 April 2025

Chair	
Name and Title:	Kaye Bentley, Independent Non-Executive Member for Finance and Performance Committee.

BAF Updates or Escalation

The Committee received a report informing them of the current position of the 2024/25 BAF Risks for which it had been identified as responsible for overseeing.

The Committee **took assurance** from the current content of the BAF.

Risk Register Review Updates / Escalation

None

Assurance Updates

Progress Report on the Requirements of the NHS Oversight Framework – Segment 4
In discussion of the report, the Committee raised some concerns in relation to the proposed assurance ratings. Whilst the Committee recognised that the current financial year was about to close and that assurance ratings had been provided in respect of each of the criteria for exiting NOF4 (strategy, leadership, urgent and emergency care (UEC), elective, and finance recovery), it was cognisant of the fact

that the One Devon Integrated Care System (ICS) was about to enter into a new financial year with a new set of challenges. It considered whether there needed to be a bridge between the two given that the NOF4 exit wasn't just about the current financial year but was actually something that was going into the new financial year.

The Finance and Performance Committee **did not agree** the assurance ratings relating to achievement of each of the NOF4 exit criteria by the One Devon Integrated Care System of **limited for UEC, and satisfactory for all others**.

NHS Devon Annual Plan – Delivery Assurance
The Committee received the NHS Devon Annual Plan – Delivery Assurance Report, noting that it showed the position as at February 2025 and that it was being asked to agree the assurance ratings at that particular point in time. In consideration of the report, the Committee observed the following: the latest report highlighted the same challenges as previously reported and discussed; the Annual Plan was not a rolling process; some of the areas that the Committee had previously raised concerns about still remained rated as 'red'; and not all objectives were equal (i.e. some were much more important than others (for example CMO 042 – Transform Acute Services)).

Going forward, it was recognised that NHS Devon needed to ensure that planning was a cyclical process going forward rather than a time limited event each year.

The Committee **agreed** the assurance ratings relating to the delivery of NHS Devon's 2024/25 Annual Plan objectives; and **noted** the proposed amendments to the NHS Devon 2024/25 Annual Plan.

Monthly Reporting

NHS Devon (ICB) Finance Report M11
The Committee **took assurance** from the information provided with regard to the NHS Devon financial position as at the period ended 28 February 2025.

One Devon (ICS) Finance Report M11
In discussion of the report, the Finance and Performance Committee noted that the Month 11 position of the One Devon ICS was now reflective of the revised position that had been discussed and agreed by NHS England's (NHSE) regional team.

The Committee was informed that each of the Chief Finance Officers (CFOs) within the One Devon ICS had confirmed that they were not anticipating any movements within their positions and that they were confident in terms of delivery of their financial positions for the 2024/25 financial year. The Committee thanked NHS Devon's CFO and finance colleagues for helping to navigate NHS Devon and the One Devon ICS through what had been a particularly challenging year.

The Committee **agreed** the overall assurance level relating to the financial position of the One Devon Integrated Care System of **satisfactory** and that adequate plans

were in place to mitigate the risks relating to the delivery of planned savings and efficiencies and to the management of the financial risks identified at plan stage.

Other Business

2025/26 Operating Plan

The Committee discussed the outstanding Key Lines of Enquiry (KLOEs) and assurances that it thought the NHS Devon Board would need in order for it to be assured in terms of delivery of a compliant Operating Plan that it could endorse for the 2025/26 financial year. Key highlights included:

- Detail on the provider assessment against the NHSE productivity and Efficiency packs; and how each organisation has responded to them in the 2025/26 plan.
- Outcome of the process in place to review all 2025/26 investments.
- Clarity on the triangulation of workforce CIPs against each providers pay / non-pay cost base split.
- Detail on Gross and Net workforce changes, and understanding of the workforce investments including the rationale, funding source and alignment to CIPs.
- Understanding of the redundancy options and risks to CIPS if funding unavailable.
- Detail on the phasing of WTE reductions including part year and full year financial impact.
- Assurance around monitoring of the impact of WTE reduction on performance and service delivery.
- Assurance on workforce controls in place in respect of system wide vacancy. controls and redeployment pools.
- Assurance on plans in place to manage potentially contentious decisions.
- Demand Management – assurance around the scale of the demand risk, how we will know if the risk materialises and what we will do in commissioning terms to mitigate (service reduction and impacts).
- Understanding of the level of each organisation's risks and mitigations, with detail of what support required.
- Assurance on compliance with patient choice in relation to IS activity shift plan
- Assurance on status of impact between outpatient and in patient stages of treatment and RTT delivery.
- Assurance on the assumptions in the SWAST contract and any risk share arrangements.
- Detail on the profiling of the triangulation of the performance against the finance and workforce.
- Assurance that the system has a process in place to ensure delivery of the plan at pace.

The Committee:

- **Noted** the progress that had been made in the development of the 2025/26 Operational Plan, since it had been presented to the Board at its meeting in private on 26 March 2025.

- **Took limited assurance** with regard to the ability of the One Devon Integrated Care System to deliver the 2025/26 Operational Plan as it currently stood.
- **Noted** that further work was required in respect of the issues identified by the Committee for the Committee to be able to provide satisfactory assurance to the NHS Devon Board with regard to the ability of the One Devon Integrated Care System to deliver the 2025/26 Operational Plan.

NHS Devon Annual Plan – Next Steps and Risks
The Committee agreed that the overarching risks in relation to change and the landing of the Operational Plan for 2025/26 were so significant that it was appropriate to defer this to a later meeting of the Committee in order to allow for further work to be undertaken on annual planning.

The Committee **noted** the report.

Closing Business

Forward Plan
The Committee **noted** its current workplan for the 2025/26 financial year, recognising that it would be amended during the year to incorporate new items as appropriate.

Committee Decisions

None

Escalation to the Board – For Information

- The Committee was unable to take assurance in terms of the levels of assurance that had been provided across all of the NOF4 exit criteria for the One Devon Integrated Care System (ICS).
- The Committee thanked the Interim Chief Finance Officer (KD) and finance colleagues for navigating NHS Devon and the One Devon ICS through what had been a very challenging financial year.
- Discussions had taken place in respect of the Key Lines of Enquiry (KLOEs) and the assurance that it and the NHS Devon Board might need in order to be assured of delivery of a compliant 2025/26 Operational Plan.
- The Finance and Performance Committee agreed that the overarching risks in relation to change and the landing of the 2025/26 Operational Plan were so significant that it was appropriate to defer the Annual Plan – Next Steps and Risks to a later meeting of the Committee to allow for further work to be undertaken on annual planning.

Escalation to the Board – For Action

- NHS Devon needed to ensure that planning was a cyclical process going forward rather than a time limited event each year.

Recommendations for the Board

None

Recommendations for Other Committees

- Other Board Assurance Committees to consider how they might seek assurance in relation to planning being a cyclical process going forward rather then a time limited event each year.

Terms of Reference or Other Committee Effectiveness Issues

None

Please note that all reports considered by Board Assurance Committees are available to Board Members on request.

NHS Devon Integrated Care Board

Committee Chair's Report – Finance and Performance Committee

Date of Meeting	Date of Committee Covered in this Report
29 May 2025	08 May 2025

Chair	
Name and Title:	Kaye Bentley, Independent Non-Executive Member for Finance and Performance Committee.

BAF Updates or Escalation

The Committee received an oral update on the proposed approach to the Board Assurance Framework (BAF) for the first part of the 2025/26 financial year. Further information about this can be found elsewhere on the agenda for the meeting of the Board in public on 29 May 2025.

Risk Register Review Updates / Escalation

None

Assurance Updates

Progress Report on the Requirements of the NHS Oversight Framework – Segment 4

The Committee considered this report in conjunction with the:

- NHS Devon Self-Assessment Against the NHS Oversight Framework Report; and
- One Devon Integrated Care System NHS Partners Self-Assessment Against the NHS Oversight Framework Report.

In consideration of all three papers, the Committee agreed that they gave an overall picture of improvement, albeit that NHS Devon and the One Devon Integrated Care System (ICS) had not achieved the exit date originally set and not all organisations within the system had assurance that they would be able to achieve the revised exit date of Quarter 1 of 2025/26. The Committee recognised the challenging position that NHS Devon and the One Devon ICS found itself in at the start of 2025/26. The Committee raised concerns with regards to NOF4 funding and additional valued capacity if it were not available going forward and the transition risk associated with this and how it could be managed.

The Committee **noted** the content of the report.

NHS Devon Self-Assessment Against the NHS Oversight Framework
The Committee **noted** the content of the report.

One Devon Integrated Care System NHS Partners Self-Assessment Against the NHS Oversight Framework
The Committee **noted** the content of the report.

NHS Devon Annual Plan 2024/25 – Delivery Assurance Close Down Report
The Committee received the NHS Devon Annual Plan 2024/25 – Delivery Assurance Closedown Report and noted the plans for the next iteration of the report which included more information in respect of those actions that had not been completed in 2024/25 and what had now happened to them. Echoing the suggestion of the Population Health and Improvement Committee, the Finance and Performance Committee agreed that information on achievement of Annual Plan objectives should be included within the Annual Report for 2024/25.

The Committee **agreed** the final positions of assurance for each directorate at 2024/25 year-end.

Annual Plan 2025/26 Reporting and Next Steps
In consideration of the paper, the Committee was assured of the proposed delivery approach but raised concerns over being asked to provide assurance of delivery in the future given the changing context of ICBs and the uncertainty that came with that. A suggestion was made in relation to whether the BAF could help with this. The Committee was provided with assurance that the Annual Plan would be a 'live' document and that objectives would remain on it until such a time as NHS Devon was either no longer responsible for them or responsibility had been transferred. It agreed that it, and other Board Assurance Committees, needed to be very agile and to revisit the Annual Plan for 2025/26 in future meetings in order to keep on top of it, and particularly given the rapidly changing context of the organisation.

The Committee:

- **Took satisfactory assurance** from the Delivery Approach described in Figure 1 and in the content of the report;
- **Noted** the Reporting Schedule and Committee Forward Plan in Appendix 1 to the report;
- **Noted** the Delivery Structure in Appendix 2 of the report; and
- **Noted** development of detailed delivery plans in Appendix 3 to the report.

Operational Plan 2025/26 – Financial Delivery Assurance
The Committee received the paper, noting that in recognition of the high level of risk in relation to deliverability of the plan, it had been necessary to make enhancements to the escalation process and the reporting and assurances around that.

The Committee:

- **Noted** the plans for increased assurance and control measures to be implemented in 2025/26;
- **Agreed** adoption of the processes / documents contained within the report; and
- **Noted** that all organisations within the system would be agreeing the processes / documents through their Committees / Boards.

Operational Plan 2025/26 – Performance Oversight Assurance
The Committee received a presentation on the proposed new approach to the Performance Management Framework, noting that the level of risk within the plan necessitated there to be sufficient grip and control in place going forward. The Committee were informed that the Performance Management Framework would be built from the Finance Risk Framework that had already been developed by the Chief Finance Officers from across the One Devon ICS.

The Committee **noted** the content of the presentation.

Monthly Reporting

NHS Devon (ICB) Finance Report M12
The Committee **took assurance** from the information provided with regard to the NHS Devon financial position as at the year ended 31 March 2025.

One Devon (ICS) Finance Report M12
In discussion of the report, the Finance and Performance Committee agreed that it would be beneficial to include the following additional items on its 2025/26 Workplan:

- A deep dive into the cash position;
- A detailed look at the underlying financial position of the ICS, including the profile of the underlying position and how it was monitored in month; and
- A deep dive in relation to contracting given that financial delivery in 2025/26 was heavily reliant on contracts, that there were new contracting arrangements in place for 2025/26 and that there were risks around patient choice and increasing demands in areas such as neurodiversity and obesity.

The Committee was informed that whilst the ICS had overachieved on its Cost Improvement Plans (CIPs) in 2024/25, it was important to recognise that one area that had not been achieved was the split between the level of recurrent and non-recurrent efficiencies. The Committee acknowledged that that there would need to be an additional focus on the delivery of the right rate of recurrent savings in 2025/26.

The Committee **agreed** the overall assurance level relating to the financial position of the One Devon Integrated Care System of **satisfactory** and **noted** the outturn for the year ended 2024/25.

Other Business

National Recovery Support Fund
The Committee received the paper on the National Recovery Support Funding, noting that part of the conditions of receiving funding to support the Devon Recovery Programme in 2024/25 was to share with the Finance and Performance Committee how the funding had been utilised by the One Devon ICS and how the One Devon ICS had achieved the SMART outcomes that had been set.

The Committee **noted** the revised letter and **noted** that the objectives had been achieved and the funding distributed.

Deep Dive – Implied Productivity
The Committee received the paper on Implied Productivity which described at a very high level, the NHSE implied productivity calculations and the recent changes to the methodology. In discussing the paper, the Committee agreed that productivity was key to improving performance whilst still remaining within the available resources and whilst maintaining quality. It recognised that the implied productivity calculation alongside things such as Model Hospital, Patient Level Information and Costing Systems (PLICS) data and Getting It Right First Time (GIRFT) were all useful tools for decision-making. It agreed that it was important for it and the NHS Devon Board to understand productivity and how it could support NHS Devon and the One Devon ICS in this space.

The Committee **noted** the changes to the methodology of the new implied productivity calculation along with the impact of the calculation.

Closing Business

Forward Plan
The Committee **noted** its current workplan for the 2025/26 financial year, recognising that it would be amended during the year to incorporate new items as appropriate.

Committee Decisions

None

Escalation to the Board – For Information

- Concerns in respect of NOF4 funding and additional valued capacity if it were not available going forward and the transition risk associated with this and how it would be managed.
- The need for the Committee to be very agile and to revisit the Annual Plan for 2025/26 in future meetings in order to keep on top of it, particularly given the rapidly changing context of the organisation.
- The Committee discussed and agreed the need for a deep dive into contracting, being mindful of the fact that delivery of the current financial year was very much dependent on contracting working as expected.
- The Committee had started work on productivity / understanding productivity, in recognition of its increasing importance. It agreed that it would take this further in terms of a development session with the NHS Devon Board.

Escalation to the Board – For Action

None

Recommendations for the Board

None

Recommendations for Other Committees

None

Terms of Reference or Other Committee Effectiveness Issues

None

Please note that all reports considered by Board Assurance Committees are available to Board Members on request.

NHS Devon Integrated Care Board

Committee Chair's Report – People and Organisational Development Committee

Date of Meeting	Date of Committee Covered in this Report
29 May 2025	09 April 2025

Chair	
Name and Title:	Salma Ali, Chair and Non-Executive Member

BAF Updates or Escalation

The Committee **took assurance** from the current content of the BAF.

Risk Register Review Updates / Escalation

N/A

Integrated Quality, Performance and Finance Report

N/A

Reports Received, Discussed, and Noted

The Committee considered progress to develop a compliant **Operational Plan** noting that considerable progress had been made but that there was still work to do to get the plan to a compliant place. However, were assured of the progress reported. The Committee set the following key lines of enquiry to enable assurance to the Board:

1. Triangulation – What is the workforce and finance being triangulated against?
2. Detail around the phasing of the WTE reduction
3. Detail around the grossing up of WTE changes and understanding of the WTE increases due to investments, and the source of the funding for investments.
4. Detail of the approach to workforce reduction before redundancy, including turnover, reducing additional payments, vacancies, pay controls
5. When is the plan good enough for the Board to be assured on deliverability?
6. If deficit support and CR funding is not available, how deliverable is the plan?
7. Detail on the systems and processes in place to enable the system to respond to risks as they materialise, and the monitoring / governance arrangements
8. Productivity – will this be high enough to deliver the required level of service?

These points, and the subsequent responses to them, were taken account of the in Board's decision to approve the 2025/26 Operational Plan at its meeting in private on 29 April 2025.

The **Workforce Dashboard** was received by the Committee. The Committee requested further assurance on corrective action to be included within the report to enable assurance to be provided by the Committee to the Board.

The Committee considered progress against the **2024/25 Annual Plan Delivery Assurance** noting that areas that had not been completed during 2024/25 had been rolled over to the 2025/26 Annual Plan.

The Committee considered next steps and risks related to the **2025/26 Annual Plan.** Of concern was whether the Objectives approved by the Board were now achievable following recent announcements within the NHS. These Objectives may need to be reviewed again by the Board following receipt of the Dash Report.

The **Integrated Care Board People Function Regulatory Requirement** provided the Committee with oversight of the progress made in relation to regulatory requirements.

The Committee noted its **work programme for 2025-26** which will be aligned with NHS Devon and system wide plans.

Committee Decisions

None

Escalation to the Board – For Information

The People and Organisational Development Committee noted progress to develop a compliant Operational Plan for 2025/26.

Escalation to the Board – For Action

None

Recommendations for the Board

None

Recommendations for Other Committees

None

Terms of Reference or Other Committee Effectiveness Issues

None

Please note that all reports considered by Board Assurance Committees are available to Board Members on request.

NHS Devon Integrated Care Board

Committee Chair's Report – Quality and Patient Experience Committee

Date of meeting	Date of committee covered in this report
29 May 2025	10 April 2024

Chair	
Name and title:	Thandiwe Hara, Independent Non-Executive Member

Board Assurance Framework (BAF) updates or escalation

The Committee **took assurance** from the current content of the BAF.

Risk register review updates/escalation

None

Deep Dives

The Committee considered progress to develop a compliant **Operational Plan** noting that considerable progress had been made but that there was still work to do to get the plan to a compliant place.

The Committee took **satisfactory assurance** of the improvements made and the work to date to produce a compliant 2025/26 Operational Plan.

Reports received, discussed, and noted

The Committee considered next steps and risks related to the **2025/26 Annual Plan**. Of concern was whether the Objectives approved by the Board were now achievable following recent announcements within the NHS. These Objectives may need to be reviewed again by the Board following receipt of the Penny Dash Report.

The Committee took assurance of the work underway to develop an **NHS Devon Quality Framework.** Guidance from the National Quality Framework and Strategy, which members from NHS Devon are involved in developing would be used to develop the framework.

The Committee considered progress against the **2024/25 Annual Plan Delivery Assurance** noting that areas that had not been completed during 2024/25 had been rolled over to the 2025/26 Annual Plan.

The **System Quality Group (SQG) Report** provided the Committee with the outputs from the meeting held on 25 February 2025. The Committee was pleased to learn that system working in relation to the Equality, Quality Impact Assessment (EQIA) process had been well received. The Committee **took satisfactory assurance** that NHS Devon was fulfilling the mandate to lead and facilitate system level quality assurance and improvement.

The Committee took assurance that NHS Devon was suitably engaged with **Regulatory Issues**.

The Committee noted the work that was being undertaken in development a **Forward Plan** for the Committee which aligned with its terms of reference. It is anticipated that this Plan will be received by the Committee at its next meeting.

Committee decisions

None

Escalation to the Board – for information

The Quality and Patient Experience Committee noted progress to develop a compliant Operational Plan for 2025/26.

Escalation to the Board – for action

There was a need to review the current NHS Devon Objectives following receipt of the outcome of the Penny Dash Review (the ICB Blueprint).

Recommendations for the Board

None

Recommendations for other committees

None

Terms of reference or other committee effectiveness issues

None

Please note that all reports considered by Board Assurance Committees are available to Board Members on request.

NHS Devon Integrated Care Board

Committee Chair's Report - Audit and Risk Committee

Date of Meeting	Dates of Committee Covered in this Report
29 May 2025	06 May 2025

Chair	
Name and Title:	Graham Clarke, Chair and Non-Executive Member for Audit and Risk

BAF Updates or Escalation
The Committee received the Risk Management and Board Assurance Framework Update Report and took satisfactory assurance from the revised proposed approach to the Board Assurance Framework for the first part of 2025/26. Further information about this can be found elsewhere on the agenda for the meeting of the Board in public on 29 May 2025

Risk Register Review Updates / Escalation
None

Integrated Quality, Performance and Finance Report
None

Reports Received, Discussed, and Noted

Draft 2024/25 Annual Report, Including Governance Statement
The Committee received the report and took assurance from the process for the production of the 2024/25 Annual Report and Accounts, including the timeline. The Committee provided initial feedback on whether the draft Annual Report reflected the work of NHS Devon in 2024/25.

Use of the Company Seal
The Committee took assurance from the content of the Use of Company Seal Report 2024/25 that use of the NHS Devon Seal has been executed in line with the Scheme of Delegation and financial limits.

Quarterly Petitions Report
The Committee received the Quarterly Petitions Report and noted that NHS Devon had not received any petitions in Quarter 4 of 2024/25, and that two petitions had been received in total during 2024/25.

Internal Audit Progress Update Report
The Committee received an update on the provision of internal audit services. Two final reports had been issued since the last update to the Committee in March 2025. Good progress had been made on completion of the Internal Audit Plan 2024/25. Of the work outstanding, three reviews were at draft report stage and three reviews were in progress but nearing completion.

Following approval of the Internal Audit Plan 2025/26, work had commenced on planning the reviews and scheduling them in.

Internal Audit Charter
The Committee noted the content of the report and approved the Audit Charter for implementation during the delivery of the Audit Plan for 2025/26.

The Committee recommends approval of the Internal Audit Charter to the Board; a copy of the aforementioned document is attached at Annex A.

Draft Head of Internal Audit Opinion 2024/25
The Committee received the draft Head of Internal Audit Opinion (HoIAO) for 2024/25, noting that the latest version of the opinion remained in line with previous reports to the Committee, that being one of a 'Satisfactory' opinion, subject to caveats. This was an improvement from the 'Limited' HoIAO provided in 2023/24. Based on the information that ASW Assurance had available at this point, they had observed good progress in relation to improving internal control arrangements, governance arrangements and risk management arrangements within the organisation over the last year.

External Audit Progress Report
The Committee noted the content of the External Audit Progress Report provided by KPMG. Since the last update to the Committee in March 2025, work had concluded on the Mental Health Investment Standard (MHIS); a report would be brought back to the next Audit and Risk Committee meeting in relation this.

Auditing of NHS Devon's draft Annual Report and Accounts for year ended 31 March 2025 had commenced.

Data Protection and Security Assurance Report
The Committee received the Data Protection and Security Assurance Report and took assurance that NHS Devon is compliant with the statutory and regulatory duties placed upon it in respect of data protection and security. In addition, it noted the six 'Not Achieved' DSPT contributing outcomes and part one audit report.

Counter Fraud Progress Report
The Counter Fraud Progress Report covering the period January 2025 to April 2025 was received and noted by the Committee and provided assurance of the work undertaken in accordance with the Government Function Standard 013 Counter Fraud.

Losses and Special Payments
The Committee noted that there had been three ex-gratia payments totalling £23,217 during the period 01 April 2024 to 31 March 2025.

Draft Annual Accounts Progress 2024/25
The Committee noted the content of the report which confirmed that the draft Annual Accounts for the year ended 31 May 2025 had been submitted as per the agreed timetable; these were now with the External Auditors, KPMG.

Quarterly Contracting and Procurement Update
The Committee took assurance from the content of the report.

Forward Plan for Future Meetings
The Committee noted its workplan for 2025/26.

Committee Decisions

The Audit and Risk Committee approved the Audit Charter for implementation during the delivery of the Audit Plan for 2025/26.

Escalation to the Board – For Information

None

Escalation to the Board – For Action

None

Recommendations for the Board

The Audit and Risk Committee recommends that the NHS Devon Board approves the Internal Audit Charter for implementation during the delivery of the Audit Plan for 2025/26.

Recommendations for Other Committees

None

Terms of Reference or Other Committee Effectiveness Issues

None

NHS Devon Integrated Care Board

Committee Chair's Report – Population Health Improvement Committee

Date of meeting	Date of committee covered in this report
	08 May 2025

Chair	
Name and title:	Lopa Patel, Independent Non-Executive Member

Board Assurance Framework (BAF) updates or escalation

An oral update was provided, confirming that the new Board Assurance Framework (BAF) had not been presented to the Committee because of the responses of Board Assurance Committees in April to the proposed new risks for 2025/26. It was proposed that the BAF risks used in 2024/25 should be retained until the new Health and Care Strategy (Joint Forward Plan) had been finalised.

The Committee **noted** the oral update provided.

Reports received, discussed, and noted

Population Health Improvement for Devon
The Committee noted a report that sought to establish an assurance framework and a shared understanding of the proposed priorities for the committee. The Committee recognised the need to communicate with external healthcare providers and socioeconomic groups across Devon to ensure the committee is presenting the data for inequalities and unmet needs of the region's population.

Population Health Measurement Framework

The Committee endorsed the Population Health Improvement Measurement Framework, which provided a consistent and structured approach evaluating the impact of population health work. The differences between measuring impact over a short and longer period were discussed, along with the inherent complexities of certain health conditions. A focus was placed on the disparities in the quality of data for certain demographics, as well as collecting more qualitative data from the population and healthcare staff.

It was proposed that the April 2025 Devon Population Summary should be presented to the Board to enhance its understanding of current and projected population trends, as this information may influence NHS Devon's delivery under the Model ICB Blueprint.

2024/25 Annual Plan Closing Report
The report provided a year end update for the 2024/25 Annual Plan and noted a positive impact on NHS Devon's objectives. 75% of objectives were on track or complete and the remaining 25%, NHS Devon was partially assured. These open objectives will carry into 2025/26. The Population Health Improvement Committee took satisfactory assurance from the content of the closedown report and provided feedback to the (PMO).

Consideration was given to whether there was effective connection between activities and outcomes. Strengthening this link would demonstrate the social value of NHS Devon's work and provide greater assurance of performance.

2025/26 Annual Plan – Looking Forward and Oversight
The Population Health Improvement Committee noted the development of detailed delivery plants and took satisfactory assurance from the Delivery Approach, Reporting Schedule and Committee Forward plan described in the report. It was recommended that the 17 objectives detailed within the report should be regrouped whilst considering the 3 strategic shifts outlined in the Darzi Report. This could help identify any gaps that need to be addressed, as well as objectives that may no longer fall within an ICB's future responsibilities.

The report's delivery structure was requested to be amended to make the role of the Population Health Improvement Committee clearer and whether objectives 3 and 15 should be allocated to the Population Health Improvement Committee.

Involving People and Communities – Assurance
The Population Health Improvement Committee noted that the Devon Engagement Partnership Group had been formalised. Terms of Reference will be developed, and discussions will be held with the Data Protection team to complete any necessary Data Protection Impact Assessments (DPIAs). Consideration was given to extending group membership to external organisations that NHS Devon has not worked with previously (such as the Coastguard).

The People and Communities Dashboard was designed with ease of access, data gathering and communication in mind between all parties and this Committee. Information would be fed into the Online Insights Library. This approach had been discussed and agreed with Healthwatch.

The impact of using Artificial Intelligence (AI) Personas to better understand the impacts of change was discussed, as the Communications and Involvement team had been testing its relevance. A Data Protection Impact Assessment (DPIA) had been undertaken to ensure safe usage and received positive feedback. It was agreed that the use of AI Personas would be discussed further in the Population Health Improvement Committee meeting in July 2025.

Committee Forward Plan of Work
The Population Health Improvement Committee noted the current iteration of the 2025/26 Population Health Improvement Committee work plan, which was a work in progress.

Committee decisions

None

Escalation to the Board – for information

The Population Health Improvement Committee agreed to escalate the following items to the NHS Devon Board for information:

- A Board Development Session on Population Health Improvement is due to be arranged for June 2025.

Escalation to the Board – for action

None

Recommendations for the Board

None

Recommendations for other committees

None

Terms of reference or other committee effectiveness issues

None

Please note that all reports considered by Board Assurance Committees are available to Board Members on request.