NHS Devon

NHS Devon Integrated Care Board (ICB) Meeting

Pomona House, Oak View Close, Torquay, TQ2 7FF

4 October 2023

10.00 – 13.30

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.

	Introductory item	Lead	Action	
1	Welcome, introduction and apologies	Sarah Wollaston, Chair	Discussion	10.00
2	Declarations of Interest	Sarah Wollaston, Chair	Noting	
3	Minutes of the Meeting held on 5 July 2023	Sarah Wollaston, Chair	Approval	
	Citizens Involvement Story	**Lead**	**Action**	
4	Urgent Care Waiting Times	Member of the Public	Discussion	10.05
1. Improving outcomes in population health and health care				
	Item	**Lead**	**Action**	
5	Integrated Quality, Performance and Finance Report	John Finn, Director of Commissioning Urgent & Elective Care	Noting	10.20
6	Committee Chair's Report: Quality & Patient Experience Committee – 19 July, 16 August and 20 September 2023	Hisham Khalil, Non-Executive Member	Assurance	10.35
2. Tackling inequalities in outcomes, experience and access				
	Item	**Lead**	**Action**	
7	Primary Care Access Improvement Plan (Primary Care Recovery Plan)	Nigel Acheson, Chief Medical Officer	Approval	10.45
8	Committee Chair's Report: Primary Care Commissioning Transitional Committee – 13 July and 14 September 2023	Judy Hargadon, Non-Executive Member	Assurance	11.00

3. Enhancing productivity and value for money				
	Item	**Lead**	**Action**	
9	Finance Reports i. NHS Devon Month 5 Report ii. ICS Month 5 Report	Bill Shields, Chief Finance Officer	Noting	11.10
10	Equity Update	Bill Shields, Chief Finance Officer	Approval	11.25
11	Winter Plan 2023/24	John Finn, Director of Commissioning Urgent & Elective Care	Approval	11.45
12	Committee Chair's Report: Finance & Performance Committee – 25 July, 1 and 26 September 2023	Kevin Orford, Non-Executive Member	Assurance	12.00
4. Organisational business, and broader social and economic development				
	Item	**Lead**	**Action**	
13	Committee Chair's Report: People & Culture Committee – 20 September 2023	Thandiwe Hara, Non-Executive Member	Assurance	12.10
5. Leadership and Governance				
	Item	**Lead**	**Action**	
14	Chair's Report	Sarah Wollaston, Chair	Noting	12.15
15	Chief Executive's Report	Jane Milligan, Chief Executive Officer	Noting	12.25
16	One Devon Partnership Chair's Report	James McInnes, Chair One Devon Partnership	Noting	12.35
17	Cornwall and Isles of Scilly ICB Update	Kate Shields, Chief Executive Officer Cornwall & Isles of Scilly ICB	Noting	12.40
18	Risk Management Policy Refresh and Board Assurance Framework Update	Philippa Harding, Company Secretary	Approval	12.45

19	Freedom to Speak Up	Philippa Harding, Company Secretary	Approval	12.55
20	Committee Chair's Report: Audit & Risk Committee – 12 July, 1 September and 26 September 2023	Graham Clarke, Non-Executive Member	Assurance	13.05

6. Closing Business				
	Item	**Lead**	**Action**	
21	Action Log	Sarah Wollaston, Chair	Approval	13.10
22	Questions from Members of the Public	Sarah Wollaston, Chair	Discussion	13.15
23	Any Other Business	Sarah Wollaston, Chair	Discussion	13.30
	Close			

Declaration of Interests Register - NHS Devon ICB Board
Register updated and generated by the Governance Team 25 September 2023

Register last updated 14 September 2023

Title	Surname	First name	Role or Position held with the ICB	Committees/Meetngs attended	Interests	Interests - Partner or Family	Date Interest from	Date Interest to	Date interest updated	Type of Interest	Is the interest direct or indirect?	Action taken to mitigate risks
Dr	Wollaston	Sarah	Chair for ICS Devon	ICB Board Audit and Risk Committee (If Required) NHS Devon Finance Committee (If Required) Remuneration & Internal ICB Workforce Quality and Performance Committee People and Culture Committee Primary Care Commissioning Transition Committee	Trustee of Landworks, a Dartington based charity that works with ex offenders and people at risk of going to prison to support them into employment and reduce the risk of reoffending	Relative is a registrar in Obstetrics and Gynaecology on the South West training scheme currently based at RDUH Relative is a registrar in Anaesthetics on the south West training scheme and currently based at Bristol Relative is a GP research registrar based in Devon	26/11/2021		31.07.2023	Indirect	Indirect	To declare a relevant interest and if appropriate withdraw from decision making that may directly affect their employment
	Shields	Bill	Chief Finance Officer	ICB Board Audit and Risk Committee Finance Committee Digital Transformation Board	Director of Shields Health Advisory Limited (Dormant) Member HMFA Digital Council Deputy Chair, HMFA ICB CFO Forum Co Chair, NHSE Integrated Finance Board Writes a blog for HMFA Occasional presentations for HMFA, EY, KPMG, Channel 3 Consulting and Deloitte		April 2017		21/04/2023	Financial/non-financial/general	Indirect	Will be managed in line with the Standards of Business Conduct Policy and advice from governance
	Braid	Helen	Head of Governance	ICB Board Audit & Risk Committee Organisational Re-Structure Programme Board Working with Industry & Sponsorship Group	No interests declared	N/A			06/02/2023			
	Renshaw	Paul	Director of Workforce Stategy	ICB Board Audit and Risk Committee (If Required) ICS Executive Committee Executive Workforce Committee People & Culture Committee	No interests declared				02/06/2023			
	Millward	Andrew	Chief Communications and Corporate Affairs Officer SIRO	ICB Senior Executive Team Staff Partnership Forum Audit and Risk Committee (If Required) Vacancy Control Panel Equality, Diversity and Inclusion Group ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group ICS Executive Committee Executive Workforce Committee People & Culture Committe Peninsula Acute Sustainability Programme	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University Non-Executive Board member of Delt Shared Services		19/06/2018		06/04/2022			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.
	Glover	Sarah Lou	Ordinary Member for the Devon Integrated Care Board for Mental Health	ICB Board Remuneration & Internal ICB Workforce	Trustee of Honiton Health Matters who hold community conversations Director of Parental Minds C.I.C. for parents/caregivers who are supporting their child/family/friend with their mental wellbeing A Director, including a Non-Executive Director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations An advocate for a particular group of patients Ambassador Volunteer with DIAS Community group which may have potential to give rise to influence decisions made by the ICB. A volunteer for a provider		28/06/2022		30/06/2022			
	Milligan	Jane	CEO ICS for Devon	ICB Senior Executive Team Senior Leadership Team (SLT) Audit and Risk Committee (If required) ICB Board NHS Devon Finance Committee ICS Executive Committee Executive Workforce Committee People & Culture Committee Remuneration & Internal ICB Workforce (If Required)	Member of Cornwall and Isles of Scilly ICB	Partner Trustee for Action for Stammering	31/12/2020		20/05/2022			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.
	Harding	Philippa	Company Secretary	ICB Board ICB Board Assurance Committees ICP Board Senior Executive Team Meeting	Founding Director of Harding Advisory Ltd, a professional services company providing corporate governance expertise.		10/07/2023		25/07/2023			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
	Masters	Susan	Deputy Chief Nursing officer	Member of Primary Care Commissioning Transitional Committee (PCCTC) Vacancy Control Panel Senior Leadership Team (SLT) Quality and Performance Committee	Trustee Director of HQIP (Health Quality Improvement Partnership)		01/03/2021		08/02/2022	Personal	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.
	Khalil	Hisham	Independent Non Executive Member - Quality and Performance Vic Chair - NHS Devon ICB	ICB Board Audit and Risk Committee Quality and Performance Committee	Practising Consultant in Derriford Hospital Limited Private Practice in Nuffield health Plymouth Director for Private Practice- Dormant Company Trustee of the Peninsula Medical Foundation Clinical Academic in the Univesity of Plymouth Working with the Devon Training Hub on a project to train GP trainees on an end-of-life care and early diagnosis of cancer Traning Programme Director for Foundation programme UHP NHS Trust Director, Peninsula Medical Foundation	Wife is an ophthalmologist at UHP	01/09/2004		19.04.2023	Financial / General	Indirect	Managed in line with the Standards of Business Conduct Policy and governance advice
	Hargadon	Judy	Independent Non Executive Member Primary Care (Interim)	Member of Primary Care Commissioning Transition (PCCT) (Chair) ICB Board Remuneration & Internal ICB Workforce Quality and Performance Committee People & Culture Committee	Member of Women's Equality Party	Spouse is Chair of Dartington Hall Trust Brother is a GP in Cornwall	01/05/2019		25/11/2021			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.
	Hara	Thandiwe	Independent Non Executive Director of Inequalities and Population Health	ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group Primary Care Commissioning Transitional Committee People & Culture Committee	Trustee of Plymouth and District Racial Equality Council, a voluntary organisation that work to promote race equality. member on the NIHR SW Clinical Research Network Board.		16/03/2022		04/05/2022	Financial / Personal	Direct & indirect	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 the meeting if necessary. This should not raise any conflict, that I can foresee except that it is research related. There is no commissioning involved, but thought to mention it anyway. I will declare my interest at any meeting that may result in them being considered for service provision and leave the meeting if necessary.
	Fitzgerald	Anthony	Chief Delivery Officer	SET Meeting NHS Devon Finance Committee ICB Senior Executive Meeting System Delivery and Improvement Meeting ICB Board ICS Executive Committee	No interests declared				03/11/2022			
	O'Kelly	Frank	Primary Care Partner for NHS ICB	ICB Board Primary Care Commissioning Transitional Committee Quality and Patient Experience Committee GP Collaborative Board Devon Drug and Alcohol Strategic Partnership Mental Health Strategic Oversight Group PASP Devon Training Oversight Group	GP Partner at Amicus Health Blundell's School Lead Doctor Member of the National Armed Forces Reference Group CQC Manager for Amicus Health Attends Tiverton High School Welfare Meeting fortnightly Contributor to FASD Forum 5 adopted children, 2 with recognised learning difficulties both recieving PIP and with residential or supported living in Devon	Wife is a book-keeper for STEER Eduction Wife registered Carer for Adopted Child with Learning Difficulties	01/01/1999		19/04/2023	Financial/Non-financial/indirect	Indirect	Will be managed in line with the Standards of Business Conduct Policy and advice from governance

	Orford	Kevin	Independent Non Executive Director of Finance and Remuneration	ICB Board Remuneration & Internal ICB Workforce Audit and Risk Committee NHS Devon Finance Commitee Quality and Performance Committee	Non Executive Director on the board of Royal Devon and Exeter NHS FT (Ceased 30.06.22) Non Executive Director on the board of Northern Devon Healthcare NHS Trust (Ceased 30.06.22) Director and Majority Shareholder of Kevin Orford & Associates Ltd, which undertakes consultancy contracts with NHS organisations outside of the South West of England Non-Executive Director on the Board of the Intellectual Property office, a government agency in the Department of BEIS.		01/01/2012		25/02/2022			
	Clarke	Graham	Non-executive member of Audit and Risk	ICB Board Audit and Risk Committee Finance Commitee Quality and patient experience Commitee	Non-Executive Director of Medicine Discovery Catapult Non Executive Member at the Deparment of Health & Social Board Chair of HUC (East of England 111 and Urgent Care Provider) Trustee and Treasurer of the Cornwall Community Foundation	Spouse is CEO of Cornwall Partnership Foundation Trust and a Board Member of Cornwall & Isles of Scilly ICB	01/01/2022		30/01/2022			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.
	Asthana	Sheena	Independent Non Executive Director of Citizen and Community Involvement	Population Management and Health Inequalities committee ICB Board Remuneration & Internal ICB Workforce Audit and Risk Committee NHS Devon Finance Committee Digital Tranformation Board	Director, Plymouth Institute of Health & Care Research (PIHR). It is likely that members of my institute will undertake funded research for NHS Devon partners Member of the Advisory Committee on Resource Allocation (ACRA) which independently advises on NHS funding formulae Member of the project board of the proposed West End Health and Being Centre in Plymouth Director, Plymouth Centre for Health Technology. It is likely that members of my institute will undertake funded research for NHS Devon		10/03/2022		27/06/2023	Financial/Personal Interest	Direct	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
	Acheson	Nigel	Chief Medical Officer, Integrated Care Board Caldicott Guardian	ICB Board Clinical and Professional Cabinet Senior Executive Team (SET) Quality and Performance Committee Primary Care Commissioning Transition Committee ICS Executive Committee Strategy and Transformation Delivery and Improvement Quality Executive Committee Urgent Care Strategic Oversight	Director of H Smith Safety Associates Patron of the FORCE cancer charity in Exeter Director on the board of the South West Academic Health Science Network	Wife works as an associate with the South West Academic Health Science Network Wife works as a Director for H Smith Safety Associates Wife works as a Consultant forensic psychiatrist for DPT Relative consultant Dermatologist at the Royal Devon University Hospital In-law is a GP partner in the Woodbury Practice	05/10/2018		04/04/2023	Financial/Non-financial/Indirect	Direct and Indirect	Manage the conflict in line with the standard of business conduct policy

Declaration of Interests Register - NHS Devon ICB Board
Register updated and generated by the Governance Team 25 September 2023

Title	Surname	First name	Role or Position held with the ICB	Committees attended	Interests	Interests - Partner or Family	Date Interest from	Date Interest to	Date interest	Type of Interest	Is the interest direct or	Action taken to mitigate risks	Employer Organisation
	Davenport	Liz	Chief Executive Torbay and South Devon Trust	ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group Integrated Care Partnership Committee ICS Executive Committee ICP Peninsula Acute Sustainability Programme	Director of Torbay Pharmaceuticals		24/11/2016		21/06/2022				Torbay and South Devon NHS Foundation Trust
	Harrell	Ruth	Director of Public Health	NHS Devon ICB Devon ICS Clinical Cabinet	Employee of Plymouth City Council Director of Plymouth Active Leisure		01/07/2014 01/04/2022		13/09/2023	General Interest	Direct	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.	Plymouth City Council
	Manson	Donna	Chief Executive Officer Devon Countil Coucil	ICB Board System Management Executive	CEO Devon County Council		08/2023			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.	Devon County Council
Cllr	McInnes	James	Chair of One Devon Partnership Board (ICP)	ICB Board	Elected member of Devon County Council		2005	2025	22/11/2022	General Interest		Where a piece of work or an item on a Board 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	Devon County Council
	Shields	Kate	Chief Executive Officer, Cornwall and Isles of Scilly ICB	ICB Board	Private patient of Lostwithiel Dental Practice	Close family member is the CEO of an out of area NHS Foundation Trust (Southern Health NHS Foundation Trust)	15/09/2022		28/07/2023			Aware of potential conflicts should they arise. If a conflict situation should arise, informat the Devon ICB Chair	CAIS

NHS Devon

DRAFT Minutes of a meeting of NHS Devon Integrated Care Board held in Public at Devon County Council and via Microsoft Teams on Wednesday 5 July 2023 between 10.00am and 1.15pm	
*Name and initials (*voting member)*	*Title and organisation*
Board Members:	
*Dr Sarah Wollaston	Independent Chair, NHS Devon
*Graham Clarke	Non-Executive Member, Audit and Risk, NHS Devon
*Judy Hargadon	Non-Executive Member, Primary Care, NHS Devon
*Professor Hisham Khalil	Non-Executive Member, Quality and Patient Experience, NHS Devon
*Kevin Orford	Non-Executive Member, Finance and Remuneration, NHS Devon
*Dr Thandiwe Hara	Non-Executive Member, Citizen and Community Involvement, NHS Devon
*Jane Milligan	Chief Executive Officer and Accountable Officer, NHS Devon
*Bill Shields	Chief Finance Officer, NHS Devon
*Dr Nigel Acheson	Chief Medical Officer, NHS Devon
*Dr Naomi Chapman	Chief Nursing Officer, NHS Devon
Partner Members:	
*Sarah-Lou Glover	Partner Member for Mental Health, Director and Founder Member, Parental Minds CIC
*Dr Frank O'Kelly	Partner Member for Primary Care, GP Partner, Amicus Health
*Steve Brown	Partner Member for Local Authorities, Director of Public Health, Communities and Prosperity, Devon County Council
Guests in attendance:	
Anthony Fitzgerald	Chief Delivery Officer, NHS Devon
Paul Renshaw	Director of Strategic Workforce, NHS Devon
Andrew Millward	Chief Communications and Corporate Affairs Officer, NHS Devon
Cllr James McInnes	Chair, Devon Integrated Care Partnership
Ann Cooper	Interim Strategic Governance Advisor, NHS Devon
Helen Braid	Head of Governance, NHS Devon
Jo Turl (Item 13 only)	Director of Commissioning, Primary, Community, MHLDN, NHS Devon
Vicks Johnson (Item 13 only)	Associate Director Commissioning LDA, NHS Devon

Richard Schofield	Director of Strategic Transformation / Locality Director, NHS England South West
Matthew Boissaud-Cooke	Health Education England South West Leadership Fellow and Neurosurgery Registrar, University Hospitals Plymouth NHS Trust
Leigh Mansfield	Programme Director for Vaccination Services, Royal Devon University Hospital NHS Foundation Trust
Katie Harding	Media & Publications Manager, NHS Devon
Steve Clark	Joint Partnerships and Involvement Manager, NHS Devon
Apologies for Absence	
*Tracey Lee	Partner Member for Local Authorities, Chief Executive, Plymouth City Council
*Professor Sheena Asthana	Non-Executive Member, Health Inequalities and Population Health
*Liz Davenport	Partner Member for NHS Trusts and Foundation Trusts, Chief Executive Torbay and South Devon NHS Foundation Trust
Kate Shields	Chief Executive Officer, NHS Cornwall and Isles of Scilly
Mark Cooke	Director of Strategy & Transformation, NHS England South West
Martin Wilkinson	Director of Performance and Improvement, NHS England South West

Item	Discussion
1	**Welcome, Introductions and Apologies** The Chair welcomed everyone to the meeting, including Matthew Boissaud-Cooke from Health Education England South West, who was observing the meeting and Richard Schofield, Director of Strategic Transformation / Locality Director, NHS England South West who was deputising for Mark Cooke, Director of Strategy & Transformation and Martin Wilkinson, Director of Performance and Improvement. The Chair also introduced Leigh Mansfield, Programme Director for Vaccination Services, Royal Devon University Hospital NHS Foundation Trust, who would be speaking about her experience of working for the NHS as part of the 75th birthday celebrations. It was noted that apologies for absence had been received from Kate Shields, Liz Davenport, Tracey Lee and Professor Sheena Asthana. The meeting was deemed quorate. The thanks of the Board were extended to Tracey Lee, who was stepping down from the role of Partner Member for Local Authorities and it was noted that the process to appoint a new Partner Member was underway. Thanks were also extended to Ann Cooper, who was attending her last Board meeting. The Chair informed those present that the Board would be meeting in private later that day and would be considering items around the organisational change, the Devon Operating Model and the Joint Peninsula Strategic Commissioning Committee. It was confirmed that these items would be considered at a future meeting in public.

2	**Declarations of Interest** Members **noted** the Register of Interests.
3	**Minutes of Previous Meeting** The minutes of the meeting in public held on 3 May 2023 were **approved** as an accurate record.
4	**NHS 75 Birthday** The Chair introduced the 75th birthday celebrations by acknowledging the importance of the NHS, as well as her own experiences within it. Thanks were extended to all of those working in the health and care sector across Devon for their dedication and hard work. To commence the staff reflections on the NHS, Leigh Mansfield, Programme Director for Vaccination Services at the Royal Devon University Hospitals NHS Foundation Trust, spoke to the meeting about her career in the NHS which had spanned 28 years and seen her progress from a trainee physiotherapist to her current role. The chair thanked Leigh for her work over many years and especially for her contribution over the pandemic. Katie Harding, Media & Publications Manager and Steve Clark, Joint Partnerships and Involvement Manager, provided the meeting with an overview of the activities taking place to celebrate NHS 75 and introduced a video providing the views of members of staff upon why they were proud to work for the NHS, their experiences and aspirations. Board members shared their experience of the NHS and their hopes for its future. Chief Executive, Jane Milligan, then cut the 75th birthday cake.
5	**Report of the NHS Devon Chair** The Board **noted** the report of the NHS Devon Chair.
6	**Report of the Chief Executive** The Chief Executive, Jane Milligan, introduced the report. It was noted that since the report had been drafted the NHS England (NHSE) Long Term Workforce Plan had been published. The Plan focussed on training and retaining staff as well as reforming ways of working and delivering services. In addition, an Executive to Executive meeting had been scheduled with NHSE. This would provide an opportunity to demonstrate the progress that had been made in relation to the performance and financial recovery plan. The Board **noted** the report of the Chief Executive.
7	**Devon 5 Year Joint Forward Plan** Chief Medical Officer, Dr Nigel Acheson (NA) presented the Devon 5 Year Joint Forward Plan (JFP) which had been approved for publication at the Board meeting in private on 7 June 2023. The following points were highlighted: • there are a number of potential risks to the successful delivery of the JFP including the possible lack of capacity to deliver the transformational change required together with the financial and clinical pressures across the system; • board members raise the need for further reference to the Green Plan and the system's response to the requirements of the Armed Forces Act for public bodies in future iterations of the JFP;

	• it was also agreed that future iterations of the JFP would need to ensure alignment with the Local Care Partnerships and Provider Collaboratives as they mature; • the governance structure around the JFP provided an escalation route through to the System Management Executive which included colleagues from across the health and social care sector; and • work was ongoing with the Local Care Partnerships to ensure engagement with the voluntary sector and other stakeholders around the aims and ambitions of the JFP. • The role of the One Devon Partnership, ICP, in holding all system partners to account for delivery was also acknowledged Whilst it was noted that NHS Trusts, Local Authorities and other providers had approved the JFP, challenge was raised as to whether all had also committed to providing the funding required to deliver it and that there was clarity around responsibilities and lines of accountability. Assurance was provided that this had formed part of the co-production approach to the JFP. The Board **noted** the publication of the Devon 5 Year Joint Forward Plan
8	**Board Assurance Framework** Interim Strategic Governance Advisor, Ann Cooper (AC) introduced the Board Assurance Framework (BAF) which provided an update on the high-level strategic risks that pose a threat to the achievement of the NHS Devon strategic objectives. The following points were highlighted: • the strategic risks had been mapped to the enabling and delivery programmes contained within the Joint Forward Plan; • the risk scores had not changed since the BAF was approved in March 2023, which was not unusual, but when the next iteration was presented to the October Board some progress should be evident; • the Board should ask its Assurance Committees to (1) review the actions under each risk to assess timescales to mitigate the risks – and obtain greater clarity on the dates as some are missing; (2) ask whether the actions on the BAF will actually reduce the likelihood of the risk; and (3) assess whether there are any additional actions that could help; and • under Objective 13 which focused on the culture for the One Devon System, a new risk had been created around the impact that failure to address the whole system working culture would have on our ability to improve the provision of care and services for the people of Devon. AC informed the meeting that, whilst the paper included a recommendation to combine the two risks that currently sit under Objectives 2 and 3, following discussion with the Executive Lead it was proposed that this recommendation be reviewed by the Population Health Committee once established. Challenge was raised as to the ambition for Objective 7 around mental health and learning disabilities and it was confirmed that this should be considered by the relevant Assurance Committee as part of its review. The Board **agreed** the updated iteration of the Board Assurance Framework and **approved** the following new risk under objective 13: “There is a risk that if current system ways of working (culture) do not change, the provision of care and services for the people of Devon will not be improved. With a knock-on impact of negatively impacting the reputation and brand of One Devon locally, regionally, and nationally.”

9	**One Devon Partnership Chair's Report** The Chair of the One Devon Partnership, Councillor James McInnes, introduced the report which provided an overview of the Partnership meeting held on 1 June 2023. The Board **noted** the update provided.
10	**Safeguarding Annual Report 2022-23** The Chief Nurse, Dr Naomi Chapman (NC), introduced the report which sought to assure the Board that NHS Devon is fulfilling its statutory duty to meet its safeguarding requirements and outlined the structures, processes, governance arrangements and activity in this area of work. The complexity of the safeguarding structure across the system was noted and that work was underway to streamline this whilst ensuring appropriate representation at each level of the structure. It was noted that in June the National Advisor for Care Leavers visited Devon and undertook a rapid assessment of the actions that should be put in place to enable the scaling up of improvements for children in care and those leaving care. Challenge was raised as to performance around health checks for children in care as whilst assurance was received from providers around compliance, this data no longer appeared in the Integrated Quality, Performance and Finance Report. A query was also raised as to the number of children placed outside of Devon. The Board **approved** the Safeguarding Annual Report 2022-23 and **agreed** its publication. **Actions:** • A detailed response to be provided as to compliance around health checks for children in care and the number of children placed outside of Devon. • Summary report of the National Advisor for Care Leavers to be circulated to the Board for information.
11	**Cornwall and Isles of Scilly ICB Update** The Board **noted** the report of the Chief Executive Officer of the Cornwall and Isles of Scilly Integrated Care Board.
12	**Integrated Quality, Performance and Finance Report** Chief Delivery Officer, Anthony Fitzgerald (AF), introduced the Integrated Quality, Performance and Finance Report (IQPR) which provided a consolidated update on key strategic issues and measures of outcomes, performance, quality, finance and activity. It was noted that: • the recent industrial action, including recovery periods, had impacted on performance; • a piece of work focused on unscheduled care was being undertaken with national colleagues to improve performance in that area; • improvements had been made in respect of elective care and diagnostics with there being continued reductions in the number of those waiting over 104 weeks and 78 weeks for treatment; • a mental health urgent emergency care process and improvement plan is currently being developed across providers, including primary care; and • data around community waiting lists was now included within the report and that this would be developed in future iterations. The Board **noted** the Integrated Quality, Performance and Finance Report.

13	**Mental Health Inpatient Treatment Beds for Autistic People or People with a Learning Disability** The Director of Commissioning, Primary, Community & MHLDN, Jo Turl, introduced the report which provided an overview of the confirmed capital investment for the provision of mental health beds for Learning Disability and Autistic People across the region to reduce out of area placements. The Board was referred to its meeting on 7 June, where this matter had been considered in detail and whilst there was support for the aim of the project, concerns had been raised around the financial sustainability of the proposals. It was noted that since that time, the business case had been presented to the Finance & Performance Committee for further consideration of the financial implications of the proposals. Chair of the Finance & Performance Committee, Non-Executive Member, Kevin Orford (KO) informed the meeting that the Committee had received some assurance that the capital costs of the scheme would come in within the allocated budget, but that if this failed to be achieved it would impact on the capital availability across the system. Whilst the funding source for the elements of "double running" had not been fully identified as yet, the Committee did not consider that this should hold up the approval of the proposals and so recommended its approval to the Board. The Board **approved** the commissioning and financial consequences of the inpatients beds and **supported** the provider's submission of the business case to NHSE once it has been through their Board for approval.
14	**Committee Chair's Report: Primary Care Commissioning Transitional Committee** Non-Executive Member for Primary Care, Judy Hargadon (JH) introduced the report which provided an overview of the meeting held on 8 June 2023. The Board **noted** the report of the Chair of the Primary Care Commissioning Transition Committee, including the statements of assurance.
15	**Committee Chair's Report: Quality & Patient Experience Committee** Non-Executive Member for Patient Experience and Quality, Hisham Khalil (HK), introduced the report which which provided the meeting with an overview of the issues considered by the Committee at its meeting on 21 June 2023. The following points were highlighted: • work continued to develop the quality indicators which would be monitored by the Committee; • the Committee will focus on the patient experience element of operational and recovery plans; and • the Oliver McGowan Mandatory Training requirement in respect of the care of patients with Learning Disability that all Board members have to complete. The training consists of two tiers: online training at level 1 for non-clinical, non-patient facing staff, and expert-led training at level 2 for other staff. The Board **noted** the report of the Chair of the Quality and Patient Experience, including the statements of assurance.
16	**Finance Reports – NHS Devon and One Devon ICS 2023-24 Month 2** Chief Finance Officer, Bill Shields, presented the 2023/24 Month 22 Finance Reports for the Integrated Care Board (ICB) and the Integrated Care System (ICS) highlighting the following: • £30m of savings have been identified and plans to deliver those savings are in development.

	• a workshop was being held in respect of new models of care and how this workstream can deliver the identified £13m of savings; and • whilst there had been a negative variance from plan due to industrial action, the expectation was that at the end of Q1 the overall plan delivery will be on track. A query was raised as to when it would be possible to consider how the system wanted to use its resources going forward, rather than using the previous year's spend. It was confirmed that the first priority was to get the system into balance, but that there was work ongoing in respect of equity and fair shares across the system which will be reported to the Board at a future meeting. In addition, the Hewitt report recommendation of the shift towards population health and prevention will also need to be brought into that discussion. The importance of non-recurrent funding for pilot projects to establish whether in the long term the proposed service is sustainable and would support effective prevention services. It was acknowledged that not all these pilots could however be resourced going forwards but that the system does need to be able to move towards more upstream prevention. The Board **noted** the 2023-24 Month 2 Finance Reports.
17	**Committee Chair's Report: Finance & Performance Committee** Non-Executive Member for Community Finance, Kevin Orford (KO) introduced the report which provided an overview of the meeting held on 27 June 2023. The Board **noted** the report of the Chair of the Finance & Performance Committee, including the statements of assurance.
18	**Committee Chair's Report: People & Culture Committee** Non-Executive Member for Citizen and Community Involvement, Dr Thandiwe Hara (TH), introduced the report which provided an overview of the meeting held on 21 June 2023. The meeting considered the NHS England (NHSE) Long Term Workforce Plan which had been referred to earlier by the Chief Executive and the following points were highlighted: • whilst the NHSE plan focussed purely on health, the Devon Strategy encompassed health and social care; • there was nothing in the national plan that wasn't incorporated within the Devon Strategy; • the challenge for the Devon system remains reaching agreement across partners as to how we can transform the way in which we deliver services and how the appropriate workforce can be attracted and retained; • a key focus over the coming months was the development of a detailed workforce plan supported by a learning education strategy; • the impact of digital developments can have upon the delivery of care and who can deliver that care; and • the importance of career pathways and making these visible to employees. Challenge was raised as to the cause of staff leaving the health sector, was often not down to pay, but rather the way that they were treated and that issues such as breaks being cut, inflexible working practices and a lack of managerial support were often cited as reasons for leaving. In response it was confirmed that people management skills at all levels were being reviewed to try and prevent staff leaving due to de-motivation and feelings of being undervalued. The Board **noted** the report of the Chair of the People & Committee, including the statements of assurance.

19	**Action Register** The Chair referred the meeting to the progress being made in respect of actions arising from previous meetings of the Board. It was noted that a number of the actions related to items being brought to future meetings of the Board and that due to the change in scheduling of Board meetings, these would now be reviewed and an updated Forward Planner and Action Log brought to a future meeting. With regard to Action 37 in respect of lessons to be learned in respect of orthopaedic pathways, it was noted that work was underway and that progress was to be communicated both to primary and secondary care. The Board **agreed** that the Action Register should be reviewed and an updated version presented to its next meeting.
20	**Questions from Members of the Public** The Chair confirmed that no questions from the public had been submitted prior to the meeting.
21	**Any Other Business** The next meeting of the NHS Devon Board to be held in public will take place on 4 October 2023.
	Meeting Closed: 1.15pm

Minutes approved	Date:	Signed by Chair:

NHS Devon

NHS Devon Integrated Care Board

Integrated Quality, Performance and Finance Report (IQPR)

Date of meeting	Date report produced
04 October 2023	25 September 2023

Author(s)		Report approved by	
Name and title:	Performance Team	**Name and title:**	Sam Wadham-Sharpe Director of Performance and Assurance
Phone:		**Date:**	25 September 2023
Email:	s.wadham-sharpe@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 consolidated update on key strategic issues and measures of outcomes, performance, quality, finance, and activity to provide the necessary assurance, at both place and system level that issues are being identified and addressed. **Unscheduled Care:** Metrics relating to urgent care have seen no improvement during August 2023. Ambulance handover delays above the 15-minute worsened in August to 8542 from 6384 hours which remains behind trajectory. Current ambulance handover data is unreliable due to the ongoing cyber-attack at South

Western Ambulance Service NHS Foundation trust (SWASFT), and solutions are being discussed through Tier 1. 4 hour performance worsened from 63.8% in July to 62.1% in August and remains below trajectory.

Category 2 response times worsened in August with an average response time of 40 minutes while there was a worsening against the 12 hour in department standard which increased to 2898.

In addition to the 7 Key areas detailed within our Urgent and Emergency Care (UEC) Recovery Plan, focus is being placed on minors' performance, overnight performance, patients that breach between 4-5 hours and virtual ward utilisation.

Elective Care and Diagnostics: The system position is close to the trajectory for the clearance of all 104ww patients with an expected completion date of the 104ww cohort by the end of October. Patients continue to be monitored weekly through provider meetings as well as the regional Tier 1 process.

The month-end position for August (Trust data) showed that Torbay and South Devon NHS Foundation Trust (TSDFT) and Royal Devon University healthcare NHS Foundation Trust (RDUH) having no patients breaching 104ww with UHP having 49. The large majority of these long waiters are concentrated in Neurosurgery and Orthopaedics. The independent sector noted only one 104ww patient at the end of August.

Ongoing issues with activity lost as a result of industrial action is a factor that continues to impact on recovery of activity and performance levels detailed within the operating plan. Without activity lost to industrial action, all providers and the system would have met the trajectory on all three standards.

Hospital Discharge: The number of No Criteria to Reside (NCTR) patients occupying a hospital bed in Devon shows continued improvement since March 2023. As of 21st August, the average weekly percentage of General & Acute (G&A) beds that were occupied with patients who had NCTR was 11% (236), although falling short of the 5% (110) target. Providers are implementing actions to reduce NCTR patients with performance managed by the monthly Discharge Improvement Tactical Group.

Primary and Community Care: NHS Devon continues to exceed 3 out of 5 access targets. GP appointments occurring within 2 weeks was 82.9% against an 85% target. Devon's Plan for Recovering Access to Primary Care (PCARP) has been reviewed and supported by the Primary Care Commissioning Transitional Committee in September and is presented elsewhere to the Board at on the agenda for its October meeting. The target of 35% of appointments occurring within 1 working day of request continues to be achieved with 49.9% patients seen within 1 working day during July 2023.

Mental Health: Access to Talking Therapies is the only Long Term Plan indicator showing in month improvement, although not achieving its target. The remaining Long Term Plan indicators are not achieving their corresponding targets.

The Mental Health, Learning Disability and Neurodiversity (MHLDN) Provider Collaborative is developing its reporting infrastructure to support subsidiary boards and committees.

Children and Young People Services: Autism Spectrum Disorder (ASD) referrals have increased above expected levels in July with over 500 received across our providers. Children awaiting ASD assessments have continued to increase with the current waiting list exceeding 4,500. Staffing vacancies are the primary factor affecting this service, resulting in limited assessments being completed.

Speech and Language Therapy (SLT) waiting times over 18 weeks performance are no longer improving but showing common cause variation, whilst referrals remain within expected levels.

Quality: Elective Improvement Board continues to receive updates on improvement and mitigating actions for patient safety and experience due to longs waits. In urgent and emergency care, long waits continue and actions to improve and mitigate risk within the UEC pathways are driven at 'place' through the Local Urgent Care Boards and reported through the System Urgent Care Board.

Workforce: At month 4, year to date (YTD) agency spending as a percentage is at 3.4% and is the lowest in the South West region. As a system, workforce spend has been £10.69M higher than anticipated total YTD (forecasted £19.35M overspend against plan to the end of the year).

Finance: At the end of August 2023, Devon Integrated Care System (ICS) reported a year to date deficit of £39.7m against a planned deficit of £32.6m (£7.2m adverse to plan). The forecast remains on plan at £42.3m deficit. Efficiency savings were £66.0m at month 5, £11.5m favourable to plan and forecast year end savings are on plan at £212.2m.

At the planning stage net risks of £159.5m were identified in addition to the deficit plan. At the end of month 5 this has improved by £53.3m and stands at £106.2m against the current forecast.

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

Quality and Performance Committee - outcomes escalated as part of chair reports

Key recommendations and actions requested

1. The Board is asked to **note** the report.

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	
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	
Area	
Quality of services	Outlines current operational and quality performance and Actions
Health inequalities	None
Workforce	Outlines current workforce performance and actions
Resources and finance	Outlines current financial performance and actions
Legal	None
Digital and Data	None
Involvement, Engagement and consultation	None

Integrated Quality, Performance and Finance Report (IQPR)

Owner: Performance Team

September 2023

DRAFT Version

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Executive Summary

Unscheduled Care

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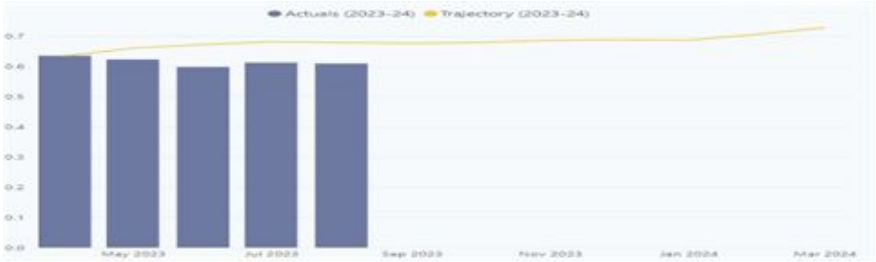
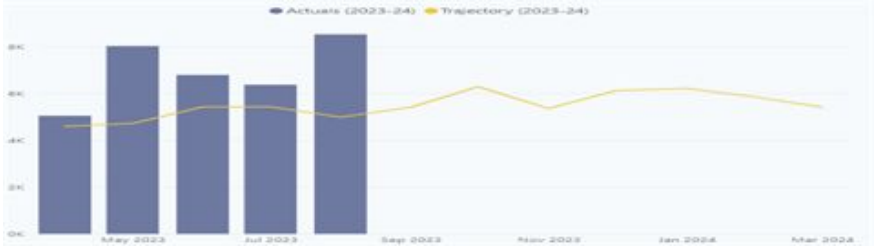
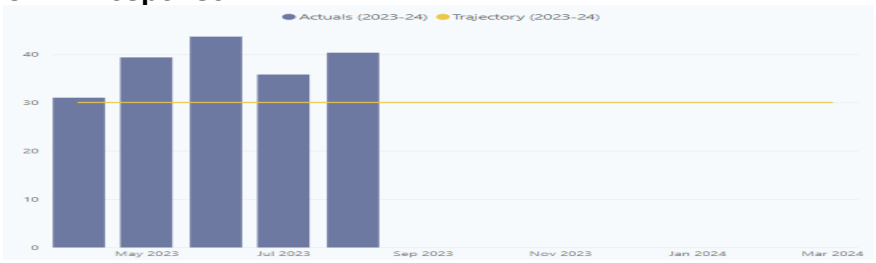
Operational Performance

Urgent and Emergency Care – System Overview

				System			Royal Devon University NHS Foundation Trust			Torbay and South Devon NHS Foundation Trust			University Hospitals Plymouth NHS Trust		
	Metric	Target	Latest Date	Value	Variation	Assurance	Value	Variation	Assurance	Value	Variation	Assurance	Value	Variation	Assurance
UEC	National A&E Type 1 Attendance		Aug 2023	29,239			13,542			6,749			8,948		
	National A&E Type 1 seen within 4 hours	95%	Aug 2023	47.5%			50.3%			51.9%			39.9%		
	National A&E all types seen within 4 hours	95%	Aug 2023	60.9%			59.2%			67.6%			58.1%		
	National A&E 12 hr waits from Decision t...		Aug 2023	542			52			156			334		
	Attendances Type 1		Aug 2023	29,202			13,434			6,832			8,936		
	Type 1 Admissions (conversion rate)		Aug 2023	28.2%			27.8%			23.0%			32.7%		
	Emergency Admissions via A&E		Aug 2023	8,227			3,736			1,570			2,921		
	4hr Performance Type 1		Aug 2023	46.5%			48.0%			51.8%			40.2%		
	Total patients waiting over 12 hours in d...	0.95	Aug 2023	2,989			761			822			1,406		
	Ambulance arrivals delayed over 15 min...	0%	Aug 2023	79.6%			76.5%			75.9%			87.8%		
	Time lost to Ambulance Handover Delays		Aug 2023	8,727			2,007			1,700			4,835		
	Mean ambulance response times cat 1	7	Aug 2023	9											
	Mean ambulance response times cat 2	18	Aug 2023	40											
	Patients who do not meet the criteria to ...		Sep 2023	7,956			2,306			1,073			3,541		
	Average Emergency LOS		Aug 2023	7			6			6			8		

Data for August saw minimal improvement, with the majority of system metrics exhibiting a deteriorating position. All types four-hour reports exhibits concerning performance at 60.9% and is statistically unable to meet the 95% target without process change. Category 1 response times show improvement but is not capable of meeting the target without process change. Category 2 response times are within common cause variation, however as the target is within the lower control limit, this demonstrates that this is achievable without process/system change.

System UEC NOF

UEC Overview	Metrics
Current Position To provide a more targeted approach to UEC recovery, a new Devon integrated UEC recovery plan has been co-produced between the ICB, localities and providers. The focus has been provided by targeting 5 key domains where GIRFT highlights that Devon providers and the system does not perform as well as national or peer averages. The UEC recovery plans will be managed at Locality UEC Boards with assurance and escalation provided to the new Urgent Care Board. This process will include the oversight of delivery and evaluation of impact of the additional funding schemes which have been identified for the £13.8m assigned to Devon ICS. Business case reviews have been undertaken against the current schemes to ratify the schemes, including key delivery milestones and expected impacts to enable effective evaluation. **Unscheduled Care Key Messages/Escalations:** • Draft winter plan was submitted on 11 September 2023, with the final submission due 25th September. • Understanding of demand and capacity schemes following agreement to identify any barriers to delivery or slippage in provision. • Full best practice pathway development for falls, frailty and end of life care. • Provider focus through Tier 1 on minors performance, overnight performance, patients that breach between 4 and 5 hours, and virtual ward utilisation. • Simulation model visits with all providers to build ED model and understand impact of recovery plan actions. • Implementation of best practice system pathways in falls, frailty and end of life • Winter Plan resubmission by 27thth September including care coordination hub and SCC. • Readiness for Winter seminar 28th September with full system representation including primary care and local authority.	**4 Hour Performance**  **Ambulance Handover**  **CAT2 Response** 

North & East Locality Board Update

Progress
Unscheduled Care Board: • Integrated UEC Plan – All areas now RAG rated to understand performance against the plan and working jointly with the Trust. • UEC Recovery Fund – Update provided on UEC Recovery Fund business cases (n=14). A number of business cases were submitted to the Devon Investment Group on the 15th August. These schemes have since been to the Financial Planning Board – and are scheduled to appear on the Devon ICB Board on the 6th September. Currently working with the BI team to monitor the impacts of the schemes and working with finance colleagues in terms of the funding allocation. • DCC footprint Hospital Discharge Transformation – Significant progress made with transformation across all workstream pathways and engagement with all key stakeholders. Highlight reports from each pathway shared with the UCB group members. • Understanding of data in North and East –work undertaken with key stakeholders to localise data, this includes the addition of primary care and UCR data. This was discussed further at the N&E UCB on the 31st August where requests for data around virtual ward, mental health and further work on UCR were requested.

Planned Activity	Expected Impact
Improving the No Criteria to Reside (NCTR) Position.	Particularly for Northern, the numbers are reducing (and improving). The positive changes / processes put in place and increased monitoring will allow for a more robust process. Decrease LoS by 1.5days. Decrease over 21day LoS.
Frailty, Falls and End of Life Care	Reduction in avoidable admissions (focus on care homes). Reduction of falls in care homes. Reduction in numbers of fractured NOF. Reduction in number of people on an EoL pathway dying in hospital. Reduction in 999 calls from care homes for falls and EoL.
Ambulance Handover Delays.	Decrease in minors breaches. Decrease in closure hours for MIUs/UTC/WIC. Improved 4hr standard position: 76% by Mar 2024.

Issue Description	Mitigation
North PCN's haven't signed up to Immedicare.	Discussed at Northern Operational Group on Tuesday 29th August. PCN's and Trust colleagues are to work with Care Homes with the highest admissions and look at rearranging the older peoples intermediate care teams around some of those. Raised at UEC delivery group and requesting support for data to target care homes.

South Locality Board Update

Progress
• Ongoing development, support and management of the agreed Integrated UEC Recovery Plan and associated Business Cases – Monthly review process, highlight reporting and 'deep dive.' • SUCB Dashboard overview and implementation agreed to take collective assurance and facilitate oversight of action, improvement and impact. • Discussed areas of particular risk that at present are not in line with required trajectory to reach the agreed targets. • Care Home Admissions & Support Offer – review of DOS, establishment of review for all Care Home Attendances/Admissions. • Review of Respective Actions / Plans associated with Urgent & Emergency Care Recovery / Improvement and Reporting to support further alignment. • Review of Winter Planning learning and development of approach including an impact assessment from 2022-23 and enhanced focus on out of hospital arrangements – locality session planned w/c 11th September, System 28th September.

Planned Activity	Expected Impact
Adoption of a Task & Finish Group drawn from across VCSE/DPT/locality/ED to focus on creating appropriate services and response to those with vulnerabilities and/or after attempting self-harm or injuring themselves who attend the ED/CUC settings.	Improvement in outcomes and reduction of risk for those within this cohort, and through the Trauma Informed and Shame Aware lens support people in their lives to reduce the risk of harm to themselves.
Integrated UEC Plan utilising the Deloitte's template to be shared with the membership, and to be adopted as a main vehicle for capturing programmes of work, outcomes and impact upon recovery and improvement across the south locality. Review of workplans by organisations to align with the Integrated Urgent and Emergency Care Recovery Plan.	A consistent and agreed framework within the wider Unscheduled Care governance structure across the ICB.
Action Plan to be created and adopted across the locality to support those that self-harm (building on the Make Space report) within the UEC pathways.	Reduce the risk to those vulnerable people that may lead them to further harm or suicide, and to create a trauma informed approach to their complex needs. Reduction of health inequalities and improve inclusion.
Care Home Admission Avoidance - Review of admissions, support offer alongside rollout of immedicare (24+8) Finalisation of community demand and capacity schemes (complex discharge schemes, falls, VCSE, PC) and forecasting to be presented to SUCB in September to allow sufficient mobilisation lead in time.	

Area of Escalation	Support Required	Expected Outcome
For an agreed NHS Devon wide escalation process and SOP to help manage and support those in the EDs awaiting MHAA or onward MH transfers of care.	MH UC Transformation Board to support this scheme of work which was presented in July 2023, and accepted as being needed by now at a high level to plan the strategy.	Agreed T&F group to include Livewell/DPT/ICB/acutes to create an escalation policy with supporting SOPs to safeguard and support those clients in the EDs.

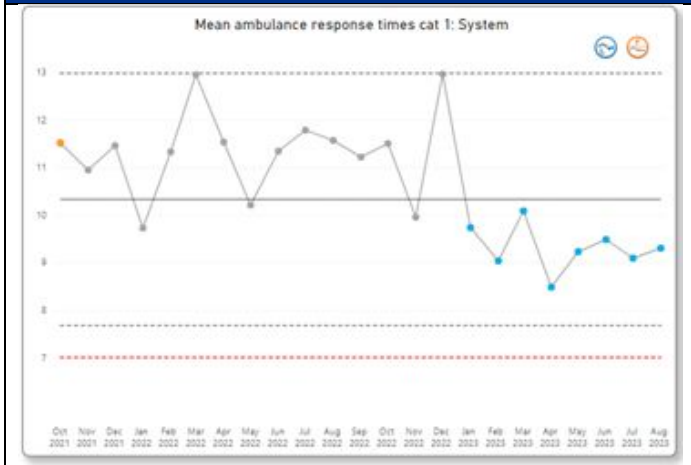
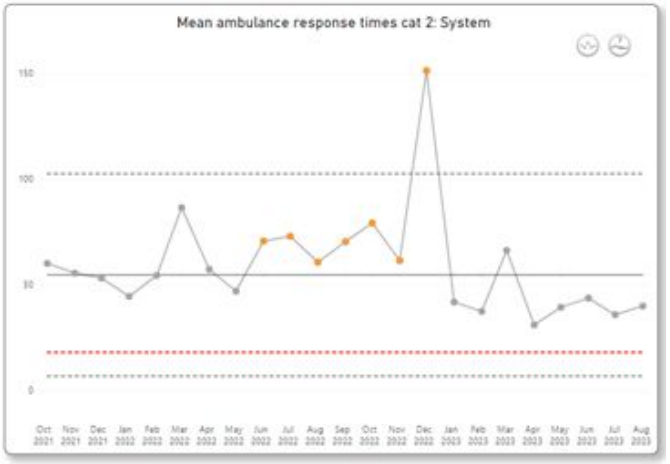
Western Locality Board Update

Progress
• Review of workplans by organisations to align with the Integrated Urgent and Emergency Care Recovery Plan. • Establishment of weekly Tier 1 meeting to monitor impact and actions for 4 hr ED target and ambulance handovers. • Care Home AA – review of DOS, establishment of twice weekly review meetings for all Care Home Attendances/Admissions (membership include Trust, Community leads, end of life leads, SWAST and commissioning). • System partners agreed to develop a peripatetic P1 delivery team offer utilising Additional Discharge funding, aligned to IPACs demand and capacity modelling and winter planning. • Approval of UEC Business cases – on-site UTC and GP Streaming. Approval of capital investment funding to support delivery of on-site UTC. 2022 Demand and Capacity funded schemes reviewed to understand impact with recommendations to recommission 3 of 4 programmes, to new specifications.

Planned Activity	Expected Impact
Ambulance handovers and 4 hour ED target • GiRFT UEC Clinical Visit – ED/Frailty and Acute Medicine Modelling Complete and daily breach validation process. • Daily Huddle to review previous days constraints. • Focus on delivering 'professional standards' improvement – led by CMO.	Improvement in 4hr ED target.
Care Home Admission Avoidance • Extension of Immedicare Service (due to end 31/12/23) to 30/4/24 to ensure continued support over winter. • Plymouth System Care Home Admission Avoidance Group to meet to identify themes and pathway/service development from twice weekly review meetings to reduce ambulance ED attendance**.**	Reduction in care home conveyances.
Non elective LOS and discharge delays • Review admission model for Discharge Assessment Unit beds at refurbished ward on the Mount Gould Site. • Priority TOC workstream as part of the DTA improvement program. • Peripatetic P1 delivery team project in design phase. Working group established. Business case to be submitted to DIG.	Increase P2 flow into the unit and greater P1 home first discharges direct from Acute setting. Improved LOS, re-admission avoidance and discharge pathway optimised. Sustained improvements in P1 capacity and ability to meet surge requirements/Winter resilience.
Development of Intermediate Care Plan for Plymouth • Underpinned by IPACS data modelling informing strategy and investment of ADF monies for 2023 – 2025.	Sustained delivery of NCTR improvements in Plymouth.
100 day challenge commences 4th September focussing on falls and frailty. • Falls Response Offer to be reconfigured due to low utilisation of additional capacity deployed. • Frailty assessment teams under development in ED, and Geriatric Assessments in the community. • End of Life - End of life pathway review ongoing, to include scoping potential of virtual wards.	Reduced attendances, admissions, length of stay and in-hospital deaths for frail and EOL patients.
Redesign of community demand and capacity schemes (complex discharge schemes, falls, FUSE) • Forecasting to be presented to WUCB in September to allow sufficient mobilisation lead in time	Ensure alignment of local investment to UEC Improvement Plan priority areas.

Issue Description	Mitigation
Impact of Cornish patients on NCTR. Improvements seen, but further activity required to ensure sustainability.	Cornwall engagement with WUCB and actions for information sharing underway.
Primary Care ‘Red-Lines’ Impact.	Workshop with agreed action plan developed and progress reporting into LCP executive.

Ambulance response times (Cat 1 and Cat 2)

Data	Analytical Summary
 	Ambulance response times are influenced by overall levels of demand, call answering times and capacity to respond - which is correlated to hours lost to handover. **Demand**: The number of incidents in August was 19,713, an increase on July's figure of 18,989 and the busiest month this year (from April). The percentage of patients conveyed to ED decreased down to 41% in August, from 43.5% in July. **Call answering**: Call answering performance is being maintained; through August 97% of calls were answered in 5 seconds, the same rate as July (target 95%). Mean call answering times also stayed the same at 3 seconds. Through July*, SWASFT call answering times were again amongst the best in England: 3 seconds mean call answering time (range 3 seconds to 130 seconds). **Response capacity**: Over 50,000 conveying resource hours were available through August, with capacity peaking at nearly 54,000 hours week commencing 14th August – the highest so far this year. These increases in capacity were put in place last winter, to partly mitigate resources lost to handover, and have remained in place utilising national UEC recovery funds. Approximately 11,000 of these hours per week were available across Devon. Across the Trust, hours lost to handover increased to 20,950 in August, up from 17,193 in July. In Devon, there has also been an increase: 8,914 hours lost in August, compared with 6,482 in July. Hours lost to handover in August are the highest so far this year (from April). **Response times**: Response times increased across all categories in August and none of the response standards were met. Of note, the category 2 response mean in August was 40 minutes, an increase on 36 minutes in July (national recovery target of 30 minutes). **Comparative information for all England ambulance Trusts is only available for July.*

Operational Summary

Causes:

- Devon incident numbers in August were 3.3% above contract activity.
- Call answering EMD establishment has increased but is below plan. Through May and June, establishment was 218 WTE and in July that increased to 227 WTE (239 WTE plan). Despite this, call answering times continue to be amongst the best in England.
- Ambulance response times have a positive correlation with hospital handover delays. In August, an increase in hours lost to handover has led to increases in response times across all call categories.
- SWASFT's average handover time remains the worst in England. In July*, SWASFT's average handover time was 41 minutes and 24 seconds (national average 28 minutes and 48 seconds; range 16 minutes to 41 minutes). Week commencing 14th August, Category 1 response times were amongst the highest in England – 8 minutes and 46 seconds (target 7 minutes) – range 7 minutes 25 seconds, to 9 minutes 9 seconds. Category 2 response times have improved in comparison with other Trusts at 31 minutes and 23 seconds (target 18 minutes) – range 24 minutes 55 seconds, to 39 minutes 36 seconds.
- Actions described below are focused on increased clinical capacity in the Emergency Operations Centre (EOC) ("clinical hub") and additional frontline resources contribute to improvements in response times.

Actions:

- SWASFT continue to recruit to EMD roles to ensure sufficient capacity to maintain good performance on call answering. The monthly establishment position is being monitored through the South-West Finance Information and Contracting Sub-Committee.
- Increased clinical capacity in the EOC ("clinical hub") and category 2 segmentation and are key elements of the UEC recovery plan. Clinical establishment in the EOC has increased from 94 WTEs in May/June, up to 104 WTE in July (plan 128 WTEs). Category 2 segmentation allows for certain types of incidents to be sent to clinicians for on-going review, and some cases will be suitable for clinical validation – which can avoid the need for ambulance dispatch. Category 2 segmentation has been live since mid-May, the number of incidents receiving clinical navigation is slowly increasing and is currently c28%; around 44% are eligible for navigation.
- Additional frontline resources hours are being funded through the UEC recovery fund. This includes maintaining and increasing private provider capacity, and recruitment in line with "People Plan 3" to deliver a longer-term increase in resource, with a focus on increasing capacity in the evenings and overnight. In July, circa 223,400 conveying resource hours were available (plan 222,300 hours). Sickness reduction schemes are also in place to increase frontline resource; sickness rates in July were better than plan: 6.2% against 7% plan. Ambulance Vehicle Preparation (AVP) schemes at 14 sites across the south-west are also being implemented, to increase capacity for response.
- SWASFT have been given an additional £500k to further increase their ambulance capacity through August, September and October. They are utilising this by offering further incentives for staff taking additional shifts overnight. Tracking and monitoring of this forms part of the Ambulance Recovery Oversight Group.
- Handovers continue to be a key interdependency to improving response times. In July*, the combined south-west trajectories for handover delays were for 17,714 hours lost to handover; the actual hours lost were approximately 17,190. In Devon, handover improvement plans are in place and monitored monthly through the ambulance cell and locality urgent care boards.
- The south-west commissioners are progressing towards a lead commissioner model for ambulance services, through NHS Dorset – the start date has been deferred (originally intended to be 1st July) and will be confirmed shortly. This will put the south-west arrangements in line with those in place for other ambulance services. The lead model will support more timely decision making, providing Dorset with delegated authority and a

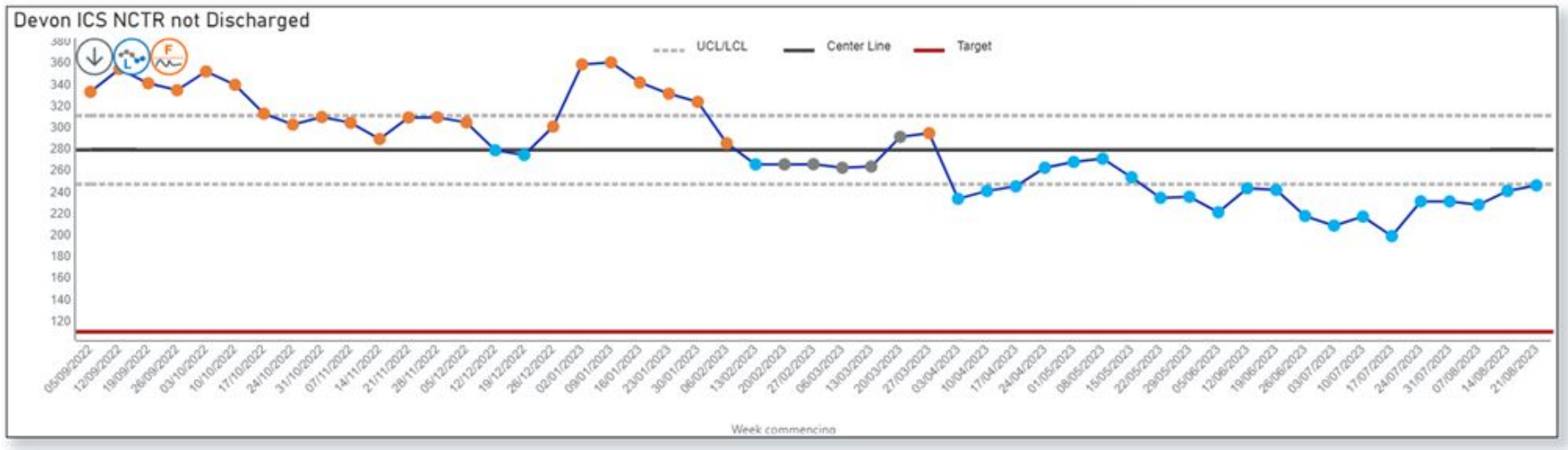
strengthened team to commission services, within a governance framework. Individual ICBs will continue to be part of the revised arrangements ensuring continued engagement and communication.

- SWASFT have been designated as a UEC Tier 1 Ambulance Trust. SWASFT will receive the highest level of support to achieve the ambitions of the UEC recovery plan including collaborative working across ambulance services through the Model Health System, improvement projects on high impact areas and, oversight and support from the National Strategic Ambulance Advisor. A range of support options have been agreed to support SWASFT including communications campaigns, clinical validation in 111, low-acuity incidents pushed to CASs, alternative acute and community pathways, access to SDEC services and care coordination schemes. These initiatives have been captured as actions under the "Ambulance" heading in the Devon UEC Integrated Recovery Plan, which is monitored weekly through executive leads and monthly through the Unscheduled Care Board.

Hospital Discharge

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
No Criteria to Reside (NCTR)	5% (110)	21/08/2023	11% (236)		

Devon – daily average of patients with No Criteria To Reside



Analytical Commentary:
The Devon target is no more than 5% (110) of General and Acute beds occupied by patients with NCTR. Since March 2023 the metric continues to demonstrate a special cause variation of an improving nature. As of 21st August, the average weekly percentage of G&A beds that were occupied with patients who had NCTR was 11% (236), which is a 1% increase from the previous months report.

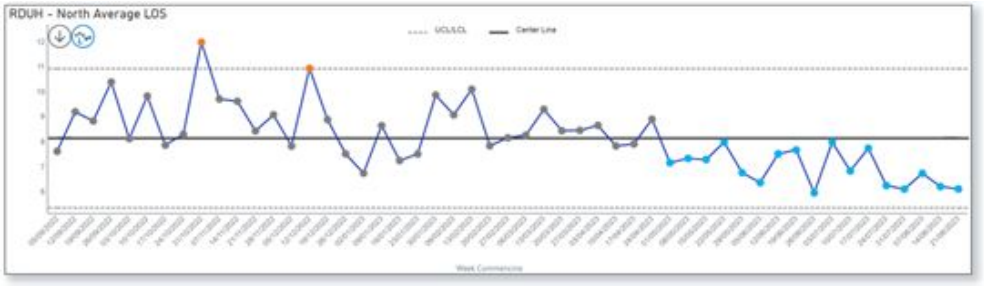
Operational Summary:
Actions to address reducing the NCTR will be managed through locality level Bronze Calls and via the newly monthly Discharge Improvement Tactical Group which is to launch 19th September 2023. The actions to be taken by trusts and those which will be maintained include:

- To achieve 60% of weekday discharge target at weekends, as a system this has on average been achieved overall. However, discharge was exceeded on Saturdays with further actions to increase on Sundays throughout October there is regional focus increasing and improving weekend discharges.
- Early discharge planning in place leading into the weekend followed by mop up meeting on Mondays to review failed planned discharges.
- Continue to roll out CLD to further medical wards within the acutes.

- Discharge Lounges in place and fully operational seven days a week to increase weekend discharges, targeting wards with lower performance of discharges before midday.
- Introducing clinical portals and dashboards to enable ward teams to monitor performance of discharges throughout the day.
- Regular manual processes to ensure patients are on the correct pathway and still have NCTR.
- Home for Lunch initiatives across all sites continues to be promoted.
- Daily P1 patients waiting for discharge are reviewed to see if can be stepped down to P0 with VCSE support.
- Consistent senior presence at Board rounds to support NCTR decision making processes.

RDUH North NCTR not Discharged.

Average Non-elective Length of Stay (by week)– RDUH North



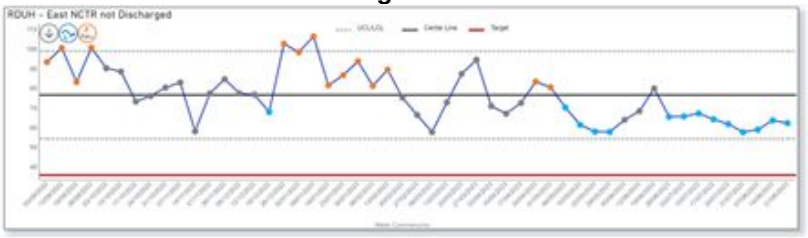
Analytical Commentary: As of 21st August, RDUHN reported the average weekly percentage of G&A beds that were occupied with patients who had NCTR was 15% (42), a 1% reduction from the previous months report. CLD continues to be embedded and is now rolled out across medicine, being used effectively and is included within the Junior doctor induction programme from August onwards. Continued discharge coordinators at weekends supporting weekend plans. On average RDUHN exceeded the 60% target and achieved 70% of the weekday discharge target at weekends during this reporting period.

Operational Summary:
Actions to address are in place with Demand and Capacity schemes planned to continue following evaluation of schemes which have contributed to positive performance and reduction in length of the delay. The LOD performance breakdown by pathway is described below:

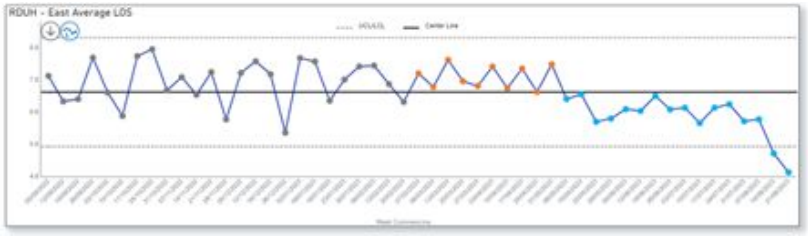
- P0 – Discharge lounge continues to be fully operational, 55% of patients discharged from Discharge lounge by happens before12pm. Average time a patient spends in discharge lounge remains at 2.8 hours The trust continues to exceed expected number of P0 discharges to maintain flow. Between 24th July and 20th August, the target set is 36 P0 discharges per weekday the trust has achieved on average 49 P0 discharges per weekday (136%).
- Management of Change was concluded enabling the presence of matrons for GOLD standard board rounds Monday – Friday, to support NCTR decision making processes, the consultation has also been completed with new rosters in place to support from October.
- Due to a data recording issue, the trust is unable to provide the average Length of delay data on each of the complex pathways for RDUH North. This continues to be investigated.

Due to relatively small volumes at this site, small numbers of patients with very long LOS can cause spikes in the graphs.

RDUH East NCTR not Discharged



Average Non-elective Length of Stay (by week) – RDUH East



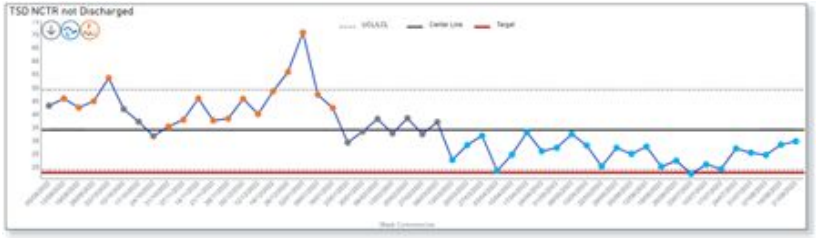
Analytical Commentary: As of 21st August, RDUHE reported the average weekly percentage of G&A beds that were occupied with patients who had NCTR was 8% (58), a 1% reduction from the previous months report. Continued roll out of CLD planned for cardiology, paediatrics, gynaecology and general medicine wards. Continue to facilitate discharge lounge utilisation over the weekend and encourage proactive discharge planning at the end of the week, to optimise weekend discharges. On average RDUHE exceeded the 60% target and achieved 80% of the weekday discharge target at weekends during this reporting period.

Operational Summary:
Actions to address are in place with Demand and Capacity schemes planned to continue following evaluation of schemes which have contributed to positive performance and reduction in length of the delay. The LOD performance breakdown by pathway is described below:

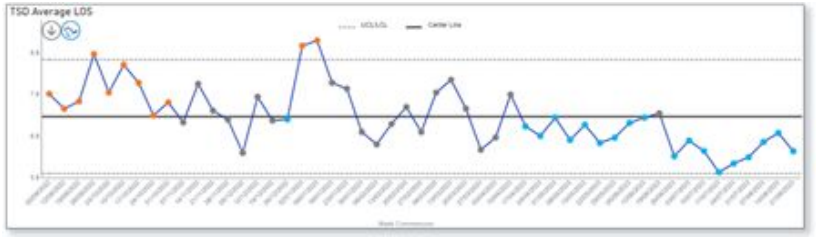
- P0 - There is a continued focus on morning discharge planning. Discharge Coordinators set to target wards with most room for improvement for earlier discharge. There is a consistent senior presence at board rounds which provide a Patient centred approach. Instil business as usual mindset for early discharge within workforce culture. Proactive outreach from discharge lounge in place. Utilising a strength-based approach for P1-P0 step down and the trust are continuing with discharge workshops and education. Between 24th July and 21st August, the target set is 91 P0 discharges per weekday the trust has exceed their target of with an average 94 P0 discharges per weekday (103%).

- Since mid-June the average LOD on:
    - P1 remained at 3 days.
    - P2 increased from 3 to 4 days.
    - P3 reduced from 7 to 6 days.

TSDFT NCTR not Discharged



Average Non-elective Length of Stay (by week)-TSDFT



Analytical Commentary: As of 21st August, TSDFT reported the average weekly percentage of G&A beds that were occupied by patients who had NCTR was 6% (22), a 1% reduction from the previous months report. Manual processes in place to review patients and ensuring they are on correct pathways once they have NCTR continue. Continue to follow weekend discharge audit recommendations supported by the UEC Board. Working with Multi-Disciplinary Teams to support increase in weekend discharges and have seen a slight improvement. Moving to Clinical portal to create MDT planned weekend discharge list and is in development. On average TSDFT did not achieve the 60% target and achieved 40% of the weekday discharge target at weekends during this reporting period.

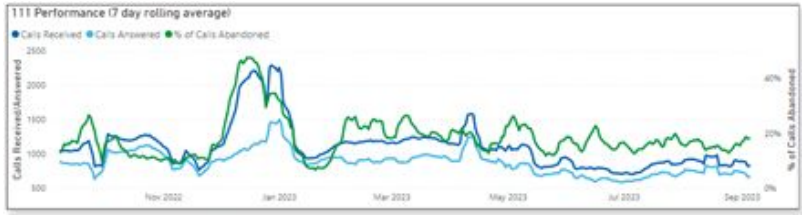
Operational Summary:
Actions to address are in place with Demand and Capacity schemes planned to continue following evaluation of schemes which have contributed to positive performance and reduction in length of the delay. The LOD performance breakdown by pathway is described below:

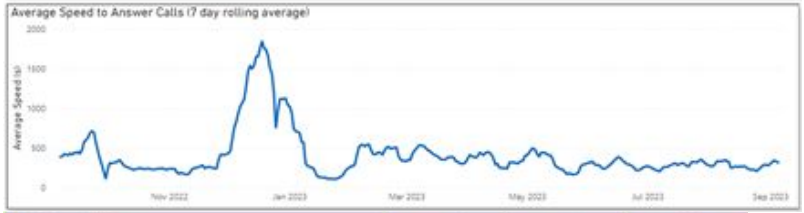
- P0 – Home for lunch promotion continues to improve pre-noon and pre 5PM discharges. New Dashboard being developed to support site management and Operation teams focus on time of day discharges. Between 24th July and 21st August the target set is 53 P0 discharges per weekday the trust has achieved on average 50 P0 discharges per weekday (94%).

- Since mid-June the average LOD on:
  - P1 remained at 4 days.
  - P2 reduced from 5 to 4 days.
  - P3 increased from 11 to 14 days.

Integrated Urgent Care Service: NHS 111/Out Of Hours

Data





C3 & C4 Validation	May-23	Jun-23	Jul-23
Validation measure	75%	75%	75%
Local KPI	90%	90%	90%
Total C3 & C4 dispositions	3330	2995	3456
Total C3 & C4 cases validated	2829	2623	2848
% C3 & C4 validated	84.95%	87.58%	82.41%
ED Validation	**May-23**	**Jun-23**	**Jul-23**
Validation measure	50%	50%	50%
Local KPI	90%	90%	90%
Total ED dispositions	4083	3627	3716
Total ED cases validated	3448	3137	3148
% ED cases validated	84.45%	86.49%	84.71%

Operational summary

The charts show the performance for PPG and appears to show a reduction of calls in the few months. However, demand from the population of Devon has not reduced; calls are being taken by other providers due to an agreement with NHS England to provide planned support across the PPG call taking network. Unfortunately, limited data is available on the total performance for the Devon population, but commissioners are assured by the overall performance of the service.

The number of calls received and answered in by PPG have increased during July and August due to the expected increase of seasonal demand. For the calls handled by PPG, the average speed to answer was 4 to 5 minutes.
Call abandonment dropped slightly to circa 16%, which although above the national average is an improvement on the previous month.

If a 111 assessment leads to an outcome that suggests a patient should be sent to an Emergency Department (ED) or sent an ambulance (category 3 – not immediately life threatening or category 4 – not urgent), the call should be reviewed by a clinician. This process is called validation and is a system priority for the ICB. For July, ED validation rate was 84.71% and ambulance validation rate was 82.41%.

OOH Consultations shows the number of patient consultations undertaken by PPG per month, by cases closed by advice (telephone), appointment at Treatment Centre or Home Visit.

PPG are currently awaiting feedback from the Care Quality Commission following their inspection in July of the Clinical Assessment Service and Out of Hours service in Devon.

Elective Care: System Overview

Data

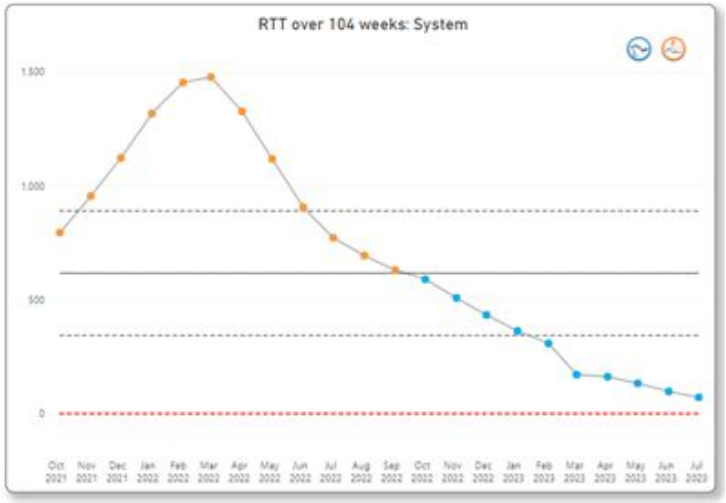
				System	
	Metric	Target	Latest Date	Value	Variation	Assurance
RTT	RTT Incomplete Waiting list		Jul 2023	168,371		
	RTT 18 weeks	92%	Jul 2023	55.3%		
	RTT over 104 weeks	0	Jul 2023	71		
	RTT over 78 weeks		Jul 2023	936		
	RTT over 65 weeks		Jul 2023	4,419		
	RTT over 52 weeks		Jul 2023	13,286		
Diagnostics	Diagnostics within 6 weeks	99%	Jul 2023	68.9%		
	Diagnostic Total activity		Jul 2023	42,211		
Cancer	Cancer 2 week wait	93%	Jul 2023			
	Breast Symptomatic 2 week wait	93%	Jul 2023	58.7%		
	Cancer 31 day First	96%	Jul 2023	92.3%		
	Cancer 31 day follow-up drug	98%	Jul 2023	98.7%		
	Cancer 31 day follow-up sugery	94%	Jul 2023	84.7%		
	Cancer 31 day follow-up radiot...	94%	Jul 2023	95.2%		
	Cancer 62 day urgent	85%	Jul 2023	65.2%		
	Cancer 62 day screening	90%	Jul 2023	47.4%		
	Cancer 62 day Upgrade	85%	Jul 2023	74.9%		
	Cancer 28 day Faster diagnosis	75%	Jul 2023	76.7%		

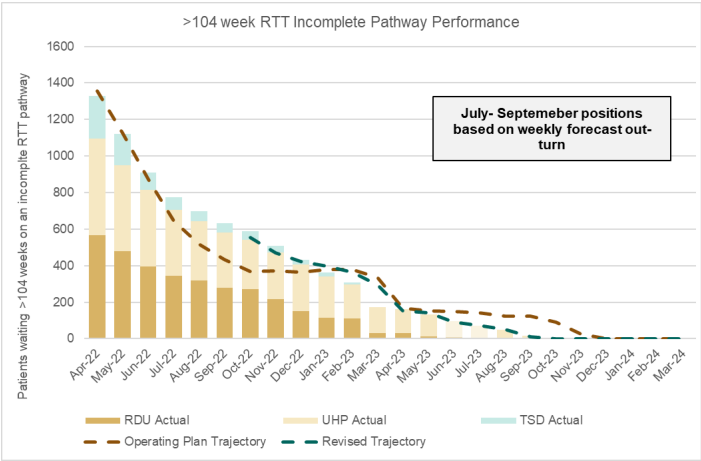
Summary

- The system remains behind the national targets for the clearance of 104ww patients and is adhering to the FY23/24 operational plan revised targets (in August, 50 waiters against a target of 50). The system is still fully committed to eliminate all patients waiting over 104 weeks by the end of September, however it is likely that there may be single digit numbers post September in light of complexity and patient choice.
- This is driven primarily as a result of industrial action, staff sickness and annual leave.
- The weekly system IPT steering group continues to challenge challenged specialities and look for inter-provider mutual aid where possible.
- Additional capacity at independent sector partners continues to be sought through weekly meetings.

Elective Care: System 104/78/65 Week Wait

Data





Analytical Summary

The target of zero patients waiting over 104 weeks remains unmet. However, performance is continuing to statistically improve and is at the lowest point since the initial reporting date (July 2021).

78 week waits are also exhibiting statistical improvement for the third consecutive month, with 974 patients waiting at the end of August.

Operational Summary

The system position is close to the trajectory for the clearance of all 104ww patients with an expected completion date of the 104ww cohort by the end of September. There are a few individual patients who may breach this date due to complexity or patient choice. However, these are being monitored weekly through provider meetings as well as the regional Tier 1 process.

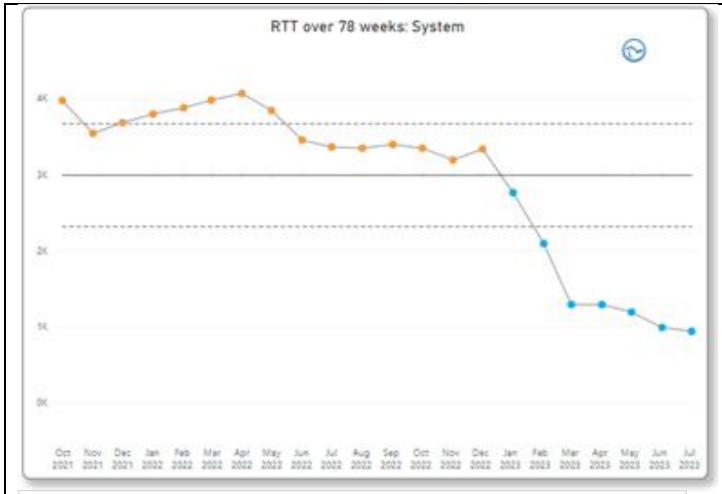
The month-end position for August (Trust data) showed that TSDFT and RDUH having no patients breaching 104ww with UHP having 49. The large majority of these long waiters are concentrated in Neurosurgery and Orthopaedics. The independent sector noted only one 104ww patient at the end of August.

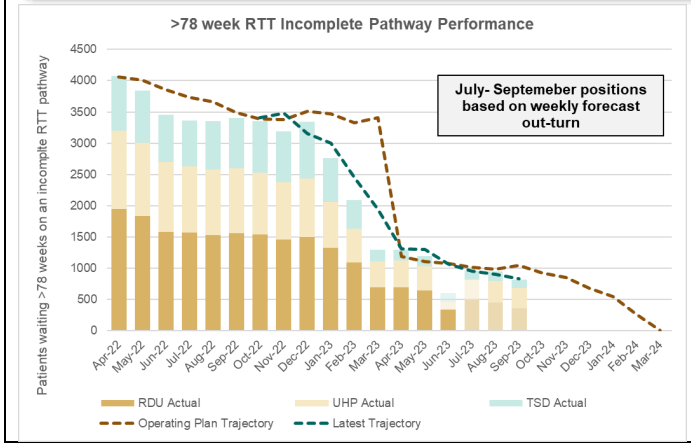
August's month end 78ww position showed that all acute providers continue to have long waiters in their most challenged specialties. The independent sector's 78ww long waiters are a combination of patient choice to delay and adopting long waiters due to patients transferring their care from an acute Trust waiting list to access treatment earlier.

Work is continuing at pace, seeking further opportunities between acute providers for in system mutual aid.

Industrial action continues to be a challenge for elective recovery of both long waiting trajectory as well as cancer and diagnostics positions.

Following provisional agreement at the Elective Care Improvement Board on the 17th August, the system is in the process of redesigning all specialty transformation programmes to align to the NHSE/I GIRFT Further Faster workstreams. This will involve combining outpatient (and an aspect of demand management) transformation work with the wider acute elective pathway work at a specialty level. Acute providers are encouraged to engage with all 16 of the Further Faster





specialities, however the system has identified nine challenged areas that will be the key focus. These are:

- Orthopaedics
- Spinal
- Cardiology
- Ophthalmology
- Urology
- Gynaecology
- Dermatology
- Colorectal
- ENT

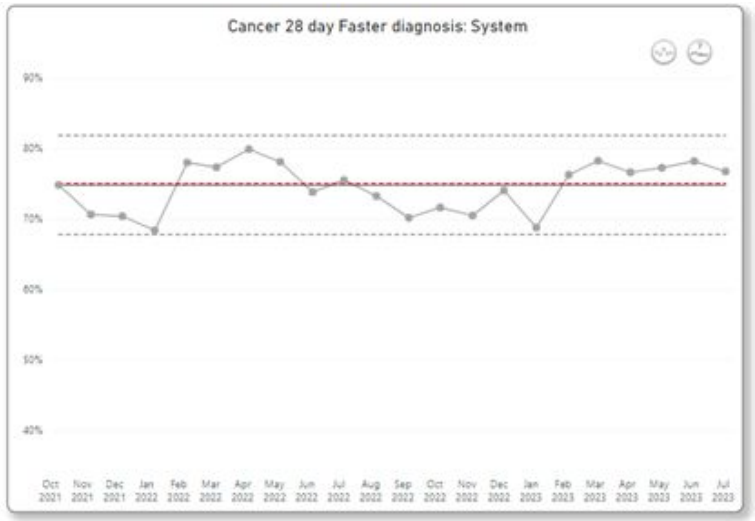
Speciality level groups existing through the wider system programme will be repurposed and expanded, with GIRFT clinical leads being brought into meetings to support the discussions and provide guidance. NHS Devon is one of the only systems nationally choosing to tackle the Further Faster work as a system and so information sharing, and lessons learnt within the process will be a key factor. A methodology similar to that of the One Devon Elective Pilot will be adopted for all specialities sat outside of this programme, with governance being overseen via the Tactical Delivery Group and the Elective Care Improvement Board.

Procurement of technology to support the non-clinical validation process has commenced but unfortunately has been slightly delayed. The new technology is expected to increase the number of patients contacted per week from 2,000 to up to 10,000. There is an optimistic operationally “go live” date of late September / beginning of October.

Progress is being made regarding a solution to validating paediatric waiting lists. The team has been working with NHSE and other providers to understand processes underway in other trusts. It is hoped that validation of Paediatric waiting lists will commence in line with the launch of the new technology.

Cancer 28-day faster diagnosis: System

Data



Analytical Summary

The Cancer 28-day Faster Diagnosis Standard for the system, has been achieved for 5 consecutive months. July's ICB performance is 77% against a 75% standard. RDUH did not achieve the standard.

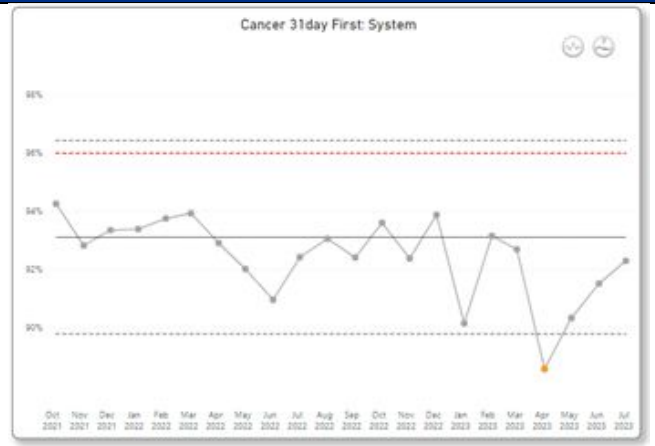
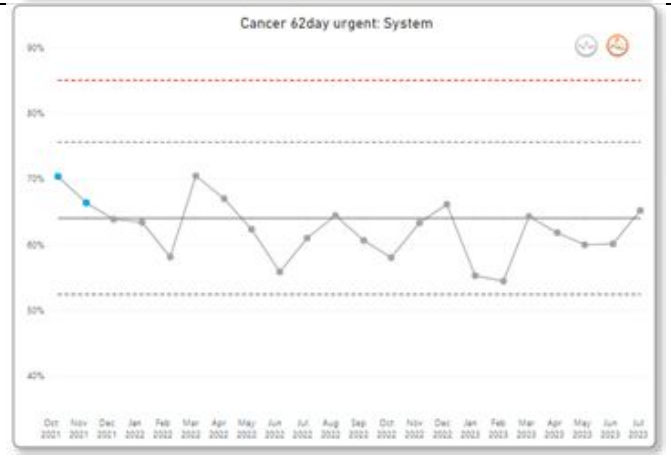
Operational Summary

RDUH has been removed from the tiering system.

Actions:

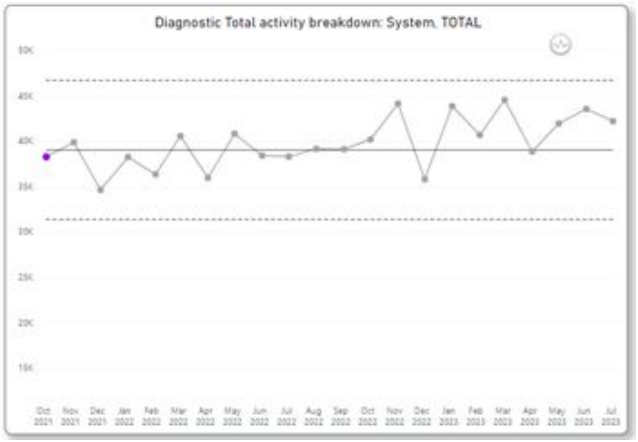
- All Trusts continue to be monitored against delivery of imaging within the standard. RDUH and UHP are on track to deliver the FDS standard, TSDFT have already achieved the standard.
- All Trusts have a cancer recovery action plan in place. Trusts, ICS, and the Cancer Alliance meet weekly to monitor and mitigate issues as they arise.
- RDUH have developed targeted improvement plans for colorectal & urology cancer and elective pathways (most exposed specialties in recovery plan). Internal demand and capacity supported by IST.
- Endoscopy CT capacity continues to be an issue for all providers, with TSDFT due to operationalise a new unit. Meanwhile the creation of a 4th endoscopy room at TSDFT is causing a reduced capacity during construction, it is due to go live in November 2023.
- In response to workforce challenges, RDUH have received approval enabling substantive recruitment of two GI surgeons, adverts currently being drafted.

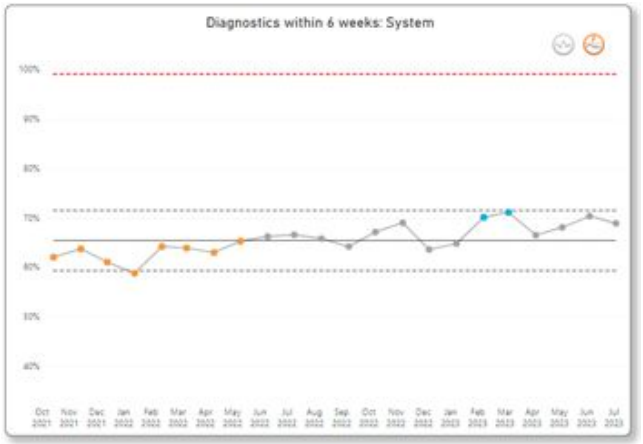
Cancer 31-day first treatment and 62-day urgent treatment: System

Data	Analytical Summary
	The Cancer 31-day metric is currently failing to achieve the standard, there is no significant change or indication of improvement in this across the system. Cancellations of outpatient activity due to industrial action has impacted on this performance. Some Outpatient sessions were pre-emptively cancelled in planning for the industrial action, reducing capacity, but patients themselves may not have been aware of the delay to their appointment. The impact of ongoing industrial action is managed across the system through the Elective Tactical Delivery Group as well as the System Recovery Board. For July 2023, performance was 93% against a 96% standard and the fourth consecutive month of improvement.
	The Cancer 62-day metric is consistently failing the target, it displays common cause variation. For July, the Devon system performance was 67% against an 85% standard which was an improvement from June. As the target is above the higher control limit, the system will currently not achieve this objective. This is a nationally acknowledged position, leading to the monitoring of improvements in FDS, reduction in the 62 day breach numbers, and improvements in the NSS pathway. Devon is on target to meet the trajectories for both the 62 day breaches and the NSS numbers.

Diagnostics

Data





Analytical Summary

Activity
The total diagnostic activity volumes delivered in Q4 of 2022/23 was the highest quarterly total for two years but still within the range of common cause variation**.**

Performance
Diagnostic performance achieved 68.9% against a recovery target of 85% for July 2023.

Operational Summary

Performance against the 6 week standard

Key challenges remain around workforce numbers which have been compounded by industrial action in July showing a small decrease in performance. In addition, physical capacity challenges are being addressed through specific initiatives to improve throughput as described in the Cancer narrative above.

Actions
Approval to spend diagnostic ERF 'at risk' to secure additional endoscopy and mobile imaging capacity, pending agreement at the August Finance and Planning Board.
Planned work:
The system is continuing its plan for delivery of the CDC program, with long term actions including:

- The development of the Trust specific project delivery groups and detailed project plans to be completed and program boards implemented.
- The development of cancer one stop diagnostic services to be agreed for implementation at Devon Diagnostic Centre and subsequently at Plymouth and Torbay.
- The development of a supporting workforce strategy in partnership with the Peninsula imaging network.
- Undertake a system demand and capacity review as the phased capacity is delivered in each locality to develop trajectories for future system strategy development.

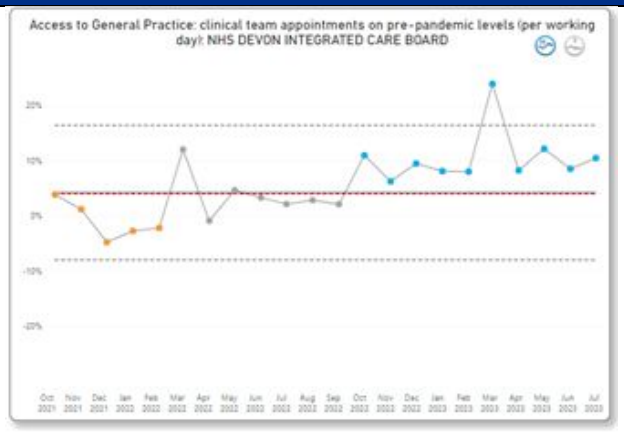
As the work progresses further updates will be provided to the group with escalation reporting if required between updates.

Primary and Community Care Performance

Metrics

	Metric	Target	Latest Date	NHS DEVON INTEGRATED CARE BOARD	East	North	Plymouth	South	West
Primary care	Access to General Practice: general practice appointments occur within 1 day of request	35%	Jul 2023	49.8%	46.8%	45.4%	50.7%	51.2%	47.3%
	Access to General Practice: appointments occur within 2 weeks of being booked	85%	Jul 2023	82.9%	79.8%	79.6%	85.2%	85.4%	78.8%
	General Practice: % Practices Latest Overall CQC Rating Good or Outstanding	100%	Aug 2023	97.5%					
	Access to General Practice: GPAS OPEL rating		Sep 2023	3	3	3		3	4
	Technology enabling access: Number of online/video consultations against target	54167	Aug 2023	75,541					
	Access to General Practice: clinical team appointments on pre-pandemic levels (per working day)	4%	Jul 2023	10.5%					

Data



Analytical summary

Analytical Commentary:
The target to increase appointments on pre-pandemic levels of 4% shows improvement and is achieving.

The target of 85% of appointments in 2 weeks is showing a deteriorating position and has not achieved target during July. However, it has achieved in Plymouth and South LCP areas.

The target of achieving 35% of appointments within 1 working day of request is above target and consistently passing. A small number of practices vary considerably above target, and therefore cause for concern.

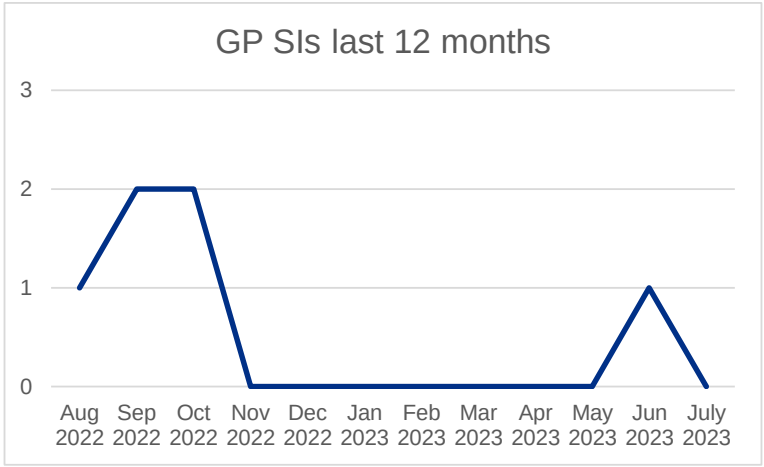
Operational Summary:
Appointments are above pre-pandemic levels and the target of 4% continues to achieve, being 10.5% above pre-pandemic levels in July 2023 when compared with July 2019.

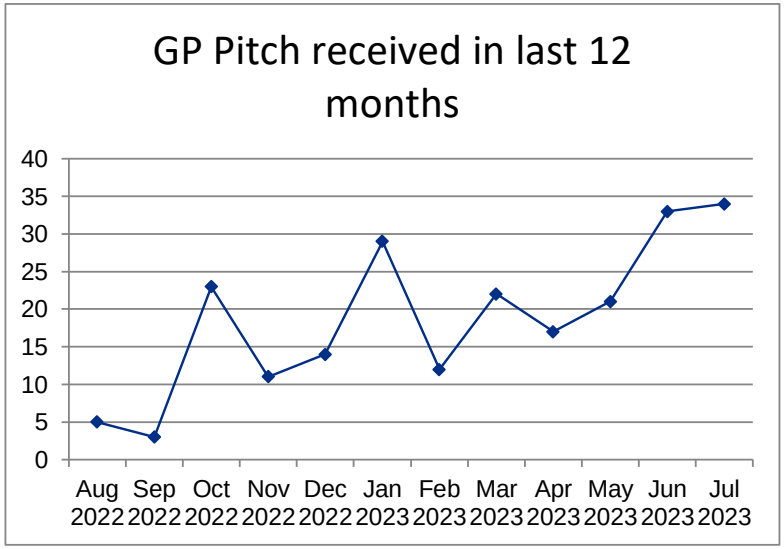
The target of 85% appointments within 2 weeks was not achieved in three LCP areas during July, with 82.9% being seen within this timeframe. Devon's Plan for Recovering Access to Primary Care (PCARP) has been supported by Primary Care Committee in September and will go to Governing Body in October, prior to implementation commencing.

The target of 35% of appointments occurring within 1 working day of request continues to achieve comfortably, with 49.8% seen within 1 working day during July 2023.

There continues to be a number of practices declaring a 'red' GPAS/OPEL 3 alert state.

Workforce metrics	June 2023
Devon PCNs to recruit 710 WTE ARRS roles by end March 2024. All Devon PCNs at 16 WTE ARRS roles by March 2024. Utilise ARRS scheme with target of 90% take-up of new ARRS roles by March 2024.	ICB total WTE ARRS roles is 539.28. At June 2023, 22/31 PCNs are at 16 WTE or above ARRS roles. We are awaiting the results of the NHSE survey on the predictions of ARRS uptake for 2024/25. We are using the estates toolkit information gathering on workforce to formulate workforce planning in conjunction with Devon Training Hub.
Achieve upper quartile performance in terms of WTE GP per 1,000 population	From most recent data May 2023, Devon is the highest in the South West at 6.5 rate per 10,000 weighted population. The South West is second highest at 6.1 behind the Midlands at 6.2.





Number of online/video consultations against annual target of 650,000 for the year 2023/24. In August 2023, 75,541 online/video consultations were carried out, which is well above the in-month target of 54,167.

98% of practices in Devon (117/120) have a CQC rating of 'Good' or 'Outstanding'. 3 are rated 'Requires Improvement' by CQC and the ICS Primary Care and Quality Teams continue to work closely with these practices.

General Practice related Serious Incidents (SIs) – No SIs were reported during the period November 2022 to May 2023. However, one SI was reported in June 2023. This relates to GP screening issues. NHSE SW Team are aware and involved. No GP related SIs were reported during July 2023. The Safety Systems Team liaises with the PSQ Primary Care Lead to ensure any PC learning from SIs is shared across the system.

GP related PITCHs – there has been an increase in PITCHs submitted post-Covid likely owing to greater awareness by practices. There was an increase in PITCHs reported during June 2023 (33) and July (34). The top 3 PITCH themes in July were: referrals, access to services and workload shift.

Note: "GP" will also include PPG/111, however, the majority are related to general practices.

Community Performance

Community Services Waiting by Provider

Total Waiting by Service for June 2023

	01/05/2023	01/06/2023	Change
(A) Musculoskeletal service	6409	7258	849
(A) Podiatry and podiatric surgery	5921	5758	-163
(CYP) Therapy interventions: speech and language	4077	4,126	49
(A) Audiology	1725	1725	0
(A) Rehabilitation services (integrated)	1650	1636	-14
(A) Weight management and obesity services	1303	1520	217
(CYP) Community paediatric service	1142	1059	-83
(A) Nursing and Therapy support for LTCs: Continence/ colostomy	850	882	32
(A) Wheelchair, orthotics, prosthetics and equipment	641	674	33
(CYP) Therapy interventions: occupational therapy	982	725	-257
(A) Therapy interventions: Orthotics	723	746	23
(A) Community nursing services	482	453	-29
(A) Therapy interventions: Dietetics	361	450	89
(A) Therapy interventions: Occupational therapy	176	164	-12
(A) Therapy interventions: Speech and language	221	184	-37
(CYP) Wheelchair, orthotics, prosthetics and equipment	133	127	-6
(A) Nursing and Therapy support for LTCs: Falls	147	150	3
(A) Nursing and Therapy support for LTCs: Respiratory/COPD	136	113	-23
(CYP) Looked after children teams	139	120	-19
(A) Nursing and Therapy support for LTCs: Stroke	145	137	-8
(CYP) New-born hearing screening	114	96	-18
(CYP) Therapy interventions: physiotherapy	119	140	21
(CYP) Vision screening	106	147	41

Operational Summary

There are currently 29,372 children and adults waiting for community services across Devon. An increase of 495 from previous month (28,877). The table opposite details the numbers of people waiting by provider and the table provides those services with the highest number of people waiting.

Significant increases in the number of adults waiting for Musculoskeletal services can be seen in the latest data. This is split across three providers with total numbers of people waiting for MSK services as follows:

- TSDFT – 2,200
- RDUH – 3,034
- UHP – 2,024

CYP therapy interventions (speech & language) has also increased with the highest percentage of children in the 2–4-year age group. Waits are decreasing within Livewell Southwest. A Devon County Council funded waitlist initiative has been in place which has included contact with 1,399 CYP/parents for review. Following review 949 were removed from the waiting list and 450 will now be seen by the community team. These figures should be reflected in July and August data when available.

Devon community services waiting lists have a reduction target of 5% in Q1 and Q2 followed by further reduction of 10% in Q3 and Q4.

Clinical validation and prioritisation work is being shared across providers.

Waiting times for Devon (June 2023) are shown below:

Overview	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	
0-1 week	1,471	2,014	1,941	2,241	2,302	2,690	
>1-2 weeks	1,478	2,019	2,252	2,083	2,121	2,413	
>2-4 weeks	3,190	3,669	4,599	4,715	4,627	4,744	
>4-12 weeks	4,944	5,993	7,892	7,740	7,769	7,491	
>12-18 weeks	2,261	2,300	2,095	2,390	2,421	Oct-06	
>18-52 weeks	5,725	5,770	7,027	6,573	6,183	6,169	
>52-104 weeks	2,241	2,086	2,623	2,728	2,916	2,886	
Over 104 weeks	352	299	439	434	466	496	

Currently we are only seeing a reduction in those people waiting >18-52 weeks.

Actions

- Devon community waiting list improvement group – meets monthly
- Each provider is expected to share local reduction trajectories & recovery action plans at the monthly review meeting.
- ICB lead, operational and clinical leads from RDUH agreed to support development of regional clinical prioritisation guidance
- SW NHSE have requested NHS Devon to share their Community W/L work at a regional Community of Practice as we have made significant progress in bringing providers and commissioners together and in having a dashboard to support in understanding our system position.

Mental Health: System Overview

Metrics

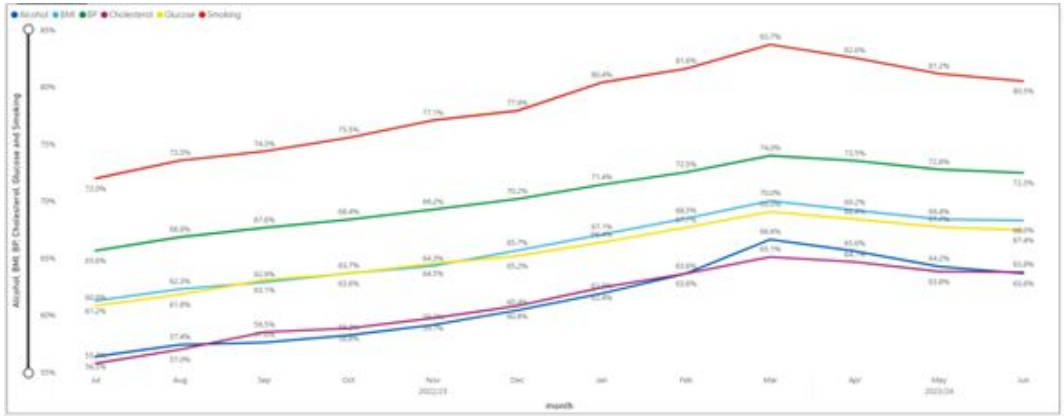
Metric	Group	Filter 1	Latest Date	Value	Variation	Assurance	Target	LPL	Mean	UPL
Perinatal Access	ICS Devon	LTP Indicator	Jul 2023	535			1115	108	391	674
Inappropriate Out of Area Bed Days	ICS Devon	LTP Indicator	Jul 2023	376			0	223	496	769
Children & Young People Access	ICS Devon	LTP Indicator	Jul 2023	9423			15754	9,098	9,357	9,617
Talking Therapies - first appointment within 18 weeks	ICS Devon	Additional KPI	Jul 2023	99.8%			95%	99.8%	99.9%	100%
Talking Therapies - first appointment within 6 weeks	ICS Devon	Additional KPI	Jul 2023	73.7%			75%	85.0%	90.8%	96.5%
Talking Therapies Recovery	ICS Devon	Additional KPI	Jul 2023	53.2%			50%	48.5%	53.0%	57.5%
Talking Therapies Access - Rolling Quarter	ICS Devon	LTP Indicator	Jul 2023	7741			7905	4,949	5,946	6,943
Talking Therapies Access - Monthly	ICS Devon	LTP Indicator	Jul 2023	2463			2613	1,340	2,051	2,763

System Summaries

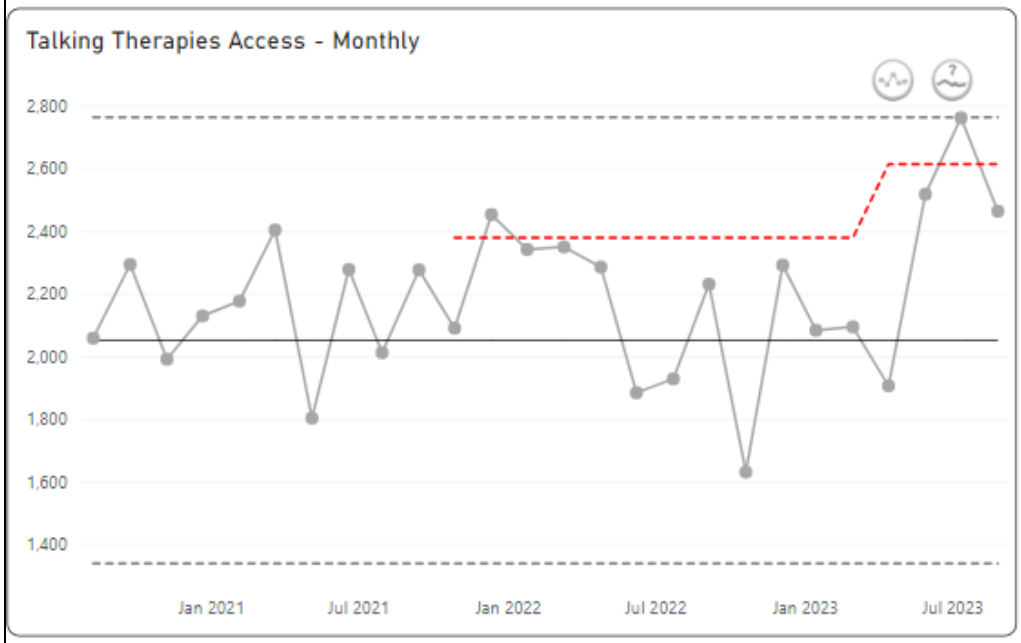
Children and Family Health Devon (CFHD) have resumed sending data although caution must be exercised when assessing performance over the period of June 2022 to March 2023 due to data quality issues. CFHD are supplying data via their monthly databooks and so data extraction by Devon ICB is currently a manual process. A request has been made to CFHD to resume sending the full KPI spreadsheet to the ICB Business Intelligence team so that data can flow through to PowerBI dashboards.

As the ICB progresses towards fuller Provider Collaborative responsibilities, there is a current focus within the MHLDN Provider Collaborative on better aligning the MHLDN reporting infrastructure and performance improvement architecture to support IQPR reporting cycles. There is currently a lag between performance reporting in different parts of the system which affects the narrative of IQPR reporting currently.

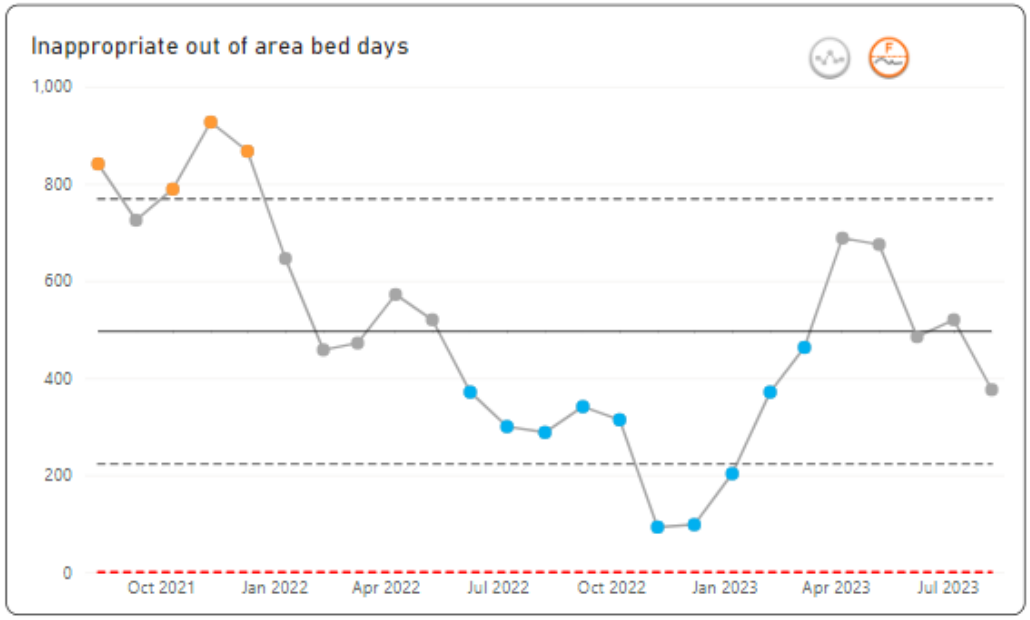
Mental Health: Severe Mental Illness – Physical Health Checks

Data	Summary
KPI Description Number of people with severe mental illness (SMI) to receive the complete list of physical health checks in the preceding 12 months. Trend of the 6 checks  Data Source: GPES, NHS Digital	**Operational Summary** The pilot to improve take up amongst hardest to reach populations in Devon, which was recently approved, is due to launch across Oct & November. Additionally, sessions have taken place aligned to each of the CMHT footprints to support targeted improvement. This in line with the operational approach to recovery reported previously. **Actions and Assurance** Pilot improvement work has attracted funding to evaluate the approach and support propagation of the learning as a sustainable model.

Mental Health: NHS Talking Therapies Access

Data	Summary
KPI Description The number of people who enter NHS funded treatment with NHS Talking Therapies services in the reporting period. Total is by rolling quarter. **Statistical Process Chart**  Data Source: Provider data	**Analytical Commentary** The KPI is within common cause variation but there are several data points close to the lower process limit showing a decline in performance. The KPI is currently falling short of the Q1 system target (2,463/2,613). **Operational Summary** For 2023/24 targets and planning, NHSE now defines a range of achievement for this performance indicator. The original Ops Plan submission targeted 94% achievement of the national lower-end target. Following operational and leadership review, planned achievement for Devon has increased to 96.5% of that national lower end target. Waiting times remain good and recovery rates meet national expectations. 2023/24 investment in capacity and in reaching and meeting needs are considered ambitious but achievable. Talking Therapies services are exploring further links with other long-term conditions pathways to potentially play a more significant role as those pathways are redeveloped. Additionally, a range of smaller psychotherapy contracts risking duplication of Talking Therapies have ended to support redirection of resource to partially resource the gaps between Talking Therapies and Adult Mental Health provision, which may affect flows in the existing services. **Actions and Assurance** As last month, the above links to Talking Therapies pathways fall within the scope of the system-wide Integrated Psychological Medicine Workstream, due to report its recommendations around Quarter 3. This workstream is currently developing a defined programme of needs assessment and service redesign and improvement. This includes establishing outcome data and outcomes informed by Experts By Experience. Oversight of Talking Therapies performance is overseen within the MHLDN Finance, Performance & Activity Group reporting to MHLDN Strategic Oversight Group.

Mental Health: Inappropriate out of area bed days

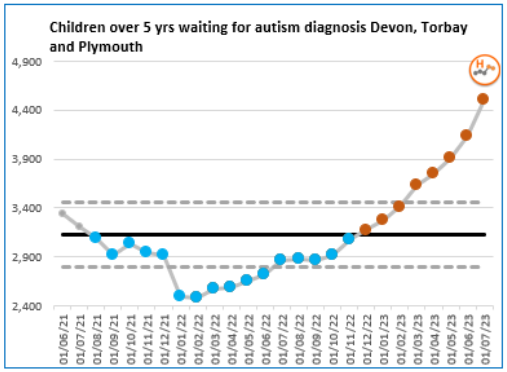
Data	Summary
KPI Description The total number of days (per month) in which patients have been placed out of area due to unavailable beds in their usual network.  Data Source: Provider data	**Analytical Commentary** The measure is within control limits and currently exhibiting common cause variation. The monthly figure is 376 bed days. **Operational Summary** As previously reported, the recent resubmission of the Operational Plan, the trajectory for Inappropriate Out of Area bed days was revised to achieve zero by the end of 2023/24. The need for such provision is fragile and vulnerable to unusual spikes in demand. **Actions and Assurance** The renewed trajectory was established through providers' re-assessment of their bed plans and CIP in respect of this target. System pressures day to day, in respect of MH bed availability (and the risks for patients awaiting a MH bed while in hospital and home settings) are managed via daily system calls supported by the System Control Centre. Recent external review (Deloitte's) concluded that the Devon system performs comparatively well in OOA bed days and also notes progress from baseline; whilst noting the challenging national target to which we are committed.

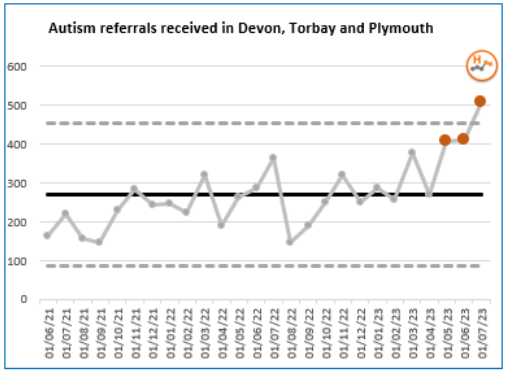
Children & Young People (CYP): Autism Diagnosis waiting times

Key Performance Indicator	Target/ Plan	Latest Period	Actual (provider averages)	Variation	Assurance
Autism Diagnosis (Waiting)	<18 weeks.	July 2023	Devon & Torbay 96.1 / Plymouth 76.3 weeks	H	F

KPI Description
NICE guidance for CYP to be seen within 18 weeks from referral to start of assessment.

Devon, Torbay and Plymouth





Operational Summary – Devon (CFHD), Torbay (CFHD) & Plymouth (UHP/LSW)

Demand:
The numbers of children waiting remains over target and is significantly deteriorating. The target cannot be met within current service provision capacity AND the continuing levels of demand.
High levels of children waiting across community ASD and Community Paediatrics within the Devon system (pre-covid).
Waits have been impacted by an increase in number of referrals when schools returned after lockdown with referrals continuing at high levels. A deficit in early help-based support and understanding that diagnosis unlocks additional support drives families to seek a formal diagnosis, further increasing referral numbers. High levels of children being referred with greater complexity making the assessment process longer. For instance, in Torbay 60% are considered complex when compared to rest of Devon 30% complex.

Capacity:
- 60% vacancy rate within CFHD.
- Providers report current commissioned capacity is challenging to meet demand.
- Potential inefficiencies within multi-organisational pathways.

Actions
- Board deep dive in to children services completed. 37% higher rate of referrals between 2019/20 and 2022/23. When fully recruited, using the current acceptance rate, the trajectory demonstrates that by August 2024 only 26% of children will have an RTT under 18 weeks.
- Additonal analysis of CFHD data (referral source; age profile) also shared.
- Options for what will it take to address waits requested and meeting planned 26th September.
- UHP have employed additional staffing as well as changes to the pre school asessment pathway to increase their capacity.
- Livewell increased SLTs in CAMHS pathway. Impact to be realised after 6 months. Monthly contract meetings.
- The TSDFT Community paediatricians are piloting joint assessment clinics with CFHD autism staff – feedback positive. Evaluation will commence once 50 cases have been completed.
- Good support for the Integrated neurodevelopmental pathway forms from providers. Particular support for a Single Point of Access for requests for diagnostic assessments to be commissioned with additonal admin support .

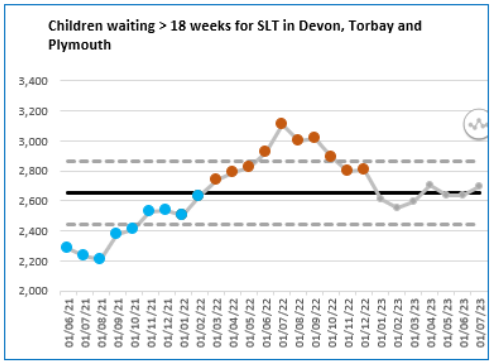
When is improvement expected?
New additional staffing recruited and will take time to be trained and inducted. Once recruitment is at full establishment, improved impact is predicted in those services in 2024/25.

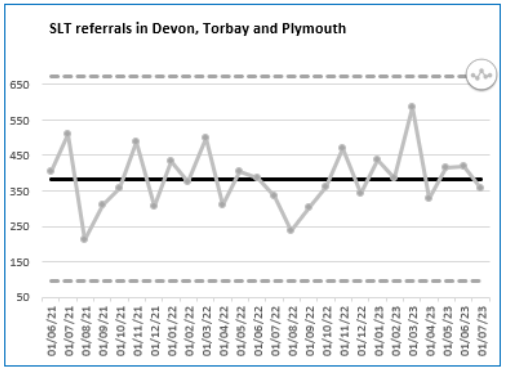
Children & Young People (CYP): Speech & Language waiting times

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
Speech and Language waiting times	< 18 weeks	July 2023	Average wait - CFHD 35.7 weeks / LSW 27 weeks. Longest wait – CFHD 132.9 weeks / LSW 78 weeks.		

KPI Description: NICE guidance for CYP to be seen within 18 weeks from referral.

Devon, Torbay and Plymouth





Operational Summary
What are the causes?

Demand: Highest percentage of children referred to CFHD speech and language are in the 2-4 year age group which is an indirect impact from COVID. LSW average waits have decreased although longest waits have increased. We would expect numbers of referrals to reduce during school summer holidays.
Capacity: Continued workforce vacancies and recruitment challenges reduces clinical capacity. A workforce ratio of between 1.9 and 2.2 WTE SLT per 1000 head of child and young person (0-18) with predicted SLCN is indicated as good practice. Based on the info shared from the intital local mapping suggests that CFHD 1.5 and Plymouth 2.14

Actions
DCC funded wait list initiative ended August 2023. 949 contacted / reviewed and removed from wait list. 450 remaining will rejoin community team waits and will not be disadvantaged. An evaluation report is being completed to ensure lessons learned are implemented.

Continued staffing recruitment to existing vacancies and new additional posts across UHP, Livewell and CFHD.

Monthly meetings with LSW & CFHD to review databook and service pressures and developments.

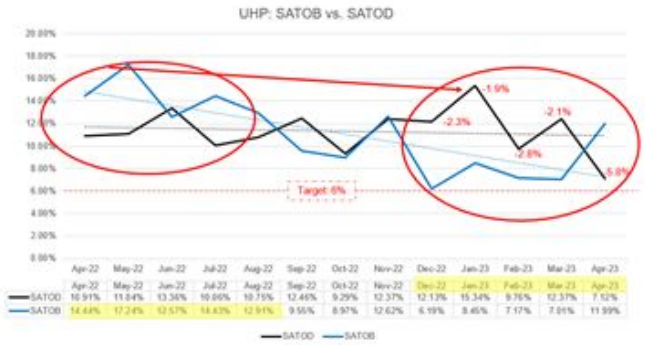
Phone support, information and advice offered to referrers and parents whilst children are waiting.

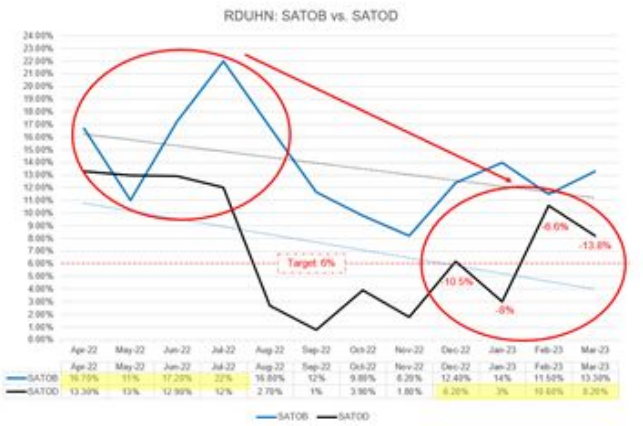
Improved preventative and early help offer in Plymouth - commencing with a 'Let's Getting Chatting' social media campaign this summer and the rollout of Parents as Early Educators Programme in the autumn.

When is improvement expected?
Pending recruitment to vacancies, induction and training (as many will be newly qualified) improvement is predicted in 24 months.

Local Maternity & Neonatal System: Smoking Cessation

KPI Description: Reduction in smoking at time of delivery (SATOD) to 6%.
All women & birthing people have access to specialist smoking cessation services.





Analytical Summary

Data has been sourced from the Trust Dashboard Data. Analysis has been provided for RDUHN & UHP.

- Data gaps due to digital system integration prevent comparative analysis in TSDFT.
- Lack of data for Q4 from RDUHE prevents comparative analysis.

Two figures indicate performance:

1) Achieving the target SATOD of 6% or less
2) The reduction rate from Smoking at Time of Booking (SATOB) to Smoking at Time of Delivery (SATOD). It is important to note that the April SATOB cohort are **not** the same as the April SATOD cohort- approximations of comparable cohorts are demonstrated by the circled figures and the highlighted cells below the charts.

- Smoking cessation interventions at UHP & RDUHN are demonstrating impact.
- UHP is currently not achieving the target of 6% or less.
- RDUHN has achieved the target in 5 out of 12 months, in the last year.
- Whilst complete data and comparative analysis is not possible for TSDFT, we are aware that their smoking cessation programme has received national recognition for its efficacy and progress in reducing smoking at time of delivery.

Actions

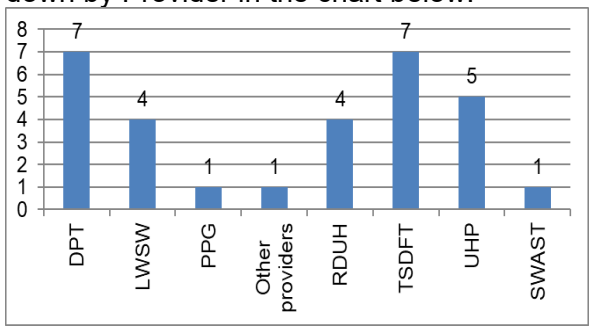
- When up to date data is available for the whole system, provide SPC chart for target of reduction of smoking at time of delivery to 6% or less. This has been requested.
- Trusts to continue developing specialist smoking cessation pathways utilising national tobacco dependency funds.
- Smoking rates will be monitored through the Saving Babies Lives V3 programme (LMNS mandatory responsibility to validate evidence) due to a lack of capacity in the LMNS/ICB to oversee the Tobacco Dependency Programme in the absence of a named lead.

Quality

Serious Incidents (all providers)

Serious Incidents received by Provider

During August 2023 there have been **30 serious incidents** reported, these are broken down by Provider in the chart below:



The **top three Serious incident** types reported in August 2023 were:

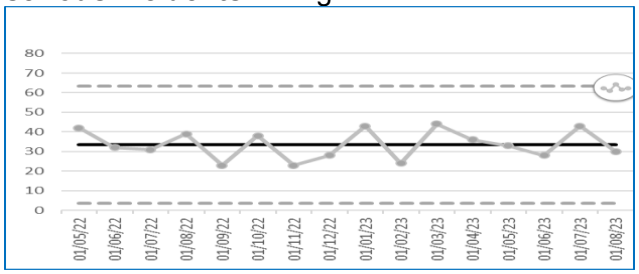
Slips/Trips/Falls (5) ↓

Diagnostic (5) ↑

Apparent self-harm (4) ↑

N.B. the arrow indicates change from previous month)

The below chart shows the number of **reported serious incidents** during the last 12 months**:**



Total number of **open incidents** for the system in August 2023 is **357**, an increase from last month (354).

Never events

There was 1 Never Event reported in August 2023.

During the fiscal year 2022/23 there were **18 never events reported** plus 2 that were downgraded. This is an increase of 6 compared to the year 2021/22 during when 12 were reported. Never event provider collaborative work now in place to share learning across the Devon System.

Multi-agency investigations

There are currently **14 open serious incidents** that have been identified as **multi-agency**. These are being investigated jointly to help improve identifying what went wrong throughout the patient's care leading up to the incident. This also enables joint learning across Providers.

Review and closure

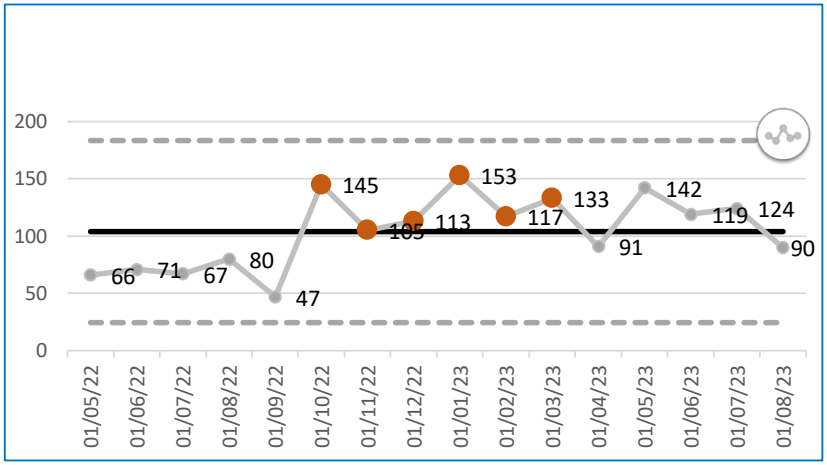
There are currently **31 incident investigations being reviewed** which are currently being monitored by the SST (Safety Systems Team) to meet the review deadline. This includes those under the new SI (Serious Incidents) review process. During August **26 incident investigations** were reviewed and assurance received for **closure**. This shows an increase from 20 in July.

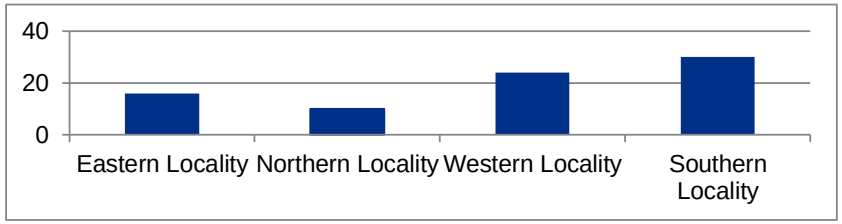
The SST continue to chase weekly these SIs (Serious Incidents) to maintain assurance from providers and record expected completion dates.

Peer Improvement Tips for Care and Health (PITCH)

Received PITCHs

During August **90 PITCHs** were reported, these are broken down by locality in the chart below together with the number of PITCHs reported since May 2022:





PITCH Closed

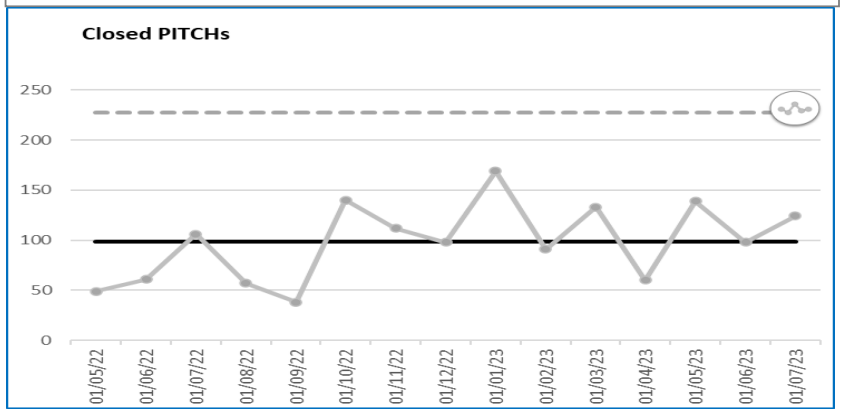
During August 79 PITCHs were closed, compared to 124 in July. The chart below illustrates the number of closed PITCHs per month since May 2022.

165 PITCHs remain open awaiting further information from provider and ICB teams.

Key themes identified in August include ongoing issues with primary care receiving poor discharge summaries. This appears to be an issue across all localities.

The **top three themes for PITCH concerns received in** August were:

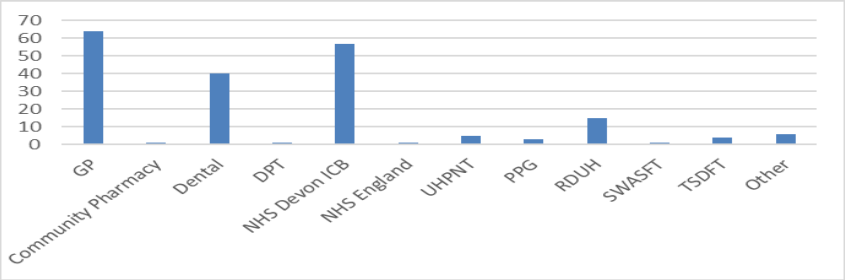
- Process or procedure (20)
- Referrals (18)
- Discharge Summary (16)



Patient Experience (NHS Devon): Patient Contacts

Patient Experience: Received cases

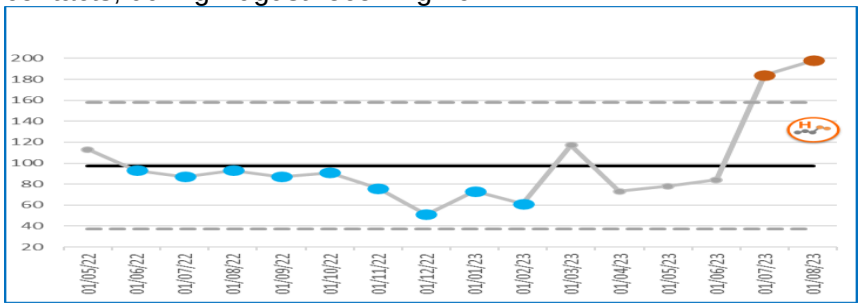
During August there were **197 new patient experience** feedback (including MP and PHSO (Parliamentary and Health Service Ombudsman) enquiries) received by the ICB (Integrated Care Board), these are broken down by Provider in the graph below:



Most contacts now relate to Primary Care services. This is following the delegation of complaints on 01 July 2023. A considerable proportion of contacts regarding Dental Practices were regarding access to services (37) with most General Practices contacts were regarding quality of care (28).

Patient Experience: Informal Concerns

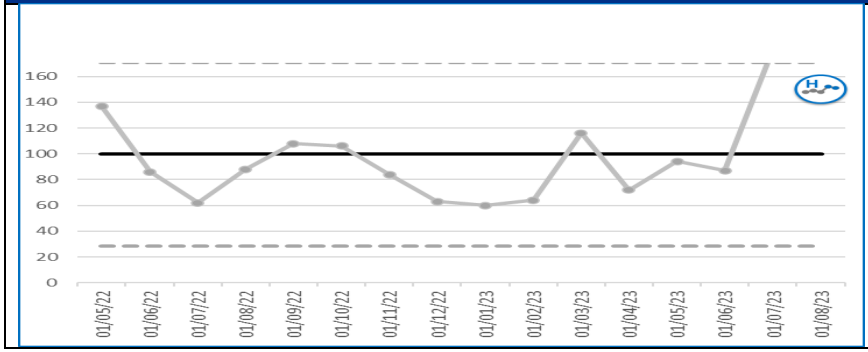
Due to delegated commissioning of Primary Care complaints there continues to be an increased number of patient experience contacts, during August receiving 197.



The **top three patient experience concerns received in August** were:

- Procedure and Process **(78)**
- Access to Services **(68)**
- Quality of care **(64)**

Patient Experience: Closed cases



Patient Experience: Summary

- There was one new formal **complaint** raised during August for NHS Devon, with a total of **7 that remain open**.
- There is 1 **contractual review open**, which are required and form part of Primary Care complaints which are managed by NHS England.
- There is 10 Complaints being managed by the Primary Care Hub.
- There are 6 **open requests for information** from the **Parliamentary Health Care Ombudsman (PHSO).**

Safeguarding: Adult Enquiries

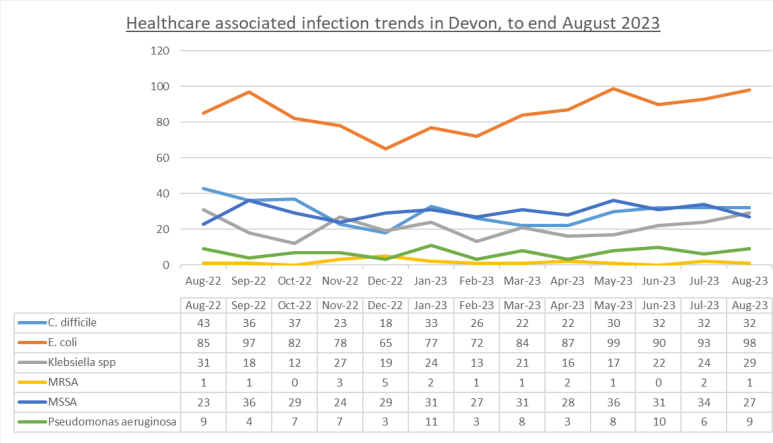
Issue: Safeguarding Adult Enquiries (Section 42.2) are undertaken when concerns about abuse and neglect within health care settings are raised. The statistics below are in relation to the new S42.2 caused out by the 3 local authorities in Devon and the primary themes of the concerns.

Data				Underlying cause
	May	June	July	**Themes:** The top issues identified within new S42.2 enquiries started in **August** 2023 related to: • Poor quality of care, across a broad range of health and care settings • Pressure ulcer whilst receiving care in a health setting. • Acts of omission regarding medications.
Total number of S42.2 enquiries	3 ↓	13 ↑	6 ↓	

Initial learning from new safeguarding enquiries, closed safeguarding enquiries and safeguarding adult reviews:	Assurance
Learning: Communication and who has the training responsibility with healthcare providers regarding medication. There have been whole service safeguarding (WSS) threshold meetings for 4 providers of nursing care encompassing 5 care settings in Devon. None of the meetings met the threshold for whole service safeguarding but the local authority Quality Assurance Improvement Team (QAIT) are providing monitoring and support to the homes. The themes were quality of care and for 1 setting, allegation of physical abuse/wilful neglect by agency staff. SAR Hermione has been published with recommendations relating to health providers and commissioners. An action plan will be created, and this will be monitored at the Safeguarding & Vulnerable People Steering Group (SVPSG) SAR Hermione - Devon Safeguarding Adults Partnership	The safeguarding team are working closely with the providers and Local Authorities to ensure patients remain safe whilst investigations are undertaken, and that mitigating actions have been taken to prevent further harm. The CHC team are carrying out monitoring visits for those care homes that were considered for whole service safeguarding to ensure safe delivery of care for those funded by NHS Devon.

Actions for next month/s	Intended impact	Date impact will be realised
The safeguarding team are working closely with the local authority to ensure robust investigation of all enquiries where the quality of care has been of concern.	Learning from both S42.2 enquiry outcomes and Safeguarding Adult Reviews will be embedded into practice. This is monitored by the Safeguarding Adults Partnerships of which NHS Devon is a statutory partner.	Action plans with completion dates are being monitored by the Provider and ICB Safeguarding Adults Teams and the Safeguarding Adult Boards.

Infection Prevention and Control

Data	Infection Highlights
	**Avian flu** The team is working with commissioning colleagues towards having a swabbing and treatment provider from October 2023. **COVID vaccination** Care home priority group- near 20% uptake after first week of programme. National comparator is 8%. The national booking service had problems with making clinic calendars visible to the public. This is a national issue, and affected sites are working directly with NBS to resolve this issue. Staff vaccination uptake in care homes is low (~15%). Noticeable improvement if there is senior staff buy-in. Local Authority happy to support with focused calls & education. New vaccine (XBB) to be distributed to vaccination centres ahead of its switchover date of 02 October 2023. **Flu vaccination** This has also been affected by the national booking service issues. Flu vaccinations have begun, with 12,536 flu vaccines delivered in Devon community settings as of 19/09/23. **MRSA** There has been a chronological cluster of 4 community onset healthcare associated (COHA) cases in the Torbay area, which has been investigated by the Torbay infection control team and no link found.

	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23
C. difficile	43	36	37	23	18	33	26	22	22	30	32	32	32
E. coli	85	97	82	78	65	77	72	84	87	99	90	93	98
Klebsiella spp	31	18	12	27	19	24	13	21	16	17	22	24	29
MRSA	1	1	0	3	5	2	1	1	2	1	0	2	1
MSSA	23	36	29	24	29	31	27	31	28	36	31	34	27
Pseudomonas aeruginosa	9	4	7	7	3	11	3	8	3	8	10	6	9

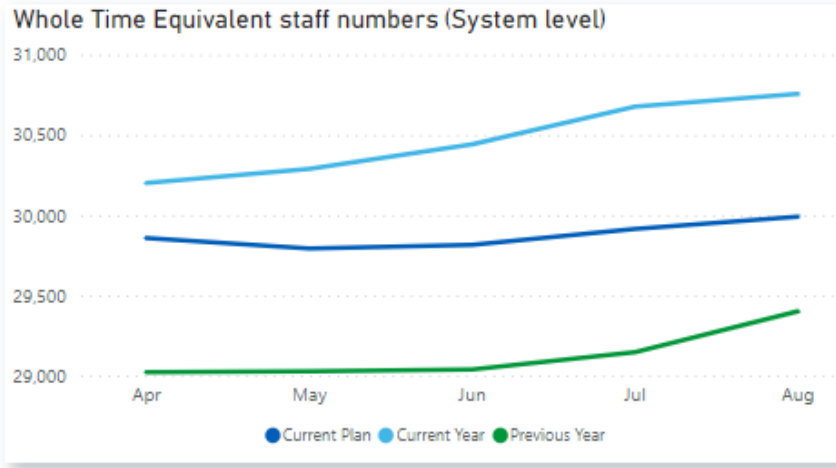
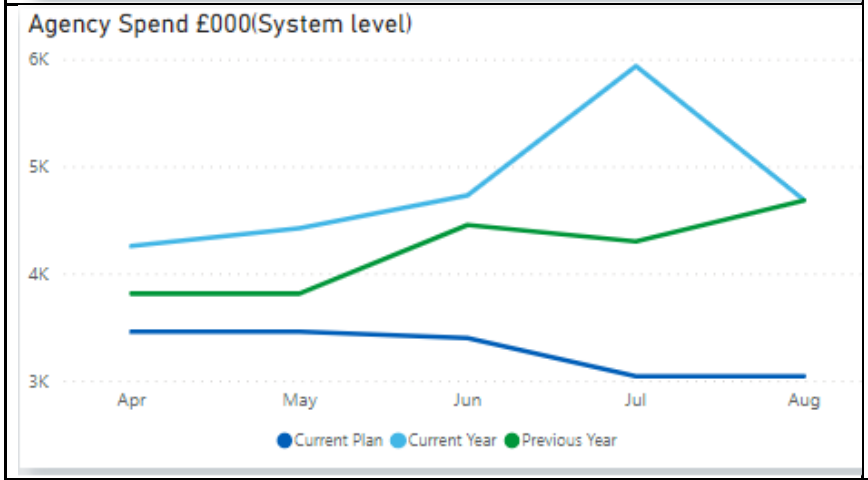
Actions undertaken in last month	Impact
Closer working with commissioning colleagues on avian flu contracting	Effective avian flu service provision likely from 01 October 2023.
Commencement of Devon system flu programme	High initial uptake and close working with system partners.

Actions for next month/s	Intended impact	Date impact will be realised
Tuberculosis commissioning pathway.	Consistent provisioned service for tuberculosis, including video observed therapy and directly observed therapy, as well as testing capacity.	October 2023
System IPC Strategic Group (IPC Forum) meeting integration with public health's Health Protection Advisory Group (HPAG)	Enhanced attendance at both groups; reduction in duplication and improvement in cross-organisational working.	September 2023
Educational resources for domiciliary care and primary care.	Purchase and distribution of infection control educational resources, including links to local community infection control teams, to these areas.	October 2023
Individual system learning/sharing sessions on *E. coli,* MSSA and *C. difficile.* To include Cornwall stakeholders	Closer system working, including sharing of good practice and challenges.	January 2024

Workforce

Workforce: Metrics

	Metric	Latest Date	System	Devon Partnership NHS Trust	Royal Devon University NHS Foundation Trust	Torbay and South Devon NHS Foundation Trust	University Hospitals Plymouth NHS Trust
Workforce	Whole time equivalent staff numbers (Current Year)	Aug 2023	30,755	3,371	11,634	6,213	9,537
	Whole time equivalent staff numbers (Current Plan)	Aug 2023	29,991	3,357	11,250	6,184	9,200
	Whole time equivalent staff numbers (Previous Year)	Aug 2022	29,402	3,350	11,271	6,022	8,759
	Vacancies (Medical/Dental Consultant)	Aug 2023	90	19	19		52
	Vacancies (Registered nursing)	Aug 2023	226	144	115		-32
	Vacancies (AHP)	Aug 2023	218	6	130		82
	Vacancies (HCAs)	Aug 2023	270	-37	167		140
	System Agency spend (£000s) (Current Year)	Aug 2023	4,686	1,052	2,402	815	417
	System Agency spend (£000s) (Current Plan)	Aug 2023	3,043	561	1,331	742	409
	System Agency spend (£000s) (Previous Year)	Aug 2022	4,682	763	2,099	1,180	640
	System Agency spend (£000s) as percentage of total spend	Aug 2023	3.13%	6.41%	4.16%	2.84%	0.887%

WTE and Agency Data and Summaries	Analytical Summary
 	At M4 (July) 2023 agency spending YTD exceeded plan by £5.98M (44.8% higher than plan) and Provider forecasted overspend to the end of a year is £4.2M. All Trusts have overspent, and Trust leads are working on enhanced agency controls, supported by Deloitte. South West Region is over plan at M4 by 30.5% (£27.9M) At M4 the Month on Month (MoM) % Agency declining trend in agency spending reversed to an upward trend as a result of 25% increase from the preceding month. At M4, MoM WTE reveals a 40 WTE drop in agency personnel usage with an 8.12 WTE marginal increase in bank usage. At M4 System Agency spend as a % of overall pay bill YTD is reported at 3.4%, the lowest in the South West Region. DPT (at 6.7%) is demonstrating the highest deviation from the target, which is 2.2% of average total workforce spend. UHP is under the target reporting 1.1% of overall pay bill YTD and in comparison, to the prior month, UHP's agency use has decreased by 0.3%▼. However, TSDFT has experienced the largest growth, going from 3.9% in June 2023 to 6.7% in July 2023 (2.8%▲). Although the Off Framework agency shifts are steadily decreasing in the South West, there is still a large percentage of shifts to be placed on framework. The South West still have the highest Off Framework agency shifts at 6.8% in Month 3 (June 2023). At M3 45% shifts in Devon were 50% or more above the national agency price cap. Price Cap Override for Devon is generally on the decline, and Devon ranks second lowest for Price Cap Override by System in the South West Region. At M4, as a system, workforce spend has been £10.69M higher than anticipated total YTD (Forecasted £19.35M overspend against plan to year end). DPT has saved £472K YTD, and now expect to underspend by £89K by year end. UHP reported overspending in all three categories of staffing, with substantive overspending by £4.11M YTD, bank overspending by £3.45M YTD, and agency overspending by £0.22M YTD. Their projection for year end indicates an excess of £13.14M over budgeted costs.

Workforce: Attraction, Retention and Workforce Solutions

- **Careers hub:** meeting held in August to determine next steps. Agreed to expand wider than just 16-18 years olds in further education. Will aim to include other areas of widening participation such as those with lived experience such as care leavers, those who have experienced the criminal justice system, people on low income and people with health care needs. Overall business case to be finalised with agreed stakeholder engagement. There will be individual locality projects depending on requirements and infrastructure set up. Funding pots to be explored.
- **MOU – Mobility of staff:** Waiting for updates to be made by Ashfords, expected towards end of September. A final document will be circulated and planned for approval in October at Social Partnership Forum. Local TU's will need to report back to their respective Trade Union partnership meetings for discussion/approval.
- **Retention Hub:** Recruitment for the Retention Hub is ongoing with new posts being advertised internally and externally as secondment opportunities. The hub continues to develop its processes and has commenced engagement with stakeholders across the ICS, identifying areas to target and initiating support for staff members within the target groups. It remains the hub's plan to provide monthly update reports on its activity and track its impact on retention of the staff groups it is working with across the system. It is also developing its strategic KPIs.
- **Simplifying recruitment and removing barriers to recruitment**: Update to be obtained at Steering Group on 27th September 2023.
- **One Devon Bank:** Cost of savings reviewed, 'go live' dates also in review and agreement to be made at next PEG meeting. RDUH continue to consult with staff. DPT aim to get internal business case to Board in November. TSDFT to agree business case timelines this week.
- **Robotics:** Project stalled due to minimal return on investment. Exploring any viability with People Digital workstream.
- **Framework:** Update to be obtained at Steering Group on 27th September 23.
- **Collaborative bank:** Continued usage from TSDFT. Around 70 additional workers from RDUH (Eastern) have been uploaded to the collaborative bank portal following data queries being resolved.

Workforce: Workforce Strategy

Workforce Strategy: Work in progress until the end of October 2023 on Phase 2 of the agreement with NHS England's Workforce Transformation and Education team. Working in collaboration to model Devon workforce data sets to produce a 5-year workforce plan, based on current staffing and delivery model, and a 5-year workforce plan based on the Devon 2035 vision.

Workforce: Learning, Education and Strategy

- **Learning and Education Strategy:** The Learning and Education Strategy reviewed amendments for approval at People and Culture Committee September 2023 – to be presented at ICB Board in October 2023.
- **Placement Expansion:** Phase one data analysis completed. Engagement events with system partners arranged and commenced. Emerging priorities for consideration alongside impact of capacity work identified and to be developed by sub-group. AHP faculty commenced phase 2 data capture specifically for AHP student placements. Bid for funding to AHP placement expansion project awarded by NHSE.
- **Advanced Practice** – 55 new trainee posts starting in September 2023. Workshops commenced across Devon to identify AP posts for September 2024. Strategy remains under development. 100% returns from providers for NHSE governance matrix.
- **Apprenticeships** – Dashboard developed to present a system picture of training posts and funding utilisation. 7 apprenticeships funded through Levy share MOU within Primary Care. Agreed priorities for the apprenticeship strategy with providers and regional stakeholders.
- **Upskilling –** Stakeholder engagement session ran led by Zebra for Strengths based approaches (SBA) training leading to positive recruitment, first cohort full for September 2023 delivery. SRO remains outstanding despite significant attempts to secure. Upskilling programme of work has been re-rated to Red and identified as risk on pillar risk register to reflect slow progress and delivery of work with risk of not achieving outcomes in planned timeframe. Action plan being developed to address this and establish interventions to return to Amber rating as a minimum. Community upskilling HEE funded projects are being revised to improve uptake and accessibility in response to feedback from providers regarding operational pressures limiting release for training.
- **Learner Experience –** Key stakeholders for learner council identified; initial engagement meetings commenced. Release of NHSE WTE Student Charter anticipated – Devon ICS response and plan to be formulated pending released of NHSE position/requirements. Clinical Educator Workforce identified as priority area of work to be delivered by this pillar.
- **Continuing Professional Development-** Draft strategy developed by working group, socialised and circulated for comments.
- **Social Care –** New lead and funding secured. First steering group meeting held. Reviewed scoping work that has been completed and identified actions for next steps. Ongoing project design being conducted.

Acronyms

Acronym	Full Meaning	Acronym	Full Meaning	Acronym	Full Meaning
AHP	Allied Healthcare Professional	**IPACS**	Improving Patient flow between Acute, Community and Social care	**OPEL**	Operational Pressures Escalation Levels
ARRS	Additional Roles Reimbursement Scheme	**IPC**	Infection Prevention Control	**PCN**	Primary Care Network
ASD	Autism Spectrum Disorder	**IPT**	Inter Provider Transfer	**PHSO**	Parliamentary and Health Service Ombudsman
AVP	Ambulance Vehicle Preparation	**IQPR**	Integrated Quality and Performance Report	**PIDS**	Project Initiation DocumentS
BI	Business Intelligence	**IUCS**	Integrated Urgent Care Service	**PITCH**	Peer Improvement Tips for Care and Health
CAMHS	Child and Adolescent Mental Health Services	**JFP**	Joint Forward Plan	**PPG**	Practice Plus Group
CAS	Clinical Assessment Service	**KPI**	Key Performance Indicator	**RDUH/N/E**	Royal Devon University Hospitals/North/East
CDC	Community Diagnostic Centre	**LA**	Local Authority	**RTT**	Referral To Treatment
CFHD	Children and Family Health Devon	**LEG**	Learning Education Group	**SAR**	Safeguarding Adult Review
CLD	Criteria Led Discharge	**LMNS**	Local Maternity & Neonatal System	**SDEC**	Same Day Emergency Care
COO	Chief Operating Officer	**LOD**	Length Of Delay	**SDF**	Service Development Funding
COPD	Chronic Obstructive Pulmonary Disease	**LOS**	Length Of Stay	**SGA**	SafeGuarding Adults
CPO	Chief People Officer	**LSW**	Livewell South West	**SI**	Serious Incident
CQC	Care Quality Commission	**LTC**	Long Term Conditions	**SLA**	Service Level Agreement
CT	Computed Tomography	**LTP**	Long Term Plan	**SLT**	Speech and Language Therapist/Therapy
CVS	Community and Voluntary Services	**MADE**	Multi Agency Discharge Event	**SMI**	Severe Mental Illness
CYP	Children and Young People	**MDT**	Multi-Disciplinary Team	**SOP**	Standard Operating Procedure
DCC	Devon County Council	**MH**	Mental Health	**SST**	Safety Systems Team
DIG	Devon Investment Group	**MHAA**	Mental Health Act Assessment	**SW**	South West
DPT	Devon Partnership Trust	**MHLDN**	Mental Health Learning Disability and Neurodiversity	**SWASFT**	South West Ambulance Service Foundation Trust
DTA	Decision To Admit	**MIU**	Minor Injuries Unit	**T&F**	Task & Finish
DUCB	Devon Unscheduled Care Board	**MOU**	Memorandum Of Understanding	**TB**	Tuberculosis
ED	Emergency Department	**MP**	Member of Parliament	**TCI**	To Come In
ED	Eating Disorders	**MRSA**	Methicillin-Resistant Staphylococcus Aureus	**TSDFT**	Torbay and South Devon Foundation Trust
EMD	Emergency Medical Dispatcher	**MSDS**	Maternity Services Data Set	**ToC**	Transfer of Care
EOC	Emergency Operation Centre	**MSSA**	Methicillin-Sensitive Staphylococcus Aureus	**TTA**	To Take Away
ERF	Elective Recovery Fund	**MUST**	Malnutrition Universal Screening Tool	**TU**	Trade Unions
FDS	Faster Diagnosis Standard	**N&E**	North & East	**UCB**	Unscheduled Care Board
G&A	General & Acute	**NCTR**	No Criteria To Reside	**UCR**	Urgent Care Response
GIRFT	Getting It Right First Time	**NHSE**	NHS England	**UEC**	Urgent and Emergency Care
GP	General Practice	**NHSP**	NHS Professionals	**UHP**	University Hospitals Plymouth
GPAS	GP Alert State	**NICE**	National Institute for health and Care Excellence	**UTC**	Urgent Treatment Centre
GPES	GP Extraction Service	**NMOC**	New Models Of Care	**VCSE**	Voluntary Community Social Enterprise
HEE	Health Education England	**NOF**	National Oversight Framework	**WTE**	Whole Time Equivalent
HfOP	Healthcare for Older People	**NSS**	No Specific Symptom	**WW**	Week Wait
ICB	Integrated Care Board	**OOH**	Out Of Hours	**YTD**	Year To Date
ICS	Integrated Care System				

Key to Variance & Assurance Icons

	Variation/Performance Icons		
Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

	Assurance Icons		
Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

NHS Devon

NHS Devon Integrated Care Board

Committee Chair's Report – Quality and Patient Experience Committee

Date of board meeting	Dates of committees covered in this report
2 August 2023	19 July 2023

Chair	
Name and title:	Judy Hargadon, Non-Executive Director

Reports discussed and assurances received

Integrated Quality, Performance and Finance Report (IQPR)

- The Head of Nursing and Quality presented the IQPR report and highlighted the following:

  - A brief report has been escalated to the programme board around attendance at the working well together in harm group. This has been escalated as some key provider members have been unable to attend this meeting, due to operational pressures.

  - Within primary care services three of the four metrics are currently at exceeding target. GP access to booking appointments within a two-week timeframe was narrowly missed meeting the 95% target.

  - It was confirmed that workshops are taking place between the quality team and the providers in relation to NEVER events.

  - The Infection Prevention and Control team are working hard to address the increasing tuberculosis situation that is being experienced within Devon at present.

A discussion took place on some gaps in reporting. Concerns were raised around long waits for a diagnosis in autism for children and young people and the impact this can have on other parts of the system, such as special educational needs and disability (SEND) assessments and access to funding.

System Quality Performance Group (SPQG) Chair Report

- We received a summary report from SPQG discussions. Planned care and the success of the waiting well work stream were highlighted. The project is regarding patients being able to make their own decisions and simple signposting to relevant information. Further funding has been approved to continue this work.
- There were no items for escalation to the Quality and Patient Experience Committee.

Corporate Risk Update

The report on corporate risks was as follows:

- As of the 06/07/23 there are thirty-four open risks within the corporate risk register. Eighteen of these risks are allocated to this committee meeting, 13 of these risks relate to nursing and quality and 5 to commissioning. These risks are to be reviewed monthly.
- Going forwards the report will now include when these risks were opened and when they were last reviewed. The interim risk coordinator has this month been working with the specific risk owners to get the compliance rate for reviews up, and the deadlines completed within a timely manner. There are meetings planned with risk owners to discuss if these are the right corporate risks, to review if they are well articulated, and that they are being reviewed in a timely manner. If these risks remain high, then the teams will need to go back and investigate the mitigating actions.
- The corporate risk score for elective surgery remains scored at 25, due to the ongoing industrial relations issues and the impact on elective waiting lists.

Mental health report on Suicides

There has been learning from seventy-two suicides across the integrated care system, which was presented to the committee. There is good collaboration between providers in this learning exercise and a recognition of key issues to be addressed, including how best to work with families and carers. The interface with Drug and Alcohol services was also noted as a key area to address. The committee asked for an update in October on progress with implementation.

Reports received and noted

Chief Medical Officer (CMO) Update

- The CMO gave an oral update on the impact of the most recent Junior Doctors', consultants and radiographers industrial action.
- There are further delays to Devon's elective care currently.
- Junior doctors' cohort will be impacted going forward and risks are foreseen for the longer term, locally and nationally. This is. not just within acute services but also primary care and mental health. Mitigation is currently put in place for the industrial action around emergency care and maternity care and for the consequences to the elective recovery plans.

Pharmacy Group Directives Review Annual Report (2022 – 2023)

The committee noted this agenda item.

Formal transfer of complaints for pharmacy, optometry and dentistry (POD) from NHS England to ICBs

The committee noted this agenda item and its impact on staff workload.

Healthwatch - Cost of living report

The committee noted the final report from Health Watch on the impact of cost of living increases on healthcare, and especially those areas that are not NHS funded.

Healthwatch – Use of Emergency Departments Review

The committee were informed that this report is now with NHS Devon for clinical verification but should be published soon.

Committee decisions

- Nil to report

Items of concern to be escalated to the board

- Nil to report

Recommendations for the board

- To consider the reports received and positions of assurance by the Quality and Patient Experience committee.
- To note that the industrial action will have longer term impact, not just the current short term concerns.

Recommendations for other committees

Nil

Terms of reference or other committee effectiveness issues

Dr Frank O' Kelly Primary Care Partner Member NHS Devon Integrated Care Board was welcomed to the committee.

NHS Devon

NHS Devon Integrated Care Board

Committee Chair's Report – Quality and Patient Experience Committee

Date of board meeting	Date of committee meeting covered in this report
04 October 2023	16 August 2023

Chair	
Name and title:	Professor Hisham Khalil, Non-Executive Director

Reports discussed and assurances received

Integrated Quality, Performance and Finance Report (IQPR)
The Head of Nursing and Quality presented the IQPR report and highlighted the following:

- There are several performance metrics in the report that impact on the quality of patient care. There was a focus on unscheduled care, specifically emergency departments (ED), where there has been a decline in performance, resulting in long waiting times and the impact this may have on the patient experience and quality of care. There are efforts to improve waiting times and reduce inappropriate admissions for end-of-life care. The committee discussed ways of enhancing the reporting of Quality metrics including incidents in Primary care.

- Patients' Experience: There were 242 concerns in the first quarter of this year, this is slightly less than the figure of the same quarter last year. There is progress with closing these informal concerns. Delays in responding to formal concerns are addressed through initial acknowledgments, with cases placed in a holding folder until they can be managed.

- The committee was made aware of the process with complaints, some requiring legal advice. The Patient Experience team is provided with regular supervision sessions and one-on-one support, particularly for those handling

Quarter 1 Safety Systems report
The Head of Patient Safety provided an update on the Patient Experience for the month of June with no significant change from previous months. These figures would transition into delegations starting in July 2023. There are 10 formal open complaints, with three closed in June. There are six open requests from the Ombudsman.

There were 117 PITCH reports in June, with a notable drop in numbers reported from Western area. The common themes in PITCH reports are inappropriate referrals to MU and urgent treatment centres, along with poor discharge summaries. Almost 100 pitches were closed, consistent with previous months.

The committee discussed 'a change in perspective' in relation to patient complaints and that these should be viewed as drivers for positive change in the system.

An Update on Patient Safety Incident Reporting (PSIR)
1. Transition to the New Reporting Framework: There is currently a transition process for healthcare organisation to use the PSIRF.
2. Engagement with GP Groups: There is ongoing engagement with GP groups introducing them to Learning from Patient Safety Events (LPSE) and helping them register and use the new reporting system.
3. Communication and Collaboration**:** There is ongoing work with various healthcare groups, and communication with Primary Care Networks (PCNs) and GPs to ensure the smooth transition to the new system.

The Head of Patient Safety also provided an update on the 'Never Events' Peer Support group.

The Outline of Quality in Pharmacy, Optometry and Dentistry (POD) Services
(Members of the Primary Care Commissioning Transitional Committee joined this section of the Quality and Patient Experience Committee meeting for this item.)

The Deputy Director of Nursing and Quality, NHS England (NHSE), presented an overview of Quality Assurance processes for POD services. Patient feedback is an important element of this. Incidents and complaints are handled in each area, with reporting occurring quarterly and urgent issues escalated as needed. These include on risk management framework development and upcoming changes related to Integrated care Board (ICB) host responsibilities.

The committee discussed that the issues impacting POD services were different and it would be beneficial to address these separately in future reporting.

The committee will receive quarterly reports on the Quality of POD services.

Corporate Risk Update
The Risk Manager presented the Board Assurance Framework (BAF) and corporate risk register. The organisation has identified 14 risks that could hinder strategic

objectives, of which 3 are assigned to the Quality and Patient Experience Committee. These include partnership work for addressing social determinants of health, reducing health inequalities, and shifting towards prevention. Updates were presented to the Committee, and risk scores remain unchanged since May 2023.

There are 34 open risks on the corporate risk register, 18 assigned to the Quality and Patient Experience Committee, with 10 deemed very high and 7 high. Of these, 10 risks have been reviewed in the last period, showing improvement in updates. There is one risk score reduction related to business intelligence support for maternity services.

The Citizens' Voice
An oral presentation from Healthwatch highlighted access issues for Dentistry services. There were also concerns regarding access to Pharmacy services impacted by closures. In addition, a meeting with the Chief Pharmacist at UHP has taken place in relation to the Outpatient Pharmacy site which has limited space, causing long queues. Mitigation plans involve identifying another retail unit on site.

System Quality Performance Group Chair Report
The Deputy Chief Nursing Officer presented the Chair's report and highlighted there were no items to escalate to the committee. The committee acknowledges the positive outcomes from the GMC survey of trainees, indicating good overall satisfaction and training experiences for doctors in the region despite the challenges.

Reports received and noted

Safeguarding Quarterly Report *(Papers taken as read)*
The Deputy CNO presented the safeguarding quarterly report to the Committee for noting. The report highlights the involvement in statutory reviews across different partnership groups. The number of ongoing children safeguarding practice reviews, adult safeguarding reviews, and domestic homicide reviews.

The Community DoLS (Deprivation of Liberty Safeguards) risk was discussed, with plans to address the gap after the delay of the Liberty Protection Standard. The safeguarding training compliance report was highlighted, with a target of 90% compliance for the ICB. The report discussed how the data is scrutinised and anomalies in reporting are being addressed manually. A new training matrix is being developed to ensure accurate levels of staff training. The ICB are meeting requirements.

Committee decisions

- Nil to report

Items of concern to be escalated to the board

The committee would like the Board to be aware of the following:

- The Chief Medical Officer highlighted a situation with the recent industrial action by junior doctors, where UHP NHS Trust made a request for a derogation during the junior doctors' strike due to patient safety concerns in three areas within the trust. This was declined by the BMA. The CMO along with the Regional Medical Director for NHS England, wrote to the BMA expressing their concern regarding this.

- The committee discussed the need for equitable treatment and funding of voluntary sector entities in relation to delivery of services and in comparison to other providers.

Recommendations for the board

- To consider the reports received and positions of assurance by the Quality and Patient Experience Committee.
- To note that the industrial action will have longer term impact, not just the current short term concerns.

Recommendations for other committees

Nil

Terms of reference or other committee effectiveness issues

Nil

NHS Devon

NHS Devon Integrated Care Board

Committee Chair's Report – Quality & Patient Experience Committee

Date of meeting	Date(s) of committees covered in this report
4 October 2023	20 September 2023

Chair	
Name and title:	Professor Hisham Khalil, Non-Executive Member

BAF updates or escalation

- None

Risk register review updates/escalation

The Risk Manager, NHS Devon provided an update on the corporate risks.Two new risks were opened. Risk184 relates to the lack of a sustainable individual funding decision-making process for Children and Young people in NHS Devon. Risk 185 deals with an increase in Tuberculosis cases in Devon that could exceed the capacity of the Devon system to respond.

Two risks have decreased in risk score:

- Risk 156 has reduced from a score of 6 to 1. This risk pertained to significant delays in processing routine referrals, which have now been resolved.
- Risk 167 has reduced from a score of 12 to 8. This risk was related to oversight of the local commissioning cycle. The reduction in risk is a result of additional mitigating actions being implemented.

Additionally, there were two risks recommended for closure:

- Risk 156, due to the resolution of the issues it addressed.
- Risk 173 has decreased in risk score from 12 to 9 as a result of business intelligence support being put in place.

There are plans to explore new risk management systems to address the limitations of the current system. In the interim, they are considering using a spreadsheet system managed by the corporate governance team to provide clearer and more accessible information about how risks are being managed.

Reports received, discussed and noted

1. Integrated Quality, Performance and Finance Report (IQPR)

- The Head of Nursing and Quality presented the IQPR report and highlighted that some performance matrices are impacting on the quality of patient care and safety.

  Urgent and Emergency Care. There continue to be issues with delays in Ambulance handover. Critical updates are monitored within the LCP urgent care board.

  Elective Care. Targets for elective care are not being met, particularly the 104 and 78-week targets. This may have a negative impact on patient experience and safety. There is a 'Harm' group that monitors this aspect. The Committee discussed the importance of identifying any 'differential' impact on certain patient groups e.g. those with learning disabilities.

  Patient Experience. There is a significant increase in concerns and complaints received since the delegation of primary care services. In July 2023. There were 189 complaints, and this number has increased in subsequent months. This surge in complaints has put a strain on the available resources and the team handling them.

  Serious Incidents. Serious incidents are still being reported as per the established framework. The top key themes for these incidents continue to be slips, trips, falls, and diagnostic issues.

  Never Events. There have been four new never events reported in July 2023. The initial reports on three of the never events have identified some learning points. Collaboration meetings are being held to discuss terms of reference and share learning across the system. The Committee voiced concerns about the increase in never events, with four reported in July 2023, bringing the total to 18 in the last 12 months. The Committee requested assurance regarding the functioning of the Collaborative Peer Support Group for Learning from Never Events and requested summary reports from their meetings to be submitted to the QPEC.

Safeguarding Adult Enquiries. The Committee enquired about the reason for the rise in Adult Safeguarding enquiries and requested assurance on actions being taken to address this issue.

Interface between Primary and Secondary Care. The Committee discussed challenges in this area including inappropriate referrals or patient attendance and the importance of taking the patients' perspective into consideration. There is a communication strategy being developed to guide patients in this area.

Infection Prevention and Control The acting CNO SM reported on the Community Infection Management Service. There are concerns regarding the increasing COVID-19 infection rates and the new variant. The system is experiencing some staff shortages due to COVID-related sickness, affecting capacity across providers.

The vaccination rollout plan is being implemented, starting with residents in care homes for older adults, which has achieved an impressive 20% uptake after the first week. There are some issues with the National booking service but assurance was received that these are being addressed. Additionally, a new vaccine, FISA, is expected to be available after 27 September2023, with new protocols in place.

2. The Citizens' Voice

The Senior Administrator, Engaging Communities Southwest provided an update on feedback received since April, 2023. Issues with access to care featured highly. There are issues with Pharmacy services, including delays in medication and unfulfilled prescriptions. Patients have reported difficulties accessing pharmacies due to closures and phone lines being unanswered. Some individuals have expressed concerns that their prescriptions were changed without their consent.

There are issues of access to information, particularly amongst the deaf community. The impact on health and wellbeing for unpaid carers was also raised as an area that requires better understanding.

3. The Mortality Report

The Head of Nursing and Quality highlighted that that the set of data to be reported include the Summary Hospital-level Mortality Indicator(SHMI,) place of death, radar-type reporting, benchmarking observed and expected deaths, excess deaths, crude mortality by underlying condition, and mortality by Primary Care Network (PCN). They plan to focus on addressing healthcare inequalities and may expand to examine morbidity leading up to death.

The ICB is moving toward a provider-driven model, with the oversight role being gradually shifted to medical directors of organisations. Collaboration with Cornwall and Public Health colleagues for data analysis and triangulation. Thandiwe Hara (TH) raises concerns about interpreting data when patients die in locations far from their residence and whether this initiative duplicates

existing local data. SW explained that they are working with public health colleagues to address these concerns and integrate various data sources. SW emphasised the imperfection of data and the need to work with the available information, stating that the data points them in the right direction, but further analysis and deep dives are essential to get a clearer picture.

4. **Owen House Update Report**

   The Head of Nursing and Quality provided an update on the enhanced quality surveillance that has been stepped down due to changes in service delivery, moving toward a community-based approach.

Committee decisions

5. The Committee approved the informal Feedback and Formal Complaints Policy

6. The Committee approved:
   i. The inclusion of risks 184 and 185, onto the corporate risk register.
   ii. The reduction in score of risks 156 and 167
   iii. The closure of risks 156 and 173 on the risk register.

-

Escalation to the Board – for information

- None

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

Management of conflict of interests:

Conflicts of interests are recorded on the register of interests. At each committee, a list of recorded declarations is provided. New declarations must be raised, recorded

and included in the minutes of the meeting and notified to the Governance team via d-icb.governance@nhs.net to update the central register.

5

NHS Devon Integrated Care Board

Primary Care Access Recovery Plan (PCARP) - System Level Access Improvement Plan

Date of meeting	Date report produced
04 October 2023	21 September 2023

Author(s)		Report approved by	
Name and title:	Jo Turl, Director of Commissioning Primary, Community and Mental Health Care Gill Munday, Joint Head of Primary Care Adam Bowles, Primary Care Support Manager Lucy Morris, Primary Care Development Officer Paul Green, Deputy Director of Primary Care Contributions from identified workstream leads	**Name and title:**	Nigel Acheson Chief Medical Officer
Phone:		**Date:**	27 September 2023
Email:	gill.munday@nhs.net		

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

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

Executive summary

Primary care is one of the most dynamic and innovative parts of the health service. We saw this, both nationally and locally, in the rapid and comprehensive rollout of the NHS COVID-19 vaccination programme.

However, the pandemic has changed the landscape, and we must endeavour to ensure practice capacity keeps pace with clinically appropriate demand. Primary care, like many parts of the NHS is under unprecedented pressure. The Fuller Stocktake stated, “there are real signs of growing discontent with primary care – both from the public who rely on it and the professionals who work within it”.

The Fuller Stocktake set a vision for integrating primary care with three essential elements: streamlining access to care and advice; providing more proactive, personalised care from a multidisciplinary team of professionals; and helping people stay well for longer.

It is acknowledged though that before we can fully implement the wider reforms necessary to achieve this vision, we need to take the pressure off general practice and tackle their demand peaks.

This plan has at its heart two central ambitions:

1. To tackle the demand peaks, particularly early a.m., and reduce the number of people experiencing difficulty in contacting their practice.

2. For patients to know on the day they contact their practice how their request will be managed.

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

Primary Care Commissioning Transitional Committee: The committee welcomed and supported the plan and provided feedback ahead of board.

The paper will be presented to the Devon General Practice Collaborative Board on 10 October 2023.

Key recommendations and actions requested
1. The Board is asked to **approve** the Primary Care Access Recovery Plan (PCARP)
2. The Board is asked to **consider** how key ambitions can be supported by wider system partners

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	Positive – better access to primary care
Improve services and reduced unwarranted variation	Positive – reduction in variation of access
Make more efficient use of our resources	Positive – maximising digital opportunities to improve efficiency in primary care
Develop our culture and how we operate	Positive - Collaborate working between ICB, Primary Care providers, system partners and national and regional leads

Outline the implications of matters covered in this report for the following areas	
Area	
Quality of services	Improvements in access to primary medical care
Health inequalities	Reduction of variation in access in particular demographics
Workforce	Maximising opportunities to expand and retain primary care workforce.
Resources and finance	National funding streams associated with PCARP
Legal	None identified
Digital and Data	Digital transformation in primary care is key focus of PCARP as well as utilising data analysis from practice systems and national data streams

Primary Care Access Recovery Plan (PCARP) - System Level Access Improvement Plan

Introduction

1. The Primary Care Access Recovery Plan (PCARP) (available via this link) forms part of the operational planning guidance. The national ambitions for the PCARP are:
    - To make it easier for patients to contact their practice and;
    - For patients' requests to be managed on the same day, whether that is an urgent appointment, a non-urgent appointment within 2 weeks or signposting to another service

2. The PCARP is divided into 4 keys areas:

Area	Focus
Empower Patients	• Improving information and NHS App functionality • Increasing self-directed care where clinically appropriate • Expanding community pharmacy services
Modern General Practice	• Implementing 'Modern General Practice Access' • Better digital telephony • Faster navigation, assessment and response
Build Capacity	• Larger multidisciplinary teams • More new doctors • Retention and return of experienced GPs • Higher priority for primary care in housing developments
Cut Bureaucracy	• Improving the primary – secondary care interface • Building on the 'Bureaucracy Busting Concordat'

3. NHS Devon Integrated Care Board (ICB) welcomes the government's focus and support in developing aspects of primary care, as this will enable us to build on the work our practices have been doing over the last few years to deliver a modern, digital access model to their patients, and optimise care navigation.

4. Devon is currently performing well in relation to the PCARP ambitions, as illustrated by the following:
    - Ease of getting through to practice – patient survey; Devon 62% National 53%.
    - 49.8% of appointments were seen within 1 working day. The national average is 50.4%.
    - 82.1% were seen within 2 weeks. The national average is 79.4%. Devon has the lowest proportion of appointments booked after 28 days.

5. However, it is recognised that within Devon there is significant variation that needs to be understood and addressed through the PCARP.

Governance

6. Nationally there are seven workstreams that sit under the PCARP and NHS Devon has identified leads for each area, namely:

Lead area	Role
SRO	Director of Commissioning
Oversight Group Chair	Deputy Director of Primary Care
Primary/Secondary care interface contracting	Primary Care Medical Director
Transformation	Head of Primary Care
Digital	Primary Care Digital Transformation Programme Manager
Pharmacy	ICS Community Pharmacy Clinical Lead
Self-referral (audiology)	Head of Planned Care Strategy
Communications	Communications Manager
Workforce	Professional Practice and Workforce Lead

7. The identified leads form the PCARP Oversight Group, chaired by the Deputy Director for Primary Care, which reports to the Improvement Board and Primary Care Commissioning Transitional Committee (PCCTC). Documentation used is aligned to that used for the other recovery plans (Urgent and Emergency Care (UEC) and Elective).

8. The PCARP Oversight group receives highlight reports for each workstream, which inform the overarching programme risk and issues log and Gant chart. Highlight reports cover:

    - Workstream scope
    - Overarching narrative for month / key messages
    - Key actions for a month ahead
    - Escalations and decisions required
    - Red/Amber/Green (RAG) rating assessment

9. It is through this established governance that NHS Devon is able to monitor and assure delivery against trajectories and milestones, manage risk and agree mitigations.

Vision and links to system strategy and policy

10. NHS Devon is proud of its track record in delivering a level of GP access that consistently exceeds national averages. Meeting patients' access needs and adoption of digital first innovations and models has been a key feature of Devon's overarching vision for General Practice, featuring prominently in its primary care focused strategic framework and policy documentation as well as wider interdependent system policy.

NHS Devon Strategic Framework

11. The Strategy for General Practice in Devon: Five-year plan 2019 - 2024 set out several actions in response to findings and trends from GP Patient Surveys and the continued progress towards a 'digital first' model in Devon. The strategy committed to:

    - Ensuring needs of patients requiring urgent primary care are met appropriately and routine appointments are available in the evenings and at weekends where there is demand or a need (building on overall high levels of patient satisfaction with appointment availability in Devon).

    - Adopting a 'digital first' approach. Where possible, the first contact with general practice services would be digital and there would be digital connectivity between organisations. Patients could expect their personal and medical history to be available wherever they 'touched' health and care systems. Patients would also be supported digitally for self-care and technology will be doing some of the routine work previously undertaken by staff.

    - Enabling GP practices to embrace and embed the functionality of the NHS App, supporting patients to access self-care, clinical advice, book appointments, order repeat prescriptions, access their medical records, choose preferences for data sharing and organ donation etc.

    - Promoting digital activation amongst all groups of patients including amongst all groups of patients including a digital guidebook developed by Healthwatch to help patients navigate the NHS and the potential Digital Drop-in surgeries at practices run by the voluntary sector.

12. Following the COVID-19 pandemic and the publication on the Fuller stocktake, the NHS Devon Strategic Framework for Primary Care (General Practice) 2022-2027, reflected on the immense progress made in digital access and reasserted the importance of meeting patients access needs thought its key strategic principles, highlighting that:

    - General Practice is a speciality which has a key role in prevention, the identification and management of long-term conditions, and the treatment of some urgent care issues. Each of these areas of activity may require a different delivery model within general practice.

- Access to good quality General Practice services for all patients, will be based on what is clinically appropriate. This includes the type of professional that a patient sees and the method for delivery of care.

One Devon's Joint Forward Plan

13. One Devon's Joint Forward Plan sets out an ambition to deliver an integrated model of primary and community care through the Devon GP Strategic Framework. The framework aligns with the output of the national Fuller Stocktake, focussing on the development of integrated multi-disciplinary neighbourhood teams at place to deliver 3 key deliverables:

    - Improved access to care
    - Improved continuity (and more proactive, personalised care) to people with complex needs.
    - Reduced health inequalities and a more ambitious approach to prevention.

14. The Devon GP Strategic framework works in parallel to the Devon Community First strategic framework, which aims to build community capacity at a neighbourhood level, focusing on proactive, reliable, resilient, safe and sustainable community services.

15. Building on the two local strategic frameworks and with the delegation of additional primary care services (dentistry, pharmacy, and optometry), Devon ICS has set out the ambition of having a filly functioning integrated model of care, which takes a more preventative approach to delivering personalised care and addressing health inequalities within each of its five Local Care Partnership areas.

Interdependency with Urgent and Emergency Care (UEC) and Winter Planning

16. The ambition of the UEC recovery plan is that, through partnerships between acute, community and mental health providers, primary care, social care and the voluntary sector, the system can provide more, and better, care in people's homes, get ambulances to people more quickly when they need them, see people faster when they go to hospital and help people safely leave hospital having received the care they need.

17. Given over 90% of contacts happen in GP practices, resilient primary care is fundamental to managing pressures across the system. Last year primary care played a key role in Acute Respiratory Infection Hubs (ARI) and are engaged in planning for this year.

Improvement Approach

18. In developing this and associated plan(s) we have been cognisant at all times of the NHS IMPACT programme and associated resources. We have of course considered those specifically identified as being relevant to Primary Care, but in line with the overarching ethos of NHS IMPACT we have sought to look carefully at the extended programme resources. This has helped us craft a plan which we

believe will achieve short term gains, but in a manner which delivers strategic legacy in terms of how, where, and with clinically based promptness patients access the services they need.

19. We recognised at an early stage that to achieve that strategic legacy we need to embed the outputs from this process not only in systems, but in people. To that end we are investing in a bespoke leadership programme for both clinical and non-clinical leaders from within our GP provider collaborative as well as our PCN Clinical Directors. This will run in parallel to our access specific plans but using the latter as opportunities to exercise leadership behaviours developed on a 'learn through practical application' basis.

20. Development programme will also include consideration of succession planning, and we hope that will in turn lead to a second cohort. This will further strengthen local leadership within our neighbourhood level and multi-disciplinary based delivery models.

21. We also intend to share the plan with the local lead commissioner of primary care training and development (DTH). This will ensure that prioritisation of future programmes adequately and appropriately aligns to delivering patient focussed outcomes as identified within plan.

22. We know from recent local piloting and subsequent showcasing of a Quality Improvement programme deployed within a limited number of Practices within our Plymouth system that there is both need and appetite to convert this into a mainstream offer. We have already tasked DTH to feed this into their next round of work programme prioritisation to assess how the need is most efficiently and effectively met.

23. Clearly, we have endeavoured with this plan, its component (PCN and Practice level elements) and associated approaches to ensure that changes are systemised such that the positive patient facing outputs become the new norm. We do though intend to revisit on a dynamic basis in post implementation periods to ensure that this is the case, to establish an understanding of best practice and showcase such the strategic legacy is assured.

Overview: Practice/PCN Plans and Actions

24. This section describes the actions required from PCN's and Practices under the PCARP and how those actions have been progressed and completed in Devon.

Capacity and Access Improvement Plans (CAIPs)

25. All 31 Primary Care Networks (PCNs) submitted Capacity and Access Plans (CAIPS) in June, in line with the national time frame. All CAIPs have been reviewed and all plans have been signed off. We continue to work closely with the emerging Devon Provider Collaborative and the Local Medical Committee (LMC).

26. PCNs have engaged with their patient groups to co-produce CAIPs.

27. The CAIPs covered three overarching areas relating to

    1) Patient Experience
    2) Ease of access and demand management
    3) Accuracy of Recording in appointment books

28. A summary of the NHS Devon position and main themes from PCN responses can be found in the table below. A summary of the responses has also been shared with the NHS England (NHSE) South West Regional team.

Patient Experience	• The key role of Digital and Transformation Leads in taking this work forward, working with ICB Digital Envoys and Digital Journey Planner • More focus on sharing best practice across the PCN re what is working well for access and supporting more consistency in models across the PCN. • Development of more targeted local surveys, working with PPGs to design and review results. • Updating practice websites with reference to national toolkit, where possible having consistent templates across the PCN • Optimising use of online consultation tools across PCNs. Several PCNs considering how total digital triage can be adopted with the possibility of a PCN access hub approach. • Promotion of ARRS roles to increase satisfaction in appointments offered. • Examples of where practices are holding sessions with patients to support them to access digital offers and use the NHS App • Intention to increase FFT awareness and uptake across all PCNs with plans to use post-appointment text messaging as main route to achieve this
Ease of access and demand management	• Practices on non-cloud-based systems committed to moving and keen to understand support available to do this. • Practices with CBT are reviewing the options for call back function but are flagging that the cost in doing this may be prohibitive. • Some practices/PCNs are regularly reviewing the data provided through their system and finding it invaluable in looking at matching demand and capacity. Others have identified the need to better utilise the data and are putting in place plans to do this and share learning across the PCN. • PCNs identifying variation in online consultation rates between member practices which may be due to differing practice demography's, patient feedback/preference and/or variation in how online consultation is embedded in practice access models. Emphasis placed on sharing learning and understanding what drives variation. All PCNs committed to increasing and optimising online consultation as per the

	national requirement. • Some practices using total triage models have (as expected) high rates of consultation therefore looking at average numbers is not always helpful baseline. Practice/PCNs keen to look at what is the right level of online consultation for them and their patients. • Plans for data to be formally and frequently reviewed by PCN Digital and Transformational leads. Some exploring implementing total triage and possible PCN hub model. • PCNs keen to look at shared appointment booking for EA subject to clarity on funding. • Many practice/PCNs using accurx florys to promote self-management.
Accuracy of Recording in appointment books.	• PCNs noted variation in approach to GPAD mapping linked to different approaches to managing appointment books and differing clinical systems. • All PCNs have committed to work across their practices to ensure the GPAD guidance is adhered to and to improve accuracy and consistency. • Planned audits to take place across PCNs. • Peer support and shared learning between PCNs • Regular reviews of the data through accessing the PCN dashboard. • Focus on the mapping of the 8 categories used for assessment for recording urgent/same day and two-week appointments. • Utilisation of Digital Transformation Leads to focus on this area and creation of a SOP

PCARP Actions

29. In addition to the CAIPs NHS Devon requested a further response from all 120 practices against the practice/PCN actions from the PCARP checklist (see appendix 1) that were not already covered by the CAIP's. In relation to the four areas of PCARP, this included:

    1) Empower Patients

    Practices/PCN are required to have enabled all four NHS App functions for patients. For NHS Devon response and actions see NHS Devon Delivery Approach for PCARP section below.

	Position in Devon
Apply system changes or manually update patient settings to provide prospective record access to all patients.	22.5% of practices enabled for prospective (future) full record access with 27 practices currently live. A further 11 have booked a slot for enablement.
Ensure directly bookable appointments are available	93.2% of practices have enabled the ability to book/cancel appointments online.

online.	
Secure NHS App messaging to patients where practices have the technology to do so in place.	Technology not currently available – subject to national solution.
Encourage patients to order repeat medications via app supported by comms toolkit.	This is offered by 100% of practices. When surveyed c.90% of practices confirmed that they were actively encouraging patients to order repeat prescriptions online. 47.3% of pts in Devon have enabled this on their NHS Apps.

2) Implement Modern General Practice

Actions required from PCNs and practices relating to this are in the main covered by the CAIPs section above and by the support offers section that follows.

3) Build Capacity

The PCARP reaffirms the requirement for PCNs to Submit ARRS and workforce plans to the ICB by 31 August 2023. This has been completed by all PCNs in Devon and NHS Devon will now work through these plans with PCNs.

PCARP also seek assurance that practices and PCNs are taking up local offers for retention. Offers in Devon are available as follows:

- GP Fellowship
- GPN Fellowship
- Supporting Mentors Scheme (GPs)
- Deep End Fellowships (GPs)
- PCN Nurse Leads
- NEW2GPN Project (new to GP nurses)
- GPN pipeline
- Practice Managers Training
- GP wellbeing
- Professional Nurse Advocate Programme
- International Medical Graduate Programme
- GP Relocation Scheme
- Plymouth Physician Associate Pilot

These offers are communicated to practices and PCNs via NHS Devon, Devon Training Hub and Devon LMC. These schemes all have good uptake, supporting recruitment and retention across multiple staff roles and assist in business continuity planning.

4) Cut Bureaucracy

Practices have had the opportunity to feed back to NHS Devon on progress against primary and secondary care interface difficulties through the LMC but

also through the PITCH reporting mechanism. There has been a focused piece of work in Plymouth Local Care Partnership and two PCNs in Plymouth are also participating in "Improvement Week" hosted by NHSE Transformation Team. This event is intended to identify opportunities for improvements within practice/PCN and primary care interface with other organisations in terms of patient pathway. It is intended that learning and opportunities are shared with other practices/PCNs and across the system as appropriate.
Areas of focus will be around:

- Transfer of work; the demand presenting in practice which we would expect another system provider to have actioned (patient or provider initiated)
- Referral pathways; all referrals e.g. self-referral, signposting and handover of care
- Rework of signposting; e.g. failure demand from community referral, 111 etc.
- Internal improvement opportunities; site specific or PCN

Take Up of Support Offers and Training

30. The GP improvement Programme offers a number of support offers, as follows;

Support Offer	Detail
Universal offer	Available to every practice in England and is comprised of webinars and online resources covering 5 key priority areas
Intermediate offer	Available to both PCNs and practices, offering a hands-on package of support over three months to enable planning and delivery of improvements. This offer includes facilitated, in person sessions with data diagnosis and a tailored analysis of demand and capacity.
Intensive offer	Provides targeted, hands-on support for those practice working in the most challenging circumstances. It will be delivered over 6 months and practices will receive on-site support and group-based sessions to facilitate peer-to-peer learning and sharing of experience across practices.
Capability building offer	Provides individuals in practices and PCNs with practical development programmes, that will increase core skills and understanding of quality improvement tools and techniques and managing change. The offer includes short-term (over 2 to 3 sessions) and longer-term (up to 12 months) development opportunities such as: • Digital Transformation Leads Development Programme • General Practice Improvement Leads Programme • Fundamentals of Change and Improvement Programme

31. As part of PCARP, NHS Devon surveyed practices to ascertain their intentions in relation to taking up these offers. The summary is below:

Programme	Already signed up	Interested in signing up? Yes	Interested in signing up? No	Unsure
Intensive (26 week)	6	14	57	39
Intermediate (13 week)	6	18	50	42
PCN Intermediate	0	16	22	78
Digital and Trans	4	28	18	66
Care Navigation Training	46	37	16	17
Fundamentals of Change Improvement programme	5	6	9	39

32. NHS Devon is cross referencing this list with sign up information form the national team and is also looking at how this aligns to perceived need based on access and quality metrics. Where the ICB feel a practice/PCN may benefit from the additional support NHS Devon will actively signpost the practice/PCN accordingly and support them to be able to take advantage of the tools and packages available.

Overview: NHS Devon Delivery Approach for PCARP

33. This section describes the actions required from ICBs under the PCARP and how those actions are being progressed in Devon.

Empower Patients	
PCARP Workstream	Digital – NHS App
Goal	Enable patients in over 90% of practices to see their records and practice messages, and book appointments and order repeat prescriptions using the NHS App by March 2024.
Narrative	
Viewing of GP records by patients, has been mandated under the new contract and is due to go live in October 2023, and we have been proactively working with practices to encourage them to sign-up to this functionality at earliest possible point to realise benefits ahead of plan. So far 81 practices have configured their systems ready for patient access and of these 80 are allowing at least some of their patients access to records. Note that 20 of these have already provided access to over 85% of their practice population. We would not of course expect any practices to reach 100% access, due to a variety of exclusions including for safeguarding reasons. We also expect the number of practices providing access and the proportions of their patients to whom it is made available to increase significantly during September and October. Following the national deadline, we will continue to work with practices who are not sharing or are but not a sufficient proportion to understand and overcome any remaining obstacles that they may have. We are working with practices directly, using the Devon Primary Care Digital Envoys to train practice staff and increase understanding of the NHS App and its full capabilities. The Envoy team are also working with practices to improve the sign-up process to ensure it is less onerous for patients.	

Repeat prescription numbers will be aided by greater NHS App uptake, with all Devon practices already offering these services to their patients. Further communications to practices and from the ICB may aid in the promotion of the advantages of using this service. It should be noted that this service will have suffered recent setbacks with the closure of many Lloyd pharmacies, something that has disproportionately affected Devon, as this will have required practices and patients to make changes to ensure they continue to receive their prescriptions.

Both repeat prescriptions and directly booked appointments will be incorporated into the Envoy programme of work to ensure increased availability and promotion by practices and increased utilisation by patients.

PCARP Workstream	Self-referral
Goal	Expand self-referral pathways by September 2023, as set out in the 2023/24 Operational Planning Guidance.

Narrative

The 2023/24 priorities and operational planning guidance states that we must:

Expand direct access and self-referral where GP involvement is not clinically necessary. By September 2023, systems are asked to put in place: self-referral routes to audiology-including hearing aid provision, with cognisance to subsequent at pace development of further self-referral routes including for certain Musculoskeletal conditions.

In view of the above the following approach has been developed and will be taken through the ICS audiology task and finish group for discussion, agreement and at pace implementation.

- The audiology self-referral task and finish group will be elective provider led and include contracting, finance, referral service, primary care commissioner and provider and elective care representation.
- Devon NHS have worked with the planned care clinical lead to produce an outline self-referral pathway for age related hearing loss to accelerate this work.
- This will see GP practices and AQP providers signpost patients to a l the self-referral pathway access point, which will have varied access points to ensure inclusivity. Including for patients that are unable to complete the form online where the call handler will complete the form on behalf of the patient.
- This will of course be an additional and ultimately primary route into the service, but GP teams will still be able to refer patients via the current process via eRS
- The self-referral form has been developed to ensure that patients fit the AQP pathway criteria.
- The form will be hosted on MyHealth website, patients can complete themselves or carers can complete on behalf of those patients.
- Devon Referral Support Service (DRSS) will download the self-referral forms,

shortlist the relevant clinics providing the patient with a choice of sites and appointment times. Patients are then able to go online to book their appointment. DRSS will monitor whether patients have used the online booking service and contact those patients that haven't booked.
- Agree with AQP providers that if patients self-refer, they will check for ear wax before proceeding with appointment
- Develop a self-help guide for treatment of ear wax prior to a hearing check.
- Confirm how to monitor invoicing to ensure we are only paying for referrals received via eRS or self-referral form (also via eRS)
- Agree monitoring and evaluation timescales for the service.

Once the above has been worked through and formally agreed via the audiology self-referral task and finish group the process will then be taken Through cross organisational formal sign off processes.

AQP providers will then be notified by contracting and comms will go out to primary care and providers notifying them of the new process.

Learning accrued will be captured and used to inform subsequent self-referral protocols for other identified conditions including those where greatest and safest patient and system benefit is identified.

PCARP Workstream	Community Pharmacy
Goal	Expand services offered by community pharmacy

Narrative

National plans for community pharmacy

The national community pharmacy contractual framework (CPCF) 2019-2024 focuses on making better use of the clinical skills within community pharmacy teams and better integrating community pharmacies into the NHS by making them the first port of call for minor common conditions.

National plans to support primary care recovery aim to build on this, expanding the Community Pharmacy services offered by:

- Introducing a Pharmacy First Common Conditions Service enabling pharmacists to supply prescription-only medicines, including antibiotics and antivirals, where clinically appropriate to treat seven common health conditions (sinusitis, sore throat, earache, infected insect bite, impetigo, shingles, and uncomplicated urinary tract infections in women.
- Expanding the blood pressure check service
- Introducing and expanding oral contraceptive services.

This is reliant on national contract negotiation, which is ongoing. Pending that agreement, Devon ICB is focussed on building a firmer foundation to support implementation of those plans once agreed. This is overseen by the newly instigated Community Pharmacy Development Group (CPDG) – a collaboration with Cornwall and Isles of Scilly (COIS) ICB ensuring opportunities are realised to reduce

duplication, share learning and best practice.

Devon and CIOS Plans to support Primary Care Access Recovery
Since 2019 the financial viability and resilience of community pharmacies is reliant on the provision of a range of clinical services. The activity associated with some of these services is reliant on referrals from the wider NHS system e.g., NHS 111, GP practices.

Increasing referrals to community pharmacy provides increased access for patients to a fuller range of services from their pharmacy. This effort will lead to a continuous rise in referrals, fostering confidence amongst clinicians and the public, leading to further referrals. This will secure associated funding pharmacies are assumed to be receiving from the national contract, enabling community pharmacies to invest in staff recruitment thereby enhancing resilience and financial viability.

However, recruiting pharmacy personnel remains extremely challenging. A new School of Pharmacy in Plymouth opening to students from October 2024 will have a beneficial impact but is reliant on the development of integrated training and development posts to improve recruitment and retention across all sectors of pharmacy. The ICB has recently appointed a pharmacy workforce post to focus on this along with schools' engagement to promote pharmacy as a career.

The challenges facing community pharmacy has and is resulting in closures and reduction in contractual hours, the impact of which is being monitored and reviewed through the Pharmacy Services Regulations Committee (PSRC) and the South-West Primary Care Operational Group (SWPCOG).

The impact of the amended Unplanned Closure Policy will continue to be monitored: there has been a gradual reduction in volume in recent months. The aim of the policy is to ensure consistent access to community pharmacy services for patients, through providers securing cover for shifts in this area. Where this is not possible, the accompanying Guidance, ensures the providers effectively communicates to patients, local partners, and commissioners, to enable effective signposting of patients.
The impact of recent and future pharmacy closures/consolidations/changes to hours has been/is reviewed and where immediate gaps are created, rota proposals (additional commissioned cover) will be considered. Information on changes is also being shared with H&WBs, for consideration of impact on the Pharmaceutical Needs Assessments (PNAs).
Regular review meetings are in place with all corporate/large multiple providers, to understand emerging pressure and respond to escalations.

Therefore, the ICB plan for primary care recovery needs to be in the context of the challenges facing community pharmacy, focusing on improving its resilience and taking opportunities where they exist and evolve to drive up implementation of clinical services through better integrated working.

The ICB plans for primary care recovery therefore focus on working collaboratively with Community Pharmacy Devon (formally known as Local Pharmaceutical Committee) and other system partners to:

- Improve system understanding, confidence and trust in services provided by community pharmacy including with patients, the public, health, social care, and voluntary sector providers.
- Improve access for patients to community pharmacy clinical services e.g., community pharmacist consultation service (CPCS), hypertension case finding service, discharge medicines service through increased referral.
- Reduce risks of harm and readmission at discharge through increasing referrals to the discharge medicines service.
- Build and facilitate working relationships between community pharmacies, GP practices, PCNs and other providers of NHS services to support integrated pathways and synergistic working e.g., flu and covid vaccination.
- Increase uptake of electronic repeat dispensing (eRD) to improve efficiency of prescribing and dispensing processes for medicines within GP practices and community pharmacies, thereby releasing capacity.
- Oversee existing locally commissioned services to ensure strategic fit e.g., Community Pharmacy Minor Ailments Service.
- Ensure local antimicrobial resistance (AMR) processes are reviewed in preparation for the nationally proposed Pharmacy First Common Conditions Service.
- Take opportunities to develop and widen the scope of clinical service provision from community pharmacies e.g., Independent Prescriber Pathfinder Programme.
- Explore opportunities to provide services more efficiently through integrated working thereby releasing capacity to increase integrated working e.g., electronic repeat dispensing releases capacity for GP and community pharmacy contractors.
- Implement pharmacy workforce plan to improve recruitment, retention, and development e.g., Teach and Treat programme focused on training community pharmacists as independent prescribers, cross sector pharmacy roles.
- Explore opportunity for UEC referral to CPCS.

This will provide a firmer foundation to support implementation of the national plans once agreed. Implementation will be prioritised to address inequality.

Initial priorities with timeframes:

Initial Priority	**Timeframe**
Instigate Community Pharmacy Development Group including system partners e.g., Community pharmacy Devon, Public Health, Urgent care	August 2023.
Ensure appropriate representation of community pharmacy within ICB and system infrastructure e.g., Primary Care Collaborative. Quarterly attendance at PCCTC agreed.	December 2023
Develop community pharmacy strategy	July 2023 – May 2024. (Enabling check

utilising similar process as Primary Care (general Practice) Strategy	of alignment against new 5-year community pharmacy contract).
Identify Community Pharmacy PCN leads with protected time to engage with GP practices to improve integrated working and increased access for patients to services	September 2023
Understand integrated working between PCNs and community pharmacies in line with PCN DES. Explore and develop a plan to improve integrated working with community pharmacy including IT systems.	October 2023
Develop community pharmacy / PCN plans	December 2023
Agree Initial Education and Training Standards of Pharmacists reforms (IETP) cross-sector training models ready for submission to Oriel.	November 2023
Establish website and social media to support careers engagement	August 2023
Plan for schools' careers engagement	November 2023
Pharmacy technician pre-registration training (PTPT) bid submission	August 23
Explore the development of a model to map community pharmacy capacity, access and activity that can be used to identify areas of greatest need.	October 2023
Assess impact of pharmacy closures and changes of hours and revision of unplanned closure policy	Ongoing

Implement Modern General Practice	
PCARP Workstream	Transformation
Goal	Delivering CAIPs and transformational support
Narrative	

Capacity and Access Improvement Plans

The ICB will continue to work with and support practices in delivering their CAIPs. The following describes the ongoing support that the ICB is planning to deliver through the next financial year. This is to support the PCNs with the delivery of their CAIP and work towards achievement of the full funding envelope:

- Webinars
- Drops in sessions
- Signposting and facilitating peer to peer support

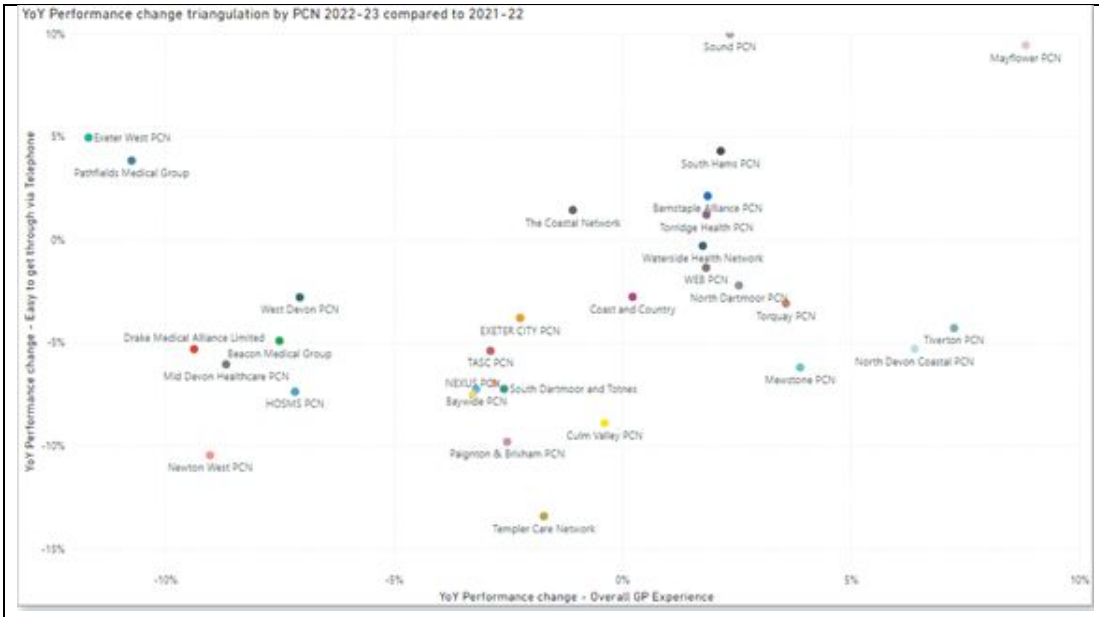
- Signposting to experts (internal stakeholders) for support with specific subject matters (e.g. CBT, workforce, comms)
- Support though Digital Envoys and commissioning of the Digital Journey Planner
- Promotion of national offers

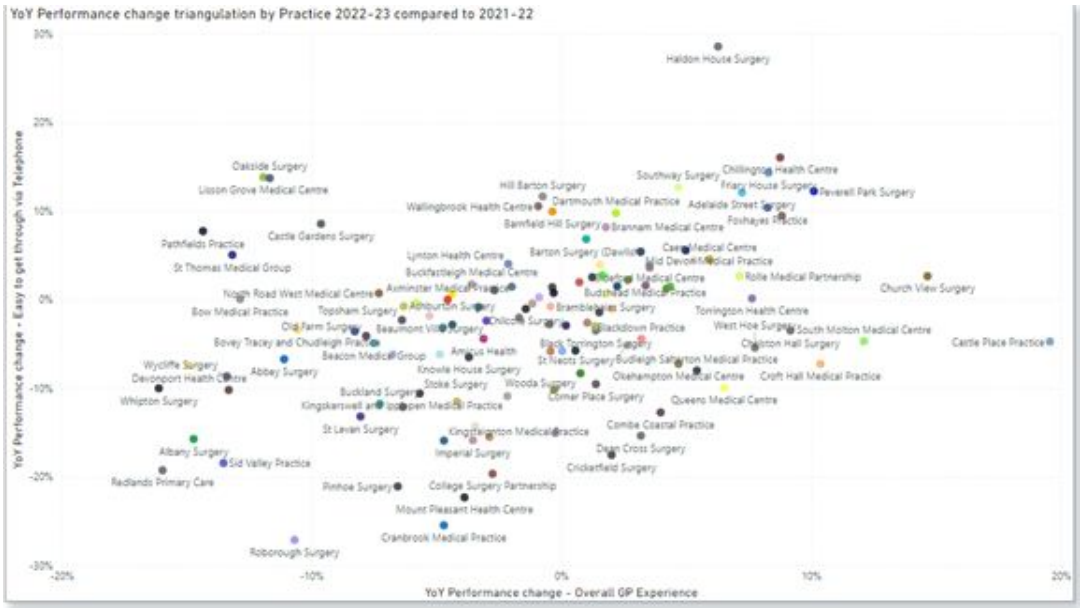
As part of our agreed process for monitoring delivery and achievement of CAIP plans and determining final payments, the ICB will meet with PCNs in October 2023 for a mid-point review before carrying out a round of final review meetings with PCNs in March 2023.

At ICB level, Devon consistently achieves above the national average on all questions highlighted for review, although in common with the national position, achievement has decreased from previous years. Devon also has the second highest number of appointments offered per 10,000 population.

Therefore, for some practices and PCNs in Devon the ICB is content that these aspects of the patient survey require a maintenance approach rather than striving for further improvement. However, we recognise (through our analysis of GPPS, GPAD, 111 data, other quality markers) that there exist pockets of variation in Devon in access to services and for these practices/PCNs more intensive support and focus on improvement is required.

Devon ICB has undertaken analysis of 2022 and 2023 GP Patient Survey results at practice, PCN and locality level, identifying trends and areas of variation. In line with national trends, results indicate a decrease in overall patient satisfaction, though Devon's position is comfortably better than the national average across all measures. As part of the ICB analysis, the ICB Business Intelligence team have looked at where providers experienced the biggest decreases in results in two main areas, ease of telephone access and overall satisfaction, in order to identify pressure points and where challenge is being felt most keenly. This analysis will allow the Primary Care team to target support to providers appropriately to ensure continued provision good access.

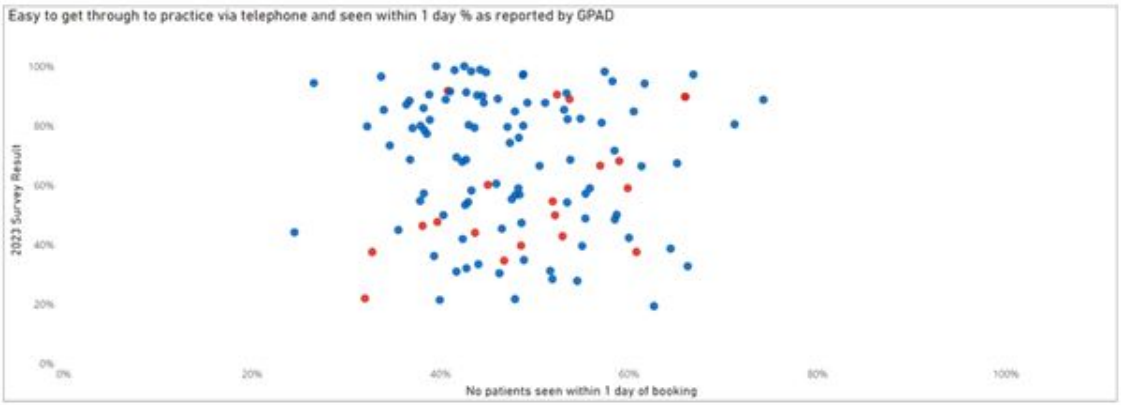




Patient Access and Practice Resilience

With cognisance to the fact that the proportion of practices in Devon identified as having material fragility and / or resilience challenges is circa 5x as great as it was in the pre pandemic period it was felt to be important to test for correlation.

Practice Level – Triangulating Seen within 1 day and telephone access Patient Survey – 'Fragile' Practices highlighted red



This indicates a number of things that are worthy of consideration in the context of supporting improved access to GP teams.

Its immediately clear that there is not a strong correlation between fragility and (same day) access performance as assessed from data driven perspective, though there is some degree of correlation to patient survey outcomes. Therefore, all approaches to upward reduction in access variation should be driven primarily by consideration of a combined access position, and not assumed as being a by-product of tackling practice fragility.

It is probable that some Practices experiencing resilience challenges have been forced to identify and adopt innovative approaches to access to balance capacity and demand as well as is possible. This might provide particularly valuable learning opportunities and the proposed contacts described in the following section might afford the chance to realise this opportunity.

Clearly practice fragility does represent a risk to good patient access in either making it far harder to deliver, and / or increasing the likelihood of not being able to maintain it. There is also the rather more significant risk of unplanned practice collapse which impacts most acutely the registered population, but also that of surrounding practices and other healthcare providers. Therefore, the ICB is committed to, in parallel to this plan, delivering a development programme co-designed with DCB, for established local providers of GP services able to position themselves to be part of a vibrant and appealing offer to those experiencing significant challenges, as well as those proactively considering transition to a different model. This will support a movement back to a more proactive stance towards mitigating resilience challenges rather than reacting to them.

To address the shorter-term challenge, we are in the process of transitioning from an ICB led support programme to one co-designed with DCB and LMC. This will see the LMC take a leadership role, especially in terms of risk identification, which will facilitate the opportunity for earlier intervention and support.

Friends and Family Test

Across Devon only 0.35% of patients completed the Friends and Family Test (FFT)

in Feb 23 (latest figures available). The majority of patients who took the test gave a positive response. On reviewing CAIP plans, it was clear there is variation in approach to, and therefore uptake of, the FFT within PCNs.

The ICB will increase focus on FFT data with a view to incorporate it as a further quality marker in our dashboard (although we need to understand why there is no national data available since February 2023). We will also take a role in promoting best practice in relation to improving uptake, working with our comms leads.

General Practice Access data (GPAD)
Between April 2023 and June 2023 (3-month period) General Practice Access Data (GPAD) indicated 2.8% of appointments were unmapped and 8.8% were classed as inconsistently mapped to the national appointment coding criteria.
The ICB is very keen to support its practices and PCNs to make GPAD data as accurate and consistent as possible. We are looking at “quick wins” guidance to support practices and PCNs.

The ICB BI team has developed a power BI tool for GPAD data that is reviewed monthly. The ICB also put forward a practice representative to support the national GPAD work.

Support Level Framework

The Support level framework (SLF) is a tool that has been developed nationally to support practices in understanding their development needs. ICBs have been asked to enable facilitated SLF conversations to take place in all practices during 2023/24, to help practices to better understand their support needs and improvement priorities.

The Practice SLF should be completed via a facilitated conversation with members of the practice team with honest reflection encouraged. The findings should then be used alongside available data to agree priorities for improvement and development of an action plan. Any practice that participates in one of the national support offers will have the SLF completed as part of the programme.

The ICB is currently considering its approach to the Support Level Framework for remaining practices in conjunction with the Devon Collaborative Board. The tool requires at least one 3-hour conversation with 2 facilitators and as such we need to be assured that the value-added warrants the investment from the ICB and practices.

As part of that consideration, it is recommended that thought is given to identifying those practices whose team and patients are most likely to realise positive benefits, and to prioritise conversations with these practices. This would support the aim of closing inequality gaps and reduce any risk of inadvertently increasing them.

Local Support and Peer to Peer Learning Infrastructure

In March 2023 the ICB employed, via Delt, four Primary Care Digital Envoys. Their principal focus was to work directly with practices in Devon to increase their

knowledge and utilisation of Digital. They were set the following goals to undertake and complete within 22 months:

1. Sign-up 80% of Devon's practices to the enhanced Digital Journey Planner and support them to complete all modules.
2. Build a self-sustaining pan Devon digital transformation peer to peer network with buy in from practices and PCNs that covers all Devon's general practice primary care. This should share learning and best practices both local and national to further digital in the county.
3. Build effective working relationships with PCN and Practice staff
4. Support practices and PCNs to positively transform their digital services to improve their digital maturity (as benchmarked by the DJP) and reduce digital variation in Devon.

This has since been expanded to include a number of additional projects and support for practices with NHS App sign-up, direct booking, electronic patient registration and other closely aligned workstreams.

The projects now being stood-up include:

- A pan Devon Primary Care Digital Library of resources for practices and PCNs
- PCN Digital Strategy and roadmap template
- Support for hard-to-reach practices
- Best practice solutions (Local and National)
- Patient engagement and Digital inequality
- Training

Ensuring uptake of national support offers

The ICB are keen to maximise the opportunity for Devon practices and PCNs to participate in the national support offers. To date, the following practices are participating in the intermediate and intensive support offers respectively.

Intermediate (allocation 7 places)	Intensive (allocation 14 places)
Bideford Medical Centre Knowle House Surgery Wooda Surgery Townsend House Medical Centre, Beacon Medical Group Leatside Surgery	Modbury Health Centre Okehampton Medical Centre Combe Coastal Practice Mount Pleasant Health Centre

There are also 3 PCNs in Devon participating in Cohort 1 of the national PCN Support offer:

- Newton West PCN
- Drake Medical Alliance
- Coast and Country PCN

The ICB will actively signpost practices where there is an indication of additional support need to national offers and ensure it is able to make full use of its allocations.

PCARP Workstream	Digital – Cloud-based Telephony
Goal	Ensure practices and PCNs are utilising cloud-based telephony solutions, supplied by nationally approved providers, with call-back and queuing functionality enabled

Narrative

In Devon:

- 38 out of 120 (32%) practices are on non-cloud-based telephony (CBT) systems (note: these practices have digital telephony systems so are not technically 'analogue')
- 82 out of 120 (68%) practices have CBT

We have received just over a £1million from NHS England to support the move to cloud-based telephony as part of our tranche one submission, however following clarity from the national team, it has become apparent that almost none of our practices meet the criteria, primarily because of local investment decisions made in previous periods. We currently await the second tranche at which point we expect to be able to support many more of the 38/120 practices not currently on cloud systems. The second tranche is due to be released in the next 4 weeks but, currently we don't have clarity on the criteria required to predict the breadth or pace of the help we will be able to provide practices. In the meantime, any practices whose contracts are due to cease or renew in the short term are being directed to the CSU for additional procurement support and to ensure they are adhering to the new framework.

For the practices that offer CBT, the usage of call back function is variable. Whilst there are some practices where call queuing and call back is working well, there are also practices that can evidence that what they have in place is meeting their patients' needs and they do not feel expanding the functionality will complement their current provision.

PCARP Workstream	Digital – Tools and care navigation
Goal	Provide tools and care navigation for Modern General Practice

Narrative

Online consultation, messaging and booking functionality is in place across Devon. Following an ICB procurement the majority of practices in Devon (86%) use accurx and the ICB receives regular data directly from accurx on online consultation rates. In their CAIP's, all PCNs included their online consultation rates but we are undertaking some validation work regarding over what time period the figures have been provided to ensure we are reviewing comparable data.

We have received notification from NHE England regarding the new "Digital Pathway

Framework, which is currently anticipated to provide an additional 92pence per patient for practices to fund “high quality digital tools”. Pre-guidance due to be released in June has been deferred so we do not have sufficient clarity on scope or funding. Until we receive further clarity this is very difficult to develop detailed plans for, though we are of course sketching provisional thoughts to enable us to respond nimbly once clarification is received.

Through its digital envoys and its commissioning of the digital journey planner (DJP) the ICB is supporting practices to look at how they embed digital tools in their modern general practice model, recognising that this needs to meet the needs of the practice population which may vary with demography, and also the need to balance this with patient expectation (and national expectation) for f2f consultation levels. The ICB will look at online consultation rates against age and deprivation markers.

From 13th September there has been an additional requirement introduced into the national PCARP checklist for ICBs to audit practice websites and develop associated improvement plans where required. Prior to this the ICB had initiated its own audit process, and this will be expanded to meet the new requirements under PCARP, utilising the digital envoys as appropriate.

Build Capacity	
PCARP Workstream	Workforce
Goal	to continue to grow the practice team and to retain experienced GPs in general practice and encourage those who have recently left, or taken a short break or time overseas, to return

Narrative

The ICB has in place a workforce strategy that has been published. This was developed in partnership with and formally agreed by all system partners across the ICS area.

Q3 2023 sees the next phase of implementation of the workforce strategy being undertaken. This includes the defining of delivery plans by providers, including primary care, that will support them to build on their workforce to meet the needs of the population. This process will include benchmarking, gap analysis, and action plans to address identified gaps.

In parallel from Q2 into Q3, the ICB Advanced practice and apprenticeship lead is working with PCN’s to review current ARRS usage and deployment and support development plans in this area. This aligns to PCN level work as part of the 2023/4 winter planning cycle to explore how ARRS roles can be optimally used to meet PCN level pressures.

Once plans are formulated a timeline for implementation of any identified change will be completed. Through the thorough work completed on the PCN Estates Toolkit the ICB has quantified the investment required in order to be able to accommodate additional staff now and in the future and consider this a key risk in terms of delivering an expanded workforce.

Devon Training Hub (DTH) are leading on development of system plans to build, develop and strengthen the primary care workforce, this includes (not exhaustive) GP retention schemes and health and wellbeing offers, and the planning cycle is expected to conclude by end of Q3 2023.

DTH have recently concluded reconfiguration work aligned to ICS strategic intentions. This sees the establishment of wholly distinct commissioner and provider entities. This will enhance both the breadth and quality of offer to primary care contractors within Devon.

The ICB have just finalised completion of a gap analysis on the NHS Impact improvement capability and capacity self-assessment. Findings are being processed with the expectation that resulting programmes of work will be initiated from October 23.

Cut Bureaucracy	
PCARP Workstream	Contracting and primary / secondary care interface
Goal	to reduce time spent by practice teams on lower-value administrative work and work generated by issues at the primary-secondary care interface. Practices estimate they spend 10% to 20% of their time on this

Narrative

Prior to the release of the PCARP, Devon ICB was already working with key stakeholders across the system (practices, DCB, LMC, acute MDs) to establish a set of agreed principles relating to transfer of work and the primary/secondary care interface. This work is being led by the ICS Primary Medical Care Director on behalf of the system and requires sign up and commitment to implement from clinical leaders across the system.

These high-level principles will span all four of the areas described in the recovery plan (onward referrals, complete care, call and recall, clear points of contact), and will include:

- Providers should establish single routes for general practice and secondary care teams to communicate rapidly, leaving direct lines and clear times to call
- The use of advice and guidance as an alternative to referral should be considered in all patients unless there is a clear pathway for referral established
- The quality of the referral for advice and guidance should abide by robust governance and the advice include the next steps, help with interpretation of tests or when to refer
- Everything possible should be done to prepare a patient for an initial secondary care appointment including pre-clinic investigations, patient questionnaires, accurate medication histories. Patients can usually help in this process.
- Whoever requests an investigation is responsible for interpreting and communicating the result to the patient

- Incidental findings, if outside of areas of expertise, should be referred on for opinions without referral back to primary care
- Secondary care providers should refer a patient on to another service, if related to the presenting condition, without referral back to the primary care team.
- If a patient has been seen virtually in secondary care and further examination is required to assist the diagnosis, this needs to be done in secondary care, unless here is an exceptional agreement with primary care.
- A clear map and outline of responsibilities is explained to patients to enable them to get appropriate help when needed, including what is going to happen next and how they can help prepare for these steps
- Patients who are under secondary care need a clear route to contact the secondary care team, including with concerns about worsening of their condition

To ensure principles are communicated and embedded across organisations (including all clinicians operating on the ground), and to therefore ensure that the associated benefits are realised in primary and secondary care, a robust implementation plan will be developed, through LCP engagement, that will require sign up from all stakeholders. This will be critically important to mitigating the risk of the policy being formally agreed but expected procedural and behavioural changes not occurring. This implementation plan will need to bridge from board to frontline, ensuring all clinical and administrative teams are aware of it, of their (and others) responsibilities under it, and feel empowered to enact it. Ongoing monitoring of adherence to principles designed to ensure system effectiveness and efficiency as well as clear routes for prompt escalation will also be established.

Communications Strategy

34. NHS Devon has developed a draft communications plan that outlines the activity to be undertaken for each of the areas of focus outlined in PCARP, both locally and nationally, as well as what is already underway. The draft plan sets out how we will improve patient understanding of the new ways of working in general practice and promote access to community pharmacy. The plan includes:

    - How we will align with national campaign activity
    - Development of a local ‘team GP/ARRS’ campaign, in line with what has been successfully employed in Cornwall and other parts of the region. Details are to be confirmed and Devon ICB’s communications team will be linking with colleagues in Cornwall and Devon Training Hub regarding evaluation and refining of existing materials. There is an opportunity to use the national ARRS resources in the interim.
    - Development of a comprehensive communications toolkit to support practice teams (template letters, social messaging etc). The toolkit will reference ARRS roles, care navigation and access routes etc.
    - Close linking with Local Pharmaceutical Committee and pharmacy development group colleagues on pharmacy planned messages and future campaign opportunities.

35. Some communications activity is already underway and will be reviewed and refreshed as part of this plan. This includes promoting community pharmacy services, GP online consultations and the NHS App.

36. The draft communications plan is attached in Appendix 2. An infographic to illustrate the PCARP "inputs" and resulting outcomes can be found in Appendix 3.

Finance Summary

37. A summary of the finance streams relating to PCARP can be found in the table below:

Funding stream	What is it	Value	How are we applying it?
IIF National Capacity and Access Support Payment	Paid to PCNs, proportionally to their Adjusted Population, in 12 equal payments over the 23/24 financial year	an average of: £115k per PCN based on £2.765 per patient £3.6m total for NHS Devon	'unconditional' funding from Network DES
IIF Local Capacity and Access Improvement Payment	Paid to PCNs based on commissioner assessment of a PCN's improvement in three areas over the course of 2023/24	an average of: £50k per PCN based on £1.185 per patient. £1.5m total for NHS Devon	Progress review in October. Final assessment in March 2024. Part of Network DES
Transition Cover and Transformation Support Funding	To support practices to make the change to a modern general practice access model	an average of: £13.5k per practice over two years. £1.8m total allocation for NHS Deon expected (£0.9m per year)	Proposal being discussed with DCB.
Primary Care Service/System Development Funding	Primary Care Service/System Development Funding. Provided to ICBs to deliver transformation and other programmes	Total SDF funding is £3,579k but has to cover the PCN Leadership & Management DES, Flexible staff pools, online consultation systems, digital first primary care, local GP	Proposal being discussed with DCB.

Funding stream	What is it	Value	How are we applying it?
		retention, training hubs, practice resilience and other developmental work in this area, such as supporting the development of provider collaboratives	
Digital telephony	To support transition of practices to CBT systems	£1,026,000 has been awarded to Devon	Unfortunately, only one practice "possibly" meets the NHS England criteria following a further discussion with NHS England. We are awaiting the second tranche of criteria which will hopefully allow us to support more practices.
Online Consultation tools -Digital Pathway Framework lot on DCS product catalogue	Funding of high-quality tools for online consultation, messaging, self-monitoring and appointment booking tools	Allocation of 93p per patient expected into NHS Devon	Awaiting framework publication - we have provided information on our contracted OC/VC systems as these will be funded out of this framework and not separately as has previously been the case.

Trajectories

38. NHS Devon has several access measures included in its strategic metrics which report to PCCTC on a bimonthly basis. These include measures that are deliverables under PCARP:

Pillar	Key Indicator	Metric
Better Access	Patient uptake of Enhanced Access slots	EA available to 100% population
		95% EA slot utilisation
	Access to General Practice	85% of appointments occur within 2 weeks of being booked (note: 85% is being used as we know c.10% of appointments are not sought within a 2-week window, not this excludes booking made on non-working days)
		35% if general practice appointments occur within 1 working day of request (note this excludes bookings made on non-working days)
	Technology enabling access	Number of online/video consultations against target of 650k a year
		75% patients would use online consultation again or recommend to a friend or family
		Enable patients in over 90% practices to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App by March 2024
	Technology enabling access	100% practices offered opportunity to move to digital telephony by July 2023 (note: post July 2023, there will be an uptake target)
		100% practices able to book appointments digitally, or by telephone, or by attending the practice in person
Patient satisfaction with getting access to GP services	Patient overall experience of GP practice (we will maintain our gap to national average and increase performance by at least 2%) (GP Patient Survey)	Patient survey results (2023) show 78.2% patients in Devon describing their experience as “good\” against the national average of 72% for the same measure.
	Patient overall ease of getting through to GP Practice on the phone (we will maintain our gap to national average and increase performance by at least 2%) (GP Patient Survey)	Patient survey results (2023) show 58.9% patients in Devon found it “easy” to get through to someone at their GP practice on the phone, compared to the national average of 50%.

Pillar	Key Indicator	Metric
	Patient perception of their needs being met (we will maintain our gap to national average and increase performance by at least 1%) (GP Patient Survey July 2022)	Patient survey results (2023) show 93.7% patients in Devon felt that their needs were met at their last general practice appointment, compared to the national average of 91% national average. .
Workforce	General Practice able to offer improved multi-disciplinary care through employment of additional ARRS roles	Devon PCNs to recruit 710 WTE roles across Devon by the end of March 2024
		All Devon PCNs at 16 WTE ARRS roles by March 2024
		Utilise the ARRS scheme with target of 90% take-up of new ARRS roles by March 2024
Pharmacy	Recover pharmacy activity	100% community pharmacies able to supply prescription-only medicines for seven common conditions by end December 2023

39. It is important to recognise the current challenges being faced across our primary care providers, with increasing numbers of practices requiring resilience support and demonstrating increasing levels of fragility. As discussed earlier, there is a challenge here in continually driving practices towards access improvement targets where, in doing so, there is an increased risk of destabilising practices by taking their focus from ensuring essential services are in place without risk of collapse ("hitting the target but missing the point"). For this reason, Devon ICB has not set individual practice trajectories, rather the focus will be on practices/PCN engagement with the ICB around PCARP and best endeavours to deliver improvement relative to the different starting points practices will have.

40. Additional monitoring and evaluation of PCARP will require additional primary care business intelligence resource.

Health Inequalities

41. As referenced throughout this document, NHS Devon is cognisant of the variation in access to GP services across Devon and is committed to working with practice and patient groups to ensure support is targeted to those areas in most need.

42. As the front door to healthcare, Primary Care, including General Practice, should be welcoming and accessible to all. Examples of our priorities include (but are not limited to):

- Ensuring availability of translation services, including non-spoken interpretation
- Ensuring cultural and patient centred awareness of our staff e.g. – cultural awareness training, Pride in Practice, and Veteran Friendly accreditation
- Being outward looking and fully inclusive of all its staff, patients, and communities

43. Implementation of this plan will improve access for same day care which has the dual benefit of allowing General Practice to focus increased time resource on providing the other aspects of care that their patient population needs.

44. As practices increasing move to modern general practice offers it is important to ensure that inequalities are not extenuated through (for example) digital exclusion. We need to collectively support patients with digital access, training, access to tools and skills, and acknowledge that for, some patients and patient cohorts, traditional approaches will remain their preference. Some practices already have great examples of in-house training that they offer to patients in using online consultations, working with voluntary sector organisations, and we need to further develop skills, knowledge and the patient facing offer across Devon.

Opportunities, Challenges and Risks

45. PCARP presents both opportunities and challenges across the Devon system as described in the table below:

Area and Focus	Challenges	Opportunities
Empower Patients • Improving information and NHS App functionality • Increasing self-directed care where clinically appropriate • Expanding community pharmacy services	• Self-referral – variation in pathways across Devon • Variation in community pharmacy capacity	• Will lead to more consistent offers across Devon and enabling clinical staff to spend more time working close to top of licence • Improved relationships and integration of GP practices with community pharmacy
Modern General Practice • Implementing 'Modern General Practice Access' • Better digital (cloud based) telephony • Faster navigation, assessment and response	• GP access in Devon already compares highly to national position therefore for some areas further improvement is more challenging • Devon already has 67 practices on cloud-based systems. However, not all with meet the new level of functionality required and it is not clear if there is national funding to support this (note: Devon has 0 practices on analogue systems)	• To identify areas of variation to enable targeted support to most challenged practices to better meet patient need • NHS Devon has already commissioned the Digital Journey Planner and put Digital Envoys in place to support practices in this work • By March 2025 all practices will have had the opportunity to move to cloud-based (subject to national programme funding)
Build Capacity • Larger multidisciplinary teams • More new doctors • Retention and return of experienced GPs • Higher priority for primary care in housing developments	• In ensuring PCNs fully utilise ARRS budgets there are significant challenges relating to accommodation in practice buildings and funding of IT equipment	• Using PCN Estates plans (est. summer 2023) to take forward GP estate modernisation (within system capital envelope) • Continued expansion of PCN ARRS roles. Devon has 539 WTE ARRS roles as of June 2023, expecting to achieve 710 WTE by March 2024 (assuming 24/25 GP contract maintains current or comparable PCN ARRS model)
Cut Bureaucracy • Improving the primary – secondary care interface • Building on the 'Bureaucracy Busting Concordat'	• Primary and secondary care interface is an area of particular focus, especially in Plymouth	• With system support for implementation of interface policy estimated 8-10% GP team capacity could be released by March 2024.

46. A risk log is maintained, and mitigations monitored as part of the PCARP Oversight Group. Main areas of risk relate to:

    - Capacity (practices and NHS Devon) to deliver given current pressures.
    - Communications budget limitations affecting reach of some campaign elements.
    - Cloud-based telephony requirements are dependent on Primary Care providers procuring themselves, within timescales.
    - Identification of leads for self-referral elements.
    - Physical space in GP practice building to accommodate additional ARRS roles

Conclusion

47. Within Devon there continues, at least on a comparative basis to be much to be proud of as regards access to GP services, such as:

    - The Devon system continues to at or close to the top of the ranking as regards raw supply per 100,000 registered population.
    - Most recent data shows 115 or 120 practices achieving the target for proportion of patients seen within 1 working day of need being identified
    - 2023 patient survey data shows Devon remains ahead of the national average for all indicators, though with declining performance compared to previous years and pre-pandemic period.

48. There can though be no room for complacency. The pandemic has changed the landscape, and we must endeavour to ensure practice capacity keeps pace with demand.

49. We know that despite generally comparatively good access to GP services in Devon, there exists unacceptable degrees of variation that need to be understood and addressed. As well as significant challenge in terms of practice fragility where action is needed to stabilise both in the short and longer terms.

50. We know that we need to shift an increased share of investment into out of hospital care settings and are committed to doing so in parallel to delivering this plan.

51. This plan can we believe, in line with the Fuller Stocktake, improve access in ways that improve both patient and GP team experience, with the greatest gains being in those communities that need them the most. And in doing so, set firm foundations on which we can deliver the broader ambitions of Fuller.

Appendices

- Appendix 1 – PCARP Checklist
- Appendix 2 – PCARP draft communications plan
- Appendix 3 – PCARP infographic

Classification: Official

Delivery Plan for Recovering Access to Primary Care (link):

Updated summary of support offer for practices and PCNs through NHS England and ICBs, and checklists of actions

Updates to the summary of support offer include:

- Revised timescales for Digital Pathway Framework
- Link added for transition cover and transformation support funding guidance
- Additional information provided on Digital and transformation lead training

	Detail	Date
	Commitment: Modern General Practice Access	
1	**Financial and procurement support** to any practice that indicates to its ICB that it wants to move from analogue to **digital telephony** The Better Purchasing Framework is live with qualifying suppliers	Final date 1 July 2023
2	**Funding of high-quality tools** for online consultation, messaging, self-monitoring and appointment booking tools Online consultation tool pre-guidance published by June (complete). Digital Pathway Framework lot on Digital Services for Integrated Care (DSIC) Summer – Autumn 2023 and fully launched in December 2023 with supplier contracts awarded	All products funded by new framework due by December 2023

	Detail	Date
3	The National General Practice Improvement Programme (GPIP) provides nationally funded tailored support through 23/24 and 24/25 to practices and PCNs to help them implement modern general practice and realise the biggest benefits in the shortest timeframe. It includes four elements: • **Universal support:** 'how to' guides, webinars and online support sessions available to all practices and PCNs • **Intermediate support for practices and PCNs:** three months of hands-on facilitated support for practices; and six months of hands-on facilitated support for PCNs • **Intensive support for practices:** six months of hands-on facilitated support • **Capability building:** provides individuals in practices and PCNs with practical development programmes that will increase their core skills and understanding of QI tools and techniques and managing change as well as support ICB to establish or further develop local communities of practices to enable peer to peer learning See here for further information	ICBs to nominate practices and PCNs likely to benefit from intensive and intermediate support offers (up to 1550 practices for 23/24 and up to 1650 practices for 24/25)
4	**Transition cover and transformation support funding** where practices/PCNs are transitioning to Modern General Practice Access Model and require additional support (e.g. extra practice shifts, locums, or peer support) utilise an average of £13.5k per qualifying practice of flexible funding through capacity fund reimbursements Available through 2023/24 and 2024/25 See published guidance on transition cover and transformation support funding	Agree with ICB as required through 23/24 and 24/25 utilising recovery planning process
5	**Care navigation training:** every practice can nominate to their ICB one member of staff to undertake training, which commenced on 10th July **Digital and transformation lead training:** designed to equip individuals in the Digital and Transformation Lead ARRS role with the core skills to be able to lead transformational change. Every PCN can nominate one lead to undertake training – see here for further information	Nominated through 23/24 and 24/25

	Detail	Date
6	**Repurposed £246 million of IIF** to support improving access and provide capacity for transformation: • Reduced IIF indicators from 36 to 5, releasing staff capacity • ~£172.2 million to be unconditional 'Capacity and Access Support Payment' paid monthly from April (~£11.5k/month/average PCN[1]) • Up to ~£73.8 million to be 'Local Capacity and Access Improvement Payment' (CAIP) awarded based on commissioner assessment of improvement in access performance, specifically patient experience of contact, ease of access and demand management, and accuracy of reporting in appointment books (paid no later than 31 August 2024) Guidance released 30 March 2023	Ongoing in 2023/24
7	**Increase in ARRS flexibility and ARRS numbers** • Increase ARRS funding by £385 million • Increase flexibility by including apprentice physician associates and advanced clinical practitioner nurses Guidance and calculator available	Ongoing in 2023/24
8	**Communication materials** available for all practices to support patients to understand digital access to practice, NHS App for repeat prescriptions, multidisciplinary general practice teams and wider care available (Pharmacy & 111) There are also other materials that practices may find useful (Enhanced access, Looking after you coaching, and staff respect)	Ongoing in 2023/24

[1] Funding is additional to Core PCN funding, the Clinical Director Payment and the PCN Leadership, Management Payment, and ARRS funding

Checklist of key practice/PCN actions[2]

Updates to key practice/PCN actions include:

- Action 9 – now references guidance shared with regions
- Action 10 – link included for draft GPAD guidance which is undergoing testing with practices
- Action 12 – clarifies digital telephony functionality
- Action 13 – clarifies timescale for ICBs to identify digital tools
- Action 14 – updated to reference importance of maximising digital tools already available and in use
- Action 18 – now references a system-wide approach to improving the primary-secondary care interface and reminds practices to share examples of bureaucracy

	Action for practices / PCNs	Measure – how will this be assured by ICBs?	Time due
	Commitment: Empowering patients		
	Practices/PCN have enabled all four NHS App functions for patients		
1	Apply system changes or manually update patient settings to provide prospective record access to all patients. See regulation, support, guidance and checklist	POMI (% of practices that have enabled prospective records, repeat prescriptions, secure messaging, and managing	By 31 Oct 2023
2	Ensure directly bookable appointments are available online following bookable online appointment guidance		By 31 July 2023
3	Offer secure NHS App messaging to patients where practices have the technology to do so in place		Ongoing

[2] Where possible Primary Care Networks should leverage scale and act together (eg in procurement of digital tools and telephony, and in developing recovery plans), but there will be variation, and some actions will happen at the practice level.

	Action for practices / PCNs	Measure – how will this be assured by ICBs?	Time due
4	Encourage patients to order repeat medications via app supported by comms toolkit	appointments) multiplied by % of population with app	Ongoing
	Practices enable self-directed care		
5	Use messaging software to support patients to communicate with practice including for self-monitoring (where not in place see 12 below)	ICB assessment	Ongoing
	Commitment: Modern General Practice Access		
	Complete IIF CAIP baselining and recovery planning		
6	Complete prework and fill in template (Annex B IIF CAIP guidance) to baseline existing position	Submit to ICB for sign off	Agreed and submitted by 30 June 2023
7	Confirm to ICB request to move from analogue to digital telephony	Submit to ICB for sign off	By 1 July 2023
8	Confirm requested support offers to ICB (including care navigator / digital and transformation lead training, GPIP transformation support, capacity backfill support (for transition cover and transformation support funding), higher quality online consultation tool, etc)	Submit to ICB for sign off	By 15 July 2023

	Action for practices / PCNs	Measure – how will this be assured by ICBs?	Time due
9	Complete PCN/practice access improvement plan[3] with committed offers Guidance shared with regional leads	Submit to ICB for sign off	By 31 July 2023
10	Sign self-certification of accurate recording of all appointments and compliance with GPAD guidance (17 appointment categories guidance, which categories are same day guidance, which categories are two-week guidance) Additional simplification and unified draft guidance published on FutureNHS	Assessment by ICB of correct use of categories or improvement	Sign self-cert and be assessed by 31 March 2024
11	Make improvements identified in practice/PCN access improvement plan (related to actions 6, 7, 8, and 9) and report to ICBs	Assessment by ICB using relevant measures identified during pre-work	By 31 March 2024
	Digital tools and implementation (including telephony, online consultation and messaging tools)		
12	If already on digital telephony, ensure call-back functionality and queuing is enabled, where the functionality is included in the current contract costs	Assessment by ICB of improvement from April 2024 achieve IIF CAIP	By 31 July 2023 and assessment from April 2024
13	Work with ICB to identify digital tools to procure in preparation for framework launch. Further purchasing guidance to be developed through procurement exercise Implement tools once acquired		Identify tools by 30 November 2023

[3] As specified in Network Contract DES IIF Capacity and Access improvement payment guidance. The plan should also cover all the items in this practice/PCN action checklist

	Action for practices / PCNs	Measure – how will this be assured by ICBs?	Time due
14	Use website guidance to update and ensure improved user experience with online tools correctly displayed and ensure that online tools already available to the practice/ PCN are maximised		Ongoing in 2023/24 and 2024/25
	Care navigation and alternative pathways for patients to use		
15	Training all practices in the PCN to understand and use local DoS including self-referral, community pharmacy and other services	Local recording of completion of training	By 31 March 2024
	Commitment: Capacity		
	ARRS planned recruitment		
16	Submit ARRS and workforce plan to ICB (Contract specification p40 & p19 DES guidance)	Data automatically collected via NWRS	By 31 August 2023
	Recruitment and retention offer		
17	Review and take up local offers for retention, see System Development Funding (SDF) guidance for 2023/24.	Money/offers awarded to practices/PCNs	Ongoing
	Commitment: Reducing bureaucracy		

	Action for practices / PCNs	Measure – how will this be assured by ICBs?	Time due
18	Opportunity to feed back to ICB on progress against primary and secondary care interface difficulties, ensuring a system-wide approach – AoRMC report. Practices are reminded of the request in the recovery plan to share examples of burdensome bureaucracy in general practice they would like to reduce, or contact the DHSC using the online form link in PCARP	ICB public board report	Ongoing

Checklist of key ICB actions

Updates to ICB actions include:

- Action 1 – reference to all 7 self-referral routes and clarification that expanding direct access is an action in operational planning guidance
- Action 2 – reference to ICBs supporting expansion of community pharmacy services included
- Action 3 – updated timescales and purpose for using the commercial hub
- Action 4 – updated acronym on framework, revised date due, clarified procurement approach
- Action 5 – updated to clarify action for ICBs in nominating practices for the GPIP and associated timescales
- Action 6 – added ‘at least’ 850 practices
- Action 7 – includes link to transition funding guidance and reference to ICBs maximising use of funding
- Action 8 – includes link to QI capability improvement training
- Action 11 – references guidance shared with regions
- Action 14 – includes link to published briefing note
- Action 16 – additional action for ICB Chief Medical Officers
- Action 17 – includes reference to a system-wide approach for improving the primary-secondary interface
- Action 18 – additional action to encourage sign up to ‘Register with a GP service’

	Action for ICBs	Reporting	Time due
	Commitment: Empowering patients		
1	**Expand self-referral routes** (falls services, musculoskeletal services, audiology for older people including **loss** of hearing aid provision, weight management services, community podiatry, and wheelchair and community equipment services) as set out in 2023/24 operational planning guidance. ICBs should also note operational planning action to expand direct access where GP involvement is not clinically necessary.	Report progress into public Oct/Nov 2023 board and public Apr/May 2024 board	By 30 September 2023
2	**Support the expansion of community pharmacy services** (including the oral contraception and blood pressure services) and coordinate local communications		Ongoing
	Commitment: Modern General Practice Access		
3	**Sign up practices ready to move from analogue to digital telephony**, and co-ordinate access to specialist procurement support through NHS England's commercial hub to achieve and track the transition of the majority of practices from analogue to CBT by 31/12/23 and the remainder by 31/03/24 Determine whether ICB wants to follow scale approach to telephony (see Leeds case study on p23 in Delivery Plan for Recovering Access to Primary Care) Use peer networks and demonstrations with practices/Practice Participation Groups/PCNs to help practices and PCNs identify and adopt digital telephony		By 1 July 2023 for sign up Ongoing for co-ordination
4	• Select digital tools from the Digital Pathway Framework lot on **Digital Services Integrated Care (DSIC) product catalogue** • Determine at what scale the procurement approach would align with local need • Use peer networks, user research and demonstrations with practices/Practice Participation Groups/PCNs to help practices and PCNs identify and adopt the most usable software		Framework due to be available by December 2023

	Action for ICBs	Reporting	Time due
5	**Nominate practices and PCNs for national intensive and intermediate transformation support** and encourage uptake and participation in GPIP hands-on support. Prioritise support to practices working in the most challenging circumstances such as areas of high deprivation and need, rurality etc. Practices will need to have data from their telephony system to participate in the support programme. See here for further information. Nominate further practices as they implement digital telephony ICBs to nominate up to 1550 practices for 23/24 and up to 1650 practices for 24/25 through NHS England phases – forthcoming phases Phase C Intensive by September and Phase D Intermediate by November. ICBs should work with regions to determine population appropriate share of nominations which map to local need. **Use the Support Level Framework during 23/24** to understand need. **ICBs to establish and/or build on current local peer to peer learning infrastructure** to develop local communities of practice to support shared learning and data driven improvement which includes enabling Modern General Practice **ICBs to put in place a strategy for auditing usability and accessibility of all general practice websites** using the GP website benchmark and improve tool. All GP websites to be audited in 23/24 and an improvement plan agreed		ICBs to collectively nominate 1550 practices by December 2023

	Action for ICBs	Reporting	Time due
6	**Fund or provide local hands-on support to at least 850 practices nationally (ICBs should work with regions to determine population appropriate share of target).** We would expect the level of support to be similar to the national GPIP intermediate offer, and offered alongside wider and/or ongoing support for practices and PCNs where required to implement Modern General Practice, using the outputs of the SLF to help guide specific support needs		31 March 2024
7	Agree and **distribute transition cover and transformation support funding** (an average of £13.5k / qualifying practice) to support practice teams seeking to implement Modern General Practice See published guidance on transition cover and transformation support funding		Maximise use of ICB allocations for 23/24 and 24/25
8	Encourage uptake and co-ordinate nominations and allocations to **care navigator training, and digital and transformation PCN leads training and QI capability improvement training** – see here for further information ICBs should work with regions to determine population appropriate share of nominations		50% of 2023/24 nominations by 31 July 2023
9	**Understand and sign off PCN/practice capacity and access IIF CAIP baseline** using guidance and Annex B template		By 30 June 2023
10	**Agree with practice/PCN support needs** (digital telephony, online tools, training, capacity backfill, intensive support, etc) Support practice/ PCN to secure and put support needs into place		By 15 July 2023 Ongoing

	Action for ICBs	Reporting	Time due
11	**Co-develop and sign off PCN/practice access improvement plans[4] -** guidance shared with regions in June Oversee and support Practices/ PCNs in implementation of access improvement plans		By 31 July 2023 Ongoing
12	**Assess improvement and pay 30% CAP IIF funding at the end of year** using progress against baseline and access improvement plans, as well as improvement activity across all three areas over the year as per template in guidance & further guidance to be issued by 30 June		Instruct PCSE by 6 August 2024 To be paid by 31 August 2024
13	**Set up process for practices to inform of diversion to 111** and monitor exceptional use when over capacity		Ongoing 2023/24
14	**Develop system level access improvement plans** which include summary of practice/PCN improvement plans, challenges, wider support needs and barriers and ICB actions (including leading local improvement communities, leveraging and promoting universal support offer, and improving the quality of core digital patient journeys for patients and staff and usability of practice websites supported by the national website audit tool). Briefing note published on 31 July to support development of system-wide plans and submission to public boards		By October /November board 2023
	Commitment: Capacity		

[4] As specified in Network Contract DES IIF Capacity and Access improvement payment guidance. Plan should also cover all the items in this practice/PCN checklist

	Action for ICBs	Reporting	Time due
15	Support **PCNs to use their full ARRS**[5] budget and report accurate complement of staff using NWRS portal		Ongoing 2023/24
	Commitment: Reducing bureaucracy		
16	ICB Chief Medical Officers to establish the local mechanism, which will allow both general practice and consultant led teams to: • raise local issues to improve the primary- secondary interface • jointly prioritise working with LMCs • tackle the high priority issues including those in the AoMRC report, and • address the four priorities in the Recovery Plan		By October /November 2023
17	Report in public board updates and plans for **improving the primary–secondary care interface** (four focus areas highlighted in the recovery plan) ensuring a system-wide approach to actions		By October /November board 2023
18	Support practices to sign up to our Register with a GP surgery service, either on an individual practice basis or via bulk ICB enrolment and track uptake of the service using regional and ICB data		By December 2023
	Commitment: Enablers		
19	**Co-ordinate system comms to** support patient understanding of the new ways of working in general practice including digital access, multidisciplinary teams and wider care available. This messaging should include system specific services and DoS (Directory of local services)		Ongoing 2023/24

[5] The ARRS scheme is highlighted in The Primary Care Access Recovery Plan. The action is therefore included here, even though it is an ongoing action for ICBs.

	Action for ICBs	Reporting	Time due
20	**Maintain an up-to-date DoS** and deliver training to all practices/PCNs on DoS		Ongoing 2023/24

Primary Care Access Recovery Plan (PCARP)

Communications plan

One Devon

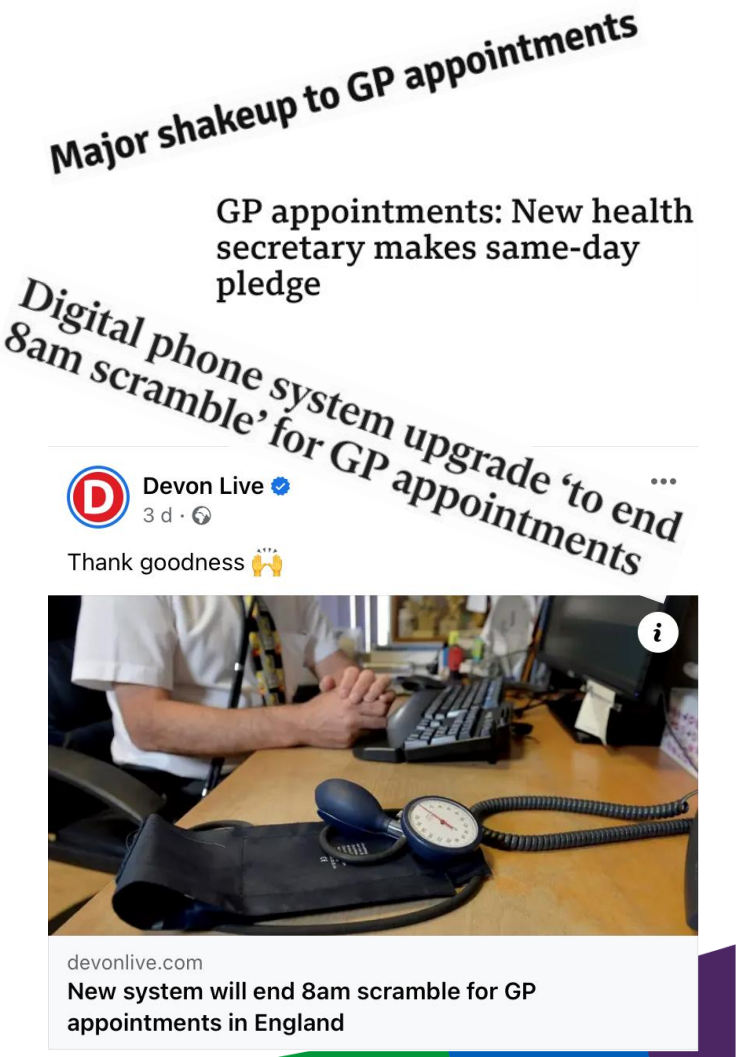
Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Context

- The Autumn Statement committed the NHS to publish a recovery plan for primary care.
- The plan focusses and prioritises the first element of the Fuller stocktake - recovering access and supports two key ambitions:

1. **To tackle the 8am rush and reduce the number of people struggling to contact their practice**. No longer will patients be asked to call back another day to book an appointment.

2. **For patients to know on the day they contact their practice how their request will be managed.**
   1. If their request is **clinically urgent it will be assessed on the same day** by call or face to face appointment, or if raised in the afternoon, on the next day if this is clinically appropriate.
   2. **If not urgent yet they need a call or appointment, it will be scheduled within two weeks**. For some routine follow up requests a longer timeframe may be clinically appropriate.
   3. In addition, where appropriate, requests will be signposted to self-care or other local services (e.g. community pharmacy or self-referral services).



Communications objectives

Continue to improve public confidence and satisfaction with general practice

Build on behaviour change campaigns to influence public behaviour in accessing general practice and community pharmacy services

Further develop messages to public and staff on how the NHS is transforming general practice and community pharmacy to better meet the needs of local communities

Refine the support to staff working in general practice and community pharmacy to deliver transformation and access improvements

National campaign

The delivery plan commits to a national campaign to increase public understanding of the changes to primary care services, the benefits they bring, and how and what services they can access.

1. Digital access

- GP digital access phase of the 'Help Us, Help You' campaign to increase uptake of the digital route for accessing general practice services.

2. Wider practice team

- PR activity to generate content and consumer media coverage to increase patients' knowledge and confidence in the triage process and the wider multi-disciplinary team of clinicians that are available in general practice.

3. Wider care available

- NHS 111 phase of the 'Help Us, Help You' campaign phases to increase the number of people with a perceived urgent care need to access the NHS 111 service so that they can be triaged and directed to the most appropriate local service.
- National campaign to support the Community Pharmacy *New Common Conditions Service* – subject to funding.

Local communications approach

We welcome the Government's focus and support in developing aspects of primary care that will enable us to build on a lot of the work our practices and teams have already been doing.

For many practices, campaigns promoting digital tools, care navigation, and community pharmacy, have been in place for many years, so this is an opportunity for more refined messaging that is supported by national activity.

- NHS Devon will collaborate with regional and national teams on national GP access communications campaign, which includes marketing activity and communications for the commitments set out in the plan - local, regional and national
- Build on the Devon system communications plan to further support patient understanding of the new ways of working in general practice
- Use national campaign materials in local channels
- Continue to implement existing local campaigns e.g. online consultations and NHS App, but refine them further as part of the plan.
- Identify further areas for opportunity and share best practice across the ICB region e.g. adapt Cornwall ARRS campaign.
- Working closely with the Local Pharmaceutical Committee and pharmacy development group on CPCS planned messages and future campaign opportunities

Audiences

- Patients over 65 – over 70% live with one or more long term conditions (or over 55 for people living in areas of high deprivation)
- Patients aged 55 – 75 susceptible to musculoskeletal, audiology or podiatry difficulties that will benefit from self-referral/pharmacy blood pressure check services
- Stakeholders: professional and patient representative groups
- MPs
- NHS: experienced GPs to benefit from NHS pension reforms; practice managers and reception teams; community pharmacists
- Public: age 18+, with particular focus on lower socio-economic groups (C2DE), and ethnic groups
- NHS: all other staff working in general practice and community pharmacy
- Community and voluntary networks: this sector can help build understanding, confidence and trust within their communities

Key messages

Primary Messages

- When you request help from your GP practice, whether that's online, phone or in person, we will ask you some questions about your condition so that you can be directed to the right health professional.
- Staff in your practice reception team are specially trained to know about the services available to you at your GP practice and in your area. The information you provide to them enables them to assess your needs and ensure you get the right kind of care from the right health professional, no matter how you got in touch.
- Sometimes a GP is not the most appropriate health professional for a patient's health needs and by assessing you when you contact us, we can get you the right care you need more quickly.
- Health professionals have been recruited to work alongside GPs at your local practice to help you get the right care
- Depending on your needs, you may be seen by another health professional at your GP practice rather than a GP .

Supporting Messages

- Your general practice team is here to help you. A range of health professionals work at your practice and in the wider community (such as community pharmacy) to help you get the right care when you need it.
- The NHS has made changes to the way you access help and receive the care you need from your GP practice to improve your experience.
- Services in general practice and the community have been changing to make it easier for you to access a wider range of help from your GP practice, closer to home, by phone or online. This is part of the NHS plan to offer people further choice and more joined-up health.
- No matter how you access help from your practice, you will get the care you need from the right health professional.
- Having a range of health professionals at your general practice and community pharmacy helps you to receive the right care quickly.

Overview

1. **Self-referrals** – expand self-referral pathways. Public comms campaign - identify case studies / promote how patients can access these pathways locally.
2. **Community pharmacy** – new common conditions service and expansion of blood pressure and oral contraception service. Build on existing campaigns for public comms campaign.
3. **Transformation** – new General Practice Improvement Programme to support implementation of the new Modern General Practice Access model, including care navigation training. Staff comms campaign – tiered support focused on helping practices improve patient experience of access and support workforce / case studies of practices. Refine a public comms campaign - role of care navigation / navigators in reception team, what they do and why
4. **Contracting** – cutting bureaucracy, engaging on 2024/25 GP contract and improving collection of data for GPAD. Staff comms campaign - sharing case studies e.g. from Academy of Medical Royal Colleges (AoMRC) report to reduce unnecessary workload in both settings
5. **Digital** – support implementation of Modern General Practice Access by improving IT systems between GP and community pharmacy, shift practices on analogue to digital telephony and support and fund digital tools for online, assessment and messaging. Public comms campaign – further develop existing campaigns to demonstrate improvements in experience of access. Staff comms: flag support offers and case studies to show how other practices have changed their approach.
6. **Workforce** – ARRS and GP recruitment/retention. Public comms campaign – build on national campaign activity to build confidence and understanding in ARRS roles. Staff-facing – retain GPs/existing workforce e.g. via coaching
7. **CVD regional campaign** – regional and local targeted campaign approach currently in development, encouraging people to get a blood pressure check and raise awareness of risks of developing cardiovascular disease (CVD)
8. **Learning disability and severe mental illness annual health checks** – local campaign plan developing

Empower patients

- Improving information and NHS App functionality
- Increasing self-directed care where clinically appropriate
- Expanding community pharmacy services

Key actions

- Extend existing NHS App campaign using national materials so patients know they can see their records and practice messages, book appointments and order repeat prescriptions
- Further develop plans to promote self-referral pathways
- Work with pharmacies on awareness campaign for expanded pharmacy oral contraception (OC) and blood pressure (BP) services
- Build on existing pharmacy campaigns to promote Pharmacy First - community pharmacies can supply prescription only medicines for seven common conditions – this, together with OC and BP expansion could save 10mil appointments in general practice a year

Modern general practice

- Implementing ‘Modern General Practice Access’
- Better digital telephony
- Faster navigation, assessment and response

Key actions

- Refine communications toolkit to support practice teams (template letters, social messaging etc) – references ARRS roles and routes to access
- Continue to support patients with using digital tools with useful guides, short videos and guidance and build on existing campaigns
- Continue to work with voluntary sector on digital inclusivity action plans and implementation
- Supporting primary care pressures - linking with the national ‘three ways to access general practice’ messaging


‘I imagine how I would feel as the patient’

Cassie Daughtry, 32, is a specialist medical receptionist at The Vine Medical Centre in Maidstone, Kent

Cassie Daughtry was initially attracted to a career in healthcare because she wanted the opportunity to help people – something her current role provides in spades. As a specialist medical receptionist trained in care navigation, Daughtry is part of a team that makes sure patients get the best care, and it's a role that demands sensitivity and excellent listening skills.

"We're providing answers for people and making sure we're directing them to the right health professional," she says.

Confidentiality is vital, Daughtry adds, as is making patients aware that, as a receptionist, she is not making any clinical decisions.

"We have a big team here and get them involved whenever they are needed. We are always able to refer back to the daily duty doctor with any questions."

Care navigation was introduced to her role in 2018. Following special training, Daughtry was able to ask patients more detailed questions, empowering her to direct them to the most appropriate care based on the patient's clinical needs or personal preference.

In short, her role is to make sure that the patient sees the right health professional as quickly as possible. She embraced the training as a very natural next step to the experience she'd already gained. "Many people think GP practices started care navigation as a direct result of the Covid-19 pandemic, but the NHS is constantly developing," she says. "Care navigation was already part of the service for us."

The sensitivity of her job is something of which she's clearly very aware, and it's something she can relate to personally. "I'm conscious that I'm often the first person someone will speak to in the surgery," she says. "And I think about how I'd feel as a patient myself. I wouldn't like to take up an urgent appointment if I didn't need it, but I find it reassuring that my own surgery can refer me directly to a physio in the practice. I feel it offers better options for care."

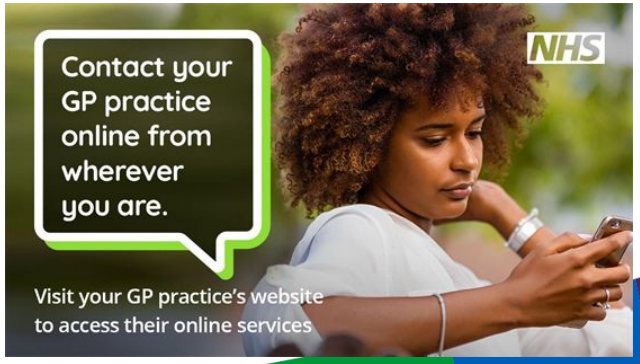
Daughtry follows guidelines developed by the GPs to assess patient requests. She says patients are highly receptive to care navigation becoming part of a GP practice's receptionist's role. It offers the opportunity for specialist receptionists to relay questions and symptoms to the duty doctor, and then report back to the patient.

"Patients realise just how many health professionals we have in the practice and how quickly we can refer them," Daughtry says. "I want to ensure their query is dealt with as quickly as possible by the right person, which may not always be the GP." For non-urgent queries, the service is fully replicated online, where patients can get a response from a professional.

While the pandemic had an effect on health services it also shone a spotlight on GP surgery provision, allowing them to utilise different skills. For patients unsure of the medical provisions available at their local GP surgery, Daughtry is always happy to share knowledge. For example, health professionals on-site could include a clinical pharmacist, advanced nurse practitioners, paramedics, physiotherapists, pharmacy technicians, podiatrists, mental health professionals and health and wellbeing coordinators. There is also a range of external services to which staff can navigate patients.

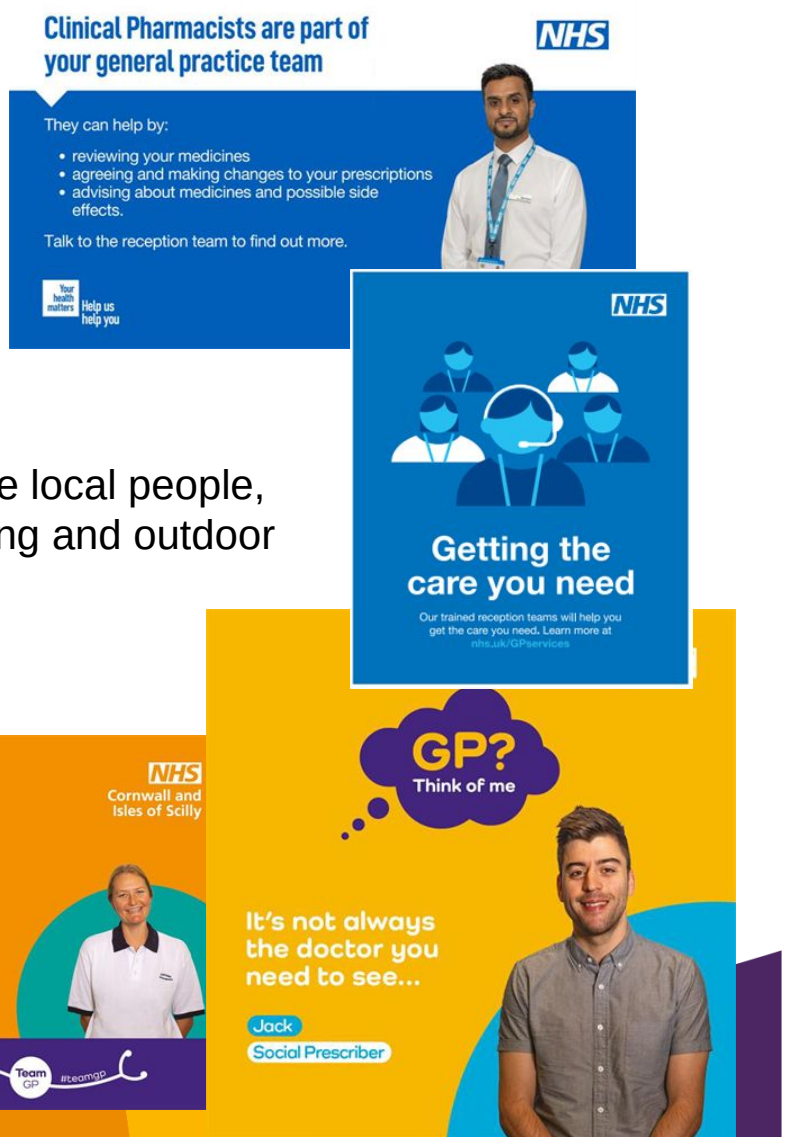
"The aim is for patients and staff to work together to ensure a service where the patient is seen by the right person, as soon as possible. The service is constantly improving and care facilitation plays a big part in this."

> I want to ensure a patient's query is dealt with as quickly as possible by the right person, which may not always be the GP



Build capacity

- Larger multidisciplinary teams
- More new doctors
- Retention and return of experienced GPs
- Higher priority for primary care in housing developments



Key actions

- Build on existing ARRS campaign to expand materials to feature local people, with promotion in general practice, social media, digital marketing and outdoor adverts (bus stops, posters, digital screens, etc.)
- Develop case study videos and promote on social media:
  - First contact physio
  - Community paramedic
  - Clinical pharmacist
  - Leg ulcer clinic nurse
  - Asthma clinic nurse
  - Care navigators

Planned activity

Public-facing

- Build public confidence in and understanding of the three routes to accessing general practice, including highlighting those practices that have transitioned to using new digital telephone and/or online systems to manage requests for care, and how this has improved patient experience of access. Promote the use of the Inclusive Routes to Access toolkit and assets to practices to do this.
- Build public confidence and trust in the wider multidisciplinary team by sharing case studies of people working in ARRS roles and showing how these health professionals provide care for patients. Use the ARRS poster campaign to do this.
- Show examples of how patients can do more to manage their health, such as use of the NHS App for repeat prescriptions and access to health records, or people using self-referral pathways for Musculo-skeletal problems, podiatry and audiology.

Planned activity

NHS staff

- Share local case studies of practices who have already adopted digital telephone systems and improved patient experience of access as a result. Promote to practices still using analogue lines how they can access funding to buy digital telephony
- Promote the AoMRC's General Practice and Secondary Care: Working Better Together report, in particular the recommendations and case studies, to help teams reduce unnecessary workload and bureaucracy, and improve the interface
- Share local case studies of practices that have already introduced care navigators to improve the patient contact and access experience process. Show how staff can access free care navigation training and transformation support via the new National General Practice Improvement Programme

Supporting patients and staff to understand new ways of working in general practice

- Ensuring staff are kept up to date via regular GP bulletin and webinar – supporting practices and PCNs with use of social media, patient engagement, campaigns etc.
- Supporting PCNs with the message around the shift to digital and what this means to patients. NHS Devon has commissioned the Digital Journey Planner and put Digital Envoys in place to support practices in this work
- Continue to work closely with practice digital champions and envoys
- Developing a communications toolkit to support practice teams
- Further develop collaboration with PCNs and practices to actively promote the good work that is happening in primary care. Regular press coverage on range of topics i.e. benefits social prescribing, expanded roles and services, trans-friendly practices
- PCN ARRS events are sharing best practice re integrating ARRS roles into PCN teams

Co-production with patients and local communities

- Working with the Devon Collaborative Board and Local Medical Committee - ensuring that GPs have a voice in our messaging to patients
- Working with Local Pharmaceutical Committee and pharmacy development group – involving pharmacists
- Working with Healthwatch (represented on NHS Devon Primary Care Commissioning Committee)
- Working with allied health professionals to develop ARRS case studies
- Involving patient participation groups and Healthwatch Assist Network
- Working with local health inequalities networks
- Utilising GP Patient Survey results
- Support equality, diversity, and inclusion throughout planned communications activity

NHS Devon

For further information, contact keri.ross@nhs.net
Senior communications manager, NHS Devon

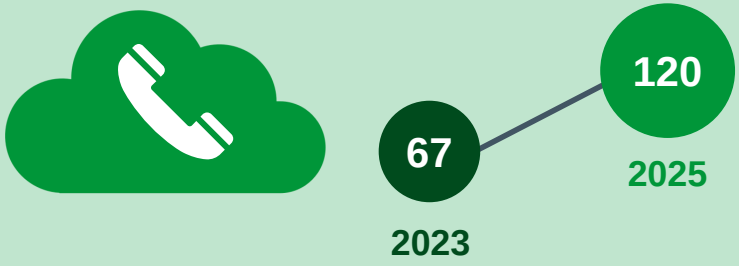
One Devon

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

Deliverables and process

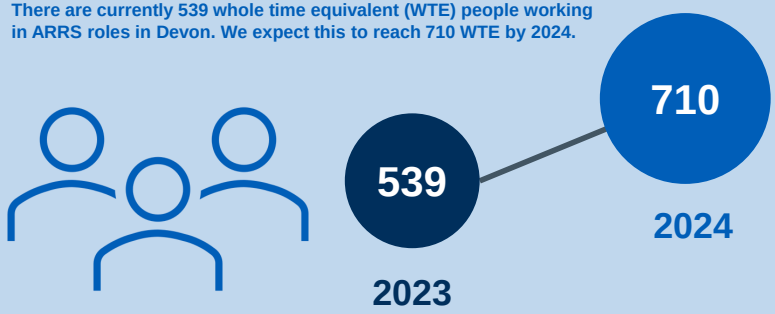
Practices with cloud-based telephony

There are 67 practices using cloud-based telephony.
We anticipate that all practices will have moved to this technology by 2025.



Number of additional roles (ARRS)

There are currently 539 whole time equivalent (WTE) people working in ARRS roles in Devon. We expect this to reach 710 WTE by 2024.



Primary and secondary interface

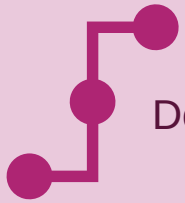
We have developed a set of principles for primary and secondary care to follow and we expect GP capacity to be released as a result.

8-10%

of GP capacity released

GP at-scale development

Developing local providers who have an appetite to deliver primary care services at a larger scale.



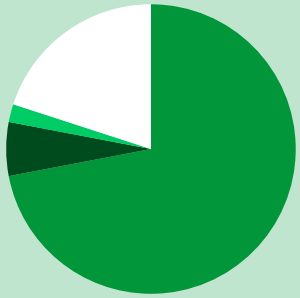
Delivered: by Q2 2024

Developed: by Q3 2023

Patient experience and outcomes

Overall satisfaction with GP practice

GP Patient Survey



National average: 72%

Current position (2023): 78%

Target 2024: 80%

Ease of access to the practice

National average: 50%

Current position (2023): 59%

Target 2024: 61%

Patient needs met within one working day

115 practices

2023

120 practices

Q4 2024 Target

Current number of practices meeting the target

Fragile practices

The number of practices we consider to be at risk with resilience (e.g. partnership resilience, staffing, buildings)

21

2023

11

Q3 24/25

4

Q4 25/26

Patient seen within two-weeks

60% Target

40 practices below target (2023)

120 practices above target by Q3 2024

Primary Care Access Recovery Plan (PCARP)

System Level Access Improvement Plan

NHS Devon Integrated Care Board- 4 October 2023

One Devon

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

Key ambitions of PCARP

1. **To make it easier for patients to contact their practice and;**
2. **For patients requests to be managed on the same day, whether that is an urgent appointment, a non-urgent appointment within 2 weeks or signposting to another service**

PCARP is split into 4 areas:

Area	Focus
Empower Patients	• improving information and **NHS App** functionality • increasing self-directed care where clinically appropriate • increasing the number of **self-referral** options, guided by clinical advice • expanding **community pharmacy** services
Modern General Practice	• better digital **(cloud based)** telephony • simpler **online consultation**, booking and messaging • faster navigation, assessment and response.
Build Capacity	• larger **multidisciplinary** teams • more new doctors • **retention and return** of experienced GPs • higher priority for primary care in housing developments
Cut Bureaucracy	• improving the **primary-secondary care interface** • building on the Bureaucracy Busting Concordat

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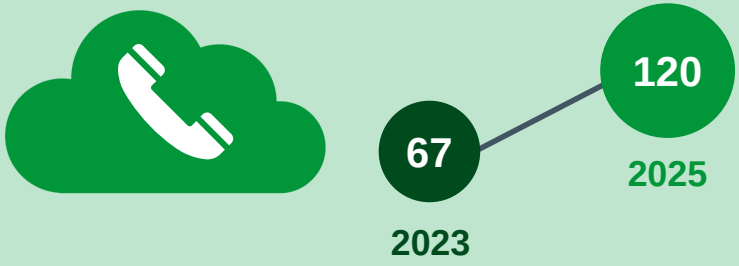

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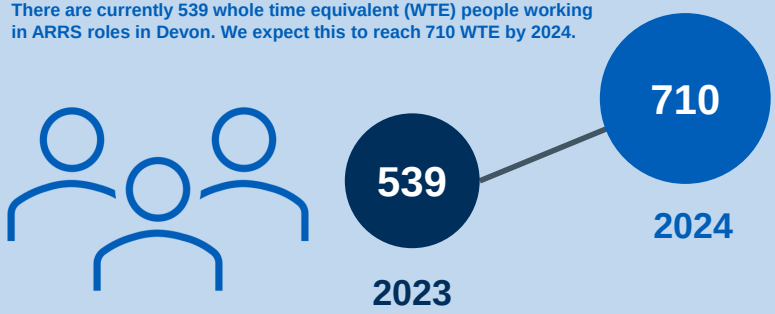

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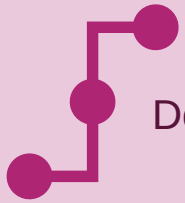

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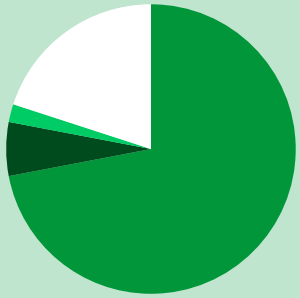

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40 practices below target (2023)

120 practices above target by Q3 2024

Primary Care Collaborative

- Past 12 months we have been working with Devon (GP) Collaborative Board (DCB) and LMC to design and develop a General Practice Provider Collaborative for Devon
- This is through development of the established DCB who are committed to progressing as a formal collaborative Board, in line with the Devon Operating Model
- ICB resource has been made available to support the enabling of strategic legacy through development of governance, leadership structure, clarity of function and appropriate form. This includes:
  - ICB commissioning of co-designed Primary Care Leadership Development programme, part of which has been tailored to specifically develop and strengthen the Provider Collaborative over the next 12 months, including focus on succession planning and enabling
  - Funding a DCB appointed Programme Director to accelerate the development journey
- DCB is increasingly taking a lead in design and deliver agenda, most recently on Primary Care (General Practice) winter planning, by making a consistent offer across Devon to proactively identify those most at risk of hospital admission and to work as an integrated MDT to avoid this (subject to funding approval)

NHS Devon Integrated Care Board

Committee Chair's Report - Primary Care Commissioning Transitional Committee

Date of board meeting	Dates of committees covered in this report
13 July 2023	29 June and 13 July 2023

Chair	
Name and title:	Judy Hargadon Independent Non-Executive Member for Primary Care

BAF updates or escalation

- None

Risk register review updates/escalation

- The meeting was updated on the corporate **risk review** and decided to note and observe the new risk 176 (There is a risk that the system will be unable to reduce the community waiting list size) but to request clarity about the appropriateness of its place with PCCTC.
- Chair of PCCTC shared concerns regarding some corporate risks not being held by appropriate committees.

Integrated Quality, Performance and Finance Report (please provide summary of discussion for Board assurance)

- The committee reviewed the **Quality and Performance** report and were updated on several areas of concern which are being monitored, supported,

and progressed including: Information on quality reporting arrangements for the newly delegated Pharmaceutical, optical and dental services and the system for supporting and correcting the situation when a complaint is made about a GP practice.

- The meeting was updated on the **Finance Report** as at the end of June 2023 and noted a quiet month with overall financial position reporting as breakeven both at the year the end of month 2 and forecast for the year. Funding arrangements of the newly delegated optical services were explained to the PCCTC.

- Extracts from the **IQPR report** that are relevant to PC were attached to the PC Metrics update. The committee noted good progress in some areas, but that in others it was hard to develop appropriate easy to use measures. Workload since POD delegation makes it hard to find time to develop these.

Reports received, discussed, and noted

- The committee was briefed on the **Optical Services Strategic position** to date and had a discussion on differences in optometry commissioning across the county and ways that optometry could ease pressures on other areas of the health system. Optical Services matters will be regularly on the agenda.

- The **Deputy Director's Report** highlighted updates on Local Medical Committee negotiations, sub-committee activities, joint working with Cornwall initiatives, list closures in 2 general practices, work with asylum seekers and refugees, an optometry pilot regarding electronic referrals and the primary care access recovery plan.

- **The NHSE Optometry, Dental & Pharmacy Monthly Report** was reviewed, and a few trends and regulation changes were pointed out to the meeting**.** This report is to be reviewed by the commissioning hub team to become more operationally focussed for the next meeting**.**

- The Committee received an update on the **Devon Collaborative Provider** meetings where there is positive news on their reformatting to become the Provider Collaborative for general practice, an offer of leadership development, proactive Winter planning initiatives and continued work on a primary/ Secondary Care interface agreement.

- A **Contracting assurance** paper was reviewed and highlighted:
  - The good news of a new Special Allocation Service provider being commissioned and beginning its service on the 1st August
  - A mid-Devon practice requiring to temporarily reduce hours in one of its branches as 2 newly doctors are not able to join the practice until the autumn

- The final **Internal audit management review** was noted as all necessary action were in hand.

- The committee received an update on **PCN** (Primary Care Network) **development,** hearing of the progress made in practices working together in networks and the challenges and opportunities in collaborative working for future focus.

- **Disposal of ward accommodation** at one of the former small South Devon Hospitals – the meeting was informed of the progress in change of usage of this space, the options, and possibilities, in a paper which is being taken to the finance committee for decision.

Committee decisions

- **Updated PCCTC Terms of Reference** (attached) were considered and are now recommended to the Board for approval.

- **Estates Toolkit Prioritisation** process was brought to the committee for review of the process so far and for approval of the prioritisation criteria for estates funding bids. **The meeting endorsed the prioritisation criteria**

- **2 Primary Care & General Practice resilience proposals** were brought to the meeting to be discussed. The ideas for supporting the evolution of the provider collaborative as an effective leadership body and voice for general practice in the system and for the support of general practice resilience initiatives are being jointly developed by ICB, Provider Collaborative and Local medical council workforce**. PCCTC agreed to support the use** of some funding on the two proposals and endorse the direction of travel

- **NB At a previous special meeting, the PCCTC approved putting the Mayflower PC services out to tender.**

Escalation to the Board – for information

- None

Escalation to the Board – for action

- PCCTC requests the Board's approval to move inappropriate risks.

Recommendations for the board

- That the updated Terms of Reference for the Committee, as attached, are approved.

Recommendations for other committees

- There should be a discussion about where risks are overseen.

Terms of reference or other committee effectiveness issues

- PCCTC formally reviewed its Terms of Reference and these are now recommended o the Board for approval.
- PCCTC Chair presented the committee annual review recommendations and the meeting discussed actions to be taken regarding them. Including adding a ‘feedback from the board’ agenda item, a trialling of an end of meeting effectiveness feedback slot, a tougher stance on late papers and agenda setting based on priorities where capacity is stretched.

Management of conflict of interests:

Conflicts of interests are recorded on the register of interests. At each committee, a list of recorded declarations is provided. New declarations must be raised, recorded and included in the minutes of the meeting and notified to the Governance team via d-icb.governance@nhs.net to update the central register.

Devon Integrated Care Board

Primary Care Commissioning Transition Committee

1. Constitutional Purpose

1.1. The Primary Care Commissioning Transition Committee (the Committee) is established by the NHS Devon Integrated Care Board (ICB) as a committee of the Board in accordance with its Constitution, Standing Orders and Scheme of Reservation and Delegation.

1.2. The Committee will function as a corporate decision-making body for the management of the delegated primary care commissioning functions and the exercise of the delegated powers. It will support the transition of primary care commissioning to operate in the same way as other commissioning in NHS Devon.

1.3. These terms of reference set out the membership, remit, responsibilities, and reporting arrangements of the Committee and may only be changed with the approval of the ICB Board. The Committee has no executive powers, other than those specifically delegated to it under the Scheme of Reservation and Delegation and delegated statutory powers as specified in these terms of reference.

2. Statutory and Delegated Powers

2.1. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to Devon Integrated Care Board (ICB).

2.2. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the Board (NHS England) and the ICB.

2.3. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the ICB acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

a) Management of conflicts of interest (section 14O);
b) Duty to promote the NHS Constitution (section 14P)
c) Duty to exercise its functions effectively, efficiently, and economically (section 14Q).
d) Duty as to improvement in quality of services (section 14R).
e) Duty in relation to quality of primary medical services (section 14S).
f) Duties as to reducing inequalities (section 14T).
g) Duty to promote the involvement of each patient (section 14U).
h) Duty as to patient choice (section 14V).
i) Duty as to promoting integration (section 14Z1).

Version: 1.0	Date Approved: 01 July 2022	Author: xxx
Date:	Approved by: ICB Board	
Date of Review:		
Pathname:		

j) Public involvement and consultation (section 14Z2).

2.4. The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

2.5. The Committee is authorised to determine matters within its remit where those matters involve expenditure up to the limit delegated to the Accountable Officer under the Scheme of Delegation, relating to expenditure within the NHS. Where the expenditure involved exceeds these sums the Committee is authorised to make representations to the ICB in respect of those matters. For the avoidance of doubt, in the event of any conflict between the terms of the Delegation and Terms of Reference and the Standing Orders of Standing Financial Instructions of any of the members, the Delegation will prevail.

2.6. The ICB has delegated the following authorities to the Committee:

For Primary Medical, Primary Ophthalmic, Primary Dental Services

a) The basis of NHS England's general rule for ICB responsibility will continue to be in relation to GP registration to ensure operational continuity. At a minimum, ICB must be identified as responsible for:
   - everyone who is provided with NHS primary medical services; and
   - everyone who is usually a resident in England and living in the geography of the ICB, even if they are not provided with NHS primary medical services.

b) ICB will have regard to NHS England guidance on the discharge of their functions. ICB and NHS England to make arrangements for the provision of primary **ophthalmic** services. NHS Act 2006 Section 116A Schedule 3(1), para 30

c) ICB must publish information about such matters as may be prescribed in relation to primary **ophthalmic** services. NHS Act 2006 Section 116B Schedule 3(1), para 30

d) ICB must exercise its powers so as to secure the provision of **primary medical services**. NHS Act 2006 Section 82B Schedule 3(1), para 3

e) ICB may make arrangements for the provision of **primary dental services**. NHS Act 2006 Section 99A Schedule 3(1), para 15

f) ICB and NHS England must publish information about such matters as may be prescribed in relation to the **primary dental services**. NHS Act 2006 Section 99B Schedule 3(1), para 15

g) ICB must publish information about such matters as may be prescribed in relation to Local **Pharmaceutical services**. NHS Act 2006 Section 144 schedule 12

h) ICB may make arrangements for the provision of **Local Pharmaceutical services**. NHS Act 2006 Section 144 schedule 12

3. Purpose and Responsibilities

Purpose

3.1. The Committee will support the ICB in delivering its statutory functions and strategic objectives by providing oversight and assurance, and where appropriate take decisions, on the following: -

a) Ensure a comprehensive primary medical care service is planned, commissioned, and delivered, based on needs assessment and in the context of the Joint Forward Plan.
b) Undertake reviews of primary care services in Devon including regular review of the challenges to effective delivery of primary care services to ensure a focus on the needs of Devon residents and to remove blocks to effective delivery
c) Oversight, and decision making where needed, of commissioning of primary care medical services including oversight of the implementation of the primary care strategic framework and work plan.
d) Oversight and assurance of commissioning of primary pharmaceutical, optical, and dental services through the regionwide joint commissioning hub.
e) Oversight of the budget for commissioning of delegated primary care services in Devon
f) Assurance of a successful transition for the commissioning of primary dental, community pharmacy, and optical services from NHSEI.
g) Assurance of a successful transition of all delegated primary care commissioning into overall ICB commissioning activity.

Delegated responsibilities

3.2. Specifically, decisions and functions delegated by the Board to the ICB Primary Care Commissioning Transition Committee are: -

a) Oversee transition of all types of primary care commissioning, including dental (and prescribed dental), ophthalmic and pharmaceutical (and local pharmaceutical) services, such that is integrated with other ICB systems and processes
b) Primary Care commissioning expenditure: All services, including business cases; final service specifications; procurement recommendations; contract award (CARRs) to be approved by Primary Care Commissioning Transition Committee in accordance with Standing Financial Instructions and Operational Scheme of Delegation.
c) Decisions in relation to the commissioning, procurement, management, planning (including carrying out needs assessments), and undertaking reviews, of Primary Medical Services, including dental (and prescribed dental), ophthalmic and pharmaceutical (and local pharmaceutical) services, and other ancillary activities that are necessary to exercise the delegated functions
d) Co-ordinating a common approach to the commissioning and delivery of Primary Medical Services, including dental (and prescribed dental), ophthalmic and pharmaceutical (and local pharmaceutical) services, with other health and social care bodies

e) Design and commission Enhanced Services, including re-commissioning of services (in line with the ICB Standing Financial Instructions)
f) Design and offer Local Enhanced Incentive Schemes for Primary Medical Services providers including those for dental (and prescribed dental), ophthalmic and pharmaceutical (and local pharmaceutical) services
g) Make decisions on discretionary payments or support in accordance with Standing Financial Instructions and Operational Scheme of Delegation.
h) Approve Primary Medical Services provider mergers and closures
i) Make decisions in relation to the management of Poorly Performing Medical Services Providers
j) Make decisions in relation to the Premises Costs Directions Function
k) Prepare a Primary Care Strategic framework and make recommendation to the Board for approval.

3.3. **Other Responsibilities (in order to achieve 3.1 and 3.2).**

a) Monitor primary care patient safety, clinical effectiveness, and patient experiences, using the primary care quality assessment framework; work with ICB Quality and Patient Experience sub-committee to do this.
b) Support the executive staff in working with the region-wide Commissioning Hub for primary pharmaceutical, dental, and optical services. The Chair should represent the ICB as needed in discussions with regional staff about delegated commissioning.
c) Review when ICB's decision making processes mature to offer opportunities for integration of primary care commissioning oversight.
d) Seek assurance that primary care issues are well understood and considered within the ICB's decision-making mechanisms, including localities and provider collaboratives.
e) Advise on decisions on investment in the infrastructure of primary medical services, to ensure adequate and high-quality provision as well as value for money for the public.
f) Provide oversight across a number of functions, including but not limited to: Primary Care Workforce; Primary Care Premises; Primary Care Information Management and Technology (IM&T); Primary Care Networks
g) Escalate issues to the Devon ICB which need further discussion or decision making.

Matters relating to the Primary Care Senior Leadership Team

3.4. The Committee will be supported by the ICB executive team, and in particular the Primary Care Senior Leadership Team, (PCSLT) and its specialised sub-groups to fulfil its responsibilities.

3.5. In addition, the Committee will oversee the decision making it has delegated to the Primary Care Senior Leadership Team (PCSLT). Decisions which set new precedents or veer from the strategic framework are referred to the full committee.

3.6. The PCSLT reviews operational contractual issues impacting on primary care delivery working within approved frameworks and decision-making authority from the PCCTC. This includes operational decisions pertaining to the Devon ICS primary medical care commissioning budget and making strategic recommendations to PCCTC. Decisions and information from PCSLT will be relayed to PCCTC in the Deputy Director's report. **Matters covered by PCSLT** include:

- Decisions in relation to the commissioning, procurement and management of GMS, PMS and APMS contract including:
  a. the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breach / remedial notices, and removing a contract)
  b. Newly designed enhanced services ("Local Enhanced Services" and "Directed Enhanced Services")
  c. Local incentive schemes as an alternative to the national Quality Outcomes Framework (QOF) (including the design of such schemes)
  d. Discretionary' payments (e.g., returner/retainer schemes)
  e. Commissioning urgent care for out of area registered patients.

- Planning the primary medical services provider landscape in Devon, including considering and taking decisions in relation to:
  a. The establishment of new GP practices (including branch surgeries) in the area, and the closure of GP Practices
  b. Approving practice mergers
  c. Managing GP practices providing inadequate standards of patient care, ensuring patients receive appropriate care
  d. The procurement of new Primary Medical Services Contracts
  e. Dispersing the lists of GP practices
  f. Agreeing variations to the boundaries of GP practices
  g. Co-ordinating and carrying out the process of list cleansing in relation to GP practices.

- Decisions in relation to the management of poorly performing GP Practices including, without limitation, decisions, and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list).

- Decisions in relation to the pharma Directions Functions.

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4. Membership and Attendance

4.1. The Committee shall consist of voting membership of:

- ICB Independent Non-Executive Member for Primary Care (Chair)
- ICB Independent Non- Executive Member for Citizen and Community Engagement (Vice Chair)
- Primary Care Partner Member on ICB Board
- Director with responsibility for Primary Care
- Chief Finance Officer or nominated deputy
- Chief Medical Officer
- Chief Nursing Officer or nominated deputy
- Deputy Director of Out of Hospital Directorate with responsibility for Primary Care
- Clinical Strategic Lead for Primary Care
- One Public Health Representative (nominated by the three Directors of PH in Devon)
- Representative of LCP senior management

In Attendance

- Staff from ICB executive teams, especially primary care, quality, finance, communications and contracting at all meetings; and IT and estates as needed
- Devon Local Medical Committee representative
- Devon Healthwatch representative
- Provider Collaborative Representative (ideally a practice manager)
- Liaison Officer nominated by NHSE/I SW Regional Head of Primary Care, until delegation complete
- Chair/CEO of Local Dental, Pharmaceutical, and Optical Committees when POD services are a meeting focus.
- Partner representatives (sector / collaborative/ clinical) may be invited to attend as required.
- Additional ICB officers may request or be requested to attend the meeting when matters concerning their responsibilities are to be discussed or they are presenting a paper, and particularly, when the committee is discussing areas of risk or operation that are the responsibility of that attendee.
- Any member of the ICB Board can be in attendance subject to agreement with the Committee Chair.

4.2. The Chair and Vice Chair of the Committee shall be ICB Board Independent Non-Executive Members

4.3. With the permission of the Chair, members of the committee may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf. INEMs can ask a colleague INEM to deputise for them if needed.

5. Arrangements for the conduct of meetings and Quoracy

5.1. The meetings will be run by the Chair. In the event of the Chair of the committee being unable to attend all or part of the meeting, the Vice-Chair shall chair the meeting.

5.2. The meetings will be held in private due to the frequent discussion of 'commercial in confidence' matters. Members of the Committee shall respect confidentiality.

5.3. For meetings to be quorate, a minimum of 50% of members is required, including the Chair or Vice-Chair and the ICB Director of Primary Care (or nominated representative).

5.4. For 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.

5.5. Members of the Committee may participate in meetings by telephone, video or by other electronic means. Participation by any of these means shall be deemed to constitute presence in person at the meeting. Members are normally expected to attend at least 75% of meetings during the year.

5.6. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence, and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

5.7. In line with the ICB's Standing Orders, it is expected that decisions will be reached by consensus. Should this not be possible, each voting member of the Committee will have one vote, the process for which is set out below:

a) All members of the committee (or nominated deputies) who are present at the meeting will be eligible to cast one vote each. (For the sake of clarity, members of the committee are set out at paragraph 4.1; attendees and observers do not have voting rights.)
b) Absent members may not vote by proxy. Absence is defined as not being present at the time of the vote, but this does not preclude anyone attending by teleconference or other virtual mechanism from exercising their right to vote if eligible to do so.
c) A resolution will be passed if more votes are cast for the resolution than against it.
d) 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.
e) Should a vote be taken, the outcome of the vote, and any dissenting views, must be recorded in the minutes of the meeting.
f) The Committee will usually meet monthly. For urgent decisions, the Chair may call a meeting at a notice of 2 days, setting out the reason for the urgency and the decision to be taken.

5.8. The committee has agreed that in the interest of expediency, or when there are few items to be discussed, that business of the committee can be conducted by e-mail and the actions/decision will be recorded by the Secretary for purposes of transparency and recording. Where a discussion is required, all members must respond, and the administrator will oversee this to ensure that all members are accounted for.

5.9. All members will have due regard to and operate within the Constitution of the ICB, standing orders, standing financial instructions and other financial procedures.

5.10. Members must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity.

5.11. Members of the Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct.

5.12. The Committee shall agree an Annual Work Plan with the ICB Board.

5.13. The Committee shall undertake an annual self-assessment of its own performance against the annual plan, membership and terms of reference.

5.14. Any resulting changes to the terms of reference shall be submitted for approval by the ICB Board.

6. Register of Interests

6.1. The Register of Interests will be reviewed at each Committee meeting.

6.2. Members will be asked by the Chair of the Committee to declare any interests at the beginning of each meeting. If a member of the committee feels compromised by any agenda item, they should declare a conflict of interest. The Chair will determine whether it is appropriate for the member to stay for the discussion, in line with the guidance on managing conflicts of interest, as set out in the ICB's Standards of Business Conduct Policy.

7. Reporting Arrangements

7.1. The Committee Chair shall report formally to the ICB on its proceedings after each meeting on all matters within its duties and responsibilities. The report shall be presented to the public meeting of the ICB. When appropriate, a report may be made to the meeting of the ICB in private. The Committee shall make recommendations to the ICB on any area within its remit where action or improvement is needed.

7.2. The Committee shall provide the minutes of its meetings to the ICB Board in private.

7.3. The Committee will receive reports relevant to its responsibilities from any sub-group or working group as appropriate.

7.4. The Committee will exchange information with other committees within the organisation as relevant to those committees and will work in conjunction with appropriate committees for decisions which are shared.

8. Administration

8.1. The Committee and its sub-groups shall be supported administratively by its Administrator. Their duties in this respect will include:

- Agreement of agendas with the Chair and attendees
- Preparation, collation, and circulation of papers in good time
- Taking the minutes and helping the Chair to prepare reports to the ICB
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments
- Ensuring that action points are taken forward between meetings
- Providing appropriate support to the Chairperson and Committee Members

8.2. Following each meeting, the Administrator will:

- Maintain an attendance log and follow up as appropriate after each meeting to ensure the Committee adheres to the required frequency of attendance by Members.
- Maintain a log of summary written reports provided to ICB from formal meetings.

9. Review

9.1. The Committee will review its effectiveness at least annually.

9.2. These Terms of Reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of references will be submitted to the Board for approval.

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NHS Devon

NHS Devon Integrated Care Board

Committee Chair's Report - Primary Care Commissioning Transitional Committee (public report from private meeting)

Date of board meeting	Dates of committee covered in this report
4 October 2023	14 September 2023

Chair	
Name and title:	Judy Hargadon, Non-Executive Member for Primary Care

BAF updates or escalation

- None

Risk register review updates/escalation

- The meeting was updated on the **corporate risk review** including assigned **Board Assurance Framework** risks.

Integrated Quality, Performance and Finance Report (please provide summary of discussion for Board assurance)

- The **Quality and performance** report was noted.
- The **General practice framework strategic metrics** update report was noted.
- The meeting was updated on the **Finance Report** as at the end of August 2023 including information on the services for which NHS Devon has delegated commissioning responsibility as well as services that are

commissioned using core NHS Devon resources or that are funded via Service Development Funding (SDF) allocations.
It was noted that Primary Care Networks have done particularly well in using the maximum amount of available additional roles reimbursement scheme (ARSS) monies.

Reports received, discussed, and noted

- The committee was briefed on the **Community Pharmaceutical Services Strategic position** to date through a slide presentation including areas of good news, key challenges, impact of developments within contracting, governance, and key priorities in the short to medium term. The meeting discussed the interface between general practice and community pharmacy, ways of engaging the population with fully using their pharmacies, and problems due to closing of pharmacy branch sites and shortening service hours. Pharmaceutical Services matters will be regularly on the agenda.

- The **Deputy Director's Report** was noted.

- The **NHSE Optometry, Dental & Pharmacy Monthly Report** was noted.

- A **Contracting assurance** paper was reviewed and highlighted the commencement in contract of the new Special Allocation Service provider – making a positive start.

- The **Primary Care Access Recovery Plan (PCARP) (including the Devon ICB System-level access improvement plan)** was presented and discussed. This is an important piece of integrated work which will see Devon's already high standard (2nd in England) of patient access continue to improve with areas of variation or less resilience being supported during the process.

- The almost final version of the **Primary and Secondary care interface** agreement was presented and discussed. It was agreed that this is an excellent document which has required commitment from acute trusts and primary care alike. It now needs a collective effort to finalise and implement at all levels so that it can improve patient experience and use of staff time. This discussion also included a report from PenRAD with information on imaging result reporting from acute trusts to general practice. PCCTC offered to support PC involvement in this important are of wwork

- **Estates Toolkit Prioritisation** decisions funding bids were discussed and noted by the committee. This list, based on a PCN and practice based inclusive approach, and considered by LCPs gives a robust base for future capital allocations.

Committee decisions

- A paper on **Cranbrook Garden Village Development** was presented to the committee. **PCCTC agreed** that the paper proceed to finance committee with its support in principle but noting that a shared health care facility will require funding from more than just primary care and that the financial arrangements will require review in the future.

- A paper of **homelessness healthcare provision**- options and recommendations for service provision were presented. After discussion the **PCCTC decided to support the recommendation to go out to tender.** PCCTC noted that we consider part of this provision is a specialist service, this part may require funding from outside primary care budget in the future.

Escalation to the Board – for information

- The Board are asked to note how important it is that there is more clarity at the interfaces between primary care and secondary care. Much time and resource is wasted as a result of confusion in this space, and service to patients is diminished as a result.

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

- PCCTC formally approved its revised ToR in July. The minutes from this meeting were formally approved at the September meeting as there was no August meeting.

Management of conflict of interests:

Conflicts of interests are recorded on the register of interests. At each committee, a list of recorded declarations is provided. New declarations must be raised, recorded and included in the minutes of the meeting and notified to the Governance team via d-icb.governance@nhs.net to update the central register.

NHS Devon Integrated Care Board

NHS Devon (ICB) Finance Report Month 5

Date of meeting	Date report produced
04 October 2023	15 September 2023

Author(s)		Report approved by	
Name and title:	Kevin Wheller Associate Director of Finance	**Name and title:**	Bill Shields Chief Finance Officer
Phone:	07825 027569	**Date:**	15 September 2023
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 Integrated Care Board's (ICBs) Finance Report seeks to provide the necessary assurance to the Board on the current and projected financial position of the ICB for the year ended 31 March 2024. This report details the ICB financial position as at 31 August 2023, setting out the year to date and forecast financial position.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
Finance and Performance Committee 26 September – discussed, agreed and noted financial position.

Key recommendations and actions requested
1. The Board is asked to **note** and **approve** the month 5 year to date performance and the forecast position including the current risks as at 31 August 2023.

Impact on NHS Devon objectives	
Objective	**Impact**
9. Move out of System Oversight framework (SOF4) – including delivery of a balanced system financial plan	The risk score for this objective remains unchanged at 16.

Does this report have implications in any of the areas highlighted below?	
Area	**Implications**
Quality of services	None
Health inequalities	None
Workforce	None
Resources and finance	Delivery of financial sustainability
Legal	None
Engagement and consultation	None

NHS Devon Integrated Care Board Finance Report - Month 5 – 2023/24

Introduction and Background

1. The presentation of the NHS Devon Integrated Care Board's (ICBs) Finance Report seeks to provide the necessary assurance to the Board on the financial position of the ICB for the year to date (YTD) 31st August 2023 and the year ended 31st March 2024.

2. Devon ICB's funding envelope includes allocations for Primary Medical Care Services, COVID, Elective Recovery and Discharge funding as well as funding for Service Development.

3. Devon Integrated Care System (ICS) submitted a deficit plan of £42.3m and an expectation that £212.2m of efficiency savings are needed to meet that plan. Within the plan the ICB's planned financial position is an underspend of £48.6m with a requirement to deliver £82.5m of efficiency savings.

Financial Position

4. The following detailed report reflects the budget set compared with the actual commitments against that budget for the period to 31st August 2023 and the year ending 31st March 2024.

As at 31 August 2023	Year to date			Forecast		
	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000
Total Net Expenditure	1,150,875	1,150,875	0	2,730,670	2,730,670	0
Resource Allocation	1,171,111	1,171,111	0	2,779,237	2,779,237	0
Total Commissioned Services	**20,236**	**20,236**	**0**	**48,567**	**48,567**	**0**

5. Overall, the ICB is reporting a YTD and FOT planned surplus of £20.2m and £48.6m respectively.

6. The ICB position sits within an overall system position of a £42.3m FOT deficit.

7. As at month 5 some service lines exceeded budget including some acute services, continuing healthcare individual placements, primary care and mental health. These variances have been covered by contingencies set aside at plan to manage variation and held in reserves.

8. Service line variances are detailed in the sections on detailed financial performance and appendix 3.

Savings Plan

9. The ICB's 2023/24 plan includes a saving requirement of £82.5m.

10. At month 5 the ICB is currently showing a YTD achievement of £26.5m against a plan of £25.5m, with a FOT of achieving the full £82.5m.

11. Details are disclosed in the section on savings and efficiencies.

Risk

12. At plan the ICB identified risks of £38.6m, including risks relating to delivery of the savings target and increases in prescription drug prices.

13. Risks and pressures arising will be addressed by appropriate mitigating actions to meet the ICB's objectives and year-end financial position.

14. At month 5 the risks total £49.1m with mitigations totalling £34.1m resulting in a net risk to the ICB of £15.0m

15. A reminder of these risks is set out later in this report.

Conclusion

16. As at 31st August 2023 the ICB is reporting a YTD and FOT planned surplus of £20.2m and £48.6m respectively.

Detailed Financial Performance

17. The YTD and FOT by main service heading as at 31st August 2023 is as follows:

Service	Year to date				Forecast			
	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000		Plan £000	Actual £000	Variance Favourable/ (Adverse) £000	
Acute	536,451	543,367	(6,916)	↓	1,265,084	1,265,710	(626)	↑
Mental Health	127,218	128,539	(1,321)	↓	305,323	308,488	(3,165)	↓
Community Health	137,426	136,698	728	↑	329,848	328,654	1,194	↑
Continuing Care	65,383	66,157	(775)	↓	156,919	159,409	(2,490)	↓
Primary Care	245,704	249,083	(3,379)	↓	589,023	594,091	(5,068)	↓
Other Programme	13,084	13,278	(194)	↓	30,161	30,387	(227)	↓
Total Commissioned Services	**1,125,266**	**1,137,122**	**(11,857)**	↓	**2,676,357**	**2,686,740**	**(10,383)**	↓
Running Costs	9,798	10,979	(1,181)	↓	23,518	26,859	(3,341)	↑
Net Expenditure	**1,135,064**	**1,148,101**	**(13,037)**	↓	**2,699,875**	**2,713,599**	**(13,724)**	↓
Reserves/Contingencies	15,811	2,774	13,037	↑	30,795	17,071	13,724	↑
Total Net Expenditure	**1,150,875**	**1,150,875**	**0**	→	**2,730,670**	**2,730,670**	**0**	→
Resource Allocation	1,171,111	1,171,111	0	→	2,779,237	2,779,237	0	→
Total Commissioned Services	**20,236**	**20,236**	**0**	→	**48,567**	**48,567**	**0**	→

18. Further detail of the budgets, actual spend and variances making up the main service areas above is provided in appendix 3.

Acute Services

19. 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, contracts for patient transport and contracts for acute procedures undertaken in the independent sector and by other non-NHS providers.

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

21. At month 5 there is a YTD overspend of £6.9m which is due to payments for Elective Recovery Funding in the independent sector, with an expectation that a future allocation will cover this cost. FOT overspend of £0.6m is driven mainly by non-contract activity and referrals and management pay costs offset by underspends in patient transport costs.

22. The restructure of the organisation is in progress which will support reducing the extent of the overspend in pay costs going forward, but with the assumption at this stage of in year organisational change savings being offset by non-recurrent cost of change.

Mental Health Services

23. 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 CAMHS service for Northern, Eastern and Southern localities being provided by Children and Families Health Devon through a contract with Torbay and Southern Devon NHS Foundation Trust. This section also includes spend relating to individual adult placements for mental health and learning disability services.

24. In 2023/24 the ICB has planned to invest £19.5m (7.22% increase) in Mental Health Services based on the Mental Health Investment Standard target. In addition to this the ICB has received £19.7m of Service Development Fund (SDF) Transformation funding for Mental Health and Learning Disability Services.

25. At month 5 there is a YTD overspend of £1.3m and FOT overspend of £3.2m, due to growth and inflationary uplift pressures in s117 learning disability and mental health placements as well as increased ADHD activity through right to choose linked to waiting times.

26. The ICB is currently reviewing its s117 cases and using Business Intelligence to assess internal benchmarking and to determine further opportunities.

Community Health Services

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

28. 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.

29. At month 5 there is currently a FOT underspend of £1.2m which includes a £0.3m underspend in Physical Disability placements, due to a reduction in the number of high-cost clients and a predicted underspend in Discharge to Assess costs as a result a fall in use of care homes beds.

Continuing Care

30. 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).

31. The placements budget represents a particular risk to the ICB financial position that requires robust financial management. The key risks relate to local authority disputes to the external provider review programme & breaches from the continuation of 4-week Hospital Discharge Programme.

32. 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
- Responsible commissioner cases

33. The Month 5 outturn position is £2.5m over budget, a deterioration of £0.8m compared to last month. This is largely a result of greater than budgeted End of Life clients, inflationary uplift & pay pressures.

34. Further mitigating actions including reviewing joint funded clients are being explored.

Other Programme

35. 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.

36. There are no particular issues to highlight in this area this month.

Primary Care Services

37. 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. From 1st April 2023 NHS Devon received delegated responsibility from NHS England for the commissioning of primary care pharmacy, ophthalmic and dental (POD) contracts.

Prescribing

38. The prescribing forecast and reported risk position has increased significantly in month 5 based upon the latest month 3 prescribing data. We are reporting a year to date over spend of £3.4m and a forecast year end overspend of £8.0m. These values are calculated using the national forecasting methodology that is produced by the NHS Business Services Authority (also known as the Prescribing Monitoring Document or PMD forecast).

39. However local analysis of our year to date expenditure using a range of forecasting methodologies all indicate that the BSA forecast is understated. We are therefore reporting an additional potential risk of overspend of £13.8m to give a potential total year end risk position of a £21.8m overspend.

40. This increase in prescribing cost is a national issue and cost pressures of this scale are being seen across all ICBs. The cost pressure is in part driven by Price Concessions (previously known as No Cheaper Stock Obtainable or NCSO) and by price increases that are greater than those provided for in our planning or in the national planning guidance.

41. To mitigate this risk NHS Devon are expecting that NHS England will make additional allocations available to ICBs. In 2022/23 £6.5m was received in this way to mitigate the Price Concessions cost pressure and we have calculated the equivalent value for 2023/24 as £4.4m. Furthermore, the price inflation seen over and above national planning guidance has been valued at £7.2m and this too is expected to be made available. This leaves an unmitigated risk position of £2.2m as shown in the table below.

42. It should be noted that at this stage NHS England has not set the same expectations in terms of funding for these pressures.

Prescribing Risk	
	£'000
Risk forecast	13,770
Less mitigations	
Price concessions	4,400
Excess price inflation	7,181

	11,581
Unmitigated risk	2,189

Delegated Commissioning

43. As at month 5 we are reporting a FOT breakeven position across delegated primary medical care, however we are now reflecting a prior year benefit in respect of QOF achievement being less than planned for by £1.2m.

Other Primary Care

44. Other primary care services include contracts for enhanced GP services, out of hours GP services, home oxygen services and provision for GP IT costs. At month 5 the forecast position is underspend by £1.8m which is due to prior year benefits being reflected in the position. This is mostly in respect of Local Enhanced Services claims being less than planned for.

Delegated Pharmacy, Ophthalmic & Dental

45. At month 5 we are reporting a FOT breakeven position against the delegated POD services.

Running Costs

46. The pay and associated costs for the ICB are categorised into administrative (running costs) and programme costs according to whether they relate to healthcare services and are solely concerned with management of the organisation. Variances relating to programme pay costs are reported within other earlier sections including acute services and placements.

47. Each year the ICB 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.

48. The ICB's allocation for the year is £23.5m and at month 5 the ICB is reporting a YTD and FOT overspend of £1.2 and £3.3m respectively.

49. The restructure of the organisation is in progress which will support reducing the extent of the overspend in pay costs going forward, but with the assumption at this stage of in year organisational change savings being offset by non-recurrent cost of change.

Resource Allocation

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

Allocation Description	Year to date ICB
2023/24 Recurrent core allocation	2,198,203
2023/24 COVID	9,321
2023/24 Capacity funding (£k)	26,768
2023/24 Additional discharge allocation (£k)	6,015
ICB running cost allowance	22,578
Allocations (primary medical care)	220,682
Primary Care DOP transfer from regional Teams	117,342
Inflation (Fair Shares)	7,164
Pay Award	30,299
M4 Allocation RC	580
M5 Allocations	12,997
Recurrent Allocation	**2,651,949**
Cancer Alliance Core Funding	7,986
Cancer Alliance Targeted Funding	6,057
Mental Health Allocations M2	17,800
Funding for Covid-19 high-throughput & rapid PCR testir	3,280
Community / Keyworkers	2,526
Community Services Transformation	1,641
Primary Care Transformation	3,579
Supporting GP Mentors Q1	44
Long Covid	1,300
Pay Award	4,646
Prevention	1,300
Other M2 Allocations	2,194
M3 Allocations	20,063
M4 Allocations	47,649
M5 Allocations	7,223
Non-Recurrent Allocation	**127,288**
Total Allocation	**2,779,237**

51. The month 5 allocations include resources for the medical pay award of £17.1m.

Savings and Efficiencies

52. The table below provides a summary of the delivery of savings and efficiencies at month 5 and the expected position for the year ended 31st March 2024.

Scheme	RAG Status	Year to date			Forecast		
		Plan Savings Delivery £000	Actual Savings Delivery £000	Variance Favourable/ (Adverse) £000	Plan Savings Delivery £000	Actual Savings Delivery £000	Variance Favourable/ (Adverse) £000
Acute		12,744	12,744	0	33,584	33,584	0
Community Healthcare		5,022	6,622	1,600	18,051	18,051	0
Mental Health		830	830	0	1,993	1,993	0
Ambulance		315	315	0	755	755	0
Primary Care		2,499	2,499	0	6,000	6,000	0
Prescribing		2,083	2,083	0	5,000	5,000	0
Continuing Care		1,744	1,445	(299)	8,186	8,186	0
Running costs		267	0	(267)	641	641	0
Other Programme Services		0	0	0	6,055	6,055	0
Unidentified		0	0	0	2,192	2,192	0
Total		**25,504**	**26,538**	**1,034**	**82,457**	**82,457**	**0**
Recurrent		18,275	19,309	1,034	64,562	64,562	0
Non-Recurrent		7,229	7,229	0	17,895	17,895	0
Total		**25,504**	**26,538**	**1,034**	**82,457**	**82,457**	**0**

53. The above figures do not tie up to those disclosed in the monthly Integrated Finance Report (IFR), that is submitted to NHS England, due to the inability to correct the profiling of the savings plans on the form.

54. The £82.5m savings plan includes £21.5m of system savings attributable to workstreams driven through the system recovery programme. These savings are profiled for delivery from October.

55. It should also be noted that £31.7m of the ICB's target of £82.5m is the internal (intra system) provider tariff efficiencies charged to our providers. These efficiencies as reported within the ICB plan are a technicality and will be delivered by provider cost improvement programmes. These are only counted once (i.e., not double counted) within the system total requirement of £212.2m efficiencies. So, the ICB CIP target which is part of the £212.2 is £50.7m.

56. Year to date we are on slightly ahead of plan and forecasting full delivery of the savings by the end of the financial year. The risk to delivery of the savings plan is covered below.

Risks

57. The assessment of financial risk (and mitigations) at month 5, for the year ended 31st March 2024, is as follows.

Headline	Description	M4 £000	M5 £000	Movement £000	Risk at Plan £000
Prescribing	Risk of additional cost where no cheaper stock is obtainable (NCSO) - Price concessions	6,000	13,770	7,770	3,090
Placements	Inflation risk on Continuing Healthcare costs	0	0	0	1,500
Contract risk	Potential additional contract costs	2,500	2,500	0	3,750
Elective Recovery Fund	Independent Sector Risk re ERF earnings	8,000	14,000	6,000	0
Efficiency risk	Estimated shortfall in required efficiency savings	5,545	4,237	(1,308)	13,122
System strategic efficiencies risk	Non-delivery of workstream efficiency savings	9,000	14,641	5,641	17,120
Total Risk		**31,045**	**49,148**	**18,103**	**38,582**
Additional cost control	Off-set risk by stretch efficiencies	6,000	5,530	(470)	6,090
Transformational / Pathway changes	Review of pathways leading to financial benefits	0	0	0	3,000
Elective Recovery Fund	ERF income assumption	8,000	14,000	6,000	0
Prescribing	Prescribing price concessions and inflation income assumption	0	11,581	11,581	0
Efficiency mitigation	Identification of opportunistic in-year savings	0	0	0	7,192
Allocation Review	Hold back non recurrent allocations	2,000	3,000	1,000	750
Total Mitigation		**16,000**	**34,111**	**18,111**	**17,032**
Net Risk		**15,045**	**15,037**	**(8)**	**21,550**

58. At plan the ICB identified risks of £38.6m, with mitigations totalling £17.0m resulting in net risks of £21.6m.

59. At month 5 the risks total £46.1m, with mitigations totalling £34.1m resulting in net risks of £15.0m.

60. Changes to the risk profile in month 5 represent:

- Increased risk in relation to prescribing price increases as a result of generic drug shortages, offset partly by an expectation that funding will be available.
- Acknowledgement that there is a risk relating to receiving elective recovery funding as a result of industrial action, mitigated by the expectation that funding will be forthcoming.
- Increased risk in relation to the non- delivery of workstream efficiency savings.

Other Financial Information

Statement of Financial Position

61. The statement of financial position (SoFP) provides a snapshot of the ICB's financial position at that date. The SoFP is made of two parts which must always equal each other: the top part (total assets employed) which shows the ICB's

assets and liabilities (what the ICB owns and is owed), and the bottom part (total taxpayers' equity) which shows how the ICB has been financed.

62. The ICB's position at 31st August 2023 is shown in appendix 1.

Capital

63. The ICB has received £138k IT capital which we requested for 2023/24.

Better Payment Practice Code

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

65. The ICB's current performance against the target of 95% is detailed below:

Better Payment Practice Code	M5	
	Number	£000
Non NHS Creditors - % of bills paid within target	99.64	98.88
NHS Creditors - % of bills paid within target	99.08	99.84

Cash

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

Recommendations

67. The Board is requested to note and approve the month 5 year to date performance and the forecast position including the current risks.

Appendix 1: Statement of Financial Position

Statement of Financial Position	M5
Property Plant & Equipment	2,596
Intangible Assets	135
Non Current Assest	**2,731**
Inventories	1,212
Trade & Other Receivables - NHS	773
Trade & Other Receivables - Non NHS	3,806
Cash & Cash Equivalents	1,287
Current Assets	**7,077**
Total Assests	**9,808**
Trade & Other Payables - NHS	6,105
Trade & Other Payables - Non NHS	(115,274)
Other Liabilities	(3,418)
Borrowings / Cash in Transit	(4,033)
Current Liabilities	**(116,620)**
Total Assets Employed	**(106,812)**
General Fund	(106,812)
Total Taxpayers Equity	**(106,812)**

Appendix 2: Cash

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

Measure	Month 5
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 £2,720m for Devon ICB for the period ended 31st March 2024.*	43.6% of the Cash Drawdown Requirement has been utilised as at month 5 where 41.7% would be expected based on a straight-line trajectory.
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.	Notional charges amount to £18,337 for August.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown.	The ICB has met the requirement to manage their 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. There were a number of expected invoices and payments that did not materialise during the 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 31st August 2023 and 31st March 2024.

Service	Year to date			Forecast		
	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000
Royal Devon University Healthcare NHS FT	160,646	160,645	0	373,650	373,650	0
University Hospitals Plymouth NHS Trust	133,738	133,737	0	316,210	316,210	(0)
Northern Devon Healthcare NHS Trust	64,020	64,020	1	153,649	153,649	(0)
Torbay and South Devon Healthcare NHS FT	112,103	112,101	1	263,307	263,307	(0)
Taunton and Somerset NHS FT	4,427	4,427	(0)	10,625	10,625	0
South Western Ambulance Services NHS FT	29,995	29,995	0	71,988	71,988	0
Independent Sector	15,608	21,975	(6,367)	37,460	37,421	39
Patient Transport	5,122	4,515	608	12,293	11,307	986
Other Acute	10,792	11,952	(1,159)	25,902	27,554	(1,651)
Acute	**536,451**	**543,367**	**(6,916)**	**1,265,084**	**1,265,710**	**(626)**
Devon Partnership NHS Trust	74,441	74,441	0	178,657	178,657	0
Livewell MH Services	3,344	3,344	0	8,026	8,026	0
University Hospitals Plymouth NHS Trust MH	18,843	18,843	0	45,222	45,222	0
Children and Families Health Devon	7,620	7,624	(4)	18,288	18,296	(9)
Individual Patient Placements	6,717	6,940	(222)	16,122	16,655	(533)
Section 117	10,107	11,135	(1,028)	24,256	26,723	(2,467)
Other Mental Health	6,147	6,214	(68)	14,752	14,908	(156)
Mental Health	**127,218**	**128,539**	**(1,321)**	**305,323**	**308,488**	**(3,165)**
Livewell Southwest	101	100	0	241	241	0
Royal Devon University Community	27,762	27,762	(0)	66,629	66,629	0
Northern Devon Healthcare Community	14,307	14,307	0	34,336	34,336	0
Torbay and South Devon Healthcare NHS FT	29,709	29,709	(0)	71,301	71,300	1
University Hospitals Plymouth Community	25,183	25,183	0	60,440	60,440	0
Children and Families Health Devon	5,636	5,655	(19)	13,527	13,573	(46)
Individual Patient Placements	783	655	128	1,879	1,572	308
Integrated Urgent Care Service	(0)	0	(0)	0	0	0
Hospices	3,563	3,565	(2)	8,578	8,578	0
MIU Contracts	321	324	(3)	771	809	(38)
Better Care Fund_Plymouth CC	2,692	2,580	112	6,461	6,349	113
Better Care Fund_Devon CC	16,105	16,105	0	38,652	38,652	0
Better Care Fund Torbay	1,613	1,613	(0)	3,872	3,872	(0)
Demand and capacity	0	(293)	293	0	(293)	293
VCSE S256	0	45	(45)	0	108	(108)
Other Community Services	9,650	9,387	263	23,160	22,488	672
Community Health	**137,426**	**136,698**	**728**	**329,848**	**328,654**	**1,194**
Continuing Healthcare	57,808	58,765	(956)	138,740	141,667	(2,926)
Funded Nursing Care	7,574	7,393	182	18,178	17,742	436
Continuing Care	**65,383**	**66,157**	**(775)**	**156,919**	**159,409**	**(2,490)**

Service	Year to date			Forecast		
	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000
Prescribing	88,641	91,991	(3,350)	212,738	220,780	(8,042)
Enhanced Services	5,255	4,513	741	12,611	11,870	741
Delegated Commissioning - Co Commissioning	91,266	93,299	(2,033)	219,045	217,894	1,151
Delegated Commissioning - Optometry	4,976	4,877	99	11,943	11,943	0
Delegated Commissioning - Pharmacy	14,640	14,640	(0)	35,136	35,136	0
Delegated Commissioning - Dental	30,361	30,360	0	72,516	72,516	(0)
GP Out Of Hours	3,881	3,886	(5)	9,315	9,315	(0)
GP IT	1,781	1,719	61	4,274	4,274	0
Other Primary Care	4,904	3,797	1,107	11,445	10,363	1,082
Primary Care	**245,704**	**249,083**	**(3,379)**	**589,023**	**594,091**	**(5,068)**
NHS 111	4,820	4,734	87	11,569	11,468	101
Chime Audiology	1,678	1,612	66	4,026	4,008	18
All Other Commisionned Services	6,586	6,933	(346)	14,566	14,911	(346)
Other Programme	**13,084**	**13,278**	**(194)**	**30,161**	**30,387**	**(227)**
Total Commissioned Services	**1,125,266**	**1,137,122**	**(11,857)**	**2,676,357**	**2,686,740**	**(10,383)**
Pay	7,293	8,558	(1,264)	17,506	20,486	(2,980)
Non Pay	2,567	2,446	121	6,161	6,387	(226)
Income	(62)	(26)	(37)	(149)	(14)	(135)
Running Costs	**9,798**	**10,979**	**(1,181)**	**23,518**	**26,859**	**(3,341)**
Net Expenditure	**1,135,064**	**1,148,101**	**(13,037)**	**2,699,875**	**2,713,599**	**(13,724)**
System Reserves	4,048	0	4,048	9,715	6,015	3,700
Investment Reserves	4,565	2,774	1,791	12,171	2,806	9,364
Non Recurrent ICB Reserves	7,198	0	7,198	8,910	8,250	660
Total Net Expenditure	**1,150,875**	**1,150,875**	**0**	**2,730,670**	**2,730,670**	**0**
Resource Allocation	1,171,111	1,171,111	0	2,779,237	2,779,237	0
Total Commissioned Services	**20,236**	**20,236**	**0**	**48,567**	**48,567**	**0**

NHS Devon Integrated Care Board

One Devon (ICS) Finance Report Month 5

Date of meeting	Date report produced
04 October 2023	18 September 2023

Author(s)		Report approved by	
Name and title:	Kevin Wheller Associate Director of Finance	**Name and title:**	Bill Shields Chief Finance Officer
Phone:	07825 027569	**Date:**	18 September 2023
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 One Devon Integrated Care System's (ICSs) Finance Report seeks to provide the necessary assurance to the Board on the current and projected financial position of the ICS for the year ended 31 March 2024.

The report details the ICS financial position for the period ended 31 August 2023 against the finance plan submitted for the financial year 23/24, setting out the year to date and forecast financial position as well as the risks to delivery of that forecast.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
Finance and Performance Committee on 26/09/23 – discussed and position noted and agreed.

Key recommendations and actions requested
1. The Board is asked to consider, review and **note** the ICS financial position as at the period ended 31 August 2023.

Impact on NHS Devon objectives	
Objective	**Impact**
9. Move out of System Oversight framework (SOF4) – including delivery of a balanced system financial plan	The risk score for this objective remains unchanged at 16.

Does this report have implications in any of the areas highlighted below?	
Area	**Implications**
Quality of services	None
Health inequalities	None
Workforce	None
Resources and finance	Delivery of financial sustainability
Legal	None
Engagement and consultation	None

One Devon Integrated Care System Finance Report - Month 5 – 2023/24

Introduction and Background

1. The presentation of the One Devon Integrated Care System's (ICS) Finance Report seeks to provide the necessary assurance to the Board on the current and projected financial position of the ICS for the year ended 31 March 2024.

2. This report details the ICS financial position as at 31 August 2023.

3. As part of the 2023/24 planning round, Devon ICS submitted a deficit plan of £42.3m with a commitment to reach a breakeven position by 2025/26.

4. As at month 5 the Devon ICS is reporting a year to date £39.7m deficit against a planned deficit of £32.6m – an adverse variance of £7.2m. (M4 £1.3m variance)

5. The reported forecast is a deficit of £42.3m which is in line with the plan. (M4 £0 variance)

6. As at month 5 the Devon ICS had made efficiency savings of £66.0m which is £11.5m ahead of plan. (M4 £6.5m). Forecast savings are on plan at £212.2m. (M4 £0m variance)

7. At the planning stage net risks of £159.5m were identified to delivery of the planned deficit. At the end of month 5, this has improved by £53.3 and stands at £106.2m (M4 £115.9m).

8. Work is ongoing to mitigate against these risks.

9. The above position represents the reported position to NHSE as at Month 5.

Financial Performance

10. The year to date and outturn by organisation as at 31 August 2023 is as follows.

Organisation	Year to date				Forecast			
	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance Favourable / (Adverse) £000		Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance Favourable / (Adverse) £000	
Devon ICB	20,236	20,236	0	→	48,567	48,567	0	→
Royal Devon University NHS FT	(15,396)	(19,282)	(3,886)	↓	(28,035)	(28,035)	0	→
University Hospitals Plymouth Trust	(17,070)	(19,052)	(1,982)	↓	(33,600)	(33,600)	0	→
Torbay and South Devon NHS FT	(20,146)	(21,439)	(1,293)	↓	(32,571)	(32,571)	0	→
Devon Partnership Trust	(188)	(188)	0	→	3,300	3,300	0	→
Total	**(32,564)**	**(39,725)**	**(7,161)**	↓	**(42,339)**	**(42,339)**	**0**	→

11. As at month 5 the Devon ICS is reporting a year to date £39.7m deficit against a planned deficit of £32.6m – an adverse variance of £7.2m. (M4 £1.3m variance)

This reflects additional unmitigated costs at Royal Devon, University Hospitals Plymouth and Torbay and South Devon from the industrial action and some year to date overspend on drugs at Royal Devon.

12. The reported forecast is a deficit of £42.3m which is in line with the plan. (M4 £0 variance)

Savings and Efficiencies

13. The delivery of savings and efficiencies as at 31 August 2023 is as follows:

Organisation	Year to date				Forecast			
	Plan CIP Delivery £000	Actual CIP Delivery £000	Variance Favourable / (Adverse) £000		Plan CIP Delivery £000	Actual CIP Delivery £000	Variance Favourable / (Adverse) £000	
Devon ICB	21,125	21,938	813	↓	50,693	50,693	0	→
Royal Devon University NHS FT	13,035	17,553	4,518	↑	60,296	60,296	0	→
University Hospitals Plymouth Trust	7,837	10,932	3,095	↑	39,477	39,477	0	→
Torbay and South Devon NHS FT	8,038	10,567	2,529	↑	46,578	46,578	0	→
Devon Partnership Trust	4,531	5,037	506	↑	15,191	15,191	0	→
Total	**54,566**	**66,027**	**11,461**	↑	**212,235**	**212,235**	**0**	→

14. As at month 5 the Devon ICS had made efficiency savings of £66.0m which is £11.5m ahead of plan. (M4 £6.5m) This is mainly due to trusts bringing forward non recurrent schemes to compensate for year to date overspends.

15. In addition to the above, Devon ICB has a target of £31.7m (CIP plan is £82.5m in total) which is delivered intra system with providers and therefore to avoid a double count this has been netted off in the table above.

16. Forecast savings are on plan at £212.2m. (M4 £0m variance)

Risks

17. The assessment of financial risk (and mitigations) for the year ended 31 March 2023 as at 31 August 2023, is as follows.

Risk description	DPT	RDUH	TSD	UHP	ICB	Total	Plan risks £'000
	£'000						
Additional cost risk (capacity, pressures, winter)	(3,000)	(1,346)	(3,000)		(13,770)	(21,116)	(10,090)
Additional cost risk (inflation)	(1,000)	0	(2,400)	(2,200)	0	(5,600)	(9,500)
High cost drugs growth		(11,426)	(1,000)	(1,200)		(13,626)	(7,300)
High cost devices NICE guidance change				(1,300)		(1,300)	
Cost of growth containment		0	(3,500)	(10,350)		(13,850)	(10,000)
Pay vacancy - risk of unwinding		0	0			0	(2,000)
Efficiency risk	(5,095)	(3,987)	(7,204)	(2,140)	(4,237)	(22,663)	(55,885)
System strategic efficiencies risk	(3,104)	(10,089)	(6,984)	(7,000)	(14,641)	(41,818)	(50,097)
Double count risk on savings		(5,511)				(5,511)	
Income risk (excl. ERF)	0	0	(2,000)	(5,000)		(7,000)	(7,100)
Liberty Protection Safeguard			0			0	(1,800)
Diagnostic Cost Pressure			(1,200)			(1,200)	(1,000)
ERF income risk		(1,734)	(1,100)	(2,000)	(14,000)	(18,834)	(10,700)
Spec comm contract income		0				0	(2,000)
CDC income						0	(5,300)
Contract risk (excl. ERF)					(2,500)	(2,500)	(3,750)
Industrial action costs		(4,500)	(1,810)	(3,600)		(9,910)	
B2 to B3 re-banding			(2,060)	(313)		(2,373)	
ASC Volume Risk			(5,800)			(5,800)	
Total risks	(12,199)	(38,593)	(38,058)	(35,103)	(49,148)	(173,101)	(176,522)
Mitigations/benefits:							
NHS Funding re NCSO/Inflation					11,581	11,581	0
Non recurrent allocations					3,000	3,000	0
Additional cost control or income (excl. ERF)		16,013				16,013	6,090
ERF income				3,600	14,000	17,600	
Efficiency mitigation	3,400					3,400	7,192
Transformational / Pathway changes						0	3,000
Pay award funding				1,000		1,000	
Other mitigations	3,000		5,808		5,530	14,338	750
Total mitigations	6,400	16,013	5,808	4,600	34,111	66,932	17,032
Total Net Risk	(5,799)	(22,580)	(32,250)	(30,503)	(15,037)	(106,169)	(159,490)

18. At the planning stage risks of £176.5m were identified along with £7.3m of mitigations, leaving a net risk of £159.5m to the delivery of the deficit plan.

19. As at month 5 the net risk has reduced by £53.3m to £106.2m (M4 £115.7m) against the planned deficit. £110.9m reported on the IFR due to the timing of the submission.

20. There are £173.1m risks (of which £70.0m relate to efficiencies) and £66.9m mitigations.

21. Work is ongoing around the system savings programme of work to ensure robust plans are in place to deliver the efficiency savings required. Internal savings programmes are also being firmed up and ideas are shared across the system to generate new schemes wherever possible.

22. Other risks are monitored by organisations and their boards and mitigations put in place to minimise these wherever possible.

Capital

System capital (Before impact of IFRS 16)

Organisation	Year to date				Forecast			
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000		Plan £000	Actual £000	Variance Favourable / (Adverse) £000	
Royal Devon University NHS FT	7,323	4,532	2,791	↑	31,074	31,191	(117)	↓
University Hospitals Plymouth Trust	1,665	4,813	(3,148)	↓	27,689	27,572	117	↑
Torbay and South Devon NHS FT	6,970	5,938	1,032	↑	21,237	21,409	(172)	→
Devon Partnership Trust	3,051	1,439	1,612	↑	7,124	6,952	172	→
Total	**19,009**	**16,722**	**2,287**	↑	**87,124**	**87,124**	**(0)**	→

23. System capital spend is under plan at month 5 by £2.3m (M4 £0.5m)

24. Forecast system capital spend is on plan as at M5. (M4 £0m variance).

25. There has been an offset arrangement between Torbay and South Devon FT and Devon Partnership Trust around the Children's estate capital spend. Another offset arrangement between Royal Devon and University Hospitals Plymouth relates to spinal equipment at Nightingale Hospital.

Total Capital

Organisation	Year to date				Forecast			
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000		Plan £000	Actual £000	Variance Favourable / (Adverse) £000	
Royal Devon University NHS FT	16,031	8,690	7,341	↑	72,305	76,209	(3,904)	↓
University Hospitals Plymouth Trust	16,981	11,146	5,835	↑	123,879	133,158	(9,279)	↑
Torbay and South Devon NHS FT	15,635	14,118	1,517	↑	56,755	47,851	8,904	↓
Devon Partnership Trust	6,596	2,978	3,618	↑	15,636	15,464	172	→
Total	**55,243**	**36,932**	**18,311**	↑	**268,575**	**272,682**	**(4,107)**	↓

26. The total capital plan includes impact of IFRS16 on leases.

27. Total capital spend is under plan by £18.3m as at month 5 (M4 £12.1m) and the forecast spend on capital by end March 2023 is over plan by £4.1m. (M4 £2.7m under plan)

28. The plan is fixed at submission and not updated as subsequent schemes are approved and PDC awarded so these schemes then show as an overspend as is the case with Royal Devon and University Hospitals Plymouth.

Agency

Organisation	Year to date			Forecast			Acency Cap	
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000	Plan £000	Actual £000	Variance Favourable / (Adverse) £000	Agreed share of agency cap £000	Variance Favourable/ (Adverse) £000
Royal Devon University NHS FT	(6,312)	(9,905)	(3,593)	(15,138)	(19,922)	(4,784)	(21,362)	1,440
University Hospitals Plymouth Trust	(2,126)	(2,352)	(226)	(4,722)	(4,722)	0	(7,200)	2,478
Torbay and South Devon NHS FT	(4,521)	(6,637)	(2,116)	(9,721)	(10,746)	(1,025)	(10,789)	43
Devon Partnership Trust	(3,099)	(5,134)	(2,035)	(6,232)	(10,677)	(4,445)	(6,232)	(4,445)
Total	**(16,058)**	**(24,028)**	**(7,970)**	**(35,813)**	**(46,067)**	**(10,254)**	**(45,583)**	**(484)**

29. As at M5 the year to spend on agency is over plan by £8.0m. (M4 £6.3m)

30. The forecast expenditure for the year end on agency is £10.3m over plan. (M4 £8.0m)

31. Devon ICS has been set an agency cap of £45.6m by NHSE which has been agreed to be shared by providers as per the table above. The system is forecast to be above the agency cap by £0.5m (M4 £1.8m below). If expenditure on agency continued at the current run rate, then the agency cap would be breached by £12.1m. (M4 £12.4m)

32. Increased agency has been required as a result of industrial action. Devon Partnership Trust also continues to experience challenges with the recruitment to nursing and medical posts and has a number of extra complex packages of care fully funded by commissioners where agency has been required to cover these.

Recommendations

33. The Board is requested to consider, review and note the ICS financial position as at the period ended 31 August 2023.

NHS Devon Integrated Care Board

Equity Update

Date of meeting	Date report produced
04 October 2023	26 September 2023

Author(s)		Report approved by	
Name and title:	Ben Chilcott Deputy Director of Finance	**Name and title:**	Bill Shields Deputy Chief Executive and Chief Finance Officer
Phone:	07789915365	**Date:**	26 September 2023
Email:	ben.chilcott@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 NHS Devon Integrated Care Board (ICB) is committed to reducing health inequalities. A key element of this is to ensure resources are distributed in line with need. NHS Devon and previous commissioning organisations have regularly analysed the expenditure of system resources compared to need, and this paper provides the latest update to that analysis. The last time the equity position was calculated was for the 2022/23 plan. This paper updates the analysis to include the 2022/23 Outturn and the 2023/24 Plan. The identification of spend by population is carried out based on the most granular level of detail available for every contract, wherever possible at GP practice level. This expenditure analysis is then aggregated at locality level.

The comparator is the resource that we would expect to spend for each locality based on the needs of the population. The weighting includes indicators of need such as age, sex, deprivation, and many other factors. The formula is the national formula for need and is used to allocate resources to ICBs. This identifies the level of resource we should be spending on healthcare in Devon – NHS Devon uses the same formula to determine how much they should be spending at locality level. This is described as their 'fair share'.

For 2023/24, Devon ICB is funded above its 'fair share' level by £109.5m and the Operational Plan provides for a further £42.4m spend above that amount. Therefore, overall, Devon will this year spend £151.9m above its fair share level. This means that each LCP area is also funded above its fair share level. For 2024/25, it is forecast that Devon ICB will be funded at £79.5m above its fair share level and the medium term financial plan currently provides for a further £30m spend above that amount. Devon is therefore planning to spend a total of £109.5m above its 'fair share' level in 2024/25. This means that each LCP will also be funded above its 'fair share' level next year.

		Eastern	Northern	Sth Devon & Torbay	Plymouth	Western	TOTAL
2023/24							
Plan Expenditure incl full net deficits	£m	806.2	362.8	728.0	602.9	95.0	2,595.0
Equitable Fair Share	£m	783.7	341.8	659.9	569.1	88.7	2,443.1
(under)/over funded	£m	22.6	21.1	68.2	33.8	6.3	151.9
		2.9%	6.2%	10.3%	5.9%	7.1%	6.2%
2024/25							
Plan Expenditure incl full net deficits	£m	797.2	356.6	713.6	592.2	93.2	2,552.7
Equitable Fair Share	£m	783.7	341.8	659.9	569.1	88.7	2,443.1
(under)/over funded	£m	13.5	14.8	53.7	23.1	4.4	109.5
		1.7%	4.3%	8.1%	4.1%	5.0%	4.5%

The current financial settlement is only known to the end of 2024/25, but Devon ICB's allocated funding will continue to be reduced to bring the ICB to its 'fair share' funding target in a process known as 'convergence' over the medium term. The ICB has already committed to distribute these reductions at LCP level and the paper sets out the steps to achieve this.

The distribution of the resource reductions for NHS Devon over this period takes the planned expenditure in each of the five localities to within 1.8% of their 'fair share' funding level. This represents a significant improvement in the allocation of resources to reflect need. Each annual planning round will consider the equity impact of investment decisions outside of the annual recurrent revenue allocation as a means of mitigating the impact to those LCPs funded at up to 1.8% below the 'fair share' level.

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

Finance & Performance Committee

Key recommendations and actions requested
The Board is asked to **agree** that: a. For 2023/24 and 2024/25, whilst Devon continues to be funded significantly above its 'fair share' level, the ICB commits to ensuring that each LCP will also be funded above its 'fair share' level as set out in the Operational Plan for 2023/24 and the Medium Term Financial Plan for 2024/25. b. In managing the impact of allocation convergence to Devon ICB 'fair share' level funding, the steps set out in the paper will be followed to ensure that each LCP is funded within 1.8% of its 'fair share' level. c. In year consideration of the equity impact of investment decisions should be considered as part of the Operational Planning process.

Impact on NHS Devon objectives	
Objective	**Impact**

Does this report have implications in any of the areas highlighted below?	
Area	
Quality of services	None
Health inequalities	Distribution of resource in line with need
Workforce	None
Resources and finance	Supporting the financial recovery planning
Legal	None
Engagement and consultation	None

Equity Update

Introduction

1. NHS Devon Integrated Care Board (ICB) considered in October 2022, in private session, a paper on equity which included several recommendations.

2. The paper confirmed that the analysis, as presented, showed that within the existing expenditure there is a level of inequity in how the resources are distributed when compared to the needs based weighted capitation for some populations.

3. The analysis within that paper was based on the NHS Devon plan for 2022/2023, which was a balanced plan for all organisations except for a planned deficit of £18m at the Royal Devon University Hospital NHS Trust (RDUH).

4. It further recognised the issue of a system that is both over target and overspending, and the difficulties in addressing inequity without additional investment.

5. The minutes of the October 2022 NHS Devon Board discussion state:

   "The Board noted the conclusion of the report that each LCP currently spends above its 'fair share' allocation…" This is as calculated, based on Devon fair share as notified by NHS England.

   The Board noted that achievement of equity in revenue allocations to LCPs will require differential reduction to spend across LCPs and agreed that this will need to be planned as part of the transformation plan for Devon and be reflected each year in the Operational Plan. The Board agreed that the 23/24 Operational Plan will start to reflect this change to LCP allocations. Those LCPs spending the most above their notified fair share revenue allocation will see a greater reduction to their allocation than those least above their notified fair share allocation as part of the Devon wide move to its overall fair share allocation."

Update

6. Since that paper a number of changes have occurred which will have had an impact on equity. These include:

   - The outturn for 2022/2023 deteriorated and all providers have delivered a deficit.

   - The allocations for 2023/2024 and 2024/2025 have been issued and signal an increase in the pace of convergence to target.

- The allocation formula for 2023/24 and 2024/25 has also received minor modifications and the data has been refreshed which impacts the allocation of resources.

- The 2023/2024 plan has been finalised and includes planned deficits in all the providers, with the exception of Devon Partnership Trust and a surplus for the Integrated Care Board.

7. This paper provides an update to the equity analysis for the 2022/2023 outturn and 2023/2024 plan when compared to the target allocations for Devon – this is the level of resource that should be consumed within Devon according to the national allocation formula as weighted for need.

8. The current Devon allocation is above this target level of resource by £109.5m. In addition to this, the Devon ICB financial plan for 2023/24 provides for a further £42.4m of spend in the system. For 2024/25, it is estimated that Devon ICB will be funded £79.5m above its target level of resource and that planned spend will be a further £30m above that. This means that for 2023/24 and 2024/25, the ICB and each LCP will be funded above the target level of resource. This is set out in Table 1 below:

Table 1: Expenditure Plans compared to equitable fair share

		Eastern	Northern	Sth Devon & Torbay	Plymouth	Western	TOTAL
2023/24							
Plan Expenditure incl full net deficits	£m	806.2	362.8	728.0	602.9	95.0	2,595.0
Equitable Fair Share	£m	783.7	341.8	659.9	569.1	88.7	2,443.1
(under)/over funded	£m	22.6	21.1	68.2	33.8	6.3	151.9
		2.9%	6.2%	10.3%	5.9%	7.1%	6.2%
2024/25							
Plan Expenditure incl full net deficits	£m	797.2	356.6	713.6	592.2	93.2	2,552.7
Equitable Fair Share	£m	783.7	341.8	659.9	569.1	88.7	2,443.1
(under)/over funded	£m	13.5	14.8	53.7	23.1	4.4	109.5
		1.7%	4.3%	8.1%	4.1%	5.0%	4.5%

9. The Devon ICB allocation will continue to be reduced on an annual basis to converge towards target. The assumed pace of this change is £30m per annum, and so will be achieved within four years. The system has already agreed that the methodology for the distribution of this convergence reduction to allocations will be initially a reduction in provider top up funding, and when that is exhausted a weighted capitation share to each locality. Providers and localities will need to reduce expenditure accordingly.

10. This analysis compares what expenditure levels will be post convergence with the allocations post convergence (ie a comparison of what will and should be spent by each locality for its needs weighted population once we are at target.)

11. Table 2 below summarises this equity position, and further detail is provided at Appendix 1.

Table 2: Post full convergence expenditure compared to equitable fair share

		Eastern	Northern	Sth Devon & Torbay	Plymouth	Western	TOTAL
post convergence							
Plan Expenditure incl full net deficits	£m	784.4	344.7	668.1	558.8	87.1	2,443.1
Equitable Fair Share	£m	783.7	341.8	659.9	569.1	88.7	2,443.1
(under)/over funded	£m	0.7	3.0	8.2	-10.3	-1.6	0.0
		0.1%	0.9%	1.2%	-1.8%	-1.8%	0.0%

The analysis demonstrates that there will be a significant improvement in the equity of expenditure for all localities within the system when compared to their needs based weighted capitation funding by the time the system is at target.

12. This assumes:

- All provider deficits are balanced through organisational and collaborative cost improvement programmes
- Target funding is achieved locally by a total convergence of £109.5m, applied to the ICS allocations at a rate of £30m per annum
- Convergence continues to be distributed in accordance with the current agreed plan reducing top up initially and then on a weighted capitation basis where convergence exceeds top up.
- Providers and localities reduce spend in line with convergence reductions

13. Given the existing agreements in place for the distribution of convergence and elimination of top up funding, there is no requirement to put further measures in place to address funding equity.

14. In year allocations can have a significant impact if distributed in an inequitable way, and consideration of the impact on equity should be considered for all investments.

Appendix 1 provides further detail for the equity calculations

APPENDIX 1

Detailed Equity Analysis:

1. The Public Service Consultants (PSC) model has been updated for 2022/2023 outturn and 2023/2024 plan values. Whilst the actual spend and new plan values have been updated, the GP level contract usage apportionment has not been. Put differently, we have updated the actual and plan expenditure values but have not refreshed the underlying data that shows which patients, and ultimately the extent that LCPs are accessing those contracts. This is not material nor volatile, the usage does not vary significantly year on year.

2. A bridge to explain the movements in equity is summarised at Table 3 below.

3. Contractual spend changes have driven a movement towards equity of 20-30% during 2022/23, and again further movement from the system plan for 2023/24. Between 2022/2023 plan and 2023/2024 plan the key movement has been to bring Plymouth and Western closer to target by £7m, and Eastern and Northern have moved from over to under target, a movement of £8m.

4. The attribution of some allocations between Royal Devon University Hospital East (RDUE) and Royal Devon University Hospital (RDUN) is increasingly more difficult as the organisation settles into a single entity, and this will likely drive some of the movement between Northern and Eastern localities. This is something we will have to pay increasing attention to as we move forward.

5. Minor changes have been made to the methodology for the 2023/2024 and 2024/2025 allocation formula and the underlying data has been refreshed.

6. Populations have been updated to include Office for National Statistics forecast population changes. This is the largest single factor impacting equity in Devon. Plymouth continues to have the lowest expected population increases which, over time, will increasingly reduce the comparative Plymouth share of NHS Devon resources. This is evidenced in step 4 below.

7. The following bridge describes the steps that move the equity analysis on from the 2022/2023 plan position (as presented to board in October 2022), through a set of movements to the conclusion of a system in balance and at target having distributed convergence in such a way that decreases inequity.

8. These steps and brief explanations are as follows:

Step 1: Following due diligence after the figures were last reported to board, an LCP mapping error for 3 GP practices was found and corrected, this leads to version 3 of the 22/23 plan. This only moved the equity position between Southern and Western, where the incorrect practices had been mapped.

Step 2: Update to 2022/2023 outturn including analysis of key movements, including,

An additional £99m was spent with our main providers on top of initially planned contract values and this value was not always invested consistently with the fair share formula creating an equity movement.

The key in year investments post plan include £26m inflation, £12m demand and capacity, £10m s256, £9m CDC, £17m elective recovery, £6m capital related revenue, £19m other adjustments.

An additional £23m was spent on operational ICB contracts. This was driven mainly by £11m primary care prescribing price concessions, £12m demand and capacity, £5m inflation, £10m low volume acute contracts, £4m NHS 111, £4m placements, and offset by a £30m reduction (investment) from reserves.

The 22/3 outturn reduced the level of inequity from 22/3 plan levels in all localities.

Step 3: Update to 2023/2024 plan including analysis of key movements

Spend with our main acute providers at plan is reduced overall by £22m from the 22/3 outturn, which has led to some equity movements. The key drivers for this include reductions in Covid funding, top up rebasing, CDC diagnostics, and section 256 funding. CDC funding was excluded from plan but is expected to continue in year and will have an impact on equity.

ERF funding has increased by £12m to £52m, however this increase is focused more towards UHP and TSD.

Other increases in funding include Section 256 funding (increased from the non recurrent levels in 22/3 by £23m), mental health SDF (£14.6m).

Once the impact of continuation of CDC is taken into account (not shown in this analysis), the impact of the 23/4 plan is to reduce inequity in all localities with the exception of Southern. This is driven mainly by topup rebasing which did not impact on the TSD contract.

Step 4: Update the allocation formula within the 2023/2024 plan. This included the updates and data refreshes to the national formula, and includes ONS population changes estimates for 2023/2024 and 2024/2025.

Step 5: After the 2023/2024 plan, the Devon system remains £109.5m over target. The current Long Term Financial Plan assumes this will be converged (which means a reduction to our allocation) at a pace of £30m per annum. This step distributes that convergence in two stages. Initially by eliminating the top up funding remaining in provider contracts (£96.1m) and secondly by distributing the remaining balance (£13.4m) to localities using the fair share formula. The model makes no assumptions about how the expenditure will be reduced, this will be for Localities to determine according to local care priorities.

Step 6: Compare post convergence adjusted spend to fair share resources. This shows that whilst Eastern, Northern and South Devon are overspending against their resources, and Plymouth and Western underspending, all

variances are within 2.0% and are therefore within the acceptable thresholds that were previously agreed.

Table 3: NHS Devon Equity Analysis as at May 2023

NHS Devon Equity Analysis 19th May 2023		Eastern	Northern	Sth Devon & Torbay	Plymouth	Western	TOTAL
	2022/23 plan v2 inequity	**- 12,102**	**16,349**	**20,700**	**- 22,105**	**- 2,843**	**- 0**
Step 1							
	v3 inequity movement	- 7	- 3	- 1,132	- 141	1,283	
	2022/23 plan v3	**- 12,109**	**16,346**	**19,568**	**- 22,246**	**- 1,560**	**- 0**
Step 2							
	Main Providers	2,937	- 5,350	364	1,897	153	- 0
	Independent Sector	387	- 338	- 1,195	957	189	-
	Main community providers	- 999	- 297	- 3,627	4,223	700	-
	BCF (Plymouth & Devon)	2,907	1,323	- 1,669	- 2,890	328	- 0
	Placements	- 534	- 92	1,954	- 1,243	- 85	0
							-
	Other 22/23 movement	- 774	- 201	- 440	1,166	249	- 0
							-
	2022/23 outturn	**- 8,185**	**11,392**	**14,955**	**- 18,136**	**- 26**	**- 0**
Step 3							-
	Main Acute Providers	- 1,414	3,661	- 2,578	426	- 96	0
	Main community providers	4,159	- 3,772	2,842	- 2,889	- 340	- 0
	BCF (Plymouth & Devon)	- 1,288	- 577	228	1,782	- 145	0
	ERF	620	- 4,934	807	2,877	630	- 0
	Top Up	- 4,507	46	2,863	1,389	209	- 0
	Mental Health (All)	- 581	- 267	- 424	1,507	- 235	- 0
	Demand and Capacity	705	530	485	- 1,404	- 316	0
							-
	Other 23/24 plan movement	297	- 195	119	- 291	69	0
							-
	2023/24 plan	**- 10,193**	**5,884**	**19,296**	**- 14,738**	**- 249**	**- 0**
Step 4							
	Formula changes - to 24/25	- 3,635	- 1,910	- 1,339	7,282	- 398	0
	23/24 plan final inequity	**- 13,828**	**3,975**	**17,957**	**- 7,456**	**- 647**	**- 0**
	Spend	804,974	361,055	707,419	587,136	92,052	2,552,636
	Allocation	818,801	357,080	689,462	594,593	92,699	2,552,636
	Inequity	**- 13,828**	**3,975**	**17,957**	**- 7,456**	**- 647**	**- 0**
	pre convergence equity	-1.69%	1.11%	2.60%	-1.25%	-0.70%	
Step 5							
	Convergence (eliminate topup)	-16,281	-14,484	-35,722	-25,091	-4,568	- 96,147
	Convergence (fair share)	- 4,297	- 1,847	- 3,616	- 3,216	- 389	- 13,365
	Post convergence spend	**784,395**	**344,724**	**668,081**	**558,828**	**87,095**	**2,443,124**
Step 6							
	Target (fair share) resources	783,674	341,761	659,883	569,084	88,722	2,443,124
	Gap to fair share resources	**721**	**2,963**	**8,198**	**- 10,255**	**- 1,627**	**- 0**
		0.09%	0.87%	1.24%	-1.80%	-1.83%	0.00%

NHS Devon

NHS Devon Integrated Care Board

Winter Plan 2023/24

Date of meeting	Date report produced
04 October 2023	25 September 2023

Author(s)		Report approved by	
Name and title:	Dilek Hill, Head of Strategic Planning and Performance	**Name and title:**	Sam Wadham-Sharpe Director of Performance and Assurance
Phone:		**Date:**	27 September 2023
Email:	dilek.hill3@nhs.net		

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

Executive summary
This report outlines NHS Devon's 2023/24 Winter Plan in response to national requirements and local demand modelling. **Context**: NHS England published the national approach to 2023/24 winter planning in July 2023, including the key steps to be taken together across all parts of the system in England to meet the challenges ahead. The guidance was centred around four main areas: 1. Continue to deliver on the Urgent & Emergency Care Recovery Plan by ensuring high-impact interventions are in place.

One Devon

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2. Completing operational and surge planning to prepare for different winter scenarios.
3. ICBs should ensure effective system working across all parts of the system, including acute trusts and community care, elective care, children and young people, mental health, primary, community, intermediate and social care and the VCSE sector.
4. Supporting the workforce to deliver over winter, including protecting the public and the health and care workforce against flu and other infectious diseases - the best way being by vaccination. Providers should also ensure they have an established pathway for identifying patients at-risk of COVID-19 and flu in their care, including those who are immunosuppressed.

National Requirements:
As part of the Winter Plan 2023/24, and to support provider and system level planning in preparation for winter, all ICBs have been asked to submit winter planning documents that build upon the operational planning work that was completed at the start of the year, and include:

1. A numerical return: Systems have been asked to quantify the extent to which additional capacity, across several key channels, can be escalated in response to operational pressure that may be experienced throughout the second half of the year.
2. A narrative return: The narrative return template requires systems to provide assurance against 6 key lines of enquiry in support of the winter planning process.

These requirements have been met, and returns have been submitted.

NHS Devon Response:
The Devon system is well-versed in managing winter pressures, and we have established robust plans to prepare for these. NHS Devon has identified areas of priority to focus on during Winter 2023/24, including:

- Prepare for new COVID-19 variants and other respiratory challenges. Central to response is our integrated COVID-19 and flu vaccination programme.
- Ensure people can be discharged safely and quickly from our acute, mental health, and community settings, by working ever more closely with social care and implementing nationally recognised improvement action plans.
- Increase the resilience of NHS 111 and 999 services by expanding the number of call handlers, ensuring the fastest possible responses. Improve the speed in which 999 Category 2 (i.e. urgent, but not emergency) responses happen and reduce how long it takes for ambulance colleagues to be able to transfer patients into hospital care.
- Improve patient experience by expanding the availability of alternative services, which means more people who need urgent (not emergency) care will be able to be seen without going to an acute hospital. This will improve the experience of people who do need emergency care in our emergency departments by reducing crowding and wait times.

- Provide better support for people at home, including expanding our existing 'virtual wards', and giving support to those people who have complex care needs or access our hospital services frequently.

Governance:

- NHS Devon ICB is ultimately responsible for coordinating, monitoring, and assuring service delivery across Devon during Winter 2023/24.
- Overall, the NHS Devon Unscheduled Care Board is the forum that will govern the plan in its entirety, and its core membership includes NHS Devon, provider leads, locality and local authority colleagues, as well as operational, clinical, nursing, and business intelligence (BI) leadership across the system.
- NHS Devon will manage the System Coordination Centre (SCC), ensuring it meets the revised specification and retaining oversight and management of the Operational Pressures Escalations Levels (OPEL) framework and responses to changes in levels.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
Finance & Performance Committee – 26 September 2023

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do
1. The Board is asked to approve the 2023/24 Winter Plan

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	The report outlines NHS Devon's response to the expected winter surge 2023/24
Improve services and reduced unwarranted variation	The report outlines the systems response to enable services to protect the most vulnerable patients in the community during winter.
Make more efficient use of our resources	The report outlines the winter schemes put in place to support patients and providers.
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	Outlines the priorities for responding to the expected demand on services during winter.
Health inequalities	Outlines the priorities for responding to the expected demand on services during winter.
Workforce	Outlines workforce plans to support the system during winter.
Resources and finance	
Legal	
Digital and Data	
Involvement, Engagement and consultation	

One Devon

DRAFT

One Devon Integrated Care System (ICS) Winter Plan 2023/24

NHS and CARE working with communities and local organisations to improve people's lives

Contents

Foreword

The Devon 2023/2024 winter plan has been created in partnership through the One Devon Integrated Care System (ICS).

It offers pledge-based opportunities for the provision of our winter care and a framework for the provision of our care in a seamless, timely, effective, and appropriate way, from a point of need along pathways to a point and place of delivery.

This plan is very much about what the system will do for you, the population of Devon.

Seasonal variation in unscheduled healthcare demand has become far less pronounced, with most services working at capacity throughout the year, not just peaking in the winter months.

Our plan is to deliver the best care we can through winter and aims to be responsive to the people and communities of Devon.

It aims to support our staff who work in our busy health and social care services, who have already worked tirelessly throughout the year, and through the peaks of COVID-19 and the pressures of last winter.

The ongoing challenges within our unscheduled care system has provided the opportunity to create a shared plan for winter that truly represents our joint priorities. We pledge to do our very best to rise to the challenge that winter will present.

Our 2023/2024 winter plan is clear and simple. We will work together to deliver joined-up urgent and emergency services, focussing on our goals of ensuring care is safe, timely and person-centred.

Our aim is to ensure our population receives the care and treatment they require in the correct setting and at the right time.

Dr Nigel Acheson

Chief Medical Officer
NHS Devon

This winter in context

Our plan to handle the pressures we know come at this time of year is more important than ever, and reflect the priorities faced by the whole country.

The Devon system is well-versed in managing winter pressures, and we have established robust plans to prepare for these. In response to the demand modelling undertaken, NHS Devon has identified areas of priority to focus on during Winter 2023/24, including:

Our priorities

Prepare for new COVID-19 variants and other respiratory challenges. Central to response is our integrated COVID-19 and flu vaccination programme.

Ensure people can be discharged safely and quickly from our acute, mental health, and community settings, by working ever more closely with social care and implementing nationally recognised improvement action plans.

Increase the resilience of NHS 111 and 999 services by expanding the number of call handlers, ensuring the fastest possible responses. Improve the speed in which 999 Category 2 (i.e. urgent, but not emergency) responses happen and reduce how long it takes for ambulance colleagues to be able to transfer patients into hospital care.

Improve patient experience by expanding the availability of alternative services, which means more people who need urgent (not emergency) care will be able to be seen without going to an acute hospital. This will improve the experience of people who do need emergency care in our emergency departments by reducing crowding and wait times.

Reduce pressure on acute and community hospital wards through a mix of new physical beds, 'virtual wards' where patients receive excellent care in their own home, and by making sure moving through our services is as smooth and timely as possible.

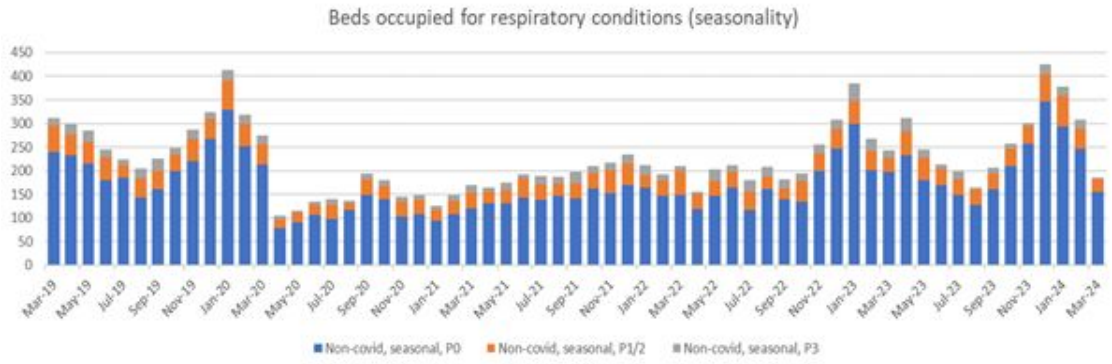
Provide better support for people at home, including expanding our existing 'virtual wards', and giving support to those people who have complex care needs or access our hospital services frequently.

Demand

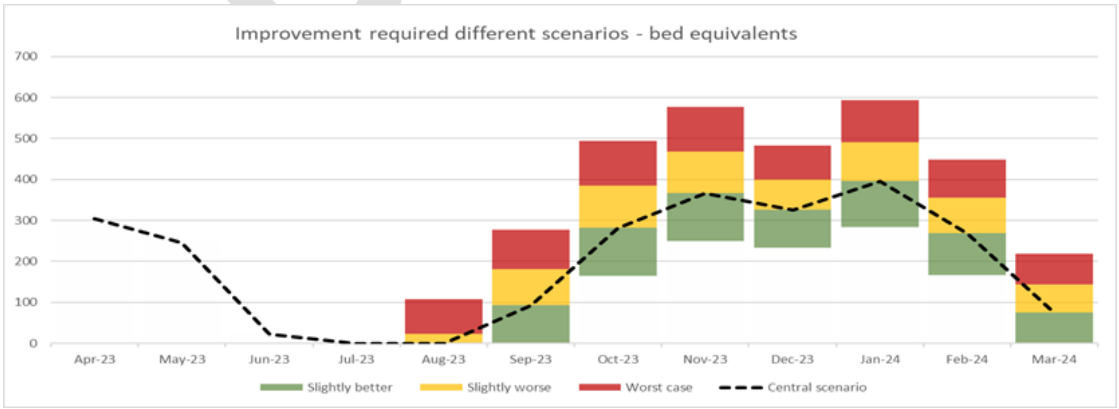
NHS Devon's winter demand modelling is based on intelligence from national surveillance data in Australia to prepare for potential peaks in flu and Covid19 infections. Based on the data, it is expected that the current flu season is more typical to pre-pandemic levels in the southern hemisphere, which is reflected in the local modelling to determine demand locally for this winter.

The demand model includes a baseline annual growth assumption of +2.5% for non-elective admissions. This growth was estimated from the changing health needs of the Devon population and includes factors such as aging and total population growth etc. The 'expected' level of demand is projected forward from pre-pandemic levels to avoid the suppressed demand that occurred during the pandemic period.

The chart below shows the trend in respiratory beds occupied. Early in the pandemic activity was a lot lower than in previous years plus any seasonality was mostly negligible. The social distancing measures in place to control covid had a secondary effect of reducing infectious diseases. The chart also shows how we are now projecting future respiratory demand to return to pre-pandemic levels. The projection below is unmitigated so the rollout of virtual wards etc should help to reduce the scale of this peak in hospital beds occupied.



Based on the initial outputs of the system demand model shows that the Devon system could be in a bed deficit position of -396 beds in January 2024 if no mitigations are put in place.



DRAFT DOCUMENT

Our system plan

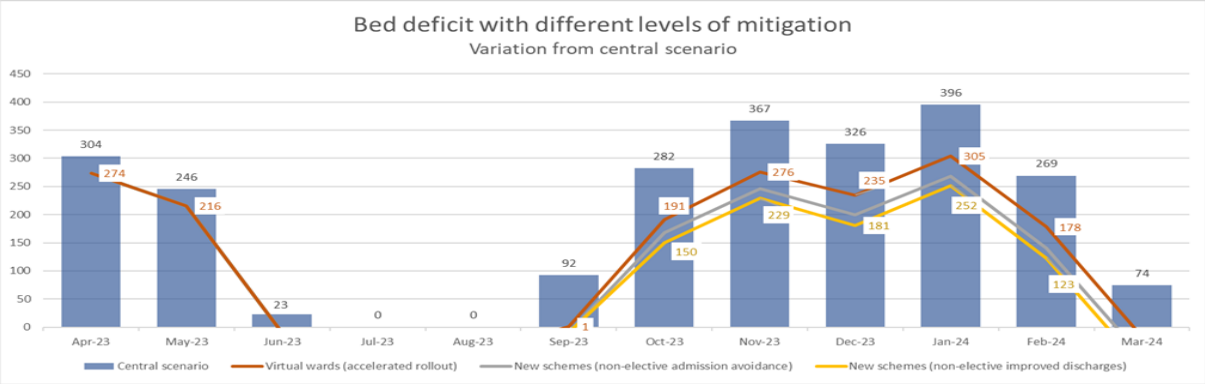
The Integrated Care Board (ICB) has overall responsibility for the coordination of all winter plans into one system plan, including the system response to the high impact interventions.

Our winter plan sets out specific examples of actions we are taking in each area that support our pledges for this winter's approach.

The chart below shows how the bed deficit can be reduced through additional mitigation. The accelerated rollout of virtual wards is expected to reduce the peak bed deficit from 396 to 305 beds. The accelerated rollout of virtual wards is above that shown in our previous planning submissions and aims to have 227 virtual ward beds available by the end of September 2023. It would also delay the point when the system potentially experiences a bed deficit in October 2023.

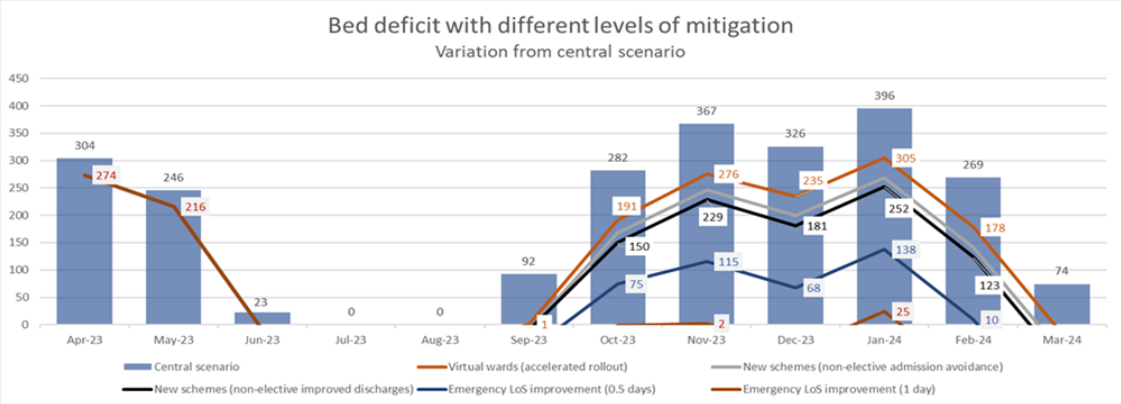
NHS Devon has funded a number of additional schemes to further mitigate against impact of the winter surge. This additional capacity is made up of both existing and new schemes and aims to reduce the bed deficit by 53.5 beds (109.9 including existing schemes).

For a full list of schemes, see Appendix 1.



The primary cause of bed pressures on the Devon system is driven by an increase in non-elective length of stay (LoS) which in turn is linked to patients requiring a complex discharge. This should also be considered alongside Devon serving a more elderly population, making our LoS even more extreme. Data suggests that as we exited the pandemic, non-elective LoS increased both locally and nationally, but by December 2021 Devon was reporting a non-elective LoS similar to the national average.
As part of our system response to mitigating the expected bed gap during Winter 2023-24, NHS Devon has been coordinating joint work with working with acute providers to explore opportunities to reduce the average LoS across Devon, Plymouth and Torbay. We are now seeing an improvement in our non-elective LoS, with a goal to bring it back to pre-pandemic levels. As Devon has a very small hospital bed base relative to the population it serves, it needs to have a non-elective LoS that is one of the lowest nationally.

Reaching agreement on system-wide consistent reduction is an ongoing and challenging piece of work, however, the system recognises that a further one-day reduction in LoS will significantly help to mitigate the impact of the expected winter surge, as outlined in the chart below:



System control centre

NHS Devon's System Coordination Centre (SCC) is managed through the ICB to manage system pressures and winter planning. This will meet the revised national specification and will retain oversight and management of the OPEL framework and responses to changes in levels. The ICB is co-ordinate the system responsibilities with the providers of children's services, including the three acutes and the two community children's providers who are responsible for delivery.

The SCC is a function of the System Delivery and Improvement team and operates Monday to Friday (0800-1800) and Saturday and Sunday (0900-1700). The SCC is managed by a system delivery and improvement manager as part of a seven-day rota.

There is also a requirement to support the ICB on-call director and manager and have ICS oversight of impact and SCC outputs in the event of an emergency, preparedness, resilience and response (EPRR) incident declaration within the SCC operating hours.

Between the hours of 2000-0800 Monday to Friday and 1700-0900 Saturday and Sunday, NHS Devon director and manager on-call arrangements are in place to maintain SCC continuity, with the ability to stand-up full SCC functionality as needed.

System control centre (SCC)

The system control centre will have visibility of operational pressures and risks across providers and system partners. This is managed through various system reporting and oversight via system calls and reactive response to operational pressures by the SCC.

This focuses on concerted action across the ICS on key systemic and emergent issues impacting patient flow, ambulance handover delays and other performance, clinical and operational challenges.

There will be dynamic responses to emerging challenges and mutual aid, either through direct intervention, or referring to specialist within the ICB or providers.

Efficient flows of information – as a part of this the ICB is commissioning a real time information system "SHREWD" which should be in place before winter.

Primary care

There are recognised national workforce pressures in primary care, including a longer-term concern regarding the numbers of GPs retiring and leaving the profession. Our GP practices increasingly work in Primary Care Networks (PCNs), groups of practices serving broadly the same community, to provide support and help to each other.

These PCNs also work together in wider geographical collaboratives called Local Care Partnerships (LCPs), with representatives from the county's health and social care organisations.

The ICB is supporting PCNs to conduct longer-term workforce planning to understand where our local gaps are and will be. The ICB will remain the co-ordinating body for primary care roles and responsibilities but will enact these at system level in collaboration with the Devon Collaborative Board, the LMCs and the Locality Care Partnerships, where this is a local delivery issue.

A weekly primary care cell will be in place throughout winter. It will report into the System Control Centre to highlight any system issues of escalation and management. The cell will monitor and deliver the primary care actions on the urgent and emergency care (UEC) improvement plan. The cell will raise any issues with the Devon Primary Care Collaborative Board where providers will be asked to work at system and locality level to respond.

Progress against primary care winter schemes, for example Acute Respiratory Infection (ARI) hubs and admissions avoidance (funding to be confirmed) will be monitored through the Devon Collaborative Board and reported to the Unscheduled Care Board. OPEL status will be collected and shared with System Control Centre every Friday to alert the system to pressures in general practice and actions being taken to support maintained access and practice resilience.

Given over 90% of contacts happen in GP practices, resilient primary care is fundamental to managing pressures across the system. Last year primary care played a key role in ARI and are engaged in planning for this year.

Primary care teams are working to deliver the Primary Care Access Recovery Plan (PCARP). The national ambitions for the PCARP are:

To make it easier for patients to contact their practice.

For patients' requests to be managed on the same day, whether that is an urgent appointment, a non-urgent appointment within two weeks or signposting to another service.

The plan is divided in to four areas:

Area	Focus
Empower Patients	• Improving information and NHS App functionality • Increasing self-directed care where clinically appropriate • Expanding community pharmacy services
Modern General Practice	• Implementing 'Modern General Practice Access' • Better digital telephony • Faster navigation, assessment, and response
Build Capacity	• Larger multidisciplinary teams • More new doctors • Retention and return of experienced GPs • Higher priority for primary care in housing developments
Cut Bureaucracy	• Improving the primary – secondary care interface • Building on the 'Bureaucracy Busting Concordat'

The PCARP will be delivered and monitored through a regular task and finish group and reported through to Primary Care Commissioning Committee.

The ICB has developed a communications plan that outlines the activity to be undertaken for each of the areas of focus outlined in PCARP, both locally and nationally, as well as what is already underway. The draft plan sets out how we will improve patient understanding of the new ways of working in general practice and promote access to community pharmacy.

Community pharmacy

Community pharmacy will support wider system capacity through delivery of the GP community pharmacy consultation services (CPCS) and hypertension case finding

through blood pressure checks. CPCS is accessed through referral from general practice. Engagement with general practice is enabled by the ICB Community Pharmacy Clinical Lead (CPCL) and Community Pharmacy PCN Leads (CP PCN Leads), with support and oversight from the ICB Community Pharmacy Development Group (in collaboration with Cornwall).

NHS Devon commissions a Minor Ailments Service enabling community pharmacies to provide prescription medicines for uncomplicated urinary tract infections, impetigo, and mild inflammatory skin conditions.

NHS Devon has an opportunity to participate in a national Independent Prescriber Pathfinder Programme, which will explore the commissioning of pharmacist independent prescriber services from community pharmacy, extending the scope of practice for community pharmacies to manage minor conditions.

We are working with NHS providers to increase referrals to the Discharge Medicines Service (DMS) in community pharmacy to reduce error, harm and readmissions.

Any impacts of the amended unplanned closure policy will continue to be monitored. There has been a gradual reduction in volume in recent months. The aim of the policy is to ensure providers prioritise filling shifts in this area. Where this is not possible, the accompanying guidance, agreed with the Local Pharmaceutical Committee (LPC), ensures the providers effectively communicate to patients, local partners and commissioners, to enable effective signposting of patients.

The impact of recent and future pharmacy closures/consolidations/changes to hours has been reviewed and where immediate gaps are created, rota proposals (additional commissioned cover) will be considered. Information on changes is also being shared with Health and Wellbeing Board local health and wellbeing boards (H&WB), for consideration of the impact on the pharmaceutical needs assessment (PNA).

Regular review meetings are in place with all corporate and large multiple providers, to understand emerging pressure and respond to escalations.

Urgent care

An overview of Devon services suggests the nature of community urgent care provision varies considerably across the Devon footprint, both within and between localities.

To provide a more targeted approach to UEC recovery, a new Devon integrated UEC recovery plan has been co-produced between the ICB, localities and providers. The focus has been provided by targeting 5 key domains where GIRFT highlights that Devon providers and the system does not perform as well as national or peer averages.

The UEC recovery plans will be managed at Locality UEC Boards with assurance and escalation provided to the new Urgent Care Board. This process will include the oversight of delivery and evaluation of impact of the additional funding schemes which have been identified for the £13.8m assigned to Devon ICS. Business case reviews have been undertaken against the current schemes to ratify the schemes, including key delivery milestones and expected impacts to enable effective evaluation.

111 and out of hours

The Integrated Urgent Care Service (IUCS) incorporates 111 call answering, clinical assessment service (CAS) and primary care treatment out of hours. It plays an important role in the urgent and emergency care system, providing a viable alternative to emergency departments (ED) and ambulance services for patients with urgent care needs. The Devon service is provided by Practice Plus Group (PPG).

The priority for NHS 111 is to improve call answering performance – reducing call abandonment rates and average speed to answer – particularly at the weekends. There is a comprehensive improvement plan for the provider and the ICB.

Actions are underway to increase capacity including recruiting an additional 70 health advisors across the call answering network, to work late evenings and weekends, with significant pay enhancements to attract applicants to these roles.

Sufficient capacity to deliver clinical validation of emergency signposting as part of the 111 contact is a high priority for the system, and we are working with the provider to ensure sufficient clinical advisor and senior clinician capacity is in place to deliver national and local targets for validation of ED and category 3 and 4 ambulance outcomes (there should be a minimum of 85% ambulance outcomes validated, and 80% of cases that are directed to ED).

The clinical assessment service (CAS) provides 24/7 access to senior primary care clinicians for patients and other health care professionals, including the ambulance service. Capacity in the Devon CAS is good, and the priority will be to maintain this as activity rises over the winter period. The Devon CAS derives significant benefit from access to the Practice Plus group (PPG) national home working clinician network. Planned developments that will support winter resilience include end-of-life clinical resource at weekends, and increased bandwidth to support additional video consultations.

Primary care out of hours face-to-face treatment services provide consultations via treatment centres and home visits when GP practices are closed. The focus for winter will be to increase capacity, in response to expected increases in demand. An out of hours (OOH) clinical workforce strategy has been agreed, which aims to consistently deliver at least 650 hours per week of out of hours capacity.

Implementation of the strategy will include innovative approaches to recruitment and retention of GPs and advanced care practitioners, together with a market-forces review to ensure pay rates are sufficient to attract and retain local clinicians.

Sufficient primary care capacity out of hours provides timely access to treatment, reducing the likelihood of patients attending ED. It will also support the service to recommence ED streaming, where patients in ED assessed at triage as having a primary care need can be streamed to the out of hours service.

Minor injury units (MIUs) and urgent treatment centre (UTCs)

Urgent treatment centres provide medical help when it's not a life-threatening emergency. Other types of urgent care services are called minor injuries units

Urgent treatment centres and minor injury units can diagnose and deal with many of the most common problems people go to ED for, such as:

- broken bones and sprains
- injuries, cuts and bruises
- wound dressing
- stomach pain
- coughs, colds and breathing problems
- vomiting and diarrhoea
- skin infections and rashes
- high temperature (fever) in children and adults
- mental health problems
- Urgent treatment centres

All urgent treatment centres are open for at least 12 hours every day, including bank holidays. This is usually 8am to 8pm, but some are open earlier and later.

Minor injuries units and walk-in centres have different opening times. You can check the opening times for the nearest services to you on the NHS website.

Virtual wards (VW)

There will be funding for 227 VW beds in Devon from September 2023. The Devon virtual ward (VW) offer is delivered and operated by the three acute hospital trusts in the Devon system. Virtual wards (also known as hospital at home) allow patients to get hospital-level care at home safely and in familiar surroundings, helping speed up their recovery while freeing up hospital beds for patients that need them most.

Just as in hospital, people on a virtual ward are cared for by a multidisciplinary team who can provide a range of tests and treatments. This could include blood tests, prescribing medication or administering fluids through an intravenous drip.

Patients are reviewed daily by the clinical team and the 'ward round' may involve a home visit or take place through video technology. Many virtual wards use technology like apps, wearables and other medical devices enabling clinical staff to easily check in and monitor the person's recovery.

Local evaluations are in place to understand patients' reduced need for hospital care across specific pathway and clinical and health outcomes, along with patient and staff experience of our existing VWs, to support this.

Additionally, there is ongoing work to understand if our workforce is in the right place to go further as workforce recruitment has been a major obstacle in implementation of VW beds. These outcomes are seen as a key driver within this transformation programme over and above the number of beds in place and will fundamentally help to support increasing capacity safely moving forwards to 2024/25.

There is ongoing work to understand if we have sufficient workforce working in the right place as recruitment has been a major obstacle in implementation of VW beds locally.

The ICB VW programme team are leading on work to standardise the VW pathways across providers in 2023/24 by:

- Provision of an updated standard Devon-wide Standard Operating Procedure (SOP) to be implemented by all providers. This sets out the minimum requirements required by each provider along with reporting indicators to support local evaluation.
- Engagement with clinical teams across the three VW providers.
- Initiation of quarterly pathway reviews to identify learning, strengths, and challenges, and support work to standardise each pathway reviewed.
- Ongoing clinical review and sharing of good practice across the ICB. This approach is already accelerating the current bed opening trajectory and is expected to have ongoing benefits.
- Existing VW services will continue to gain momentum, while we look at innovative ways to develop pathways that link to urgent community response (UCR) 2-hour response services, the acute respiratory infection (ARI) hubs and SWASFT.
- Early exploratory work is underway to look at service development with primary care to support acute admission avoidance for patients presenting in ED or Same Day Emergency Care (SDEC).

Urgent community response (UCR)

Devon's urgent community response (UCR) service is delivered by locality-based teams across Devon who provide urgent care to people in their own homes, helping to avoid hospital admissions and enable people to live independently for longer.

They provide a rapid response service carrying out assessments and provision of equipment, as required, within two hours of referral.

The service is available from 8am to 8pm, 7 days a week, with some localities able to offer a 24-hour response to specific pathways.

The role of the ICB is key to supporting delivery and improving provision of UCR services. We will continue to collaborate with key delivery partners, ensuring standardisation of UCR coverage at both a locality and system level.

During winter 2023/24

- Services will continue to ensure that the referral acceptance criteria include common clinical conditions, inclusive of those in line with national guidance and reflected via the Directory of Services (DOS) to enable equitable referral pathways across the system.
- Self-referrals via pendant alarms have recently gone live as a referral pathway to UCR/intermediate care. This pathway is early on in its development so will be monitored and adapted as required but is providing positive outcomes for patients and reducing SWASFT usage, particularly category 2 activity.
- UCR services across the Devon system are exceeding the 70% 2-hour response target. Staff within the teams can flex to meet the demands of discharge whilst also maintaining a focus on rehabilitation and improved outcomes of patients to return home. The Directory of Service for SWAST reflects the ability for the UCR teams to take direct referrals for Level 1 and Level 2 fallers, which includes multi-disciplinary team (MDT) intervention, and the use of appropriate equipment, such as the Raizer chair. Category 3 and 4 calls are also taken directly from 111. This work supports the reduction of health inequalities across Devon.
- Across two of the three Devon localities, UCR is operated 24/7 for level 1 and 2 fallers. Some of the investment has been requested to reduce the UCR inequality across the Devon system.
- Access to in and out of hours services (community nursing/UCR) for care homes and personalised Care and Supportcare and support planning with residents and carers is via the weekly clinical review and local MDT meetings.
- A targeted communication to care homes about Urgent Community Response (UCR) services will support an increasing number of referrals to UCR services.

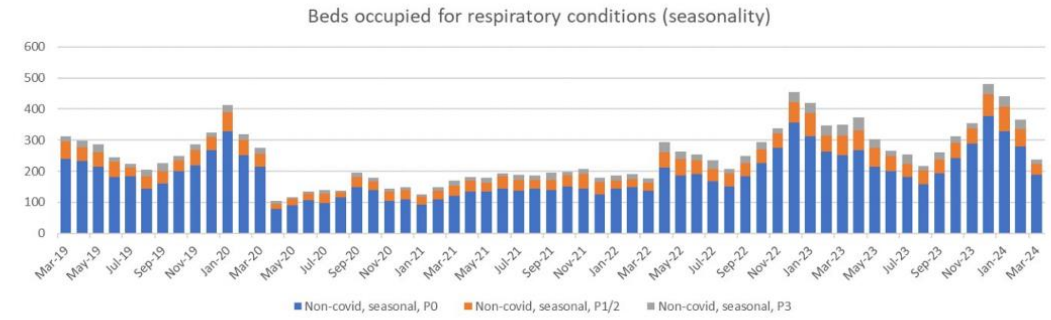
Acute respiratory infection (ARI) hubs

Following evaluation of the 2022/23 ARI Response Service delivery model across Devon, a further system planning group was convened in June 2023 to initiate early planning for 23/24.

The system planning group meets monthly – membership includes clinical leads, providers and commissioners and Devon Primary Care Collaborative Board

Demand modelling has demonstrated a slightly later peak expected in January 2024:

Demand Model and Projection – Respiratory



The main source of the increased demand in the winter is linked to respiratory admissions

- Historically the Devon system has increased respiratory bed usage in the winter by approx. 200 beds (8% of the total bed stock)
- This was significantly depressed during the pandemic as social distancing used to control covid also reduced the spread of other infectious diseases
- We are now expecting respiratory demand to return to pre -pandemic levels
- The aging population will slowly exacerbate the scale of the winter surge

Each local planning group includes clinical lead, local commissioning managers and primary, community and secondary care providers. Each locality has identified learning from last year and plans to replicate a similar primary care-based model for additional capacity specifically for ARI presentations.

Access to specialist services will be via ‘hot clinics’ in East, or via virtual wards for the other localities, and these pathways are currently under development.

The system has currently identified £435,000 worth of funding, which will enable an extra 16,000 appointments.

Winter schemes

Our System Recovery Programme is creating an environment that encourages new ways of working, continuous improvement and embraces change by streamlining our decision making and improving the pace of change. Our UEC approach is based on using evidence to focus collective resources on the areas which will have the most beneficial impact on patient care.

Diagnostic work identified seven key areas of opportunity within Devon where we are an outlier and performing less favourably compared to other systems. These include:

1. Falls
2. Frailty
3. End of Life
4. Ambulance Handovers
5. Length of Stay
6. Discharge
7. Mental Health

Key actions include the development of a standardised system-wide pathway for these areas. We have facilitated system-wide workshops and discovery sessions and are considering ideas for implementation. Beyond pathway development, we are working on prevention strategies to support sustained improvements across all three pathways. Where possible, and particularly for ARI hubs, services have an all-age approach.

Across the Devon footprint there are several initiatives and schemes to support attendance and admission avoidance. These include:

- Development of a Care Coordination Hub function
- Development of UCR services across the Devon system
- High impact support to care homes
- Enhancement of Same Day Emergency Care (SDEC)
- GP streaming

Some schemes have been funded through the additional capacity to support winter pressures, totalling £13.8 million. The impact of these schemes has been modelled, and is included in the table below:

Scheme	Scheme start dates	Month of impact
Eastern GP streaming	1 Nov 2023	5
Northern GP streaming	1 Nov 2023	5
UTC to national specification (Tiverton)	1 Dec 2023	4
Provision of primary care medical cover for all pathway two patients placed in care homes in North and East	1 Oct 2023	6
North and East Tactical Provider Support Team (TPST) 1:1 hospital discharge to care home support	1 Oct 2023	6
North and East live-in carers support	1 Oct 2023	6
Northern discharge hub	1 Sept 2023	7
Northern – staff and resource of 12 additional beds across Roborough Ward (8 beds and additional 4 community rehab beds at South Molton)	1 Sept 2023	7

Northern: Additional discharge co-ordinators for wards	1 Sept 2023	7
Eastern - community hospital beds – Sidmouth	1 Sept 2023	7
Eastern frailty - Hospice care nurse within single point of access (SPOA) – Focus on end of life care, Hospice and P3 discharge	1 Oct 2023	6
Eastern - Virtual ward night sits	1 Oct 2023	6
Out of hours district nursing call handling service (Provided by HUC)	NO MODELLING	
Northern - Discharge liaison officer and clinical admin support to clinical site team	1 Oct 2023	6
Clinical capacity in 111/IUCS (OOHs)	1 Oct 2023	6
Clinical capacity in 111/IUCS – dedicated CAS resource for EOL	15 Oct 2023	6.5
IUCS digital implementation of new post-event texting option	1 Sept 2023	7
IUCS care navigation service	NO MODELLING	
SWASFT overnight mental health desk	1 Dec 2023	4
UTC to national specification – Cumberland	Included UHP UTC	
UTC to national specification – Newton Abbot	1 Oct 2023	6
Continuation of 17-bed ward used over winter	1 Sept 2023	7
ED-based Same Day Emergency Care – Torbay	1 Sept 2023	7
GP streaming at UHP – Derriford	1 Sept 2023	7
GP streaming at UHP - Derriford	1 Dec 2023	4

Locality approach

One Devon is a collaboration of the NHS and local councils, as well as a wide range of other organisations like the voluntary sector, who are working together to improve the lives of people in Devon. We are making our system as strong and effective as possible, through partnership working and with the ambition to tackle health inequalities, help communities thrive and achieve the very best for everyone.

Delivering a plan that meets the needs of the populations across Devon requires the partnership of health and care organisations across the county. NHS trusts and Integrated Care Bodies, local authorities, GPs and primary care colleagues, voluntary and independent sector partners work collaboratively to improve health and services.

Local care partnerships (LCPs) are collaborations between a wide range of local organisations and groups. Many factors affect people's health and wellbeing from their homes and personal finances to their education and employment. LCPs bring together the organisations and groups that provide these services (and many others) to better support people and communities.

North and East Locality

The North and East locality is served by the Royal Devon University Healthcare NHS Foundation Trust, with acute hospital sites in Exeter and Barnstaple.

Stretching across Northern, Eastern and Mid Devon, the Trust delivers a wide range of emergency, specialist and general medical services through North Devon District Hospital and the Royal Devon and Exeter Hospital. Alongside our two acute hospitals, they provide integrated health and social care services across a variety of settings including community inpatient hospitals, outpatient clinics, and within people's own homes. Areas of focus for winter 2023-24 include:

Same Day Emergency Services (SDEC)

- Provision in place for Medical SDEC 7 days per week, 12 hours per day at RDUH (Exeter)
- Provision in place for medical SDEC currently 5 days per week at RDUH (Barnstaple). There are plans in place for this to increase to 6 and subsequently 7 days. This remains a trust priority but continues to be impacted by medical workforce challenges with a response expected in early September.
- Surgical SDEC is open across both sites 7 days per week – 24 hours per day.

Alongside the two acute hospitals, they provide integrated health and social care services across a variety of settings including community inpatient hospitals, outpatient clinics, and within people's own homes.

Inpatient flow and length of stay

- The system is committed to improving admission avoidance and discharge process to enable the 'home first' approach.
- There is a detailed internal action plan in place with a continued focus on inpatient flow and LoS which is being managed through weekly meetings on both trust acute sites. These actions feed directly into the Integrated UEC plan, which is held jointly between RDUH and NHS Devon.

Frailty

Frailty services remains a significant focus for both acute sites and the community services division for RDUH.

- Acute frailty service provision - in place in Eastern services, but workforce issues in Northern Services to be addressed to increase provision, especially at weekends.
- Community services utilise Frailty flags on Electronic Patient Record (EPR) to support the identification of patients who would benefit from frailty services.

Patients in the community are then discussed at Core Group meeting with primary care, DPT etc.

- Acute Care of the Elderly team and therapy led admission avoidance team in the East seek to avoid admission for patients presenting to hospital.
- Referrals to avoid admission – Referrals proactively made to Virtual Ward Service, which is expanding.
- There is a detailed Frailty Action plan with key areas of focus:
    - Development of Frailty Navigator
    - Roll out of Clinical Frailty Scale to ED
    - Enhancement of Frailty training for key clinical staff groups
    - Completion of Baseline Assessment Tool for the NICE Delirium Guideline
    - Ensure effective use of Virtual Ward
    - Pilot ring-fenced “step-up” beds in Dec/Jan.

Community bed productivity and flow

Royal Devon University Hospital Trust (Northern and Eastern Services) delivers community services in North and East Devon alongside acute services. This enables a smooth transition in acute and community patient care.

RDUH are fully engaged with the Devon-wide and ICB-led transfers of care hub work. There are centralised discharge hubs for both North and East.

There is an ongoing focus on falls, frailty and end of life care, including admission avoidance and a detailed targeted action plan to improve performance. This work is also aligned to the ICB led system improvement focus on falls and frailty. Advanced data and monitoring is in place via the EPIC EPR system and live operational dashboard to manage daily capacity and demand and service overview.

The Improved patient flow between acute, community and social care (IPACS) model has been adopted as the basis for the Devon County Council footprint hospital discharge transformation programme. This aims to support the strategic, operational, and cultural transformation of all partners delivering services within the scope of the programme. This is to enable capacity allocation to follow complex discharge pathways and consider total cost, patient experience and outcomes.

Plymouth

Plymouth remains an area with significant pressures and challenges but has an approach that is built on strong integration across strategy, commissioning, and delivery. These are well recognised and include the impact of deprivation, access to suitable housing and the wider determinants of health and wellbeing for of its population.

Urgent care and system flow remain one of Plymouth's most significant challenges, with ongoing pressure experienced within the urgent care system. The acute hospital, University Hospitals Plymouth (UHP) continues to be a national outlier in terms of ambulance handover delays and has been supported through the National Hospital Discharge Programme. To address the Plymouth urgent and emergency care challenges there are three areas of focus: admission avoidance, improvement of flow and expediting discharge. Specific services to support Plymouth during winter 2023/24 include:

Same Day Emergency Care (SDEC)

- SDEC services are well established across the site.

Frailty

- Frailty services are in place however, there is some capacity and space issues due to estates infrastructure and workforce is also a limiting factor.
- The UEC Innovation in effective navigation 100-day challenge workstream 'Tackling avoidable admissions from falls' in Plymouth and the focus of the UEC improvement plan around falls and frailty link into this work.
- Further provision of frailty specialist nurses, funded by the Better Care Fund (BCF), provide in-reach at the front door of University Hospitals Plymouth emergency department and as part of the acute frailty unit. The service provides a nurse lead
- In-reach approach into ED and Medical Assessment Unit (MAU) for 12 hours, 7 days a week - this has meant that the frailty service is not limited to the footprint within the unit.
- Nurses provide specialist input into comprehensive geriatric assessment to promote patient choice and options. The specialist nurses prevent, where possible, admission into hospital, support discharge, promote and access community services to provide an alternative to hospital admission and reduce length of stay in hospital if the admission was unavoidable.
- The nursing team supports better outcomes for patients by focusing on a home first approach to their care, ensuring wherever possible patients are discharged to their usual place of residence. Empowering patients improve outcomes to have choice and control, through shared decision making with the specialist nurses and patients aiding in reducing the length of stay in hospital.
- The intention is to further improve the service increased training and development opportunities for team members - looking at non-medical

prescribing, HEE (Health Education England) funding for enhanced practice models to further support patients and the medical teams.

Inpatient flow and length of stay

- Ambulance handover improvement plan in place
- An individual placement and support service (IPS) has been launched and dashboard in final planning stages for implementation and to be used in improvement huddles. Themes will be picked up through 4-hour validation process and huddles.
- A length of stay improvement program is in place.
- Revised executive led ward managers flow meetings established to improve early flow home and to the discharge lounge.

Community bed productivity and flow

- Quality academy work has taken place with teams to improve MDTs at the Local Care Centre rehabilitation unit ensuring LOS is in line with the aim of achieving 18-day average LOS allowing for the complexity of referrals for this rehabilitation unit. The new Discharge Assessment Unit is a therapy led unit to support reablement for P1 and P2 patients with aim to discharge patients' home with minimal support as necessary – this is achieving a 9-day LOS ambition between 7 and 14 days.
- The 2023/24 Operating Plan included the establishment of additional beds as part of the elective recovery fun (ERF)/targeted investment fund (TIF) schemes for 2023/24. Due to slippage on these schemes the dates at which these beds will be operationalised has moved and trust currently in the process of reviewing timelines against the original submission.
- A full capacity protocol is in place providing an additional 15-20 boarding spaces per day. Occupancy monitored as per operating plan trajectory with specific work on reduction in no criteria to reside stays ahead of winter to 5% target in progress.
- Revised bed model completed in line with increased demand, reducing length of stay, no criteria to reside and virtual ward opportunities.
- 4-hour operating plan trajectory is in place and is monitoring through daily ED huddles, 4 hour validation, PMO meetings, Delivery and Improvement Board, Western Unscheduled Care Board and Devon Unscheduled Care Board. Improvement plan in place detailing actions, owner and timelines. UHP in Tier 1 for UEC and monitored at Regional and National weekly meetings.

Targeted actions are in place focussing on validation for:

- no-admitted performance.
- primary care streaming, and
- UTC performance

The Healthy Lives Partnership (formerly known as ICP) is fully engaged with local and ICB wide workstreams with a particular focus on transfer or care hubs, pathway 1 capacity and improvement and falls and frailty workstreams. The work is underpinned by demand and capacity modelling to ensure that any improvements made will meet the needs of the population.

South and West Locality

Torbay and South Devon NHS Foundation Trust provides community care, including adult social care (Torbay), and acute care, from Torbay Hospital and a range of community sites.

Working together within the locality, a range of services have been commissioned to ensure people remain independent for longer, where possible to remain in their own home and demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home:

- Increasing Urgent Care Response support workers to help maintain patients to remain at home.
- Recruited assistant practitioners to review patients in short-term services, to ensure the correct support needed to maintain independence.
- A pilot in intermediate care (IC) has placement and own-home teams to maximise staff capacity and skills and increase focus on length of stay.
- Community therapies work flexibly to support intermediate care
- Commission night sits. Roaming night sits for level night needs, which if unmanaged would lead to deterioration of health and potential hospital or care home placement.
- Upskilled community nurses to manage complexity in the community.
- Occupational therapist outreach (OT) in-reach model
- OT in-reach - expanded the model due to success- data shows 46% reduction in provision of support or pathway of care.
- Duty teams for both health and social care, with an integrated response.

SDEC and pathways utilisation

- Creation of an urgent care village co-located with the ED incorporating the discharge lounge and a frailty area
- Medical and surgical SDEC already in place seven days per week, twelve hours per day, with a new acute medical unit (AMU).

Frailty

- Use of a frailty area within ED footprint, under the leadership and support of the Trust frailty team, which will link in with virtual ward utilisation and community/VCSE pathways. New GP Frailty Lead in post to support the work.
- In partnership with PCNs, the locality has established a Healthy Ageing Partnership and Board using population health management data to help identify and support strategy and modelling.
- Investment to supporting the uptake and use of identification flags for frailty in primary care and the use of a comprehensive geriatric assessment.
- ARI Hubs: Reviewing learning/impact from approach last winter between acute trust and primary care-based model.

Inpatient flow and length of stay

- Dedicated workstream via the provider UEC Programme Board used to support this area of work.
- Daily site command meetings with control centre to support dynamic and flexible response to the site needs and OPEL status.
- “Home for Lunch” programme utilising the SAFER principles and MDT huddles on all wards, including community hospitals.
- Use of a discharge lounge seven days per week, 12 hours per day, with a dedicated team.
- McCullum Ward - ready-to-go unit (17 beds- funded via the UEC additional funding programme) is used for the cohorting of NCTR clients using an allied health care professional model to continue rehab potential and focus discharge support.

Community beds

- IPACS modelling undertaken for P1-3 demand/capacity. Also completed via the BCF process (to be aligned).
- Transfer of Care Hub in place with a multidisciplinary team, including VCSE at TSDFT, with an OT reviewing all P1-3 referrals to ensure appropriate pathway utilisation. Complex review meetings take place Monday-Friday to review all P1-3 with a no criteria to reside patients, and at least twice weekly review of all P1-3 with criteria to reside (CTR).
- All general and acute wards have discharge co-ordinators to support P0-3 discharges and liaison.
- Consideration to include the community hospital clients in that process to help reduce LoS and push the Home First principles with a focus on P0 and the management of Community/D2A bed flow.
- Immedicare/Whzam pilot to commence in October 2023 to include 20 Torbay residential care homes and 4 in South Devon who were identified as high users of SWAST conveyances to ED. This will enable a virtual and immedicare response to the care home to a clinician to review their change in health
- 24/7 integrated model of support to offer falls services and UCR response across the TSDFT footprint using various teams and services.

Voluntary, Community and Social Enterprise Sector

There are more than 7,000 organisations in Devon making up the county's voluntary, community, and social enterprise sector (VCSE). It has almost twice as many registered charities compared to the national average, with extensive experience in developing and promoting positive activity around health and wellbeing.

The VCSE employs almost 5% of Devon's working population and there are 59,000 volunteers, giving over 115,000 hours of their time each week equating to an annual value of £74 million.

The VCSE is represented at the ICS Partnership Board, in the ICS system executive group, in LCP leadership and in provider collaborations.

Approximately £3.2million of additional funding has been received into the Devon system in partnership with the local VCSE (e.g.. Kings Fund, Big Lottery, etc).

The VCSE are working directly with us on key priorities e.g. discharge pathways, waiting well, mental health, cost of living crisis and Core20Plus 5.

More than 60% of social prescribing roles in Devon are directly employed by VCSE organisations.

Community Mental Health Framework funding went to the Devon Mental Health Alliance – a partnership of 5 key mental health charities in the county.

There is a Torbay, Plymouth and Devon VCSE Assembly. This is funded by NHS Devon and provides a key element of the ICS infrastructure. The Assembly provides a pipeline of organisations that sit on the many fora within NHS Devon, as well as acting as our key point of communication to and from the sector.

Each of NHS Devon's localities utilises VCSE schemes support individuals to access community-based services when they need to, coupled with reducing the demand on Adult Social Care and NHS services as a preventative measure.

Plymouth

The collaborative approach to commissioning VCSE services in Plymouth has provided the opportunity to ensure that they provide effective and efficient support to enable hospital discharge, providing direct support to get people home safely. The VCSE providers collaborate closely with one another alongside the Integrated Hospital Discharge Team, wards, Home First teams, as well as community teams.

Torbay and South Devon

Developing a co-ordinated prevention programme focusing on those areas which we know will have the greatest impact on population health in Devon (mental health, CVD, diabetes, respiratory and frailty) and will involve health and care services working with local communities and the VCSE to deliver CORE20Plus5 targets and implement high impact interventions.

North and East

Work with VCSE organisations helps secure community support contracts including support for dementia cafes, learning disability review teams and mental health out of area placements across the county.

BCF funding supports many additional roles, linked to the improvement and coordination of out-of-hospital services, such as a rapid response and reablement service in Northern locality.

Case studies

Age UK. Providing packages of care to support people in their own home following a stay in hospital for a period of up to four weeks.

Defence Medical Welfare Service. Supporting veterans, the DMWS support the discharge hub to help military patients that are in the hospital and work with the patients to offer welfare support.

This supports clinical teams and helps earlier discharge from hospital, while ensuring appropriate community support to prevent readmittance. This has considerable financial benefits for the NHS, as well as significant health and wellbeing benefits for patients.

Mental health services within Plymouth. The Community Mental Health Framework (CMHF) is in place across the whole of Devon to support a range of people with mental health interventions that do not require secondary level of support.

Our primary care mental health team and the VCSE Alliance have worked together to develop a triaging service, offering the best intervention and supporting people via a partnership model.

Within the first six months, the service had supported over 1,400 people.

British Red Cross (BRC). Jointly commissioned with the support of the Better Care Fund (BCF) to provide an Assisted Discharge Service to support patients going home from hospital.

The service supports more than 500 people a year.

It works holistically to help vulnerable people to get home and settle in safely in a way that increases confidence and the speed of discharge, by supporting the following tasks:

- Conducting a comprehensive home risk assessment to identify hazards, linking with fire services as needed and identifying unmet support needs.
- Ensuring the house is warm
- Waiting with them to meet ongoing care package providers if booked,
- Informing friends, neighbours, and family of arrival home.
- Carrying out essential food shopping and prescription collection.
- BRC can also return patients for appointments associated to their recent hospital stay/medical appointments to enable them to remain at home.

Mental health

Local organisations in Devon are working together as part of a new Mental Health, Learning Disability and Neurodiversity (MHLDN) partnership.

Partners from across Devon, including Devon Partnership Trust and Livewell Southwest, are leading the work across the county to support patients with a range of health needs for both adults and children.

As part of winter planning, the Mental Health, Learning Disability and Neurodiversity partnership has been leading the work to assess planned capacity for its population. There are several initiatives in place that will support patients in the community and support admissions avoidance for mental health patients, including:

Winter

- Extend Crisis Café opening times
- Deliver VCSE element of First Response
- Set up Discharge Peer Support programme (evidence of success in past two years regarding reduction in delayed transfers of care (DTOC)
- Ensure mental health winter planning and opportunities to align are fully considered at system level via the Devon MHLDN Collaborative
- Develop a VCSE offer for First Response Service for mental health – in discussion with partners
- Business case in development to support additional workforce to support children and young people presenting with eating disorders, as well as additional capacity for the online platform.

Child and adolescent mental health services (CAMHS)

Additional children and young people (CYP) community health-based services (including CAMHS) and a range of other community-based provision has been commissioned including:

- All0age online platforms (KOOTH and QWELL) – these enable access to quality assured resources, as well as online anonymous counselling and one-to-one support outside of traditional office hours. Commissioning outside of traditional office hours, aligns to the periods of the day that analysis of presentations to ED demonstrated a ‘peak time’ of presentation.
- In-reach discharge service. Youth workers and mentors have been commissioned to work with CYPs who have either escalated in need and have already presented to paediatric wards, or who CAMHS have identified in the community as being at risk of escalation. Data shows the positive impact of youth workers in reducing length of stay (LOS) and preventing admission

- Community-based wellbeing conversations, wellbeing cafes and counselling provisions. Evidence shows the positive impact that this VCSE provision has on de-escalating presenting needs.

Additionally, non-recurrent funding secured from the South-West Provider Collaborative is enabling a training programme to be rolled out across the footprint. This training is aimed at operational staff within acute hospitals and includes suicide awareness and prevention, Pathological Demand Avoidance (PDA) Society training, Royal Collage of Paediatric and Child Health (RCPCH) managing eating disorders training, trauma-informed training, and restrictive practice reduction.

Devon has a health-based place of safety for CYPs with an aligned section 140 protocol should a CYP detained on a section 136/135 require a hospital bed to be detained to under the Mental Health Act and one cannot be identified through the Southwest Provider Collaborative within the time requirements.

Local authority

There is a joint approach to development of the Better Care Fund (BCF) that clearly articulates our integrated approach to commissioning and delivery. Additional Discharge Fund deployed jointly to respond to gaps identified in Demand and Capacity modelling. Local improvement activity associated with discharge pathways and optimising outcomes for individuals are driven through joint Discharge to assess (DTA) Improvement programme architecture and LA representatives are supporting key priorities including the development of Care Transfer Hubs.

Further enabling joint delivery of winter services, a Discharge Improvement Tactical Group (DTIG) launched in September with representation from ICB, local authority, acute, community, mental health and VCSE providers. The group will report to locality and Devon-wide unscheduled care boards and will support the delivery of focus areas, which incorporate the commitments of the UEC improvement Plan with the specific aim to improve discharge. It aims to provide system oversight, assurance and support of discharge performance, activity, and pathways.

A local review of intermediate care services has been completed. This has been informed through demand and capacity analysis completed in Plymouth covering both health and social care to ensure available capacity to support flow and better alignment to best practice models through increased Homefirst approach, moving away from bed-based approaches utilised historically.

Improving Patient flow between Acute, Community and Social care (IPACS) demand and capacity modelling has been undertaken via the ICB and shared with council colleagues for mapping against to assurance core commission stock is block-purchased and fit for purpose, and contract (block/spot) in place for seasonal and escalation changes.

We are using the IPACs model to map demand against existing capacity across discharge pathways from hospital across all local authority areas leading into the winter period, which will support the Devon system flow.
The data shows that to align ourselves closer to best practice models, maintain flow and improve outcomes for patients, we need to increase P1 capacity and reduce length of stay within the pathway.

There is an overreliance on bed capacity, and we aim to reduce this across P2 whilst increasing P1 capacity. The utilisation of virtual ward capacity will be needed to support those discharges from hospital increasing capacity within P1. Targeted MDT resource focused on cohorted beds within P2 aims to reduce readmission.

Process and policy mapping has been undertaken across all localities, led by the South Locality team, to ensure consistent modelling of P1-3 (including end of life referrals) out of the general and acute beds.

Winter vaccinations

For some, flu and COVID-19 are unpleasant. But for many, particularly those with certain health conditions, older people and pregnant women, they can be very dangerous and even life-threatening. Every winter, thousands die from flu and people can still get very ill or die from COVID-19. Catching both viruses over winter increases the risk of serious illness even further.

In line with expert advice, the NHS will offer flu and COVID-19 vaccines to those at greater risk of serious illness this winter. Those who can get both vaccines through the NHS will include everyone aged 65 and over, pregnant women, care home residents, people aged 6 months old or above with certain health conditions, frontline health and care staff, unpaid carers and household contacts of those at higher risk.

The flu vaccine is offered to most children including all aged 2 and 3 years old, school aged children from reception to year 11, as well as those with relevant health conditions.

Children aged 5 and over with certain health conditions will be able to get the COVID-19 vaccine from October.

Adult flu and COVID-19 vaccinations started on 11 September, for residents of care homes and people who are housebound. Other eligible adults will be able to book their COVID-19 vaccination online or by phone from 18 September, and flu vaccinations can be booked through their GP practice or local pharmacy.

COVID-19 appointments can be made by downloading the NHS App, visiting the NHS website, or calling 119. Some areas will also offer local walk-in COVID-19 vaccinations. Flu appoi**ntments will be available nationally from early October on the NHS website.**

In Devon, winter vaccinations are offered from a range of sites including GP practices, community pharmacy, large vaccination sites, hospitals, care homes, at home for people who are housebound, and through outreach sessions in local communities.

A focus on health inequalities is driven through the Seasonal Vaccination Health Inequalities Hub. The work of the Hub is informed by a data dashboard and local intelligence and focuses on increasing uptake amongst seldom heard groups and within geographical areas of greatest need and building vaccine confidence through innovative approaches to vaccine delivery and bespoke insight and engagement work.

The outreach covid-19 vaccination fund has been established to allow organisations from the voluntary care and social enterprise (VCSE) sector across Devon to run innovative engagement activities to support the outreach plans, build vaccine confidence in areas of low uptake and increase engagement with vulnerable communities.

Governance and oversight

NHS Devon is responsible for coordinating, monitoring and assuring service delivery across Devon during Winter 2023/24.NHS Devon is responsible for the coordination of all winter plans into one system plan, including the incorporation of all high impact interventions and oversight of all elements of the Devon system.

Overall, the NHS Devon Unscheduled Care Board is the forum that governs the plan in its entirety and the core membership includes ICB, provider (acute, mental health and integrated care), locality and local authority colleagues, as well as operational, clinical, nursing, and business intelligence (BI) leadership across the system. Each locality has an unscheduled care board that manages unscheduled care services and challenges at a more local level. The locality unscheduled care boards have responsibility for the development of the winter plan for their local health system.

The ICB will manage the System Coordination Centre (SCC), ensuring it meets the revised specification and retaining oversight and management of the OPEL framework and responses to changes in levels. The ICB will co-ordinate the system responsibilities with the providers of children's services, including the three acutes and the two community children's providers who are responsible for delivery.

There are system arrangements across all partners to manage patient flow between services. Working together, we use the Operational Pressures Escalation Levels (OPEL) system, which identifies the actions partners need to take during periods of increased pressure.

At a system level we work together to drive delivery of the plans set out in this document, managing risk and daily patient flow between all our partners through the system control centre.

As a tier one system, Devon ICB and providers participate in weekly monitoring meetings chaired by NHS England South West. Performance against trajectories and delivery of actions against both the recovery plan and winter plan will be scrutinised and any risks mitigated.

The Chief Delivery Officer is the ICB executive responsible for the development, implementation, and oversight of the strategic delivery of the system control centre. The Chief Medical and Nursing Officers provide executive level oversight and support for all aspects of escalation where there is a clear and identified need for clinical expertise, judgement and decision making on escalation unresolved by the system control centre function. This is undertaken in collaboration with executives as part of system planning.

Prioritisation of surgical patients and tracking of waiting lists is facilitated by the surgical operational delivery network (ODN). Assurance is sought from the providers and surgical teams that elective recovery is protected to ensure that activity levels continue to be maintained, as per the requirement set out in the CYP minimum expectation for elective recovery.

Mental health providers are part of the current SCC planning, through:

- Corporate on call arrangements
- Attendance at planned system calls – Senior ops
- Attendance at unplanned system calls – Senior ops/Director on Call (DOC)
- Completion of sitreps – Senior ops admin
- DPT Winter Task Force

Risk and mitigations

Risk	Mitigation
Current Position: NHS Devon is currently behind planned performance trajectories for 4-hour ED, ambulance handover delays, and 12 -hour targets. This starting position, coupled with	NHS Devon has developed a comprehensive UEC improvement plan to identify opportunities across the system enabling it to address existing performance challenges.

pressure within our UEC system, is a risk to winter performance.	The delivery and oversight of the UEC improvement plan is monitored though a new governance process at locality and system level.
Demand: There is a risk that the demand on services is greater than predicted, especially if there is a more virulent Covid variant circulating. This will challenge the frontline services and may reduce the system's ability to deliver on elective care recovery plans.	The system has modelled different scenarios for demand on urgent care services. The winter plan outlines the mitigations the system is putting in place to respond to this: • Early rollout of vaccination programmes for the most vulnerable in the community • New and strengthened system-wide governance processes to identify and respond to changing demand. • Additional funding into new winter schemes supporting the whole urgent care pathway.
Industrial action: There is a risk that ongoing industrial action across the NHS may impact on the deliverability of the plans both in UEC and elective care. This may result in procedures being cancelled, exacerbating the impact of the risk stated above. NHS Devon is working with providers across the system to develop contingency plans, overseen by its tactical team, to respond to and mitigate any impact of future industrial action	NHS Devon, working with its partners, is continually assessing the impact of industrial action on urgent care services through the system control centre and the long-term impact through its elective care governance processes. Acute providers have plans in place to protect elective care and to minimise the impact on quality and patient safety.
Workforce: Our workforce continues to support the challenges of restoring services, meeting the new care demands and improving performance across a range of specialities. Recruitment continues to be a challenge for the ICB.	The ICB strategic workforce group is looking at ways to address this through a system approach to understanding areas that are difficult to recruit to, learning what has worked well, regularly reviewing the recruitment position, and re-visiting the potential for collective recruitment across Devon.
Mental Health: there is a risk that Devon mental health providers will not be able to meet demand due to a lack of additional resources, putting pressure on the wider UEC services.	The mental health provider collaborative is supporting the system to stretch services during winter to support patients in Devon.

What can you do to help?

- Follow local social media and our website for updates on our services
- Get flu and COVID-19 vaccinations in good time for winter
- If you are feeling unwell but have no specific symptoms, use your local pharmacy for advice on self-help, or contact your GP practice for a telephone or face-to-face appointment
- If you're not sure, always contact NHS 111 first to get advice and guidance
- If you feel very unwell, or you think it might be urgent, use NHS 111 online or by telephone. Please do not use the ED department at your nearest hospital as a first option for treatment unless it is a serious or life-threatening emergency
- Don't come in to visit patients in our acute or community hospitals if you feel unwell and/or have symptoms of COVID-19, flu or vomiting and diarrhoea. We will try to support you in contacting loved ones in hospital in other ways Order your medication ahead, don't risk running out – if you have a smartphone, try the NHS App, which gives you access to order repeat prescriptions, make GP appointments, and see parts of your medical history
- Have simple medicines you can buy over the counter in your cupboard to treat minor illness e.g. paracetamol and ibuprofen
- Stay hydrated (8 glasses of water per day for an adult) and try to regularly eat the most balanced, healthy diet possible
- Keep warm; have warm drinks, layers of clothing, blankets ready for use, hot water bottles and reliable heating sources
- Stay in touch with friends, family and neighbours

Glossary

The organisations that provide your health and social care and support:

Organisation	What they provide	Where they provide it
GP practices	Broad diagnosis, treatment and care of non-urgent illness Support and decisions to refer patients to specialist services in other organisations Long-term care and supporting self-care	Through 120 GP practices across the county, and their branch sites Via the Out of Hours service
Community pharmacy	Dispensing of NHS prescriptions Non-prescription medicines like paracetamol	Through more than 150 community pharmacy sites across Devon, Plymouth and Torbay

	disposal of unwanted or out-of-date medicines advice on treating minor health concerns and healthy living	
Royal Devon University Healthcare NHS Foundation Trust (RDUH) www.royaldevon.nhs.uk/	Specialist medical treatment and care, and diagnostics Emergency department for the most urgent and serious accidents and illness District nursing Health services, clinics and therapies Inpatient care, rehabilitation and Minor Injury and Illness Units	In people's homes At NHS clinic sites around the county At community hospitals
Torbay and South Devon NHS Foundation Trust (TSDFT) www.torbayandsouthdevon.nhs.uk/	Specialist medical treatment and care, and diagnostics Emergency department for the most urgent and serious accidents and illness District nursing Health services, clinics and therapies Inpatient care, rehabilitation and Minor Injury and Illness Units	In people's homes At NHS clinic sites around the county At community hospitals
University Plymouth Hospitals NHS Trust (UHP) www.plymouthhospitals.nhs.uk/	Specialist medical treatment and care, and diagnostics Emergency department for the most urgent and serious accidents and illness Health services, clinics and therapies Inpatient care, rehabilitation and Minor Injury and Illness Units	In people's homes At NHS clinic sites around the county At community hospitals
Devon Partnership NHS Trust (DPT) www.dpt.nhs.uk/	Mental Health assessment, treatment and care services	In people's homes At NHS clinic sites around the county At community hospitals

DRAFT DOCUMENT

Livewell Southwest (LWSW) www.livewellsouthwest.co.uk/	District nursing Health services, clinics and therapies Inpatient care, rehabilitation Mental Health assessment, treatment and care services	In people's homes At NHS clinic sites around the county At community hospitals
Devon County Council (DCC) www.devon.gov.uk/	Social care services Domiciliary care visits Carer assessments	In people's homes At social care units around the county Via independent sector units
Plymouth City Council (PCC) www.plymouth.gov.uk/		
Torbay Council www.torbay.gov.uk/		
South West Ambulance NHS Foundation Trust (SWASFT) www.swast.nhs.uk	999 call handling Ambulance and paramedic prioritisation and despatch Transfer of patient care appropriate for other services	Ambulance main hub, local ambulance stations, a range of ambulance vehicles and in people's homes
Voluntary, Community and Social Enterprise (VCSE) organisations	Ranges from small community-based groups/schemes through to larger registered Charities that operate locally, regionally and nationally	Within communities and peoples' homes and health and social care facilities
Practice Plus Group (PPG) www.practiceplusgroup.com/	NHS 111 call centres, advice, clinical review and booking into urgent care services Out of Hours GP services	Online and via telephone Primary Care centres
Devon Integrated Care Board (ICB) www.devon.icb.nhs.uk/	Oversight and commissioning (purchasing) of all health and care services for Devon, Plymouth and Torbay	

Terms and acronyms

Not every one of these terms appear in this plan, however you may see or hear them referenced if you use our urgent and emergency care services.

A&E	Accident and Emergency, operated from acute hospital Emergency Departments (ED)
ARI	Acute respiratory infection
ARRS	Additional Roles Reimbursement Scheme, expanding kinds of roles in primary care
ASC	Adult Social Care, a function of local authorities
BCF	Better Care Fund
CAS	Clinical assessment service
CYP	Children and young people
D2A	Discharge to Assess
DoS	Directory of Services
ED	Emergency Department, dealing with the most serious injuries and illness
EPR	Electronic Patient Record
FAU	Frailty Assessment Unit – a dedicated unit to assess underlying frailty
GP	General practitioner
HALO	Hospital Ambulance Liaison Officer – a dedicated function to enable flow
HIU	High Intensity User – patients who have complex and frequent health issues
HOSC	Health Overview and Scrutiny Committee holding organisations to account
IAPT	Adult Improving Access to Psychological Therapies
ICS	Integrated Care System, now enshrined in law
IPACS	Improving patient flow between acute, community and social care
IPC	Infection Prevention and Control
IUCS	Integrated urgent care service
LA	Local Authority (Devon County Council, Plymouth City Council, Torbay Council)
LoS	Length of Stay, a key measure in hospital-based care
MDT	Multi-Disciplinary Team, an approach to care that looks after all a patient's needs
MH	Mental health
MIU	Minor Injury Unit, based on community hospitals and some GP practices

NEPTS	NHS funded Non-Emergency Patient Transport Service
NHS 111	Free telephone and online service for patients to access urgent health care advice
NHSE	National Health Service England, the national body that oversees delivery of services
OOH	Out Of Hours (usually in reference to primary care services at night and weekends
OPEL	Operational Pressures Escalation Levels (1,2,3, 4)
SDEC	Same Day Emergency Care
UEC	Urgent and Emergency Care
UTC	Urgent treatment centre
VCSE	Voluntary, Community and Social Enterprise

Appendix

NHS Devon

NHS Devon Integrated Care Board

Committee Chair's Report - Finance and Performance Committee

Date of board meeting	Dates of committees covered in this report
4 October 2023	25 July, 1 September and 26 September 2023

Chair	
Name and title:	Kevin Orford, Independent Non-Executive Member for Finance and Remuneration

Reports received, discussed and noted

- Performance Report June, July, August 2023
- ICS Financial Report June, July, August 2023, including CIP progress review.
- ICB Financial report June, July, August 2023
- Investment proposals relating to Urgent and Emergency Care
- Corporate Risk Register (Finance)
- NHSE feedback to Devon System relating to Operating Plan 23/24
- Financial Recovery progress Report
- Non-Emergency Patient Transport Procurement
- Board Assurance Framework
- Medium Term Financial Plan
- Further controls on non-pay expenditure
- Former Ward Accommodation at Seaton Hospital
- Transfer of Skills and Knowledge relating to system financial recovery.

Committee decisions

Performance Report

Over the three meetings, the Committee:

- Noted the continuing pressures on Urgent and Emergency Care and endorsed the UEC Recovery plan being led by Local Urgent Care Boards.
- Reviewed the System response to the 'Key Lines of Enquiry' on the Winter Plan.
- Reviewed the public facing winter plan document.
- Noted the near delivery of treatment of all patients who are waiting more than 104 weeks. We are forecasting that no patient will have waited more than 104 weeks by end of September 2023.
- Noted the progress on the plan to reduce the number of 78+ week waits and 65+ week waits.
- Received assurance that the Elective Improvement Board continues to review patient safety and experience during long waits for admission and the operation of the 'waiting well' programme.
- Received assurance on achievement of clearance of the cancer waiting backlog and meeting of the 28 day faster diagnosis target, but noted challenges on the 62 day target and on diagnostic elements of the pathway. A deeper analysis of system response to this will be undertaken at a future meeting of the committee.
- Noted risk to delivery of all performance trajectories related ongoing national industrial action.

ICS and ICB Finance Reports

Over the three meetings, the Committee:

- Noted that the forecast outturn remains at £42.3m deficit in accordance with plan.
- Reviewed the detailed strategic CIP report, noting the risks to delivery and mitigations under development.
- Reviewed the risk rating re financial delivery and agreed to make no change to 16 risk rating, pending Q1 stocktake.
- Noted and discussed the financial risk relating to industrial action, national cost pressures and inflation and received assurance on system response to financial management to mitigate those risks.
- Approved the medium-term financial plan for submission to NHSE in accordance with delegation from the ICB Board. The plan provides for a deficit of £42m in 2023/24 in accordance with the agreed Operational Plan, a deficit of £30m in 2024/25 for which we seek approval from NHSE, a break-even financial outturn in 2025/26, a financial surplus of £6.6m in 2026/27 and a financial surplus of £12.3m in 2027/28.
- Endorsed the System agreement on further controls on non-pay spend between now and the end of the financial year.

Investment proposals relating to urgent and emergency care
The Committee:

- Noted that the ICB has been successful in its bid for £13.8m to invest in UEC.
- Noted that there has been a governance framework in which the detailed bids have been prioritised according to expected benefits to the System although the Committee has not been sighted on the detail. However, we have reassurance this has been put in place.
- Approved the TPST business case at the cost of £703k.

Procurement
Over the three meetings, the Committee:

- Reviewed the procurement process and outcome relating to Non-Emergency Patient Transport Services and made a recommendation to the Board on award of the contract.
- Noted that two service specifications have been published for procurement of further system financial recovery support and for digital consultancy report.

Estate

- The Committee received a report on options for the use of void space at Seaton Hospital and received detailed assurance relating to the governance of the process followed. The Committee noted the stakeholder engagement process and communications approach and supported the recommendation that the ICB should submit an application to NHS Property Services to undertake a surrender of the accommodation.

Risk register review updates/escalation

The Committee:

- Agreed to remove risk 160 from the Corporate risk register
- Closed ICS System Delivery 22/23
- Closed ICB Operational Plan Compliance 23/24
- Closed ICS Operational Compliance 23/24
- Added at a risk score of 16: ICB Long Term Financial Sustainability
- Added at a risk score of 16: ICS Long Term Financial Sustainability
- Added at a risk score of 12: ICB Planned Delivery
- Added at a risk score of 16: ICS System Planned Delivery with a query as to whether this score is too low
- Agreed that in future, the finance corporate risk register will be the responsibility of the CFO and does not need to be reviewed by the Finance and Performance Committee.
- That those elements of the BAF delegated to the Finance and Performance Committee will be brought to the next meeting of the Committee.

BAF updates or escalation

- BAF reviewed. Noted and supported new process for updating BAF in September 2023.

Escalation to the Board – for action

- None

Recommendations for the board

- The Committee recommends to the Board the approval of the Winter Plan 2023/24.

Recommendations for other committees

- None

Terms of reference or other committee effectiveness issues

- None

Management of conflict of interests:

Conflicts of interests are recorded on the register of interests. At each committee, a list of recorded declarations is provided. New declarations must be raised, recorded and included in the minutes of the meeting and notified to the Governance team via d-icb.governance@nhs.net to update the central register.

NHS Devon

NHS Devon Integrated Care Board

Committee Chair's Report – People and Culture Committee

Date of Board meeting	Date of the committee covered in this report
4 October 2023	20 September 2023

Chair	
Name and title:	Thandiwe Hara Non-Executive Member for Citizen and Community Involvement

BAF updates or escalation

The People and Culture Committee agreed the BAF updates were all active and up to date.

Risk register review updates/escalation

N/A

Reports received, discussed and noted

An emerging 'grow our own plan'.

A major element of our workforce strategy is to ensure we have more locally grown talent and a significant element of this work will be to have an effective plan and architecture for attracting people into health and social care for our 'entry level' roles. We were advised that this plan is being worked on at present and will be brought to the Committee early in the New year for comment and advice. This will build on the success of the system wide Health and Social care Skills Accelerator programme which finishes in March 2024. An early part of our approach is the New Plymouth Skills Hub which opens on 5 October and is being hosted by Plymouth City College and will be focussed on attracting 16–18-year-olds into health and social care.

One Devon Bank

Paul Renshaw brought to the committee's attention the One Devon Bank which is a system solution to temporary staffing and Bank management across our health partners has been designed in collaboration with NHS Professionals. The System solution will standardise temporary staffing and Bank management supply and processes across our health providers as well as enabling collaboration of Bank supply across providers, thus reducing our reliance on costly agency resource.

UHP and Live Well have been working with NHS Professionals for over 10 years. RDUH are in the process of implementing the NHSP solution. TSD and DPT are both in the process of developing their internal business case to migrate to the NHSP model, supported by ICB colleagues to ensure timely delivery and optimisation of associated benefits. We expect the migration to a System model with NHSP for our health providers to deliver a full year effect saving of c2m per annum as well as support process improvement and increase bank worker engagement.

SWIFT workforce planning tool

The committee were updated as the work continues on the development of our One Devon workforce planning tool SWIFT (Strategic Workforce Intelligence & Forecasting Tool) and all work is on track for the planned go live in November. Product Champions have been identified within each NHS health provider and are actively engaged in the development of the tool and will support the user testing process throughout October. Discussions will then focus on how this tool can be used for social care and primary care will commence in 2024.

Once launched this tool will combine future population demand, finances, and workforce to provide scenarios for future workforce models. This has been produced by the NHS Devon workforce team with significant collaboration with system partners and the regional NHS team and will be shared with the regional and national teams early in 2024 to enable potential adoption outside of Devon.

Workforce productivity and efficiency update (year to July 23 data)

Paul Renshaw advised that the NHS workforce spend is higher than plan for all providers across all staff categories due to a combination of high levels of patient activity, industrial action driving premium rate spend to cover gaps and models of care remains largely unchanged.

Agency spend continues to receive significant focus. The year-end target was to spend no more than 2.2% of our overall pay bill on agency and at present we are running at 3.4%. This current rate is close to last year's outturn; however, it should be noted that we have the lowest agency bill as a % of our turnover in the Region. The non-framework agency spend is continuing to reduce and we are the third lowest user of non-framework in the Region as a % of overall spend.

The Chief People Officers are very focused with their Executive colleagues on ensuring that the highest possible workforce controls are in place for vacancy and agency spend control and this is subject to weekly scrutiny at the Finance and Planning Board and at weekly Chief People Officer meetings.

We discussed the issue of the system needing to transform the way we deliver our services at greater scale and pace in order for us to have workforce models that are affordable and realistic from a recruitment point of view.

Paul Renshaw informed that the system wide turnover rate continues to be lower than the regional average at 12.1% compared to 13.6% for the Region and that absence is now just 0.2% higher than the regional average (4.3%) down from normal rates which have tended to be circa 0.5% higher.

People Digital vanguard

Paul Renshaw highlighted to the committee that Devon has been selected as one of a dozen national NHS vanguards for innovating our people/HR services.

The vanguard project will be focused on scaling and digitising our HR / people processes. We are working with Deloitte using national funding to scope out how we approach this exciting programme, which is led by Hannah Foster, Chief People Officer for RDUH.

This work will transform the way we use technology across the whole pre-employment and employment life cycle and will reduce the cost on HR administration significantly.

We would expect that savings will start to be seen during 2024/25 onwards since this is a major piece of service transformation and culture change.

Learning and Education Strategy – Presented by Natasha Goswell, Professional Practice and Workforce Lead

Natasha Goswell, Professional Practice and Workforce Lead presented the updated Learning and Education Strategy, the committee were advised that there had been a few small changes to the strategy, but the principles remain the same which was recommended for approval by the People and Culture committee in July 23. The committee were happy to support these changes and agreed to recommend approval of the Strategy to the ICB at its meeting on 6 December 2023. Once the 5-year workforce plan is finalised in November /December, we will create a Learning and Education plan that will be designed to deliver the future for the future in line with our needs and the National Long term workforce plan.

One Devon System Leadership Development Approach

Katy Kerley, System Development Lead presented an update on the One Devon System Leadership Development approach work that is underway across the system. The recommendations were designed collaboratively with each of the OD Leads across the system with the recommendations being signed off by the Devon LMC, Clinical and Professional Cabinet and HRDs/CPOs.

The recommendations are over the next 1-2 years to focus implementation on:

1. Spread adoption of outward mindset – facilitation and coaching provided by One Devon's 10 certified trainers and implementation coaches.
2. Adoption of the One Devon Leadership Framework 'One Devon System Leadership way'.
3. Review of Leadership Academy offers.
4. Establish a Multi-professional leadership development approach.
5. Developing/utilising existing opportunities for a system-wide coaching and mentoring network providing a consistent approach and equality of access.

6. Establish an evaluation methodology to assess impact of leadership development and enable continuous learning.

The People and Culture committee all agreed with the endorsement of this work to get underway.

One Devon 2023 System Evaluation

Tracey Cottam presented a summary of the 2023 System Evaluation and shared the detailed analysis and findings with the Committee. The overarching ambition set out in the Devon Plan describes increased collaborative and integrated ways of working being a key determinate in One Devon's success to deliver the Devon Plan.

As part of the System Development enabling plan, One Devon has evaluated its progress to become a thriving ICS by 2026/27. The summary findings of the 2023 System Evaluation indicate that, overall, One Devon is between 'emerging' and 'developing' (1.7 out of 4 on the maturity scale) based on the national ICS Maturity Assessment which is the same position to the 2022 baseline. There have been improvements over the last 12 months including: One Devon is described as an improving system which is developing; significant improvement in collaboration between system partners; increased involvement of system partners in system-wide decision making. However, the counterbalance to this improvement is that trust is perceived not to have improved since 2022 and a perception this will counteract the improvement in collaboration if continued system development work is not undertaken.

Feedback from system colleagues is that One Devon needs to make a decision on its short, medium and long term focus. The ICS may decide to focus only on shorter-term recovery work, or it may decide to have a combined focus on short-term recovery with medium to longer term transformation and development. There is a clear message from system colleagues for One Devon to decide the latter, and a recognition that both are required. The Committee highlighted the potential risks of not continuing with the transformation and developmental work as a system and that these needed to be considered further.

The Committee considered the findings and endorsed the need for One Devon to continue to implement the System Development work outlined in the Devon Plan, and for this to be escalated to the NHS Devon Board to discuss further. It also discussed the current low participation in elements of the system development work such as the Outward Mindset Adoption by the One Devon Partnership, NHS Devon Board and System Management Executive groups and the need to reset this work urgently for it to have the positive impact needed.

Committee decisions

- The People and Culture Committee endorsed the Learning and Education Strategy which will be presented to the ICB Board meeting for approval on 6 December 2023.
- The People and Culture Committee agreed to endorse the work on the One Devon System Leadership Development Approach.

Escalation to the Board – for information

- N/A

Escalation to the Board – for action

- N/A

Recommendations for the Board

To convene a senior system leader summit to understand the underlying reasons for low participation and to agree a single core purpose which individuals can affiliate with and to focus adoption of supporting teams to achieve this purpose. This will enable improved participation, ownership, and accountability for the system development work.

Recommendations for other committees

- N/A

Terms of reference or other committee effectiveness issues

- None

Management of conflict of interests:

Conflicts of interests are recorded on the register of interests. At each committee, a list of recorded declarations is provided. New declarations must be raised, recorded and included in the minutes of the meeting and notified to the Governance team via d-icb.governance@nhs.net to update the central register.

NHS Devon Integrated Care Board

Chair's Report

Date of meeting	Date report produced
04 October 2023	22 September ,2023

Author(s)		Report approved by	
Name and title:	Nick Pearson, Chair and Chief Executive's Office	**Name and title:**	Dr Sarah Wollaston, ICB Chair
Phone:	-	**Date:**	22 September ,2023
Email:	Nick.pearson@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 document includes updates on the appointment of the new NHS Devon Chief Executive, awards success, a new inpatient facility for mental health and visits and speaking engagements.

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

Key recommendations and actions requested
1. The Board is asked to **note** the report.

Impact on NHS Devon objectives	
Objective	**Impact**
Objective 1	**All**
Objective 2	
Objective 3	
Objective 4	

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	None
Legal	None
Digital and Data	None
Engagement and consultation	Engaging communities and stakeholders in our work

Chair's Report

Leadership update

1. I would like to start by expressing our thanks as a Board to Jane Milligan. I will say more about this during the meeting but I wanted to place on record our gratitude to Jane for her dedication to what is always a very challenging role but particularly so over the last two-and-a-half years. Her decency and kindness to all helped us to get through the very worst a pandemic could throw our way – and she has laid the foundations for better performance and improved finances.

2. We wish her all the best in what we hope will be a very long and happy retirement.

3. The process of appointing a new Chief Executive Officer (CEO) is underway with stakeholder panels and the main interview panel taking place on 04 and 05 October 2023.

4. The candidates have been shortlisted and we have reached out to a wide range of individuals across our Devon system, inviting them to sit on the various panels. I would like to thank those who have offered to contribute towards appointing our new CEO and look forward to updating the Board further in due course.

NHS Devon Annual General Meeting

5. The NHS Devon Annual General Meeting (AGM) will have taken place on Wednesday 27 September 2023. This is a statutory requirement and covers the 2022/23 financial year. We decided to broadcast online with the ability for viewers to be able to watch the event and post questions in real time. A recording will be published on the NHS Devon website after the event for those who were unable to attend and I will provide a further update in my next report.

One Devon Integrated Care Partnership (ICP)

6. There was no formal ICP meeting in September, but instead a workshop was held to facilitate discussions by the Partnership. The Partnership agreed that it would have a priority focus on Children and Young People, to influence and encourage action across Devon, particularly with regards to employment and education, housing and health inequalities. The Partnership seeks to encourage all member organisations to work together to help address the inequalities faced by those with care experience, and it has been suggested that a system call to all partners would be useful, to allow acknowledgment of the role we play as corporate parents, and to ensure this is central to the work that we do, and how we do it. I look forward to continuing to be a part of the Partnership and assisting with the progression of this work.

NHS Devon Awards Success

7. I am delighted to report that NHS Devon has been shortlisted for two Health Service Journal (HSJ) awards. The first is in the category 'Digitising patient care' – and is for our GP in the Cloud (GPitC) project. This project enables GPs located anywhere in the UK to carry out consultations with Devon patients from their own IT devices and is a collaboration between NHS Devon, DELT Shared Services, Intergy and the National Association of Sessional GPs (NASGPS). Practices using GPitC reported that they improved access, were more resilient when impacted by unplanned staff absence and found significantly reduced costs. Following the successful roll-out, NHS Devon was asked by NHS England to develop a blueprint to support regional and national roll out of the technology.

8. The second shortlisted project is in the category of 'Reducing Healthcare Inequalities for Children and Young People' for the South West Provider Collaborative (SWPC). The SWPC was shortlisted with its entry 'Transforming access to, and experiences of, specialised mental health care for children and young people in the South West'. To be shortlisted in the HSJ awards is a genuine recognition of quality and I would like to congratulate the nominees for their hard work and dedication in getting this far. The awards will take place on Thursday 16 November in London.

Women's Health Hub

9. The Women's Health Strategy for England sets out national ambitions for improving health and wellbeing outcomes for women and girls throughout their life course. One of the top priorities for the strategy is the expansion of Women's Health Hubs to bring together healthcare professionals and existing services to provide integrated women's health services in the community, with a focus on improving access and reducing health inequalities.

10. In March 2023, the government announced a £25m investment in these services with each integrated care system receiving £595k of funding over a two-year period.

11. In Devon two priority areas have been identified and agreed by the Executive Lead (NHS Devon Chief Medical Officer).

    - Services to support Menopause
    - Access to Long-Acting Reversible Contraception (LARC) for contraceptive and non-contraceptive reasons, using the model of a Women's Health Hub

12. The intention is to use this funding to meet these two priorities in the first instance, recognising that there are many other areas of demand for women and girls in Devon. The vision is to establish remote and physical hubs across Devon, allowing an iterative 'test and learn' approach to best meet local needs and improve the overall quality of the service. The initial proposals include

- A specialist menopause service that will offer both remote and face to face support for women utilising existing NHS systems where possible.
- A network for clinicians to share specialist knowledge.

13. As the programme of work progresses, more specific services will be established to meet the priority areas.

14. The public and clinicians have been involved in the development of the initial plans and there will be opportunities for further involvement as the programme progresses and the service develops. I am sure you will all agree that this is extremely important work and it is great to see that funding has been provided for these initiatives

Chair's visits and speaking engagements

15. I've had the privilege of visiting several providers over the last few months.

16. I undertook an observer shift with South Western Ambulance Service NHS Foundation Trust (SWASFT) in the Summer, where I joined an ambulance crew for one of their shifts and also had an opportunity to meet with other paramedics and Trust leaders, to listen to their views on improving joint working – my particular thanks to Laura Bright, Sally-Ann Macefield, Christopher Turner and Tim Blower.

17. I was also invited to attend a roundtable event being hosted by Lord Markham, who as Parliamentary Under Secretary of State, has responsibility for NHS capital, estates and finances. The event was hosted at North Devon District Hospital and we heard their plans for the transformation in buildings, clinical ways of working and patient pathways.

18. The visit also provided an opportunity for the Trust leadership, local stakeholders, colleagues and patients to share their views on the future of healthcare in North Devon and to highlight the challenges faced currently and ideas on what is needed to futureproof healthcare in the area.

19. I was hugely impressed by the South Molton Eye Centre which I visited with colleagues from Royal Devon University Healthcare NHS Foundation Trust and North Devon MP Selaine Saxby. It was a great opportunity to see first-hand the excellent work that they are doing there since it opened in June 2022 and how they are improving access and helping to reduce waiting times for both diagnostics and treatment for a number of eye disorders.

NHS Devon

NHS Devon Integrated Care Board

Chief Executive's Report

Date of meeting	Date report produced
04 October 2023	22 September 2023

Author(s)		Report approved by	
Name and title:	Nick Pearson, Chair and Chief Executive's Office	**Name and title:**	Jane Milligan, Chief Executive
Phone:	-	**Date:**	22 September 2023
Email:	Nick.pearson@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 updates on system pressures and industrial action, the NHS Devon Annual Assessment 2022/23, Care Quality Commission framework, Special Education Needs and Disability (SEND) inspection outcomes, Modern Slavery Statement and the Policy for the Development and Management of Procedural Documents.

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

Key recommendations and actions requested
1. The Board is asked to **note** the report.
2. The Board is asked to **approve** the Policy for the Development and management of Procedural Documents.

Impact on NHS Devon objectives	
Objective	**Impact**
Objective 1	**All**
Objective 2	
Objective 3	
Objective 4	

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	None
Legal	None
Digital and Data	None
Engagement and consultation	Engaging communities and stakeholders in our work

Chief Executive's Report

My final Board meeting

1. Board members will be aware that I am due to retire at the end of October and therefore, I am sad to say, this will be my last meeting with you all and the final report that will be submitted by me as Chief Executive of NHS Devon.

2. I will of course say more at the meeting itself, but before I do so I would like to place on record my thanks to the board, executive team and other colleagues for their support.

3. Thank you also to the many patients I have met since coming back to Devon after some years away.

4. I wish everyone in the Devon system the very best for the future.

Industrial Action and System Pressures

5. During September, the Devon System experienced a high degree of pressure.

6. Specifically, the system experienced:

    - Increased numbers of people in Devon hospitals experiencing symptoms of infections such as, COVID-19 and norovirus resulting in the closure or restriction of bed capacity.

    - An increase in the number of hours lost to ambulance handover delays, with ambulances queuing outside Devon Hospitals.

    - Increased levels of demand coming into emergency departments

    - Increased numbers of patients requiring a Mental Health bed with a shortage of beds within Devon.

    - Increased numbers of patients requiring repatriation to areas outside of Devon and delays in getting these progressed.

    - Reduced community capacity to enable timely discharge of patients with more complex needs which impacted the flow of patients through the hospitals leading to an increase in length of stay and an increase in the number of patients with no criteria to reside in a hospital bed.

    - Short term closure of Minor Injury Units and Urgent treatment centres due to staff sickness and/or increased levels of demand.

- Impact of industrial action taken by Junior Doctors and Consultants resulting in the need to prioritise only urgent elective work.

7. Due to the ongoing pressures and challenges presented by the industrial action the system declared OPEL 4 on 21 September 2023. As a response to this, actions were put in place to enable the system to de-escalate which focus on reducing demand on emergency departments and increasing the number of discharges, as well as the introduction of a daily meeting cadence which provides the opportunity for issues to be escalation to senior decision makers within the Devon System. At the time of writing, the OPEL status was due to be reviewed.

8. As the Board will be aware, further industrial action took place over the summer with junior doctors taking industrial action on 11 – 15 August 2023 and consultants on 22 August 2023.

9. There was more action on 19 and 20 September 2023 – with junior doctors joining consultants on strike for the latter, and there is further similar action due next month on 2 – 4 October 2023.

10. Devon prepared for the impact of the junior doctors and consultants striking together for the first time on 20th September and will be doing the same for the action in October.

11. Appropriate steps were taken to ensure that support was in place, with cover arrangements being provided at a “Christmas day” level.

12. Patient safety was, of course, the number one priority and all providers adjusted their services accordingly to ensure the best quality of care possible.

NHS Devon Annual Assessment 2022-23

13. On 11 August 2023, NHS Devon received its first annual assessment from NHS England (NHSE) which focussed on key objectives set by the Secretary of State; a selection of statutory duties and NHS Devon’s role within the Devon Integrated Care System (One Devon).

14. In undertaking its assessment NHSE considered evidence from the draft annual report and accounts; available data; feedback from Health and Wellbeing Boards and Integrated Care Partners; and discussions that had taken place throughout the year.

15. The assessment outcome, which was published as part of the NHS Devon Annual General Meeting papers, confirmed that NHS Devon has “discharged its duties and met its wider objectives”.

16. The assessment highlight areas for further development and improvement and the Senior Executive Team has agreed an action plan to address these, progress of which will be monitored throughout 2023-24. The plan will be brought to the December Board meeting.

NHS Devon organisational change

17. We are continuing to progress with work to reduce NHS Devon's running costs by 30%, which is a hugely difficult challenge.

18. We have made a decision on consolidating our five offices into one, and we have a planned move-in date in December this year. We have revised our flexible working policy to support staff and teams across the organisation.

19. We have also made big changes in reducing Fixed Term Contracts, secondments into NHS Devon and consultancy contracts. Joint work between HR and finance has reduced these by 50%, which will save NHS Devon £2 million on our running costs.

Modern Slavery Statement

20. The Modern Slavery (MS) Act 2015 require business and organisations over a certain size to disclose each year what action they have taken to ensure there is no modern slavery in their business or supply chains.

21. This means as both a commissioner of health services and as an employer, NHS Devon should provide a statement on its website in respect of its commitment to, and efforts in, preventing slavery and human trafficking in the supply chain and its employment practices.

22. Although NHS Devon does not fit the criteria under the MS Act to publish a public statement, one has been provided within the annual report for the past 4 years.

23. To be open and transparent and provide public confidence, it is best practice to provide a stand-alone Modern Slavery Statement, which has been drafted.

24. The Modern Slavery Statement has been co-produced in consultation with representatives of the Commissioning Support Unit, Contracts, Governance and Human Resources teams. It is supported the Senior Executive Team and the Quality and Patient Experience Committee.

25. I have appended our statement to the end of my report (see appendix a).

One Devon Elective Pilot

26. I am pleased to provide an update on the One Devon Elective Pilot programme which commenced in January 2023 and has brought together a core team from NHS England (NHSE), system colleagues and a Getting it Right First Time (GIRFT) leadership perspective.

27. The key aims of the pilot are to maximise day case and High Volume Low Complexity (HVLC) activity, standardise patient pathways, increase efficiencies in theatre utilisation and develop Devon system's ability to support cross site working.

28. As a result of the pilot, we are seeing an increase in best practice across the system's Trusts which is improving the quality of services and supporting elective improvement. There has been a reduction in the long waiter position for both orthopaedics and spinal surgery in Devon together with a reduction in ophthalmology cataract waiting times as a result of the increase of HVLC activity being provided.

29. The system's participation in the pilot has led to the Southwest Ambulatory Orthopaedic Centre (SWAOC) at the Nightingale, Exeter being one of only eight elective surgical hubs to been awarded accreditation with its work now forming part of the GIRFT national evidence base.

30. Phase 2 of the pilot commenced in September and will run through until March 2024. Objectives for this phase include utilising SWAOC ambulatory pathways at the Torbay & South Devon NHS Foundation Trust day case theatres and the University Hospitals Plymouth NHS Trust orthopaedic theatres, which are scheduled to open in February 2024; delivering a 7 day a week service at the Royal Devon University Healthcare NHS Foundation Trust day case cardiology unit; reviewing the orthopaedic pathway and also ensuring sufficient capacity for spinal services to meet the needs of the Devon population.

31. The One Devon Pilot has identified the importance of system level leadership/ programme management to ensure best practice and that system solutions to productivity challenges and opportunities are realised.

CQC Inspection of Devon Integrated Care System

32. On 01 April 2023 the Care Quality Commission (CQC) took on powers to assess Integrated Care Systems (ICSs). These assessments will be carried out using a sub-set of the quality statements in the single assessment framework that the CQC will be using across all its work. This will involve using 6 evidence categories to assess ICSs against 17 quality statements (describing what "good" looks like) mapped across three overall themes - quality and safety, integration, and leadership. It will also include looking at how ICSs are achieving their core purposes (to improve outcomes in population health and healthcare; tackle inequalities in outcomes, experience and access; enhance productivity and value for money; and help the NHS support broader social and economic development).

33. For the initial assessment, the CQC will consider evidence that it already has, followed by evidence it needs to request and finally evidence that it needs to actively collect.

34. Two pilot assessments are being undertaken this Autumn, these being for the Birmingham and Solihull Integrated Care System and the Dorset Integrated Care System. The learning from these pilots will then be fed into the CQC's final published approach to ICS assessments. The CQC will then carry out baseline assessments of all 42 ICSs and the resulting assessment reports will be published together with ratings.

35. As well as the pilot assessments, the CQC will be carrying out a separate review of data and published documentary evidence across all 42 ICSs in England. This will focus on the 'equity in access' quality statement. This aims to show whether systems are working together to support people to access the care, support, and treatment they need when they need it. The CQC's findings will be published in its annual 'State of Care' publication in the Autumn.

36. Looking ahead beyond the baseline assessment period, the CQC will move to ongoing assessment of ICSs. This will be a risk-informed approach, involving gathering/assessing evidence at different points in time and updating the information it publishes about an ICS as and when needed. The aim of the second phase is to complete all the initial assessments and award a rating for each one, to be completed within two years.

37. Nigel Acheson, as Chief Medical Officer, has been allocated the role of Senior Responsible Officer (SRO) for the CQC registration/regulation process and Chairs a cross directorate working group which is leading the work to ensure our preparedness for the CQC inspection regime. In addition, a "Guardian" has been allocated for each of the three overarching themes of leadership; integration; and quality and safety. These Guardians will be working with identified Leads to progress the preparedness work.

38. In order to assess that we are taking appropriate steps to ensure readiness, care is being taken to engage with colleagues from other ICSs to understand the work that they are undertaking in this space which will include colleagues from another ICS being invited to undertake a peer review of the work being carried out to ensure NHS Devon's readiness. Once work on the pilot assessment has been completed, colleagues from NHS Dorset will also be invited to share their experiences of this.

NHS Devon Policy for the Development and Management of Procedural Documents

39. As with all organisations, NHS Devon needs to ensure clarity about its procedural documents. In recent months we have undertaken a review of the current process and existing documentation to establish whether our policies are relevant up to date and comprehensive. As a result of this review revisions have been made to the Policy for the Development and Management of Procedural Documents (the Policy), a new Policy Register has been established and an action plan has been agreed for the updating and approval of all relevant policies.

40. The updated Policy has been updated to provide a clearer typology of procedural documents and to distinguish between the actions required for the development of new strategies and policies and those required for the review/amendment of existing ones. A lighter touch process has been introduced for minor amendments to strategies and policies (i.e., those which will not alter current practice and involve only minor changes, such as changes to personnel and job titles, changes required to reflect organisational change, changes to reporting cycles, template changes and changes to any processes appended to policies). The updated Policy sets out clear approval routes for different types of procedural documents as also the required consultation, implementation plans and impact assessments that are required.

SEND Inspection Outcomes

41. I wish to update the board about the recent Plymouth Local Area Special Educational Needs and Disabilities (SEND) inspection in Plymouth.

42. The inspection was led by Ofsted and CQC (Care Quality Commission) in late June 2023.

43. The inspection endorsed long term plans and direction of travel for the multiagency work.

44. The subsequent report concluded that there were serious weaknesses with five priority areas, all of which must be addressed.

45. The Department for Education (DfE) have indicated that there will also need to be an external board (parallel to the Plymouth Children's Board).

46. The report also noted some areas of positive work and was published on 22 August.

47. I include a summary below.

Areas noted as effective

48. A number of areas were noted as being effective. These included:

- Leaders across the partnership sharing a commitment to improve the way they work together in the future.
- Leaders strengthening the support for young children with language and communication difficulties.
- Children and young people with SEND benefitting from a range of services to meet their social and emotional needs. For example, the Child and Adolescent Mental Health Service has developed a responsive early help offer with an initial assessment and brief intervention.
- Local leaders working together to reduce the high number of young people with SEND who are not in employment, education and training.

- Effective identification and support for children and young people with autism spectrum disorder or those with a learning disability at times of crises to prevent hospital admission.
- Parents providing positive feedback around the impact from key workers on their children and young people's mental health.
- In some schools, pupils with SEND are assessed in a timely way and get the help they need to do well.

Areas for priority action

49. The following are the areas for priority action. Inspectors will return in 18-months to assess progress against these areas.

Responsible body	Areas for priority action
Plymouth City Council, NHS Devon Integrated Care Board, school and college leaders.	Leaders, including Plymouth City Council, Devon Integrated Care Board, and school and college leaders, must put children and young people with SEND at the centre of all improvement plans by ensuring that those plans contain clear oversight and tracking in order to measure the direct impact on children, young people and their families.
Plymouth City Council, NHS Devon Integrated Care Board, school and college leaders.	Leaders, including Plymouth City Council, Devon Integrated Care Board, and school and college leaders, should work together and share information to enable the earlier identification of children and young people with SEND who are at risk of increased vulnerability and negative outcomes.
Plymouth City Council, school and college leaders	Leaders, including Plymouth City Council and school and college leaders, should work together to reduce the likelihood of exclusion for pupils with an EHCP.
NHS Devon Integrated Care Board	Devon Integrated Care Board should work with partners to risk assess children on waiting lists, ensuring that those with multiple needs get the earliest support possible.
Plymouth County Council	Plymouth County Council leaders should ensure that children and young people with SEND who also have social care needs get the care and support they need, particularly: ▪ vulnerable children living in residential special schools and children's homes at a distance; and ▪ children receiving short breaks without effective oversight and review,

	including reassessment when needs escalate.

Areas for improvement

50. The following recommendations would usually be assessed in three years' time i.e. July or September 2026. Progress will be checked in the earlier monitoring visit.

Leaders across health, social care and education should improve the consistency of the support offered to children and young people with SEND by ensuring: ▪ all children receive the mandated checks in line with the Healthy Child Programme; and ▪ all children and young people benefit from a consistently applied graduated response.
Leaders across the partnership should continue to address long waiting times for children and young people requesting support from health services.
Leaders must ensure that all social care, health and education practitioners have the training they need to provide consistent identification, care and support for children and young people with SEND.
Leaders should use the information available to them to plan ahead, ensuring the right services and support are in place to meet the future needs of children and young people with SEND in Plymouth

Actions, opportunities and risks

51. Urgent action has been taken by Plymouth City Council around the fifth priority action area: *Plymouth County Council leaders should ensure that children and young people with SEND who also have social care needs get the care and support they need, particularly*:

- *vulnerable children living in residential special schools and children's homes at a distance; and*
- *children receiving short breaks without effective oversight and review, including reassessment when needs escalate.*

52. Since the end of the inspection on 30 June 2023, when this action was fed back verbally, the Children with Disabilities Team have been assessing and reviewing all children in the first group (twelve children) above (completed) and using a triaged approach for the second group (approximately one hundred children). In total 41 children's support has been reviewed.

53. Planning is well underway to produce the action plan needed by the end of September. There are a wide range of stakeholders to involve so the workshop planned to take this forward on 20 September is an important milestone in the partnership response.

54. Engagement at senior officer level between health and Plymouth County Council, and with the DfE and NHSE is strong and work has taken place, including shaping the governance arrangements and making arrangements for the external board.

55. Action has been taken to secure for a longer period interim expertise in SEND, which had been secured in the run up to the inspection.

56. In terms of opportunities, the clarity and urgency of the report's priority actions will galvanise the joint work of all partners, including schools and colleges, to provide a more inclusive, joined up network of support for our children with SEND and vulnerabilities. The focus on putting children at the heart of what we do is essential. The emphasis on plans and their implementation showing impact, which is overseen by senior leaders is crucial.

57. But there are also **risks**. There is a risk to morale: early positive communication and engagement is important so that colleagues and parents/carers and children see that there is purpose and drive to deliver improvement. There is a risk of overload of change and monitoring, given the oversight of Children's Services already in place: streamlining, prioritising, and having manageable timelines is crucial. There is a risk in terms of capacity to implement change well and as the plan is shaped, we will be able to determine and manage it.

Brief overview of timeline following Area SEND inspection 2023

Dates	Event/activity	Lead
Ongoing August and September	Implementation of urgent actions across our partnership	All through Working Group.
Ongoing August and September	Development of action plan by working group. NB Urgent involvement of school and college leaders in September. **Workshop involving stakeholders – date tbc mid September: confirmed 20 September**	Working group NB School and college leaders named as well as PCC and NHS Devon ICB.
29 September	Action plan to be published.	
September onwards	Plan cohered with current strategy and action plans. Ongoing senior level monitoring of plan.	

Visit to South West Ambulance Service

58. While our chair Sarah went out with the ambulance crew on the frontline this summer, I had the pleasure of visiting South Western Ambulance Service NHS Foundation Trust (SWASFT) headquarters in Exeter.

59. I was met by Will Warrender, Chief Executive and Will Lee, the Assistant Director of Operations who showed me around and I was able to see the Emergency Operations Centre in action - before a meeting with them.

60. My thanks to SWASFT for accommodating me on this visit.

Appendix A

Modern slavery statement

Introduction

The Modern Slavery (MS) Act 2015 require businesses over a certain size to disclose each year what action they have taken to ensure there is no modern slavery in their business or supply chains. As both a commissioner of health services and as an employer, NHS Devon should provide a statement on its' website in respect of our commitment to, and efforts in, preventing slavery and human trafficking in the supply chain and employment practices.

Though the ICB does not fit the criteria under the MS Act to publish a public statement, one has been provided within the annual report for the past 4 years. To be open and transparent and provide public confidence, it is best practice to provide a stand-alone Modern Slavery Statement. NHS Devon is currently the only ICB within the Southwest to not publish their MS statement on their website. It is proposed the following statement be agreed, receive sigh off by the Board and be uploaded onto the One Devon public facing website and staff intranet.

The modern slavery statement has been co-produced in consultation with representatives of the Commissioning Support Unit, Contracts, Governance and Human Resources teams.

The Statement:

Modern slavery is the recruitment, movement, harbouring or receiving of children or adults through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting.

The Modern Slavery Act 2015 introduced changes in UK law, which focus on increasing transparency in supply chains. As both a local leader in commissioning health care services for the population of Devon and as an employer, NHS Devon Integrated Care Board (ICB) provides the following statement in respect of our commitment to, and efforts in, preventing slavery and human trafficking practices in the supply chain and employment practices.

Our organisation

As an authorised statutory body, NHS Devon ICB is responsible for commissioning health care services (including acute, community, mental health and learning disability services) in the Devon area covering a population of approximately 1.2 million. (When this statement is approved a link to the website can be provided to provide further information.)

The Chief Executive for NHS Devon ICB has ultimate accountability for ensuring that the health contribution to safeguarding and promoting the welfare of children and

adults is discharged effectively across the whole health economy through commissioning arrangements. The Chief Nursing Officer is the executive lead for safeguarding and has responsibility for providing leadership and gaining assurance in relation to safeguarding issues within the ICB and locality. The ICB employs the expertise of designated safeguarding professionals for both children and adults who support the delivery of the adult safeguarding and safeguarding children's agendas.

Our approach

Our overall approach will be governed by compliance with legislative and regulatory requirements and the maintenance and development of good practice in the fields of contracting and employment.

NHS Devon ICB expects commissioned organisations and other companies it engages with to ensure their goods, materials and labour-related supply chains fully comply with the Modern Slavery Act 2015 and are transparent, accountable, and auditable

All of our staff have mandatory safeguarding training which includes awareness on Modern Slavery.

As part of our commissioning assurance process, we will request evidence, via the NHS Contracts, from those providers who are required to publish an annual statement in regards to their arrangements to prevent slavery in their activities and supply chain.

Our policies and arrangements

Our recruitment processes are robust and adhere to safe recruitment principles. The ICB complies fully with the NHS Employment Check Standards and the Disclosure & Barring Service (DBS) Code of Practice which includes strict requirements in respect of identity checks, work permits and criminal records.

Our policies such as Safeguarding Adults and Children policies, Fair Treatment (including Grievance and Dignity at Work/Bullying and Harassment) policy and Whistleblowing policies provide an additional platform for our employees to raise concerns about poor and inappropriate working practices.

Our procurement approach follows the Crown Commercial Service standard. When procuring goods and services, we apply NHS Terms and Conditions (for non-clinical procurement) and the NHS Standard Contract (for clinical procurement). Both require suppliers to comply with relevant legislation.

Review of effectiveness

We will continue to raise awareness of the Modern Slavery Act 2015 internally and as part of all procurement processes.
We commit to:

- continuing to provide expert support and advice, via ICB Designated Safeguarding Leads, into the commissioning process and supporting multi-agency work to respond to modern slavery and human trafficking
- continuing to gain assurance that all commissioned services have access to training on how to identify those who are victims of modern slavery and human

trafficking. This training will include the latest information for staff to develop the skills to identify and support individuals who come into contact with health services

- continuing to work with NHS funded and partner organisations to ensure modern slavery and human trafficking are appropriately prioritised

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the current financial year ending 31 March 2024.

If you require further information, please make contact with the modern slavery lead via d-icb.safeadults@nhs.net

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NHS Devon

Policy for the Development and Management of Procedural Documents

NHS Devon

One Devon

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

Version	0.1
Policy Sponsor	Choose an item.
Policy Lead	Choose an item.
Approver	NHS Devon Board
Approval Date	Select a date
To be reviewed by	Select a date

Document change history (to add rows, copy and paste)		
Date	**Change**	**Comments**
Select a date	Select	
Select a date	Select	

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 Care Act 2022 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 Care Act 2022 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: pals.devon@nhs.net

Contents		
Section	**Title**	**Page**

1. Introduction

1.1. The Devon Integrated Care Board (NHS Devon) is required to have procedural documents acknowledging and complying with the Health and Care Act 2022, other relevant legislative and regulatory requirements and national standards relevant to fulfilling planning and allocation decisions and promoting collaboration in the health and care system, as well as quality and safety of the population of Devon. This policy sets out how NHS Devon will go about developing, approving and reviewing these procedural documents.

2. Purpose and objectives

2.1. The purpose of this policy is to ensure a well governed, structured and systematic approach to the development, approval, implementation and review of all procedural documentation in use throughout NHS Devon.

2.2. This policy will:

- Ensure that NHS Devon complies with the Health and Care Act 2022 and other relevant legislation and national standards in developing and reviewing its procedural documents.
- Provide a standard format and corporate style for drafting all NHS Devon procedural documents.
- Set out the requirements for the development and approval of all NHS Devon procedural documents.
- Establish the requirements for regular reporting and provision of assurance with regard to the efficacy and effectiveness of the NHS Devon policy framework.

3. Definitions

3.1. “Procedural documents” is a collective term relating to any of the following documents in the hierarchy set out below:

Figure 1: Procedural Document Hierarchy

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Table 1: Definitions

Terms	Definition
Law/ Regulations	Laws are created by an Act of Parliament or statute. The Health and Social Care Act 2006 and the Health and Care Act 2022 are the key statutes providing the law governing health and care in the UK. Regulations are secondary to statute as they are made under the authority derived from a statute. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulations 2009 are examples of regulations.
Constitution	The NHS Constitution establishes the principles and values of the NHS in England and sets out rights to which patients, public and staff are entitled, and pledges that the NHS is committed to achieving. The NHS Devon Constitution outlines how it will comply with its statutory duties set out in the Health and Care Act 2022 and associated regulations.
Strategy	A high level plan of action designed to achieve a long-term or overall aim. Strategies identify the medium- to long-term aims and objectives of a given subject (for example the Digital Strategy).
Policy	A high level agreed statement intended to assign responsibility and to direct subsequent decisions, actions and other matters. Should state NHS Devon's commitment to deliver one or more duties and will be written for audiences at all levels. Acknowledges legislation, regulation, Department of Health and Social Care and NHS England direction or guidance and best practice that will be complied with in the discharge of NHS Devon's duties.
Procedure/ Protocol	An established or official way of doing something in the organisation. Describes the activities that, in support of the relevant policy, will deliver the discharge of NHS Devon's duties. Can be amended when NHS Devon assesses that the current procedure is not effectively supporting the relevant policy.
Supporting Documents	Describes the steps that are taken by individual teams in support of relevant procedures. These steps may be used a few or many times. Includes Guidelines, Forms, Handbooks and Manuals providing general advice but allow for local discretion.

5 – NHS Devon - Policy for the Development and Management of Procedural Documents

4. Style and format of procedural documents

4.1. A standard template has been developed for the formation of NHS Devon policies. This can be found at Appendix D. There is no standard format requirement for any other procedural documents used by NHS Devon. The Corporate Governance team, with support from the Communications team, will be responsible for ensuring that the authors of procedural documents are aware of corporate style requirements. Procedural documents should be concise and clear, using unambiguous terms and language. The organisation's Style Guide [insert link] should be referred to when drafting these documents.

4.2. Titles should be simple and informative of the document's contents. They should ensure that the procedural document is easy to find via the NHS Devon website search function. Document titles should not begin with "Approved", "Final" or a date.

5. Accountabilities, duties and responsibilities

5.1 Chief Officers will act as policy sponsors and will determine if a new strategy, policy, or other approved document is required. They will support policies appropriate to their responsibilities and approve the strategy or policy as set out in section 12 of this policy.

5.2 Policy owners are staff charged with producing or reviewing policies and must follow the guidance contained in this policy when writing their documents. They will be identified by the Chief Officer and tasked with producing a draft policy or taking responsibility for the review of an existing policy, and where appropriate forwarding to the appropriate group for feedback. They will then work through and consider any feedback on the policy. Policy owners will also be responsible for the review process which occurs on a regular basis.

5.3 The Corporate Governance team will maintain a Policy Register to prevent part or whole duplication of another approved strategy or policy in operation. Policy leads should liaise with the Corporate Governance team, who will check the Policy Register to ensure that proposed strategies or policies do not duplicate any other work. Where a potentially similar strategy or policy is already in operation, the policy lead will be asked to discuss with the policy sponsor whether it is more prudent to develop the existing document further, rather than develop a new one.

6. Developing a new procedural document

6.1. NHS Devon will identify the need to develop new procedural documents in line with the priorities of the organisation e.g., national guidance, legislation, organisational changes, service requirements and evidence-based practice whether in the form of the latest research, audit findings, national inquiries, or serious investigation reports. Once a requirement has been identified, a policy sponsor (relevant Chief Officer) and policy lead should be confirmed. The policy sponsor and/or policy lead, with the support of the Corporate Governance team,

will be responsible for confirming the nature of the procedural document (whether it is a strategy, policy, procedure/protocol or supporting document).

6.2. The policy sponsor will be responsible for ensuring that any proposed strategy or policy (procedures/protocols do not require a policy sponsor) is appropriate for consideration via the relevant approval route. The policy lead will be responsible for the content and drafting of the proposed strategy, policy, or procedure/protocol.

6.3. Any proposals for a new procedural document should be discussed with the Corporate Governance team to determine applicable legislation, regulations, and standards.

6.4. The Corporate Governance team will advise policy leads of the requirements of this policy and relevant approval routes for proposed procedural documents (see section 12 below). The Corporate Governance team will also advise on the process and expected timeframes for the approval of any proposed procedural documents.

7. Reviewing and amending existing procedural documents

7.1. All approved strategies and policies will be published on either the NHS Devon intranet, the NHS Devon internet or in some cases both. Any strategy or policy available on the intranet should be considered to be the current version and the one by which NHS Devon stands, even if the review date has passed. An expired date does not automatically indicate that the strategy or policy has been superseded.

7.2. Policy sponsors and policy leads are responsible for maintaining and updating procedures/protocols and other supporting documents. These will not be included on the Policy Register maintained by the Corporate Governance team.

7.3. All procedural documents should be reviewed at least every three years and preferably annually. However, a review may take place earlier if new evidence becomes available that renders this necessary e.g., changes in legislation, or to reflect changes to working practices.

7.4. The Corporate Governance team will take responsibility for contacting policy leads and policy sponsors 3 months before their policies are due to become overdue to advise on the process and expected timeframes for approval.

7.5. If, when undertaken, a review indicates that only minor amendments are required, which will not alter current practice and as such involve no significant change to the document, the requirement to consult on a revised strategy or policy (see section 10) does not apply. Similarly, appendices, which can be reviewed, revised and replaced at any point without the need to follow the consultation process set out below. Proposed minor updates to strategies or

policies can go forward for approval via the relevant approval route (see section 12 below), once the relevant impact assessments (see section 8) and implementation plans (see section 9) have been completed.

7.6. If a review indicates significant changes in current practice and major amendments to the document will be required, the procedures outlined in section 5 above apply and must be followed.

7.7. If a policy lead is unclear whether the proposed changes to a procedural document constitute a significant change to current practice or not, they should consult with the Corporate Governance team, who will provide advice on this matter.

8. Impact Assessments

8.1. All public bodies have a specific duty under the Equality Act 2010 to carry out equality analysis and to have clear arrangements to assess and consult on how their policies and functions impact on the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation.

8.2. A Quality, Equality Impact Assessment (QEIA) should be completed for all NHS Devon's new and reviewed (with significant changes) strategies and policies to ensure fairness, transparency and that the strategy or policy will not adversely impact individuals in protected groups as provided in the Equality Act 2010. An EHIA will also help the organisation to open services up to new groups and ensure focus on the impact of the change on the user. Further information on EHIAs can be found on the intranet: Equality and Health Inequalities Impact Assessment

9. Implementation

9.1. All strategies and policies need to identify arrangements for training, support and implementation as necessary. An implementation plan (template at Appendix C) should be completed by the policy lead and included in the consultation on the policy (see section 9 below).

9.2. For strategies and policies with minor changes following a review, if the document already has an implementation plan in place, then a new one is not required to be completed. If a strategy or policy which requires minor changes following a review does not have an implementation plan in place, then one should be completed.

9.3. Completed implementation plans should be submitted alongside the proposed strategy or policy to the policy sponsor for sign off and with the final draft submitted for approval.

10. Consultation

10.1. In order to obtain approval for a strategy or policy, it must be accompanied by evidence of robust consultation. The policy sponsor will identify those stakeholders directly or indirectly involved and engaged with the policy area, who should take part in the consultation process and the policy lead should ensure that this takes place accordingly. The consultation process should be managed by the policy lead and the outcomes should be submitted alongside the proposed strategy or policy to the policy sponsor for sign off and with the final draft submitted for approval.

10.2. It should be noted that NHS Devon is committed to full Staff Partnership consultation on its people-related policies. People-related policies should always be subject to full Staff Partnership Forum consultation before being submitted for approval.

10.3. To allow a reasonable time for responses, a consultation period of two-four weeks is generally appropriate. All comments received should be recorded by the policy lead and amendments to the document considered accordingly. If the decision is taken not to amend the document in line with comments received during consultation, relevant consultees should be provided with a written response explaining why. If the consultation process results in a substantial change to the consultation document, a revised draft document should be sent out again to stakeholders for further consultation and comment.

10.4. For strategies and policies with minor changes following a review, a consultation period is not required.

10.5. Consultation is not required for the approval of protocols, procedures or other supporting documents; however, it is recommended.

11. Interagency Policies, Procedures and Guidelines

11.1 NHS Devon is signed up to a number of countywide interagency documents which support local practice and collaborative working arrangements as part of integration. For these documents, the lead agency is responsible for the style and format, distribution and archiving arrangements of the publication, regardless of whether it adheres to NHS Devon's recommendations. Wherever possible, each interagency document must have a relevant member of NHS Devon's staff on its working group to ensure that appropriate consultation at the development stage is achieved.

12. Approval

12.1. The approval routes for procedural documents are shown below:

Procedural document	Review	Assurance	Approval
Strategy	Senior Executive Team and approval of onward submission to Board	Relevant Board Committee	ICB Board
Policy	**Core corporate governance and finance policies** - Senior Executive Team and approval of onward submission to Board	Audit and Risk Committee	ICB Board
	High risk or high impact policies other than core corporate governance and finance policies - Relevant Chief Officer	N/A	Senior Executive Team
	Remaining policies - Relevant Chief Officer with the consultation of at least one other Chief Officer	N/A	Chief Officer
Procedure/Protocol	N/A	N/A	Senior Leadership Team member with responsibility for relevant policy area.
Supporting Documents	N/A	N/A	Team Leader with responsibility for implementing relevant policy area.

12.2. The review routes set out in the table above are a formal part of the corporate governance process for the approval of procedural documents and not part of the consultation process set out in section 9 above, which should be completed prior to the document's submission for review.

12.3. In the absence of a specified Chief Officer to approve a policy, policies can be approved by their nominated deputy for that period of absence. It is not possible for policies to be approved by any other member of staff than Chief Officers, or their nominated deputy in the event of their absence.

13. Dissemination and monitoring of compliance / effectiveness

13.1. All policies and procedures can be accessed electronically via the NHS Devon intranet. All newly uploaded policies and procedures are highlighted in the latest documents area on the intranet, to alert and direct staff who access the intranet, to their publication and availability. The Corporate Governance team will also provide a notification and a link to the policy or procedure via the staff bulletin.

13.2. Departmental managers, team leaders and professional leads are responsible for having a system in place within their sphere of responsibility that ensures their staff are aware of and have read and understood relevant new and revised policies.

13.3. The Corporate Governance team will make available a report to the Senior Executive Team on a quarterly basis setting out the details of all new policies and procedures that have been ratified and uploaded on to the intranet and those which are due for review in the next month.

11 – NHS Devon - Policy for the Development and Management of Procedural Documents

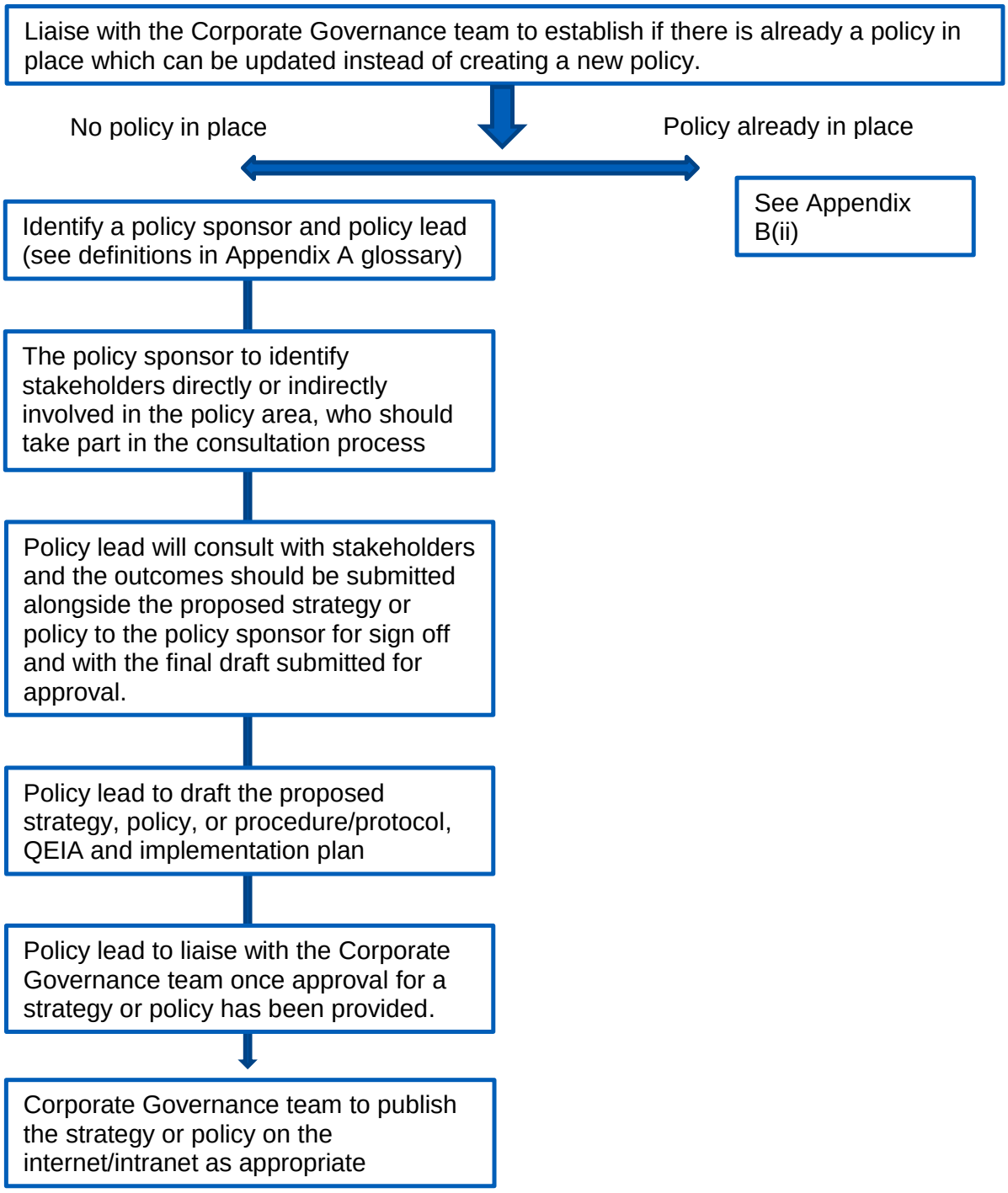
APPENDIX A – Glossary of terms used

Terms	Definition
Health and Care Act 2022	The law establishing Integrated Care Boards as statutory bodies
NHS Devon	Name that will be used for the Devon Integrated Care Board (ICB).
Quality Equality Impact Assessment (QEIA)	The QEIA process considers the extent to which a policy or strategy (including strategic decisions, service or function) may impact, on any groups of the community within Devon. The impact may be neutral, negative or positive and where appropriate the QEIA process allows recommendations or alternative mitigation measures to be made to ensure equal access to services and opportunities
Dissemination	Policy dissemination will include publication of policies and enable target audience internally and externally to access and understand the policy
Implementation Plan	The Implementation Plan identifies the steps and communication strategies for new or amended policies and procedures.
Policy Sponsor	The policy sponsor should be a Chief Officer, who will be responsible for ensuring that any proposed strategy or policy (procedures/protocols do not require a policy sponsor) is appropriate for consideration via the relevant approval route.
Policy Lead	The policy lead will be responsible for the content and drafting of the proposed strategy, policy or procedure/protocol.
Chief Officer	A Chief Officer is a direct report of the Chief Executive.
NHS Devon Board	The NHS Devon Board is the “controlling mind” of NHS Devon – it acts as the agent for the organisation and exercises power on its behalf.
Senior Executive Team	The Senior Executive Team consists of the direct reports of the NHS Devon Chief Executive. It supports the Chief Executive in the discharge of their NHS Devon executive functions.
Policy Register	The Policy Register is the formal list of NHS Devon strategies and policies. It includes information about approval routes and review dates.
Law/ Regulations	Laws are created by an Act of Parliament or statute. The Health and Social Care Act 2012 and the Health and Care Act 2022 are the key statutes providing the law governing health and care in the UK.

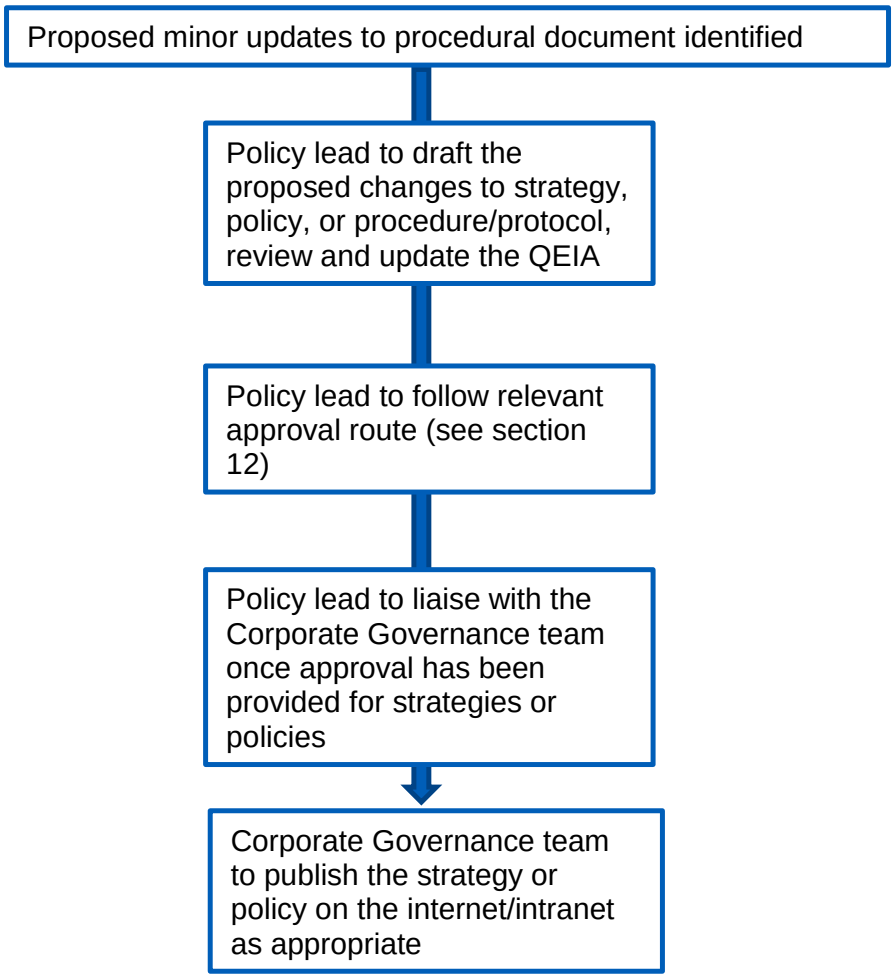
12 – NHS Devon - Policy for the Development and Management of Procedural Documents

Terms	Definition
	Regulations are secondary to statute as they made under the authority derived from a statute. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Care Quality Commission (Registration) Regulations 2009 are examples of regulations.
Constitution	The NHS Constitution establishes the principles and values of the NHS in England and sets out rights to which patients, public and staff are entitled, and pledges that the NHS is committed to achieving. The NHS Devon Constitution outlines how the organisation will comply with statutory duties set out in the Health and Care Act 2022 and associated regulations.
Strategy	A high level plan of action designed to achieve a long-term or overall aim. Strategies identify the medium- to long-term aims and objectives of a given subject (for example the Risk Management Strategy).
Policy	A high level agreed statement intended to assign responsibility and to direct subsequent decisions, actions and other matters. Should state NHS Devon's commitment to deliver one or more duties and will be written for audiences at all levels. Acknowledges legislation, regulation, Department of Health and Social Care and NHS England direction or guidance and best practice that will be complied with in NHS Devon's duties.
Procedure/ Protocol	An established or official way of doing something in the organisation. Describes the activities that, in support of the relevant policy, will deliver NHS Devon's duties. Can be amended when NHS Devon assesses that the current procedure is not supporting the relevant policy.
Supporting Documents	Describes the steps that are taken by individual teams in support of the relevant procedure. These steps may be used a few or many times. Includes Guidelines, Forms, Handbooks and Manuals providing general advice but allow for local discretion.

APPENDIX B(i) – Developing a new procedural document (flow chart)



APPENDIX B(ii) – Reviewing and amending existing procedural documents (flow chart)



APPENDIX C – Procedural document implementation plan (Template)

Title	*Add in title of procedural document*
New/Revised	*Is this a new policy or a revision of an existing policy?*
Policy Sponsor	*Add information about Policy Sponsor (Chief Officer)*
Policy Lead	*Add information about Policy Lead (individual responsible for*
Overview	
Provide a brief overview of the proposed procedural document.	
Anticipated impact	
Changes in practice anticipated	*Provide a brief summary of the anticipated impact on working practices arising from the proposed procedural document and the outcomes expected as a result.*
Stakeholders likely to be affected	*Provide a brief summary of the members of staff, patients and the public likely to be affected by the proposed procedural document.*
QEIA outcome	*Provide a brief summary of the outcome of the Quality, Equality Impact Assessment undertaken in relation to the proposed procedural document.*
Implications	
Training	*Provide a brief summary of the likely training requirements associated with the proposed procedural document and how these will be addressed.*
Resources	*Provide a brief summary of the likely resource implications associated with the proposed procedural document and how these will be addressed.*
Communications	*Provide a brief summary of how the proposed procedural document will be disseminated.*
Effectiveness	
Monitoring and Measuring effectiveness	*Provide a brief summary of how the anticipated changes in practice and outcomes will be monitored and measured.*
Approval of Implementation Plan	
Policy Sponsor	
Signature: **Date:**	

APPENDIX D – Standard Policy Template

Policy Title

NHS Devon

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Version	0.1 is first draft of new policy and first approved version is 1.0. First draft/amendment of version 1.0 is 1.1 and incremental until approved as version 2.0
Policy Sponsor	Select Policy Sponsor
Policy Lead	Enter job title of responsible Director
Approved by	Select the Approving Route
Approved on	Select a date
To be reviewed by	Select a date

Document change history (to add rows, copy and paste)		
Date	**Change**	**Comments**
Select a date	Select	
Select a date	Select	

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: pals.devon@nhs.net

18 – NHS Devon - Policy for the Development and Management of Procedural Documents

Contents		
Section	**Title**	**Page**

Red text is provided to support you in writing your policy.
This text is to be removed once the policy is.

1. Introduction

Why is this policy needed? Provide a summary of the subject matter, legislation, regulation, national standards, NHS Devon Constitution context.

2. Purpose and objectives

Explain what this policy seeks to achieve e.g., meeting a regulatory or legislative requirement or how the policy will support NHS Devon in achieving its strategic objectives.

2.1 The aim of this policy is

2.2 This policy will:

- Set out clearly and succinctly what will happen or change as a result of the adoption of the policy

3. Scope

3.1 This policy applies to all staff of NHS Devon [delete the following if not applicable – with the exception of *insert any groups or individuals as appropriate]*

4. Definitions

Include in the table brief definitions of the terms contained in the policy, such as abbreviations, technical terms and acronyms. (N.B. if required, more terms can be appended in a Glossary.

Terms	Definition

5. Content – key aspects of your policy [title this section as appropriate and ensure that this is reflected in the content list]

5.1 This is the main part of the document – the bit that the reader probably wants to get to and should include all of the key aspects of how NHS Devon will deal with the particular issue which is the subject of the policy.

5.2 **Sub-Section title**

5.2.1 Add the content relevant to the policy in as many sub-sections as necessary to aid clarity and in a way that concisely conveys the information.

6. Accountabilities, Duties and Responsibilities

This section is to clarify the specific duties associated with the policy and where the responsibilities lie.

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. [This paragraph to be included in all policies]
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; • [include any specific responsibilities in respect of this 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. • [include any specific responsibilities in respect of this policy]

Title of any other relevant Officer	[Set out the specific responsibility for implementation of any part of the process, clearly stating what that officer's responsibility is, including who is responsible for drafting and updating any part of the document]
Titles of any Committee	[Set out the specific responsibility for any part of the process, including reviewing the policy and receiving updates on its effectiveness and compliance]
Line Managers	Line managers have a responsibility to ensure their staff comply with NHS Devon policies and standards within their areas of responsibility. [This paragraph to be included in all policies]
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. [This paragraph to be included in all policies]

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.

An implementation plan should be completed for all new policies. The template can be found here – insert link. The completed implementation plan should be submitted with the policy to the Policy Sponsor with the final draft at approval stage.

7.3 If the need for training has been identified for all staff or particular groupings of staff, include an overview here. Reference should be made to who will require the training, the type of training, how it will be delivered and how often it should be undertaken.

8. Approval and Review

8.1 Insert the approval route for this policy. Please contact the Governance Team for confirmation of the correct route.

8.2 This policy will be reviewed annually, 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 Explain how the policy will monitored to provide assurance as to its application and effectiveness. Areas to consider are include:

- Is the policy achieving what we said it would?
- Are we doing all of the things that we said we would?
- Is the policy making a difference?

Be realistic around the frequency and detail of the monitoring process. Specify what will be monitored, how this will be done and by whom and where this will be reported and when.

10. Quality & Equality Impact Assessment (QEIA)

A QEIA should be completed for all new policies and where **significant amendments** are made. The NHS Devon QEIA can be found here – *insert link.*

Confirmation that a QEIA has been completed in respect of the policy should be included, together with a brief overview of the findings and any subsequent actions.

The completed QEIA should be submitted with the policy to the Policy Sponsor for sign off with the final draft at the approval stage.

11. References

Other related policy documents

11.1 List any other NHS Devon policies which relate to the subject matter of this policy.

Legislation and statutory requirements

11.2 List any relevant legislation and statutory documentation including a link the documents referred to.

Best practice recommendations and other key guidance

11.3 List any best practice and other guidance including a link the documents referred to.

APPENDIX A – Glossary of terms

List terms/definitions used in this document, including abbreviations, technical terms, and acronyms

Terms	Definition

APPENDIX B –[insert title, which should match the title included on the contents page]

NHS Devon Integrated Care Board

One Devon Partnership Chair's Report

Date of board meeting	Date of committee covered in this report
04 October 2023	07 September 2023

Chair	
Name and title:	Cllr James McInnes, Chair of the One Devon Integrated Care Partnership

Update from the Partnership

The One Devon Partnership, a statutory committee that includes a range of partners who influence people's health, wellbeing and care, has agreed a priority focus on children and young people, to influence and encourage action across Devon.

The Partnership held a workshop and agreed it was important that there should be some dedicated officer time from across the Partnership to support the One Devon Partnership to address issues going forward. It was also agreed that we should have one overarching priority this year Children and Young People which is connected to employment and education, housing, and health inequalities for children and young people.

The Partnership Chairman James McInnes, who is also Cabinet Member for Integrated Adult Social Care and Health on Devon County Council, said: "We had an honest and open conversation among members. Plymouth City Council and Devon County Council are formally recognising care experience as a protected characteristic and we will be encouraging all our member organisations to follow suit."

The Partnership highlighted what inequalities that those with care experience face, including:

- A University College London study which showed 70% of care experienced people die early.
- Over 50% of people who are in custody up to the age of 21 have been in care (Become Charity)
- A quarter of the homeless population is care-experienced (The Independent Review of Children's Social Care).
- Only 14% of care leavers go to university, compared to 46% of young people who didn't grow up in care and that it will take 107 years to close the gap at the current rate of progress (Breaking the Care Ceiling, Civitas).

Cllr McInnes added: "We will also be making a call to partners across our system to acknowledge the role we all play as corporate parents, and to ensure this is central to the work we do and how we do it."

Recommendations for the board

- To note the contents of this report

NHS
Cornwall and
Isles of Scilly

Paper number: ICB2324/97

Board meeting of the Integrated Care Board

Agenda item: ICB chief executive update

Date of meeting: 14 September 2023
Meeting section: Public session (part 1)
For: Discussion

Author: Kate Shields, chief executive

1. Executive summary

The chief executive's update is a regular feature of each board meeting.

The report focuses on highlighting emerging issues and significant developments that are not otherwise covered on the board agenda. It helps ensure members are aware of key areas of work happening within the Cornwall and Isles of Scilly integrated care system (ICS). A verbal update on other key areas may also be given.

2. Recommendations

The ICB Board is asked to receive the chief executive update and enquire further, as necessary.

3. Main report

3.1 Annual General Meeting – September 2023

The ICB Annual General Meeting (AGM) is taking place on Thursday 14 September 2023 and will be followed by a showcase event to mark our first-year achievements, to outline our long terms plans and to say thank you to the people and teams who have delivered through this year.

NHS Cornwall and Isles of Scilly Integrated Care Board
Call us on 01726 627 800
Email us at ciosicb.contactus@nhs.net
Visit our website: cios.icb.nhs.uk

Part 2S, Chy Trevail,
Beacon Technology Park,
Dunmere Road,
Bodmin, PL31 2FR
Chair: John Govett
Chief executive officer: Kate Shields

3.2 Reinforced Aerated Autoclaved Concrete (RAAC)

NHS England issued an updated guidance letter on 5 September detailing actions and responsibilities which includes Integrated Care Boards and assurances relating to the primary care estate. The ICB has a duty to ensure that investigatory processes undertaken by our providers and GP contractors are robust and should any suspect materials be identified, a mitigation and remedial plan is put in place for any premises our patients and staff visit.

To support in this process the ICB is instructing a structural engineering firm to undertake assessments of the whole primary care estate including provisions on the Isles of Scilly. The estimated duration of the work is 10 weeks and we shall follow up any actions or recommendations as soon as they are received.

3.3 Pre-Delegation Assessment Framework (PDAF)

The pre-delegation assessment framework (PDAF) has been developed to support Integrated Care Boards (ICBs) prepare for delegation arrangements; and underpins the assessment of system readiness. It is aligned to the framework developed for the delegation of primary care Pharmaceutical Services, General Ophthalmic Services, and Dental (Primary, Secondary and Community) Services commissioning functions, and has been tailored specifically for specialised services commissioning.

For the avoidance of doubt, it would not be possible (at this stage) for the ICB to make a formal acceptance decision that would satisfy its own statutory duties and internal audit requirements given the extent of information currently unavailable and further financial diligence required. It is noted therefore the PDAF submission is the opportunity in which the ICB can formally feed into the NHS England Board decision in December 2023 on whether to delegate specialised services for April 2024. To avoid a situation where the NHS England Board is not fully aware of ICB positions when making its own decision, it is appropriate for the ICB to give an indication of intent.

In submitting this PDAF the Integrated Care Board is signalling:

- a commitment to the direction of travel and eventual delegation of specialised commissioning to ICBs.
- the PDAF accurately represents the joint working arrangements in place and currently under further development.
- the PDAF accurately represents the risks of delegation, including remaining unquantified and unmitigated risks.

Therefore, the Integrated Care Board is recommending the continuation of joint working in 2024/25 and a deferral of formal delegation until 2025/26.

3.4 System recovery

The Cornwall and Isles of Scilly integrated care system has commenced an important initiative which will shape the future of healthcare delivery in our region. With a renewed focus on financial and operational recovery, we have established a system recovery function to drive improved performance, ensure financial sustainability and ensuring we

optimise the safety and quality of our services across Cornwall whilst also removing unwarranted variation for our population.

The NHS system in Cornwall and Isles of Scilly has faced significant financial and operational challenges, compounded by the COVID-19 pandemic and a national drive to recover the productivity deterioration across our service during that period.

The system recovery function will be responsible for overseeing and coordinating recovery efforts The ultimate goal of this endeavour is enhanced financial stability, operational efficiency, and reduced variation will deliver better patient outcomes so people that live across Cornwall and the Isles of Scilly can start well, live well and age well.

We are incredibly fortunate to have the expertise, dedication, and passion of all those who work across our integrated care system and will be working in partnership with Deloitte who will bring additional impetus and capacity to enable improvement at pace. We look forward to navigating these challenges together to help make our health and care system as resilient and accessible as possible.

3.5 Health and Adult Social Care Overview and Scrutiny Committee (HASCOSC) informal briefings

We are proud of the relationship between the integrated care system and the Health and Adult Social Care Overview and Scrutiny Committee, with our regular participation into their informal sessions and formal meetings. Recent informal session presentations were made to update on our intermediate care strategy, dementia care, and private providers.

We welcome and look forward to these ongoing opportunities to brief our health and care and Council members colleagues on key topics, achievements and performance matters.

3.6 Winter planning workshop

Preparedness for winter has commenced with a well-attended system wide workshop held on 17 August during which focused on learning from our own winter 2022/23 as well as from the southern hemisphere, immediate commitments and next steps in preparing for winter 2023/24.

Our clear focus for winter will be falls, frailty and end of life and this is the first phase of our intermediate care strategy.

NHS Devon Integrated Care Board

Risk Management Policy Refresh and Board Assurance Framework Update

Date of meeting	Date Report Produced
04 October 2023	12 September 2023

Author(s)		Report Approved By	
Name and title:	Philippa Harding, Company Secretary	**Name and title:**	Andrew Millward, Chief Communications and Corporate Affairs Officer, NHS Devon
Phone:	01392 675 116	**Date:**	15 September 2023
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 paper provides the NHS Devon Board members with an update on the recent review of the NHS Devon Risk Management Policy and an update on the Board Assurance Framework (BAF) which includes the high-level strategic risks that pose a threat to the achievement of NHS Devon's strategic objectives.

Committees that have previously discussed / agreed the report, and outcomes of that discussion
NHS Devon Senior Executive Team (SET) on the 19 September 2023 – Agreed
Audit & Risk Committee (ARC) on the 26 September 2023 – Endorsed

Key recommendations and actions requested
1. The Board is asked to **approve** the new Risk Management Policy.
2. The Board is asked to **approve** the updated iteration of the BAF and the proposed approach to developing a system approach to the BAF and risk management.

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.

NHS Devon

Risk Management Policy Refresh and Update

Introduction and Background

1. This report provides the NHS Devon Board with information about the ongoing work to develop risk management systems and processes within NHS Devon. This is to facilitate the Board in discharging its duties with regard to:
    - Reviewing the adequacy and effectiveness of the system of integrated governance, risk management and internal control across the whole of the NHS Devon activities that support the achievement of its objectives.
    - Reviewing the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of NHS Devon objectives and the effectiveness of the management of principal risks.
    - Seeking reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
    - Identifying opportunities to improve governance, risk management and internal control processes across NHS Devon.

Review and Revision of the Current Risk Management Framework

2. Throughout August and September 2023, the Corporate Governance team has been reviewing the adequacy of the current NHS Devon Risk Management Framework. In order to ensure that the policy is as clear as possible and secure widespread engagement from across the organisation, the following amendments have been made:
    - Greater clarity about risk management activities and processes.
    - Distinction between the treatment of strategic and operational risks and the associated distinction between the corporate risk register and the Board Assurance Framework.
    - Clarification of roles, responsibilities, and accountabilities.

3. The revised “Risk Management Policy” is attached at Annex A to this report. It was presented to the Senior Executive Team (SET) on 19 September 2023 and is being presented to the Audit & Risk Committee (ARC) for assurance on the 26 September 2023.

4. The draft policy has been shared with NHS Devon's internal auditors for additional assurance.

5. **Board members are asked to approve the new Risk Management Policy.**

Board Assurance Framework (BAF)

6. An organisation's Board Assurance Framework (BAF) brings together in one place all the relevant information on risks to the Board's strategic objectives. The HM Treasury Guidance on Assurance Frameworks (2012) defines an assurance framework as: "a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect."

7. The BAF was discussed and agreed at SET on 19 September 2023 and is being presented to the ARC for assurance on the 26 September 2023. It provides a constantly evolving picture of the principal risks that could impede the organisation from achieving its strategic objectives.

8. The BAF:

   a) Assigns a risk to each of the Board's Committees:

      - Quality & Patient Experience Committee
      - Finance & Performance Committee
      - People & Culture Committee
      - Primary Care Commissioning Transition Committee

      As well as the SET. This is to ensure that each of the identified risks has robust oversight and granular review before consideration by the Board.

   b) Aligns with the One Devon Integrated Care System strategy, aims and challenges.

   c) Maps the Delivery and Enabling Programmes from the Joint Forward Plan (JFP) and the underlying risks relating to the Organisational Change Programme, to each of the objectives and strategic risks.

   d) Shows if there have been any movements in risk core between reporting periods.

9. Individual BAF risks were reviewed with Executive Leads at the beginning of September 2023. The details for each risk are attached at the Annex B and the scoring methodology in Annex C of this report. The table on the next page of this report provides a high-level summary of the current risk position.

10. Key changes from the BAF presented to the Board at the end of Q1 of the 2023/24 financial year are as follows:

    - "Anchor" risk – risk score increased.

- “Inequalities” and “Prevention” risks – individual risks amalgamated, and new (reduced) risk score applied.
- “Recovery” risk – previously a single risk, this has been separated into two risks, one relating to the unscheduled care and one related to elective care and new (increased) risk scores applied.
- “Primary Care” – no change at current time but propose that this risk is re-articulated in the future to reflect additional primary care activities in additional to those carried out by GPs.
- “MHLD” risk – no change at current time but propose that this risk is re-articulated in the future to reflect the significant scope of the activities covered.
- “Finance” risk – no change at current time but propose that this risk is re-articulated in the future to reflect the changing nature of this risk.
- “Workforce” risk – slight amendment of the articulation of this risk.
- “Digital” risk – slight amendment of the articulation of this risk.
- “Green Plan” risk – slight amendment of the articulation of this risk.
- “Culture” risk – amendment of the articulation of this risk to reflect organisational change and new (increased) risk score applied.
- “Operating Model” risk – risk score reduced.

Current Risk Position

Title	Strategic Objective	Monitoring Committee	Inherent Risk Score	Historical and Current Risk Q1 **2023/24**	Historical and Current Risk Q2 **2023/24**	Change	Target	Risk Appetite	Last Review
Improve Population Health									
Anchor	1	Quality	25 (Prev. 16)	16	20	Increased	8	Seek	Sept 23
Inequalities & Prevention	2 & 3 (Previously Separate)	Quality	16	16 (Inequalities) 12 (Prevention)	12	Decreased	8	Seek / Open	Sept 23
Improve Services and Reduce Unwarranted Variation									
Recovery (Unscheduled Care)	4	Finance	20 (Prev. 16)	9	16	Increased	6	Open	Sept 23
Recovery (Elective Care)	5	Finance	20 (Prev. 16)	9	16	Increased	6	Open	Sept 23
Primary Care	6	Primary Care	16	16	16	No Change	8	Seek	Sept 23
MHLD	7	Finance	20	16	16	Increased	10	Open	Sept 23
Community	8	Primary Care	20	16	16	No change	8	Seek	Sept 23
Make More Efficient Use of Resources									
Finance	9	Finance	20	16	16	No change	8	Open	Sept 23
Workforce	10	People & Culture	16	12	12	No change	6	Open	Sept 23
Digital	11	Finance	16	12	12	No change	8	Seek	Sept 23
Green Plan	12	Finance	16	12	16	No change	8	Seek	Sept 23
Develop Our Culture and How We Operate									
Culture	13	People & Culture	25 (Prev. 16)	8	20	Increased	6	Seek	Sept 23
Operating Model	14	System Exec	16	16	12	Reduced	6	Seek	Sept 23

Developing a System Approach to the BAF and Risk Management

11. In order to ensure that the BAF enables oversight of risks to the achievement of One Devon Integrated Care System's objectives, further work is planned with NHS and system partners to move towards a system approach to the BAF.

12. The refresh of the Joint Forward Plan (JFP) will incorporate a refreshed view of system-wide risk. As part of this work consideration will be given to the identification of risks to (JFP) objectives. It is anticipated that these risks will be multifactorial and complex and that, consequently, it will be necessary to develop a strong alignment of the BAFs of all system partners. This will in turn allow assurance to be drawn from a range of internal and external sources.

13. The Corporate Governance team will also conduct a review of the BAFs of all Devon NHS providers, to inform thinking on the development of the content of the NHS Devon BAF. A network of system governance leads is being established to consider this work further before the end of 2023.

14. **Board members are asked to approve the updated iteration of the BAF and the proposed approach to developing a system approach to the BAF and risk management.**

Conclusion

15. The Board is asked to:

- **Approve** the new Risk Management Policy.
- **Approve** the updated iteration of the BAF and the proposed approach to developing a system approach to the BAF and risk management.

ANNEX A

NHS Devon

Risk Management Policy

NHS Devon

One Devon

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

Version	**0.1 is first draft of new policy**
Policy Sponsor	Chief Communications and Partnerships Officer
Policy Lead	Company Secretary
Approved by	NHS Devon Board
Approved on	Select a date
To be reviewed by	Select a date

Document change history (to add rows, copy and paste)		
Date	**Change**	**Comments**
Select a date	Select	
Select a date	Select	

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: pals.devon@nhs.net

Contents

3 – NHS Devon Risk Management Policy

1. Introduction

1.1 Risk management plays a critical role in helping NHS Devon understand and manage risks to the achievement of its priorities. It helps us to determine an appropriate control environment and balance of strategies to address risk, so that we use resources both efficiently and effectively. It involves making decisions and establishing governance systems that embed and support effective risk processes, as well as building an organisational culture that supports integrity, accountability, honesty, openness, and responsiveness to change.

1.2 This policy sets out the key principles that guide risk management within NHS Devon.

1.3 Further advice and guidance is available from the Corporate Governance team by emailing d-icb.governance@nhs.net.

2. Purpose and Objectives

2.1. Risks will always occur. Many risks are manageable, but others pose a more serious possibility of impact on the organisation, staff, patients and / or the general public. Once identified, risks must be assessed, recorded, managed according to severity, reported and scrutinised.

2.2. NHS Devon is required by statute and by guidance from the Department of Health and Social Care (DHSC), to systematically identify and control all significant strategic and operational risks. These arise across the organisation and include clinical and corporate services.

2.3. The Board is required to ensure that robust risk management processes exist and assured that there are systems in place to control and manage risk and that these systems are working effectively. This involves the proactive identification and management of risks that may threaten achievement of NHS Devon's objectives and the response to adverse events or learning from audits and other independent reviews.

2.4. The Chief Executive Officer (CEO) is required to sign an Annual Governance Statement (as part of the Annual Report and Accounts) to provide reasonable assurance that NHS Devon has been properly informed about the totality of its risks and can evidence they have identified NHS Devon's strategic and corporate objectives, and managed the principal risks to achieving them. This includes all measures and practices that are used to control and manage risks. The system operates at all levels within NHS Devon and is continuously monitored for effectiveness on behalf of, and by, the Board.

2.5. This policy will:

- Establish a framework for risk management and board assurance which embraces organisational, financial, clinical, and non-clinical risks and in which all parts of the organisation are involved.
- Provide an environment for proactive decision making.
- Empower all staff to manage risk within delegated limits.
- Provide a proactive early warning system and enable a comprehensive response to mitigate risk where indicated.
- Establish a platform for managing risks within partnership working.
- Ensure the integration of risk management with NHS Devon's strategies and objectives and with local (directorate / team) objectives that these support.

2.6. This policy also helps to reduce the risk of fraud and bribery by providing a robust system of internal control for risk management. It supports and complements NHS Devon's Counter Fraud, Bribery and Corruption Policy and has been reviewed by the organisation's Local Counter Fraud Specialist. Fraud and bribery risks will be included in NHS Devon's risk register and its performance against standards will be assessed annually via completion of the NHS Counter Fraud Authority (CFA) Self Review Tool.

2.7. The NHS Devon Board recognises that risk management is an integral part of good management practice and an effective corporate governance framework and, to be most effective, it must become part of the organisation's culture. The Board is therefore committed to ensuring that risk management forms a part of the NHS Devon philosophy, practice, and planning, rather than being viewed or practised as a separate programme, and that responsibility for implementation is accepted at all levels of the organisation.

2.8. The Board acknowledges that the provision of appropriate training is central to the achievement of this aim.

2.9. A critical role of any Board is to focus on the risks that may compromise the achievement of the organisation's strategic and corporate objectives. In order to be confident that the systems of internal control are robust, the NHS Devon Board must be able to provide evidence that it has systematically identified its strategic objectives and managed the principal risks to achieving them.

2.10. The NHS Devon Board is committed to the following key principles:

- **A Just Culture** – Staff reporting or directly involved in incidents are assured that any investigation will be carried out fairly, openly, transparently, without prejudice and with the aim of identifying learning and correcting underlying causes of the incident to prevent recurrence.
- **Freedom to Speak Up (Whistleblowing)** – All staff should be familiar with NHS Devon's Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy, available on the staff intranet, which sets out procedures and guidance to staff on raising concerns. NHS Devon has

Freedom to Speak Up Guardians to whom staff may raise concerns; their details can be found on the staff intranet.

3. Definitions

3.1. For a full glossary of terms used within this policy document and in risk management in general, please refer to **Appendix A**.

Risk

3.2. Risk is defined as:

"An uncertain event or set of events, that should it occur, will have an effect on the achievement of objectives. A risk is measured by the combination of the probability of perceived threat or opportunity occurring and the magnitude of its perceived impact on objectives".

(Management of Risk: Guidance for Practitioners, Officer of Government Commerce, 2010)

3.3. For example, the potential occurrence of an event that may either cause harm or have an impact on patients, visitors, partner organisations, strategic objectives, assets and / or reputation.

3.4. In particular:

- Any element which has the potential to damage or threaten the achievement of the strategic and corporate objectives, programmes, or service delivery of NHS Devon.
- Anything that could damage the reputation of NHS Devon and undermine the public's confidence in NHS Devon.
- Failure to guard against impropriety, malpractice, waste and / or poor value for money.
- Non-compliance with regulations and / or legislation such as those covering health and safety, safeguarding and the environment.
- An inability to respond to, or manage, changed circumstances in a way that prevents or minimises adverse effects on the delivery of NHS Devon's strategic and corporate objectives.

3.5. NHS Devon distinguishes between **inherent risks** and **residual risks**. An inherent risk is one that is unmitigated whilst a residual risk is the risk that remains once the inherent risk has been mitigated or managed. **Appendix B** provides an illustration of the difference between these two types of risk.

Issues

3.6. An issue is an event that has happened or is happening. It is a 'known' as opposed to an 'unknown' quantity. The outcome of the actions and events is no longer subject to uncertainty as in the case of a risk. The consequences may be observed and measured. However, that is not to say that new risks

will not emerge as the 'issue' continues. **Appendix C** provides more detailed information in relation to the key differences between risks and issues.

In simplistic terms, the difference comes down to whether the event has the **potential to occur** (i.e. it is a risk), or **has already occurred** and the impact / consequence is now present (i.e. it is an issue).

Risk Management Principles

3.7. Risk management within NHS Devon will be carried out in accordance with the principles set out in **Appendix D**. Examples include alignment with objectives, fits the context, promotes, guides, and supports a clear and consistent approach, informs decision-making, facilitates continual improvement, and achieves measurable value.

4. Risk Management Activities and Processes

4.1. Risk management involves the following activities (see **Appendix E**):

4.1.1. **Identify the risk:** Consider how and why the successful achievement of a goal / objective might be prevented. Hazards, barriers, and challenges to achievement of objectives, at strategic and operational level, can be identified from a variety of internal and external sources such as staff resource issues, workforce recruitment problems, incompatibility of IT systems, a lack of assurance on areas of quality and performance data or information from staff and / or patients etc.

4.1.2. **Assess the risk:** Describe the risk and give it a succinct title which clearly identifies the risk, the area to which it relates and, where appropriate, the financial year to which it relates. Consider how the risk could occur, who or what might be involved, what the effect(s) would be if the risk were to materialise and how this could be reduced or minimalised. Describe the risk clearly and concisely; think in terms of the "**if**" and "**then**" statement e.g. **if** some event or condition occurs, **then** a specific positive or negative impact or consequence to objectives will result.

4.1.3. **Analyse, evaluate and score the risk:** Assess the likelihood of the risk materialising, and the level of its impact should it occur; it informs the risk score matrix. See **Appendix F** to assess whether the risk scores highly enough to take action. The total risk score will also determine whether the risk is managed at a team / directorate level or via the NHS Devon Corporate Risk Register (CRR).

4.1.4. **Treat the risk:** Determine which of the following actions will be required:

Treatment	Treatment Description
Treat	Draw up a specific action plan (which includes consideration of funding / associated costs) to reduce the impact or likelihood scores to an acceptable level, as articulated in the 'risk appetite' agreed by the NHS Devon Board, in order to gain further control.
Tolerate	It is not always possible to identify and then fully implement actions that eliminate or minimise the risk. Where this is the case, it is essential that the significance of the risk that remains (the residual risk) is understood and the organisation, in accordance with the level of authority for risk management, confirms that it is prepared to accept that level of risk.
Transfer	Transfer the risk to another organisation (this is rare).
Terminate	Close the risk (subject to approval) – for example, decide to no longer do the activity that is causing the risk.

4.1.5. **Report the risk:** All identified risks should be recorded on a risk register; the risk score determines where it is reported:

4.1.5.1. **All team / directorate risks** (generally scoring 10 or below) are reported and managed locally via a team / directorate risk register. The risk register should be reviewed monthly and escalated to the relevant Chief Officer as required.

A quarterly review of all team / directorate risk registers should be undertaken by the Corporate Governance team to ensure oversight of any risks that may need to be escalated.

All teams / directorates should maintain their own risk registers.

If a risk is deemed to be a risk to the achievement of NHS Devon's corporate objectives or statutory purposes, and not just those of the team / directorate, and scores 12 or above, then it can be escalated for inclusion on the NHS Devon Corporate Risk Register (CRR).

4.1.5.2. **All project / programme risks** (any score) are reported and managed locally via a project / programme risk register. The risk register should be reviewed regularly by

the Project / Programme Manager. Where there is a significant risk to the non-achievement of the project / programme objective which may then pose a further risk to the achievement of an organisational objective, operational or strategic, the Project / Programme Manager will discuss with the most senior officer with portfolio responsibility for the risk and seek advice and guidance from the central Corporate Governance team as appropriate.

4.1.5.3. **All operational risks** (generally scoring 12 and above) are added to the NHS Devon Corporate Risk Register (CRR); this is done in conjunction with a member of the Corporate Governance team. Operational risks are reviewed on a monthly basis. The review is overseen by a member of the Corporate Governance team.

Operational risks scoring 15 and above are reported alongside the Board Assurance Framework (BAF) to the Senior Executive Team (SET).

4.1.5.4. **All strategic risks** (generally scoring 15 and above) are included on the Board Assurance Framework (BAF) and are reviewed regularly and reported alongside operational risks (scoring 15 and above) to the Senior Executive Team (SET), the NHS Devon Board, and its associated Assurance Committees.

Refer to **Appendix G** for a summary of risk action and reporting requirements.

4.1.6. **Monitor / review the risk:** Monitor the risk impact and review the effectiveness of action / actions taken. It is important to consider whether the risk score / risk priority has changed as a result.

4.1.7. **Communicate with and consult those impacted by the risk:** It is important to identify who is affected by the risk and who needs to know about it e.g. internally and / or externally.

5. Strategic and Operational Risks

5.1. Risk related activity within NHS Devon is derived from two directions

- **Bottom up:** Individuals, teams, directorates, Executive Leads, the Senior Executive Team (SET), and Board Assurance Committees can identify a risk and this risk would then be recorded and managed accordingly in accordance with the details laid out in this policy document. These risks are operational risks and collectively they form the NHS Devon Corporate Risk Register (CRR).
- **Top down:** The NHS Devon Board discusses and agrees those strategic risks that it considers the organisation faces in the achievement of its agreed corporate objectives or other statutory

functions. These form the strategic risks of NHS Devon and are recorded in its Board Assurance Framework (BAF).

5.2. Both operational and strategic risks should be aligned to NHS Devon's corporate objectives (as articulated in the Integrated Care Strategy and Joint Forward Plan (JFP)). In the absence of corporate objectives at any point, operational and strategic risks should be expressed and recorded against one of the four statutory purposes of Integrated Care Boards:

- Improve outcomes in population health and healthcare.
- Reduce health inequalities in outcomes, experience, and access.
- Enhance productivity and Value for Money (VfM).
- Support broader social and economic development.

5.3. **Risk Scores** are calculated in accordance with the National Patient Safety Agency (NPSA) Model Risk Matrix and are the product of the impact / consequence and the likelihood of the risk arising (see **Appendix F**).

5.4. NHS Devon adheres to the Nolan Principles of openness and accountability, however occasionally there is the requirement to make a risk **confidential** which means that it is not reported within the public domain. A risk can be classified as confidential, with the approval of the Corporate Governance team and Executive Lead, if it contains clinically or commercially sensitive information. The classification of a risk as being confidential due to clinically sensitive information also requires the approval of either the Chief Medical Officer (CMO) or the Chief Nursing Officer (CNO).

6. Corporate Risk Register (CRR)

6.1. **Risk escalation to the NHS Devon Corporate Risk Register** (CRR) - All directorates should maintain their own risk registers. If a risk is deemed to be a risk to the achievement of NHS Devon's corporate objectives or statutory purposes, and not just those of the team or directorate, and scores 12 or above, then it can be escalated for inclusion on the NHS Devon Corporate Risk Register (CRR). The Corporate Governance team reviews any such risk with the risk assessor and owner to establish whether this is appropriate, and the scoring is proportionate. If the risk is deemed appropriate for inclusion, it is added to the NHS Devon Corporate Risk Register (CRR).

6.2. **Risk Management System** – All managers have a responsibility to record identified corporate risks on NHS Devon's risk management system. This ensures risks at all levels are held in a central location which is fully auditable (please contact the Corporate Governance team for access to and training on how to use the risk management system if required). The use of the risk management system enables staff to add new risks or make updates to existing risks at any time. As a minimum, corporate risks must be reviewed and updated at least every two months by the named assessor. Following this review the update will be agreed by the risk owner and reported as appropriate.

6.3. Regular reviews are undertaken across NHS Devon to ensure that:

- New risks are identified and assessed.
- A careful watch is maintained on cumulative risk across NHS Devon to ensure that this is identified and properly escalated.
- Existing risks and their mitigating actions are tracked and kept up to date.
- A summary of all incidents within teams / directorates is reviewed and this information is disseminated to ensure that appropriate learning takes place to reduce future risks.
- Risks that are no longer being faced by NHS Devon are closed.

6.4. The full process for the identification, scoring, management and reporting of risks is detailed within **Appendix H**.

7. Board Assurance Framework (BAF)

7.1. The Board Assurance Framework (BAF) provides a structure and process that enables NHS Devon to focus on the risks that might compromise achieving its most important goals and objectives, to map the controls that should be in place to manage those objectives, and to confirm that the Board has sufficient assurance regarding the effectiveness of those controls. The Board Assurance Framework (BAF) also identifies any gaps in control and / or assurance and articulates action plans in place to address them.

7.2. In advance of each financial year, the NHS Devon Board should agree overarching corporate goals for that year. These goals have a number of underpinning corporate objectives. The Board Assurance Framework (BAF) captures these corporate goals and the strategic risks applicable to them. Each goal and the strategic risks associated with this goal will be assigned to a Board Assurance Committee for scrutiny, monitoring, and testing of whether evidence provided to substantiate the levels of control applied. In the absence of corporate objectives at any point, operational and strategic risks are expressed and recorded against one of the four Statutory Purposes for Integrated Care Boards, those being:

- Improve outcomes in population health and healthcare.
- Reduce health inequalities in outcomes, experience, and access.
- Enhance productivity and Value for Money (VfM).
- Support broader social and economic development.

7.3. Any Board Assurance Committee responsible for scrutinising an area of risk can escalate a risk onto the Board Assurance Framework (BAF) when one or more of the following criteria are met:

- The current score is significantly in excess of the target score;
- It is a long-standing risk that shows little or no reduction in current risk score; or

- The Committee has not received sufficient assurance that the risk is being appropriately and effectively managed.

7.4. The Board Assurance Framework (BAF) is updated by Executive Leads in conjunction with the Corporate Governance team, on a bi-monthly basis, and reported to the Senior Executive Team (SET) for recommendation to the NHS Devon Board. The Board Assurance Framework (BAF) will set out the controls, assurances, gaps and associated mitigating actions relating to each gap. The details in relation to mitigating actions will also require an 'action owner', the 'action status' and 'planned implementation date' to be recorded; this is so that progress against plan can be monitored, and corrective action taken where there is deviation from plan.

7.5. The Board Assurance Framework (BAF) will be used as a tool for setting the agendas of Board meetings and development sessions (as well as Board Assurance Committee agendas). It will be presented at each formal meeting. To be an effective tool, it should be possible to map items identified in the Board Assurance Framework (BAF) to papers presented to the meeting which address those items. This may be through specific papers, or within standing agenda items such as finance, quality, or performance report.

8. Risk Appetite

8.1. 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.

8.2. **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. It can be influenced by personal experience, political factors, and external events.

8.3. 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.

8.4. The NHS Devon Board should articulate, as part of the annual risk cycle, its appetite in relation to each of the corporate objectives (or strategic purposes), expressed using the following Corporate Governance Institute (CGI) Framework:

Risk Appetite Level	Risk Appetite Level - Description
Avoid	The avoidance of risk and uncertainty is a key organisational objective

Risk Appetite Level	Risk Appetite Level - Description
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 limited reward potential
Cautious	The 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 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

8.5. Based on risk appetite, a 'target' risk score is set for individual risks, this is the level to which the risk is managed to. The benefits of this approach include:

- Management focus on risks that can be managed / reduced;
- Identification of targeted actions to reduce risks to 'target';
- Timely reduction of risks;
- Identification of static risks / ineffective actions; and
- Management focus on risks that are not reducing.

8.6. The process for setting and reviewing risk appetite (including 'target' risk scores) is detailed in **Appendix H** together with the current risk appetite statement agreed by the NHS Devon Board.

9. Accountabilities, Duties and Responsibilities

9.1. The **NHS Devon Board** is ultimately responsible for the organisation's systems of internal control (financial, organisational, clinical, and non-clinical) and risk management arrangements, and for demonstrating leadership, active involvement, and support for risk management across the organisation. It is supported in the discharge of its responsibilities by the Audit & Risk Committee (ARC), other Assurance Committees, and the Senior Executive Team (SET).

The Board receives assurance as to whether operational and strategic risks are being effectively managed. It reviews and approves the Board Assurance Framework (BAF) on a regular basis to monitor the actions and assurances against the strategic risks and assesses the overall impact on delivery of the NHS Devon corporate objectives.

In addition to the above, it is also responsible for determining the risk appetite of NHS Devon and for approving the organisation's Risk Management Policy.

9.2. The **Audit & Risk Committee** (ARC) provides an objective view on internal control and risk management systems to the NHS Devon Board that is independent of the executive. The Audit & Risk Committee (ARC) also:

- Reviews the adequacy and effectives of the system of integrated governance and risk management and internal control across the whole of the NHS Devon activities that support the achievement of its objectives, and to highlight any areas of weakness to the NHS Devon Board.
- Reviews the adequacy and effectiveness of the assurance processes that indicate the degree of achievement of NHS Devon's objectives, the effectiveness of the management of principal risks.
- Maintains oversight of organisational and system risks where they relate to the achievement of NHS Devon's objectives; the Board maintains overall responsibility for risk management.
- Seeks reports and assurance from directors and managers as appropriate, concentrating on the systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
- Reviews the outcome of the annual internal audit of governance and risk management arrangements which, along with other assurances received, will enable the committee to recommend the Annual Governance Statement is signed off by the Chief Executive Officer (CEO) at the end of each financial year.
- Identifies opportunities to improve governance, risk management and internal control processes across NHS Devon.

The Chair of the Audit & Risk Committee (ARC) will provide a summary to the NHS Devon Board of its assurances and where necessary, request deep dives to be undertaken in areas of risk where further assurances are required.

9.3. The **Head of Internal Audit** (HoIA) is responsible for implementing a programme of verification to ensure that the risk management systems and controls NHS Devon has in place are sufficient and will enable the provision of an audit assurance opinion to the Chief Executive Officer (CEO) and the Audit & Risk Committee (ARC).

9.4. The **NHS Devon Board Assurance Committees** have specific roles in relation to operational and strategic risks assigned to them and as set out in their Terms of Reference.

9.5. The **Senior Executive Team** (SET) provides oversight and delivery of risk management arrangements. It regularly has oversight of the NHS Devon Corporate Risk Register (CRR) to review whether individual operational risks are being effectively managed and whether the action plans are sufficient and having the desired effect within the agreed timescales. In addition, it regularly has oversight of the Board Assurance Framework (BAF) to monitor the actions and assurance against the strategic risks and to assess the overall

impact on delivery of NHS Devon's corporate objectives, and approves its submission to the NHS Devon Board.

9.6. The **Chief Executive Officer** (CEO) has overall responsibility for ensuring that an effective risk management system is in place. They are also responsible for ensuring that there is an adequate system of internal control in place. The work of ensuring that this system is in place is delegated to the Company Secretary in practice, who is also responsible for overseeing the management and maintenance of the Board Assurance Framework (BAF) and ensuring the Board follows due process with regards to the overall management of risk. The Company Secretary is accountable to the Chief Communications and Partnerships Officer and is responsible for ensuring (and reporting to the Board and to the Audit & Risk Committee (ARC)) that systems and structures are in place for the effective management of financial risk and organisational controls.

The Chief Executive Officer (CEO) is responsible for the preparation of an Annual Governance Statement setting out how these responsibilities have been discharged.

9.7. The **Chief Nursing Officer** (CNO) is accountable to the Chief Executive Officer (CEO) and is responsible for ensuring (and reporting to the Board or appropriately established committees) that systems and structures are in place for the effective management of clinical quality and safety. As the **Caldicott Guardian** they ensure that the Caldicott principles for managing information and ensuring its security and integrity are adhered to by staff within NHS Devon.

9.8. The **Chief Medical Officer** (CMO) provides Clinical Leadership for NHS Devon and is accountable to the Chief Executive Officer (CEO) and is responsible for providing strategic and operational leadership and management of the clinical risk within NHS Devon and organisational assurance on all matters of clinical risk and clinical outcomes to the NHS Devon Board.

9.9. The **Corporate Governance team** is responsible for overseeing the day-to-day management and co-ordination of the risk management system.

9.10. The **Risk Manager** is responsible for providing support and advice on risk management issues across NHS Devon. In addition, they will work closely with specialist advisers within NHS Devon who provide advice on specific areas of risk management, for example, Health and Safety; Fire; Infection Control; Manual Handling; Security; and Information Governance. The Risk Manager will provide information about corporate and strategic risks for the Senior Executive Team (SET), Board Assurance Committees, and the NHS Devon Board. This forms the basis of 'bottom up' population of the risk register and will be used to inform the Corporate Risk Register (CRR) and the Board Assurance Framework (BAF). They are responsible for the ongoing development, implementation, and evaluation of risk management systems.

These systems will align with the requirements of related regulatory bodies such as NHS England and the Care Quality Commission (CQC).

9.11. The **Senior Information Risk Owner** (SIRO) is accountable to the Chief Executive Officer (CEO) and is responsible for managing information assets and risks across the organisations. The role of the Senior Information Officer (SIRO) for NHS Devon is undertaken by the Chief Communications and Partnerships Officer.

9.12. The **Company Secretary** reports to the Chief Communications and Partnerships Officer and is responsible for ensuring the development and implementation of Risk Management Policy across NHS Devon, ensuring that risk management processes are effectively coordinated, implemented, and monitored. This responsibility incudes:

- Maintenance of the Board Assurance Framework (BAF) and the NHS Devon Corporate Risk Register (CRR) as active documents with clear monitoring of mitigation and action plans.
- Supporting the implementation of NHS Devon's Risk Management Policy (including the provision of advice and training).
- Overseeing and reporting on risk management compliance requirements.

9.13. All **Chief Officers, Senior Leadership Team** members and **Managers** are responsible for:

- Implementing the Risk Management Policy and procedures within their scope of responsibility.
- Ensuring that NHS Devon's risk management processes, including risk assessments, monitoring and escalation of cumulative risks and regular reviews are embedded in their team / programme management functions, included as a standing item on the monthly team meeting agenda and ensuring risk discussions are minuted or included in an action log.
- Ensuring that NHS Devon's risk management processes, including risk assessments, are in place within their scope of responsibility.
- Ensuring that relevant risks are identified, assessed, reviewed, and appropriately managed.
- Ensuring that they discuss risks with relevant senior managers and directors as appropriate.
- Implementing and monitoring any risk management actions within their designated area. Where local actions are considered to be inadequate, senior managers are responsible for escalating these risks through the agreed committee or management structure if local resolution has not been satisfactorily achieved.
- Reviewing a summary of all incidents within their teams or their scope of responsibility on a regular basis and disseminating this information to ensure that appropriate learning takes place in order to reduce risks.

- Ensuring that all staff are given the necessary information and training to enable them to be aware of the risks to their local objectives, those in their work environment and of their personal responsibilities and responsibilities towards working safely.
- Ensuring that staff undertake all relevant mandatory training.
- Ensuring staff compliance with this document.

9.14. All **Staff** have a responsibility to co-operate with managers and they are encouraged to identify risks and advise their line managers accordingly. Risk management is the responsibility of all employees. Key responsibilities include:

- Being familiar, and complying with, the Risk Management Policy and supporting procedures and with all other relevant policies and procedures.
- Reporting incidents, accidents and "near misses" following procedures set out in the Incident Reporting Policy and supporting procedures.
- Being aware of their duty under legislation to take reasonable care for personal safety and the safety of all others who may be affected by the business of NHS Devon.
- Complying with NHS Devon rules, regulations, and instructions to protect the health, safety, and welfare of anyone affected by the business of NHS Devon.

10. Monitoring Compliance and Effectiveness

Training

10.1. Knowledge of how to manage risk is essential in embedding and maintaining an efficient risk management system. To this end, the Corporate Governance team will work in conjunction with Human Resources (HR) to ensure that the necessary training and education needs, and methods needed to implement this policy and any supporting procedure(s) are identified and resourced as required. This may include identification of external training providers and / or development of an internal training process.

Implementation

10.2. NHS Devon 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.

Review

10.3. NHS Devon will review its performance on risk management through a specific annual internal audit on Risk and Assurance Processes. This annual audit is submitted to the Audit & Risk Committee (ARC) and is reflected in the Head of Internal Audit Opinion (HIAO) on the organisational arrangements for risk management and internal control.

10.4. The Chief Executive Officer (CEO) will review compliance with, and effectiveness of, the risk management system of internal control annually in preparing the Annual Governance Statement.

10.5. The Audit & Risk Committee (ARC) will review risk through information submitted to it throughout the year. In addition to this, risk reports will be submitted to the NHS Devon Board Assurance Committees as appropriate. These Committees can request information on specific risks to seek further assurance and details of actions being taken to address the risk.

10.6. The NHS Devon Risk Appetite will be reviewed annually by the NHS Devon Board.

10.7. Any trends resulting from possible policy non-compliance will be raised with staff through appropriate management routes.

10.8. Delivery and records of attendance at risk management awareness training will be reviewed annually by the Corporate Governance team.

11. References

Other related policy documents

11.1 Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy
11.2 Internal Incident Policy
11.3 Serious Incidents Policy

Legislation and statutory requirements

11.4 Equality Act 2010:
www.legislation.gov.uk/ukpga/2010/15/contents

11.5 Freedom of Information Act 2000:
www.legislation.gov.uk/ukpga/2000/36/contents
ico.org.uk/for-organisations/guide-to-freedom-of-information/what-is-the-foi-act/

11.6 Health and Safety at Work Act 1974:
www.hse.gov.uk/legislation/hswa.htm

11.7 Human Rights Act 1998:

www.legislation.gov.uk/ukpga/1998/42/contents

11.8 Management of Health and Safety at Work Regulations 1999:
www.legislation.gov.uk/uksi/1999/3242/contents/made
www.hse.gov.uk/pubns/hsc13.pdf

Best practice recommendations and other key guidance

11.9 Caldicott Principles:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942217/Eight_Caldicott_Principles_08.12.20.pdf

11.10 Department of Health and Social Care Group Accounting Manual 2021/2022:
www.gov.uk/government/publications/dhsc-group-accounting-manual-2020-to-2021

11.11 Good Governance Institute ‘The New Good Governance Handbook 2016’:
www.good-governance.org.uk/wp-content/uploads/2017/04/The-new-Integrated- Governance-Handbook-2016.pdf

11.12 Federation of European Risk Management Associations (FERMA):
www.ferma.eu/about/about-ferma

11.13 Financial Reporting Council ‘UK Corporate Governance Code 2018’:
www.frc.org.uk/directors/corporate-governance-and-stewardship/uk-corporate-governance-code

11.14 Health and Safety Executive ‘Managing for Health and Safety 2013’:
www.hse.gov.uk/pubns/books/hsg65.htm

11.15 The Institute of Risk Management ‘A Risk Management Standard 2002’:
www.theirm.org/media/4709/arms_2002_irm.pdf

11.16 International Organisation for Standardisation (ISO) Guide ‘73:2009 Risk Management’ (Revised 2016):
www.iso.org/standard/44651.html

11.17 NHS England - Learning from patient safety events:
https://www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/

11.18 NHS Resolution:
resolution.nhs.uk/

11.19 NHS Leadership Academy – The Healthy NHS Board 2013:
www.leadershipacademy.nhs.uk/wp-content/uploads/2013/06/NHSLeadership-HealthyNHSBoard-2013.pdf

11.20 HM Government: The Orange Book – Management of Risk – Principles and Concepts:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1154709/HMT_Orange_Book_May_2023.pdf

APPENDIX A: Glossary of Terms

Terms	Definition
Acceptance	Informed decision to take a particular risk.
Avoidance	Informed decision not to be involved in, or to withdraw from, an activity in order not to be exposed to a particular risk.
Consequence	Outcome of an event affecting objectives.
Control	Measure that is modifying risk. Control include any process, policy, device, practice, or other actions which may modify risk.
Governance	Is a system by which organisations are directed and controlled. It defines accountabilities, relationships and the distribution of rights and responsibilities among those who work with and in the organisation, determines the rules and procedures through which the organisation's objectives are set, and provides the means of attaining those objectives and monitoring performance. This includes the establishing, supporting, and overseeing the risk management framework.
Likelihood	Chance of something happening.
Monitoring	Continual checking, supervising, critically observing, or determining the status in order to identify change from the performance level or expected. Monitoring can be applied to a risk management framework, risk management process, risk, or control.
Residual Risk	Risk remaining after risk treatment.
Resilience	Capacity of an organisation to adapt in a complex and changing environment.
Risk	Is the effect of uncertainty on objectives. Risk is usually expressed in terms of causes, potential events, and their consequences.
Risk Appetite	Amount and type of risk that an organisation is willing to pursue or retain.
Risk Assessment	Overall process of risk identification, risk analysis and risk evaluation.
Risk Management	Is the co-ordinated activities designed and operated to manage risk and exercise internal control within an organisation.
Risk Management Process	Systematic application of management policies, procedures, and practices to the activities of communicating, consulting, establishing context, and identifying, analysing, evaluating, treating, monitoring, and reviewing risk.

Terms	Definition
Risk Matrix	Tool for ranking and displaying risks by defining ranges for likelihood and impact.
Risk Owner	Person with the accountability and to make a decision regarding the management of a risk.
Risk Profile	Description of any set of risks.
Risk Register	Record of information about identified risks. The term 'risk log' is sometimes used instead of 'risk register'.
Risk Reporting	Form of communication intended to inform particular internal or external stakeholders by providing information regarding the current state of risk and its management.
Risk Source	Element(s) which alone or in combination has the intrinsic potential to give rise to risk.
Stakeholder	Person or organisation that can affect, be affected by, or perceive themselves to be affected by a decision or activity.
Tolerance	Organisation's or stakeholder's readiness to bear the risk after risk treatment in order to achieve its objectives.
Treatment	Process to modify risk. Risk treatment can involve: ▪ Avoiding the risk by deciding not to start or continue with the activity that gives risk to the risk; ▪ Taking or increasing the risk in order to pursue an opportunity; ▪ Removing the risk source; ▪ Changing the likelihood; ▪ Changing the impact; ▪ Sharing the risk with another party or parties (including contracts); and ▪ Retaining the risk by informed decision. Risk treatments that deal with negative consequences are sometimes referred to as "risk mitigation", "risk elimination", "risk prevention" and "risk reduction".

APPENDIX B: Inherent and Residual Risk

Event	Inherent Risk
Event: Getting into the driving seat of a car, turning on the engine and moving of off	**Inherent Risk:** Damage to vehicles and injury to driver, other road users and pedestrians
Risk Management Action	***Residual Risk***
▪ Instructions to check mirrors and use indicators appropriately before moving off and to wear a seat belt	▪ Reduced possibility of damage to vehicles and injury to driver, other road users and pedestrians
Further Risk Management Action	***Residual Risk***
▪ Driver must obtain permission to move off from passenger who will ensure that mirrors are checked, indicator used appropriately, and seat belt is properly worn	▪ Further reduced of the possibility of damage to vehicles and injury to driver, other road users and pedestrians
Further Risk Management Action	***Residual Risk***
▪ In addition to the two measures above the car is immobilised, that is mechanically unable to move, until such a time as the passenger is satisfied that all safety precautions have been undertaken. The passenger will then flick a switch which will disengage the immobiliser	▪ Even less possibility of damage to vehicles and injury to driver, other road users and pedestrians

APPENDIX C: Risks and Issues

The table below summarises the key differences between 'risks' and 'issues':

RISK	ISSUE
An event that **may** occur	An event that is **currently happening or has happened**
Described in the **future tense**	Described in the **present tense**
Has a material impact on objectives[1]	Has a material impact on objectives[1]
Can be **beneficial or harmful / positive or negative**	**Issue itself is always negative** *(however, the outcome of solving an issue may still be beneficial, albeit it may take more time and effort)*
Can be mitigated against to prevent the risk from becoming an issue	**Prevention is not possible**; action is needed to mitigate its impact or to resolve the issue
Management Techniques: **Reduce risk; transfer the risk; manage the risk; contingency plan; accept risk or terminate risk**	Management Techniques: **Problem solving; decision-making**

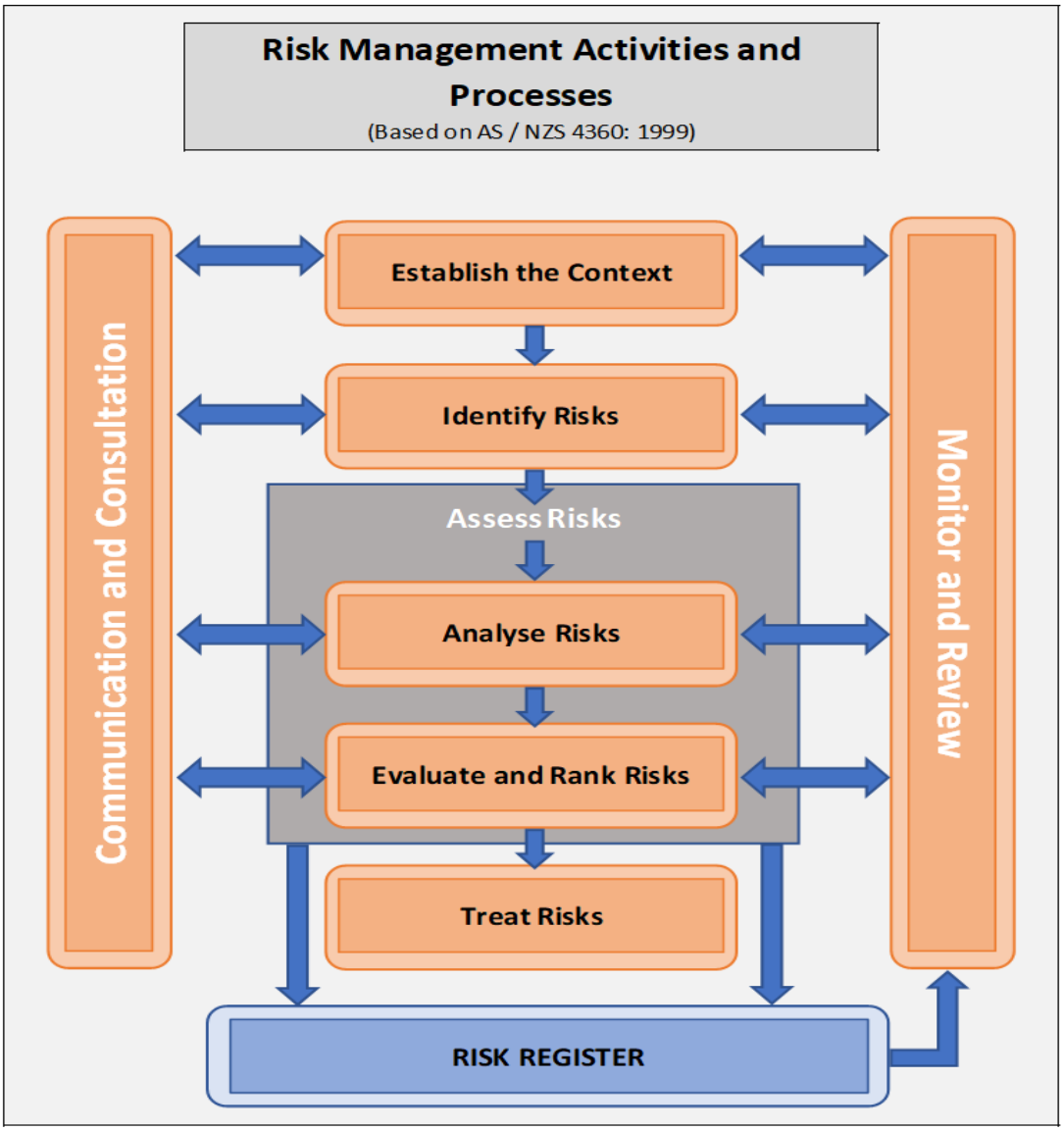
[1] *Material Impact on Objectives – this can be in terms of programme / project objectives, team objectives, directorate objectives, corporate objectives, or strategic objectives.*

APPENDIX D: Risk Management Principles

Principle	Principle Description
Proactive	Risk management will be used proactively to manage key risks and used as an active management tool. This helps to ensure that risks are considered, and future actions planned in a visible, consistent, and controlled manner. Risk management will form part of plans with work on risk management being front loaded.
Aligns with Objectives	Risk management will be focused on the key uncertainties which may impact on the achievement of one or more objectives. Risks will be identified and given the appropriate priority for action.
Fits the Context	The risk management approach will be designed to fit the internal and external environment in which NHS Devon operates and so that time, effort, resources, and energy will be used in the appropriate way.
Engages Partners and Stakeholders	Risk management will engage with the right partners and stakeholders in the Integrated Care System (ICS) and deal with different perceptions of risk. Appropriate risks will be identified early and dealt with at the right level.
Promotes, Guides and Supports a Clear and Consistent Approach	Risk management will provide clear and coherent guidance to staff and key stakeholders so everyone can see how NHS Devon identifies, assesses, and controls key risks, and is consistent across the organisation. This enables people to compare results with plans and enable better decision making about how resources will be deployed. It also provides clear guidance on roles within risk management and explains responsibilities and accountabilities.
Informs Decision Making	Risk management will be linked to and inform decision making across the organisation. This enables important decisions to be made with explicit consideration of the impact of risks and the status of risk management. This also helps to safeguard the decision making process to allow for good decision making.
Facilitates Continual Improvement	Risk management will be used to help NHS Devon to improve by proactively managing risks and increasing organisational risk maturity. The organisation will use its experience of risk management to continually improve through 'lessons learned' and best use of the resources available.
Creates a Supportive Culture	NHS Devon will create a culture that recognises uncertainty and supports considered risk taking. The organisation recognises that zero risk taking is neither possible nor desirable.
Achieves Measurable Value	Risk management will help to achieve measurable value through the effective identification and management of key risks. In general, it costs less to anticipate and manage a risk than it does to recover from an issue.

APPENDIX E: Risk Activities and Processes

The following diagram sets out NHS Devon's approach to risk management:



APPENDIX F – Model Risk Matrix

Instructions for use:

1. Define the risk(s) explicitly in terms of the adverse impact(s) that might arise from the risk.

2. Use **Table 1** to determine the impact score (I) for the potential adverse outcome(s) relevant to the risk being evaluated. Choose the most appropriate domain for the identified risk from the left hand side of the table then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

3. Use **Table 2** to determine the likelihood score (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability, then use the probability descriptions to determine the most appropriate score.

4. Calculate the risk score by multiplying the impact by the likelihood: I (impact) x L (Likelihood) = R (risk score) - **See Table 3**.

5. Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings, the risk ratings and the organisations' risk management system. Include the risk in the organisations' risk register at the appropriate level.

Table 1 – Impact (Consequences) - Scores

Impact (Consequence) Score (Severity Levels) and Examples of Descriptors					
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the Safety of Patients, Staff or Public (Physical / Psychological Harm)	Minimal injury requiring no / minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR / agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity / disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Impact (Consequence) Score (Severity Levels) and Examples of Descriptors					
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Quality of Service	Peripheral element of treatment or service suboptimal Informal complaint	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints / independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Inquest / ombudsman inquiry Gross failure to meet national standards
Human Resources / Organisational Development / Staffing / Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective / service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory / key training	Uncertain delivery of key objective / service due to lack of staff. Unsafe staffing level or competence (>5 days). Loss of key staff. Very low staff morale. No staff attending mandatory / key training	Non-delivery of key objective / service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training / key training on an ongoing basis

Impact (Consequence) Score (Severity Levels) and Examples of Descriptors					
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Statutory Duty / Inspections	No or minimal impact or breach of guidance / statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations / improvement notice	Enforcement action. Multiple breaches in statutory duty. Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty. Prosecution Complete systems change required. Zero performance rating. Severely critical report
Adverse Publicity / Reputation	Rumours Potential for public concern	Local media coverage – short- term reduction in public confidence	Local media coverage –long-term reduction in public confidence	National media coverage with service well below reasonable public expectation <3 days	National media coverage with service well below reasonable public expectation >3 days MPs concerned (questions in the House).
Business Objectives / Projects	Insignificant cost increase / schedule slippage	Elements of public expectation not being met. <5 per cent over project budget Schedule slippage <5 per cent	5–10 per cent over project budget Schedule slippage 5–10 per cent over	11–25 per cent over project budget Schedule slippage 11–25 per cent over Key objectives not met	Incident leading to >25 per cent over project budget Schedule slippage >25 per cent over Key objectives not met

Impact (Consequence) Score (Severity Levels) and Examples of Descriptors					
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Finance, Including Claims Service / Business Interruption Environmental Impact	Small loss Risk of claim remote Business loss / interruption of >1 hour Minimal or no impact on the environment	Loss of 0.1 – 0.25 per cent of budget Claim less than £10,000 Business loss / interruption of >8 hours Minor impact on environment	Loss of 0.26 – 0.5 per cent of budget Claim(s) between £10,000 and £100,000 Business loss / interruption of >1 day Moderate impact on environment	Uncertain delivery of key objective / Loss of 0.6 – 1.0 per cent of budget Claim(s) between £100,001 and £1 million Purchasers failing to pay on time Business loss / interruption of >1 week Major impact on environment	Non-delivery of key objective Loss of >1 per cent of Budget. Failure to meet specification / slippage. Payment by results Claim(s) >£1 million Permanent loss of service or facility Catastrophic impact on environment

Table 2 - Likelihood Scores (L)

What is the likelihood of the risk occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood Score	1	2	3	4	5
Description	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
Frequency How often might it / does it happen	This will probably never happen / recur	Do not expect it to happen / recur but it is possible it may do so	Might happen / recur occasionally	Will probably happen / recur but it is not a persisting issue	Will undoubtedly happen / recur, possibly frequently

Table 3 - Risk Scoring = Impact x Likelihood (I x L)

Impact / Consequence	Likelihood				
	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
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:

	1 to 6	**Low Risk**
	8 to 10	**Moderate Risk**
	12	**High Risk**
	15 to 25	**Extreme Risk**

APPENDIX G:
Risk Action and Reporting Requirements

Score	Risk	Action	Reporting Requirements
1 to 6	Low	Tolerate / Managed Through Normal Control Measures	• Report to Line Manager. • Enter onto the local Team / Directorate Risk Register (TRR / DRR). • Managed by Local Manager and escalated to relevant Chief Officer / Executive Lead as required.
8 to 10	Moderate	Consider Treat / Review Control Measures	
12	High	Treatment Plans to be Developed, Implemented, and Monitored	• Entered onto the Corporate Risk Register (CRR) in liaison with Corporate Governance team. • Included in Corporate Governance team's bi-monthly report to the Senior Executive Team (SET). • Oversight by the Senior Executive Team (SET) through bi-monthly report from Corporate Governance team.
15 to 25	Extreme	Immediate Action Required. Treatment Plans to be Developed, Implemented, and Monitored	• Report immediately to Corporate Governance team. • Entered on to the Risk Register in liaison with the Corporate Governance team. • Included in the Corporate Governance team's Board Assurance Framework (BAF) reporting bi-monthly to the Senior Executive Team (SET). • Reported in Corporate Governance team's Board Assurance Framework (BAF) reporting to each meeting of the NHS Devon Board and Committee-specific risks reported via Board Assurance Committees.

In addition the NHS Devon Board receives the Board Assurance Framework (BAF) at each meeting with:

- Details of all of the strategic risks, their control measures, and assurances.

- Changes to the strategic risks since the previous report, including scoring.
- Current review narratives for each of the strategic risks.
- The level of assurance on each of the NHS Devon corporate objectives or Statutory Purposes in light of the risks which may impact on those objectives.
- Changes in the totality of risk facing NHS Devon (the total of the strategic level risks) and how this may have changed in the previous twelve months.

This process, its robustness and its deployment is scrutinised by the NHS Devon Audit & Risk Committee (ARC). The Risk Management System is subject to annual review by the Internal Auditors and a report is received by the Audit & Risk Committee (ARC).

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APPENDIX H – Risk Appetite

Risk appetite specifies the overall risk levels NHS Devon is willing to accept while operating in full compliance with regulatory and legal requirements. In addition, it establishes principles for risk taking to ensure that the totality of risk remains within the defined risk appetite boundaries.

The 'Risk Appetite' will be reviewed and agreed at least annually by the NHS Devon Board.

The 'Risk Appetite' is framed around the priorities set out in the [specify here] and the statement was agreed by the NHS Devon Board in [specify month and year]. The statement is based on the premise that the lower the risk appetite, the less NHS Devon is willing to accept in terms of risk and consequently the higher levels of controls that must be in place to manage the risk.

Priority	Board Assurance Committee	Risk Appetite	Maximum Acceptable Target Score
EXAMPLE:			
Patient Experience	*Quality & Patient Experience Committee*	LOW	6
▪ *We will accept risks to the experience of people using services, their relatives and carer if they are consistent with the ultimate goal of achieving patient safety and quality improvements.* ▪ *We will only accept service redesign and divest risks in the services we are commissioned to deliver if these are assessed as safe and effective, whilst high quality care is maintained.*			

ANNEX B&C

<table>
<tr><td colspan="6"><u>Improve Population Health</u>
Corporate Objective 1:
Work in partnership with community and ‘anchor’ organisations to address the social detriments of health.</td><td>Director Lead:
Nigel Acheson, Chief Medical Officer (CMO)</td></tr>
<tr><td colspan="6" rowspan="3">Risk:
If the ‘Anchor Organisation’ programme of work is not part of a more strategic plan, then there will be a lack of focus to address the social detriments of health. As a consequence the partner and community organisations will become disengaged, and NHS Devon will fail to achieve this objective.</td><td>Principal Assurance Committee:
Quality & Patient Experience Committee (QPEC)</td></tr>
<tr><td>Devon Challenge: (3) Complex patterns of urban, rural, and coastal deprivation; (4) Housing quality and affordability; (6) Access to services, including socio-economic and cultural barriers; and (11) Poor mental health and wellbeing, social isolation, and loneliness.</td></tr>
<tr><td>ICS Strategic Goal:
Helping the NHS Support broader social and economic development.</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Move</td><td>Risk Score</td><td>Target</td><td rowspan="3"><u>Joint Forward Plan Delivery Programme:</u> Community Development and Learning</td></tr>
<tr><td><u>Inherent</u> Risk Score</td><td>5</td><td>5</td><td>↑ (Previously Scored 16)</td><td>25</td><td rowspan="2">8</td></tr>
<tr><td><u>Residual</u> Risk Score: Sept 23</td><td>5</td><td>4</td><td>↑ (Previously Scored 16)</td><td>20</td><td>Risk Appetite: Seek</td></tr>
<tr><td colspan="7">Key Update on Actions – Sept 2023:
Mapping contracted spend from Torbay and South Devon NHS Foundation Trust, making visible the buying power of the NHS and how this can be re-invested in the local community. Promoting the NHS Devon Community Connect guidance which allows NHS staff to volunteer with community organisations within Devon, with a link to health and wellbeing activities.</td></tr>
<tr><td colspan="5">Key Controls:</td><td>In Place</td><td>Assurances:</td></tr>
<tr><td colspan="5">‘Anchor Organisation’ work programme</td><td></td><td>Reporting to the Executive Strategy and Transformation Group</td></tr>
</table>

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Articulate the overarching vision and ambitions of the 'Anchor' work		Updates to Integrated Care Partnerships (ICPs)
		Health Inequalities and Prevention Steering Group workplan includes Anchor Organisation workplan
Control Gaps		**Assurance Gaps**
Work on 'Anchor Organisations' not embedded across NHS Devon and the and One Devon Health and Care System		Yet to establish assurance committee of the NHS Devon Board to oversee the 'Anchor Organisation' programme of work
Workforce: Programme support identified within the Population Health Team		Community collaborative yet to be formally established. This is dependent on the adoption of the Devon Operating Model

Mitigating Actions:	**Action Owner**	**Action Status**	**Planned Completion Date**
Working with SW Academic Health Science Network (AHSN) and Exeter Science Park which will feed into 23 November 2023 event (see below) and wider Anchor ambitions for Devon.	Kristian Tomblin		November 2023
Organising an 'Anchor' event on 23 November 2023 to showcase the work around this (Michael Wood Head of Economics at NHS Confederation attending).	Kristian Tomblin		November 2023
Through Organisational Change Phases 1 & 2, consideration will be given to the impact of workforce reductions on NHS Devon's ability to deliver these objectives.	Piers Tetley	Ongoing	TBC

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ANNEX B&C

<table>
<tr><td colspan="6"><u>Improve Population Health</u>
Corporate Objective 2:
Reduce Health Inequalities (HI) through public health and mental health support.
Corporate Objective 3:
Enable a greater shift from treatment to prevention.</td><td>Director Lead:
Nigel Acheson, Chief Medical Officer (CMO)</td></tr>
<tr><td colspan="6" rowspan="2">Risk:
If there is insufficient capacity and capability in NHS Devon to ensure that the system focuses on the necessary, work to improve population health management and prevention then it will not successfully reduce health inequalities and shift to prevention. The consequence will be that health inequalities will continue across Devon and worsen in some areas.</td><td>Principal Assurance Committee:
Quality & Patient Experience Committee (QPEC)</td></tr>
<tr><td>Devon Challenge: (7) Poor health outcomes caused by modifiable behaviours and earlier onset of health problems in more deprived areas; (8) Earlier onset of health problems in more deprived areas; and (11) Poor mental health and wellbeing, social isolation, and loneliness.</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Move</td><td>Risk Score</td><td>Target</td><td>ICS Strategic Goal:
Population heath and prevention will be everybody's responsibility and inform everything we do. The focus will be on the top five modifiable risk factors for early death and disability.
People in Devon will be supported to stay well at home, through preventative, pro-active and personalised care. The focus will be on the five main causes of early death and disability.</td></tr>
<tr><td><u>Inherent</u> Risk Score</td><td>4</td><td>4</td><td>No change</td><td>16</td><td rowspan="2">8</td><td rowspan="2">Joint Forward Plan Delivery Programme: Health Protection
Joint Forward Plan Enabling Programme: Equality, Diversity, and Inclusion; Population Health</td></tr>
<tr><td><u>Residual</u> Risk Score:
Sept 23</td><td>3</td><td>4</td><td>↓
(Objective 2 Previously Scored 16)</td><td>12</td><td>Risk Appetite: Objective 2 – Seek; Objective 3 - Open</td></tr>
</table>

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Key Update on Actions – September 2023:

Health Inequalities:

Capacity within Population Health Management Team has reduced further since this risk was first identified, and therefore reviewing and re-prioritising with partners (Local Care Partnerships (LCPs), Provider Collaboratives, and Public Health) the health inequalities and prevention programme plan to identify who will take ownership for different parts of the plan. The Population Health Improvement Committee has been established and is meeting for the first time on 27 September 2023. Delegated £800k of Population Health funding to LCPs for 2023/24 to support the building of capability and capacity to understand and address population health.

Treatment to Prevention:

Population Health Improvement Committee established and meeting on 27 September 2023 for the first time. Population Health Management action learning sets moving into action phase across all Local Care Partnerships (LCPs) with a focus on prevention and early intervention. Healthy Devon Learning Labs (complications of excess weight) developing opportunities for prevention and early intervention.

Key Controls:	In Place	Assurances:
Population Health Team to provide support, advice, and capacity		Formal governance arrangements approved and in place by September 2023
Health Inequalities and Prevention Steering Group		
Health Inequalities and Prevention Programme Plan		
Population health inequality considerations are taken into account when NHS Devon makes decisions about the use of resources to deliver its objectives		Policy to ensure that health inequalities are addressed in NHS Devon decision making
Prevention plans mapped and appropriately resourced		Formal governance arrangements approved and in place by September 2023
Diabetes Prevention Plan in place		

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Falls & Frailty • earlier identification of risk cohorts through admission avoidance proposal (DCB) • Care Co-ordination hub(s) development • Standardise care homes training & education • Signposting for home management • Community falls services – prevention and post fall services		12.09.2023 - Further system falls & frailty workshop to agree requirements

Control Gaps	**Assurance Gaps**
Workforce: Gaps in project management support and vacancies in Population Health Team	
Workforce: Insufficient capacity throughout ICB to prioritise health inequalities	
Workforce: Insufficient resources for Cardiovascular (CVD) Prevention Plan	
Structure of public health and population health management teams in ICB not finalised	
NHS Devon evaluation capability and capacity (simple logic models, development of measurement frameworks etc.) not established	
Insufficient resources for Cardiovascular (CVD) Prevention Plan	
Limited capacity for data analysis and reporting	

Mitigating Actions:	**Action Owner**	**Action Status**	**Planned Completion Date**
Health Inequalities:			
Recruitment and induction of team – update: due to organisational change NHS Devon are unable to recruit to the Population Health Management Team.	Ginny Snaith		Ongoing
Refresh of Health Inequalities and Prevention Steering Group.	-	Complete	March 2023

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Refresh of Population Health Programme – update: re-evaluating the programme with System partners.	Kristian Tomblin		October 2023
Establish formal governance to oversee Health Inequalities and Prevention Programme Plan – Population Health Improvement Committee established and meeting on 27 September 2023.	-	Complete	March 2023
Establish formal assurance committee of the ICB Board to oversee population health and health inequalities – Population Health Improvement Committee established and meeting on 27 September 2023.	-	Complete	September 2023
Organisational restructure and implementation of Operating Model to address capacity – will continue to lobby for, and influence on, decisions around resources.	Ginny Snaith		April 2024
Prevention to Treatment:			
Identify resources for CVD Prevention Programme – identified money, exploring how to use this to increase capacity	Ginny Snaith		August 2023
Review use of Quality and Equality Impact Assessment (QEIA) and assess further development requirements – Kristian Tomblin will meet with Steve Clark to discuss.	Kristian Tomblin		Ongoing
Falls and Frailty Prevention Plan	Ginny Snaith		August 2023
Spirometry Commissioning – full business case in development, aiming to get that to Devon Investment Group (DIG) in November 2023. This will implement / restore diagnostic spirometry across the System (currently only in Plymouth).	Lorraine Webber		November 2023
Establish formal assurance committee of the NHS Devon Board to oversee population health and health inequalities - Population Health Improvement Committee meeting for first time on 27 September 2023.	-	Complete	September 2023

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<table>
<tr><td colspan="6"><u>Improve Services and Reduce Unwarranted Variation</u>
Corporate Objective 4:
Deliver safe and effective urgent and emergency care services that better meet people's needs.</td><td>Director Lead:
Anthony Fitzgerald, Chief Delivery Officer</td></tr>
<tr><td colspan="6" rowspan="2">Risk:
If the system does not have robust systems and processes to enable NHS Devon to coordinate the delivery of urgent and emergency care services, then it will fail to ensure timely access to these services. This will result in poor patient experience, failure to ensure the best possible physical and mental health outcomes and resulting quality of life; generating inappropriate and inefficient use of resource in primary care and a loss of confidence from the community and regulators.</td><td>Principal Assurance Committee:
Finance & Performance Committee (FPC)</td></tr>
<tr><td>Devon Challenge: (12) Pressure on health and care services (especially unplanned care)</td></tr>
<tr><td colspan="6"></td><td>ICS Strategic Goal:
People in Devon will know how to access the right service first time and navigate the services they need across health and care, improving personal experience and service productivity and efficiency.</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Move</td><td>Risk Score</td><td>Target</td><td rowspan="2">Joint Forward Plan Delivery Programme: Acute Services Sustainability</td></tr>
<tr><td><u>Inherent</u> Risk Score</td><td>5</td><td>4</td><td>↑ (Previously Scored 16)</td><td>20</td><td rowspan="2">6</td></tr>
<tr><td><u>Residual</u> Risk score Sept 23</td><td>4</td><td>4</td><td>↑ (Previously Scored 9)</td><td>16</td><td>Risk Appetite: Open</td></tr>
<tr><td colspan="7">Key Update on Actions – Sept 2023:

Out of Hospital Improvement:
System Urgent Care - Improvement focusing on:
• Creation of additional out of hospital capacity through operational plan investments for 2023/24 focussing on increased community capacity via agreed locality plans.
• Ongoing delivery of improved performance of Integrated Urgent Care Service (IUCS) (Out of Hours (OOH) and 111).
• Enhance Urgent Community Response (UCR) Fallers Service to reduce ambulance conveyance.
• Development of a Care Coordination Hub offer to support better navigation and admission avoidance.</td></tr>
</table>

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- Prevent avoidable admissions through work with care homes and GP practices.
- Delivery of the Integrated Urgent & Emergency Care (UEC) Improvement Plan, which focuses on 7 key areas, Falls, Frailty, End of Life (EOL), Discharge, Length of Stay (LOS) and Mental Health). The plan also aims to improve resilience in the UEC system to allow for the delivery of elective activity to continue to be delivered at planned operational rates all year.
- This plan will be monitored on a weekly basis by the combined UEC / Elective / Cancer now in place.

2. In Hospital Improvement :

- Increase Same Day Emergency Care (SDEC) usage.
- Focus on Minors performance.
- Enhance Triage Unit (MTU) model.
- Meet 50% of initial assessments completed within 15 mins.
- Meet 80% of patients discharged by 17:00hrs.
- Increased virtual ward capacity quantified and delivered through the 2023/24 operating plan and reflected in performance trajectories.
- Maximise boarding opportunities to minimise Emergency Department (ED) occupancy.
- Develop non-elective LOS improvement trajectories.
- Increase in weekend discharge – insourcing of additional medical staffing and embed ward standard processes.
- Delivery of the transformation workstreams including low risk chest pain, abdominal pain, and paediatric assessment.
- Impact of 2023/24 operational plan investments / Better Care Fund (BCF) at place.

Key Controls:	**In Place**	**Assurances:**
Devon Unscheduled Care Board and Locality Unscheduled Care Board (South, West, and North/East)		Monthly Integrated Quality and Performance Reports (IQPRs) to the Board
U&EC Programme to support creation of the right conditions for success – enabling effective navigation of UEC care through 111.		Realignment of plans
National weekly Tier 1 meetings in place		Realignment of diagnostics
System Quality Group		Integrated UEC Improvement Plan

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Control Gaps	Assurance Gaps
System-wide Urgent and Emergency Care Strategy not signed off.	NHS Devon missing key performance targets No high-level summary on risks and issues on the IQPR

Mitigating Actions:	Action Owner	Action Status	Planned Completion Date
Develop Care Coordination Hub to support the appropriate navigation of patients via suitable pathways and expert advice. This will evidence by a reduction in admissions and increased referrals to services such as Urgent Crisis Response teams and Virtual Wards.	James Wenman		01.11.2023
Focus on Falls, Frailty and EOL. System workshops facilitated to process map existing pathways across these three high impact areas. Identification of short to medium term actions, which include, communications with Care / Residential homes to support identification of suitable alternative options to 999 / 111. Educational material to better equip care homes to make the right decision. Identification of patient at EOL and ensure they have Treatment Escalation Plans (TEP) forms and advanced care plans in place. Furthermore, those patients have 'Just In Case' medicines to support symptom control and prevent admission.	James Wenman		01.12.2023
Increase capacity and utilisation of Virtual Ward beds. Ambition to achieve and sustain 227 beds and 80% utilisation. Map pathways and explore the interface between Virtual Wards (VWs) and other community-based services in order to support increased usage.	Mark Dewick / Vanessa Vale		01.10.2023
Establish a discharge taskforce to deliver standardised system-wide discharge pathways. Ambition to reduce discharge delays by 20%.	Lucy Pare		Ongoing

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<table>
<tr><td colspan="6"><u>Improve Services and Reduce Unwarranted Variation</u>
Corporate Objective 5:
Reduce the number of people waiting for elective care.</td><td>Director Lead:
Anthony Fitzgerald, Chief Delivery Officer</td></tr>
<tr><td colspan="6" rowspan="2">Risk:
If the system does not have robust systems and processes to enable NHS Devon to coordinate the delivery of elective care services, then it will fail to ensure timely access to these services. This will result in poor patient experience, failure to ensure the best possible physical and mental health outcomes and resulting quality of life; generating inappropriate and inefficient use of resource in primary care and a loss of confidence from the community and regulators.</td><td>Principal Assurance Committee:
Finance & Performance Committee (FPC)</td></tr>
<tr><td>Devon Challenge: (12) Pressure on health and care services (especially unplanned care)</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Move</td><td>Risk Score</td><td>Target</td><td rowspan="2">ICS Strategic Goal:
People in Devon will know how to access the right service first time and navigate the services they need across health and care, improving personal experience and service productivity and efficiency.</td></tr>
<tr><td><u>Inherent</u> Risk Score</td><td>5</td><td>4</td><td>↑ (Previously Scored 16)</td><td>20</td><td rowspan="2">6</td><td rowspan="2">Joint Forward Plan Delivery Programme: Acute Services Sustainability</td></tr>
<tr><td><u>Residual</u> Risk score Sept 23</td><td>4</td><td>4</td><td>↑ (Previously Scored 9)</td><td>16</td><td>Risk Appetite: Open</td></tr>
<tr><td colspan="7">Key Update on Actions – Sept 2023:

Out of Hospital Improvement:
Elective Care Recovery - Focusing on:
Plan in place to deliver 104 week wait (ww) for all specialties at trust level and maintaining this position in 23/24.
Ensure all patients waiting > 78 ww have had a clinical review or clinical validation within 12 weeks of last review, supported by NetCall technology.
Review all 65 ww and 78 ww cohort patients to ensure no Evidence Based Interventions (EBI) procedures are planned outside of agreed policies, if any identified clinical review must identify if DTA can be reconsidered.
Implement the interim operational guidance on managing patient choice and active monitoring to best effect.
Review and improve Length of Stay (LoS) for all specialties to improve flow and enable protection of agreed elective bed.
Maximise capacity through system working and inter-provider transfers (IPT)</td></tr>
</table>

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- Implement Getting It Right First Time (GIRFT) Further Faster best practice opportunities alongside existing commissioning intentions in key challenged specialities and manage this at a system level.

Key Controls:	In Place	Assurances:
Planned Care Board		Monthly Integrated Quality and Performance Reports (IQPRs) to the Board
National weekly Tier 1 meetings in place		Elective Recovery Fund (ERF) and Targeted Innovation Funding (TIF) received.
System Quality Group		Realignment of plans
Tactical Delivery Group		Realignment of diagnostics
		Western Recovery Plan
		Elective Recovery plan

Control Gaps	Assurance Gaps
None identified	NHS Devon missing key performance targets No high-level summary on risks and issues on the IQPR

Mitigating Actions:	Action Owner	Action Status	Planned Completion Date
Oversight and challenge of system operational performance via the Tactical Delivery Group (TDG).	Karen Barry		Ongoing
Rollout of nine additional GIRFT Further Faster task and finish groups in key specialities (4 already in place via the One Devon Pilot / Trauma & Orthopaedics (T&O), Spinal, Ophthalmology & Cardiology), namely Urology, Colorectal, Gynaecology, Ear, Nose & Throat (ENT) and Dermatology.	Sean Beeken		31.10.2023
Delivery of the System Theatre Transformation Programme. This is to include key deliverables such as a system standard 85% day-case rate, at least 1 list per week is to be High Volume Low Complexity (HVLC), implementation of system theatre Standard Operating Procedures (SOPs) and 85% theatre utilisation.	Sean Beeken		31.03.2024
One Devon Implementation - All providers to implement South-West Ambulatory Orthopaedic Centre (SWAOC) pathways at base sites and in new assets going live or sooner to fully maximise productivity.	Emma Herd		31.12.2023

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One Devon Implementation - All providers to implement HVLC cataract lists at existing and new assets going live or sooner where possible.	Emma Herd		31.03.2024
Mobilise additional HVLC capacity at Nightingale Hospital for spinal services.	Emma Herd		31.10.2023
Implement high flow diagnostic linear acquisition pathways for non-cataract ophthalmology services to reduce outpatients (OP) backlog and waiting times.	Rachael Burridge / (Emma Herd)		31.03.2024
Develop a 2023/24 Optimising Referral Primary Care Local Enhanced Service (LES) to improve quality of Advice and Guidance (A&G) referrals and sharing of learning from A&G returns within primary care teams.	Kim Maby		31.10.2023
Continue to develop and embed Clinical Referral Guidelines (CRGs), commissioned pathways and policies.	Sean Beeken		Ongoing

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<table>
<tr><td colspan="6"><u>Improve Services and Reduce Unwarranted Variation</u>
Corporate Objective 6:
Maintain and enhance the capacity and resilience of Primary Care providers to improve patient outcomes through prevention, long term condition management and appropriate on the day demand, with particular attention to challenged areas.</td><td colspan="2">Director Lead:
Jo Turl, Director of Commissioning Primary, Community and Mental Health Care</td></tr>
<tr><td colspan="6" rowspan="3">Risk:
If NHS Devon does not support the post-Covid recovery and transformation of general medical, dental, pharmaceutical, and optical practice then Devon will not have adequate Primary Care Services. The consequence will be increased population morbidity, increased health inequalities and increased pressure across other parts of the health and care system.</td><td colspan="2">Principal Assurance Committee:
Primary Care Commissioning Transition Committee (PCCTC)</td></tr>
<tr><td colspan="2">Devon Challenge: (1) An ageing and growing population; (3) Complex patterns of urban, rural, and coastal deprivation; (7) Poor health outcomes caused by modifiable behaviours; and (8) Earlier onset of health problems in more deprived areas.</td></tr>
<tr><td colspan="2">ICS Strategic Goal:
We will have a safe and sustainable health and care system.</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Move</td><td>Risk Score</td><td>Target</td><td colspan="2" rowspan="2">Joint Forward Plan Delivery Programme: Primary and Community Care</td></tr>
<tr><td><u>Inherent</u> Risk Score</td><td>4</td><td>4</td><td rowspan="2">No change</td><td>16</td><td rowspan="2">8</td></tr>
<tr><td><u>Residual</u> Risk Score: Sept 23</td><td>4</td><td>4</td><td>16</td><td colspan="2">Risk Appetite: Seek</td></tr>
<tr><td colspan="8">Key Update on Actions – Sept 2023:

General Practice Strategic Framework providing direction of travel for primary care and a focus on areas of greatest need and inequality, for example parts of Plymouth and Torbay. This work has involved collaborative work between primary care and their local hospital, and support to practices whose accommodation issues are most demanding through no fault of their own. Localities to create local delivery plans

New ways of providing additional capacity with third party providers being tested in Plymouth and Torbay.

Primary Care Networks (PCNs) to create plans for recruiting using the additional roles reimbursement fund.

Primary Care Access Recovery Plan (PCARP) now published. Practices required to submit improvement plans that will also inform system access recovery plan (reporting to boards in the autumn). Includes national support offers and transition funding for practices.</td></tr>
</table>

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Key Controls:	In Place	Assurances:
Primary Care Commissioning Transition Committee (PCCTC)		Monitoring reports in place showing General Practice dental, pharmaceutical, and optical metrics – access, workforce etc.
General Practice Strategic Framework		
Control Gaps		**Assurance Gaps**
Resources: Funding gap in general practice in capital allocation and winter monies; lack of funding for dental care		**Demand and Capacity:** Continuing high demand for primary care services alongside responding to the backlog in lower clinical priority, but essential work
System Constraints: Operating within the national dental contract; still part of a hub system of commissioning		**Workforce:** Workforce shortages (across all allied professionals, nurses, GPs, dentists, and community pharmacists)

Mitigating Actions:	Action Owner	Action Status	Planned Completion Date
Support and test different models of primary care provision to address practice sustainability for example, Plymouth integrated model with Livewell.	Jo Turl	Complete	August 2023
Development of provider collaborative through delivery of Leadership Programmes to commence in October 2023 and agreement of funding and objectives for a fixed term Programme Director for the Provider Collaborative.	Jo Turl / Paul Green	Complete	September 2023
Establish task and finish group to oversee development and delivery of Primary Care Access Recovery Plan. First report to Primary Care Commissioning Transition Committee in September 2023.	Paul Green	In Progress	End September
Work with Provider Collaborative to define and develop local alternative at scale models of care provision. Also exploring provider support by learning from Welsh model.	Jo Turl / Paul Green	In Progress	March 2024
Develop and implement programme to provide intensive early support for practices who are vulnerable or on the edge of crisis, including funding independent managerial and clinical expertise to enable turnaround in conjunction with Local Medical Committee (LMC).	Paul Green	In Progress	September 2023
Deliver action plan to recruit and spend all Additional Roles Reimbursement Scheme (ARRS) funding in Devon.	Natasha Goswell	In Progress	October 2023
Completion of Primary Care Estates toolkit.	Mat Chetwynd	In Progress	November 2023

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<table>
<tr><td colspan="6"><u>Improve Services and Reduce Unwarranted Variation</u>
Corporate Objective 7:
Improve access to and outcomes for mental health (MH), learning disability (LD) and neurodiversity services.</td><td>Director Lead:
Jo Turl, Director of Commissioning Primary, Community and Mental Health Care</td></tr>
<tr><td colspan="6" rowspan="2">Risk:
If NHS Devon does not improve access to mental health, learning disability and neurodiversity services then patients will continue to experience significant waits for specialist care which means more people are likely to access healthcare when in crisis. Consequence will be a worsening in mental health conditions leading to poor health outcomes. This may lead to an increased population morbidity, increased health inequalities and increased pressure across other parts of the health and care system.</td><td>Principal Assurance Committee:
Finance & Performance Committee (FPC)</td></tr>
<tr><td>Devon Challenge: (7) Poor health outcomes caused by modifiable behaviours; and (12) Pressure on health and care services (especially unplanned care) caused by increasing long-term conditions, multi-morbidity, and frailty.</td></tr>
<tr><td colspan="6"></td><td>ICS Strategic Goal:
People in Devon will be supported to stay well at home, through preventative, pro-active and personalised care. The focus will be on the five main causes of early death and disability.
People in Devon will have access to the information and services they need, in a way that works for them, so everyone has an equal opportunity to be healthy and well.</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Move</td><td>Risk Score</td><td>Target</td><td rowspan="2">Joint Forward Plan Delivery Programme: Mental Health, Learning Disability and Neurodiversity</td></tr>
<tr><td><u>Inherent</u> Risk Score</td><td>4</td><td>5</td><td>No change</td><td>20</td><td rowspan="2">10</td></tr>
<tr><td><u>Residual</u> Risk Score:
Sept 23</td><td>4</td><td>4</td><td>↑
(Previously Scored 15)</td><td>16</td><td>Risk Appetite: Open</td></tr>
<tr><td colspan="7">Key Update on Actions – Sept 2023:
See mitigating actions.</td></tr>
</table>

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Key Controls:	**In Place**	**Assurances:**
Mental Health and Learning Disabilities Provider Collaborative monitoring performance and issues.		Performance data available to workstreams, oversight group and provider collaborative.
Control Gaps		**Assurance Gaps**
Workforce: Difficulties in recruiting to specialist Mental Health (MH) posts in providers. For example, Learning Disability Nursing, Continuing Healthcare (CHC) and the impact of a competitive market in Right to Choose (RtC) providers in Attention Deficit Hyperactivity Disorder (ADHD) offering remote working and financial benefits outside of NHSE Agenda for Change (AfC)		Integrated Quality and Performance Report (IQPR) does not map all waiting times such as Child and Adolescent Mental Health Services (CAMHS) No assurance data on providers outputs is being addressed
Commissioning Resource: Project support and reduction in commissioning personnel through key roles on maternity and vacancy control.		Significant waiting times for patients trying to access Community Mental Health Teams; Autism and ADHD; Specialist MH Services e.g. eating disorders; and CAMHS
Demand and Capacity: High demand post COVID outstripping capacity		**MH Care Records:** Eight-month gap in records as a consequence of a cyber-attack in 2022. Data only available post March 2023. Impact on receiving activity and waiting times data for CAMHS
ADHD: • Financial risk to NHS Devon in the form of Non-Contract Activity (NCA) with the RtC legislation and numerous independent providers offering a service • Growth in demand – with no national framework or operational guidance for this pathway – no identified financial resource to support commissioning developments		Significant growth in demand, with current provision limited to original population commissioning. Independent providers monopolising RtC impact on primary care, pharmacology, and shared care agreements

Mitigating Actions:	**Action Owner**	**Action Status**	**Planned Completion Date**
Operating Planning process run through Mental Health, Learning Disabilities and Neurodiversity (MHLDN) Primary Care (PC) to agree system priorities.	Adam Carrick	Complete	April 2023

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Prioritisation process to identify system priorities and alignment to available resources.	Adam Carrick	Complete	May 2023
ADHD Paper addressing prioritisation and commitment from the ICB due to Investment Group Meeting 20th June 2023.	Jo Turl / Vicks Johnson	Complete	June 2023
Confirmation and assurance that action plans to deliver agreed operating plan trajectories to be monitored through MHLDN Provider Collaborative.	Adam Carrick	In progress	October 2023
Agreed action plans to support delivery of dementia diagnosis and Serious Mental Illness (SMI) Annual Health Checks (AHCs) to be signed off.	Adam Carrick	In Progress	End October 2023

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<table>
<tr><td colspan="6"><u>Improve Services and Reduce Unwarranted Variation</u>
Corporate Objective 8:
Support and treat more people in their homes and communities to help them live healthily and independently.</td><td colspan="3">Director Lead:
Jo Turl, Director of Commissioning Primary, Community and Mental Health Care</td></tr>
<tr><td colspan="6" rowspan="2">Risk:
If NHS Devon does not drive change required in working practices across the system to support people and communities to stay healthy and live independently the consequence will be poorer outcomes for the population of Devon.</td><td colspan="3">Principal Assurance Committee:
Finance & Performance Committee (FPC); and
Primary Care Commissioning Transition (PCCTC)</td></tr>
<tr><td colspan="3">Devon Challenge (1) An ageing and growing population.</td></tr>
<tr><td colspan="6" rowspan="3"></td><td colspan="3">ICS Strategic Goal:
People in Devon will be supported to stay well at home, through preventative, pro-active and personalised care. The focus will be on the five main causes of early death and disability.</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Move</td><td>Risk Score</td><td>Target</td><td rowspan="2">Joint Forward Plan Delivery Programmes:
▪ Community Development and Learning; and
▪ Primary and Community Care</td></tr>
<tr><td><u>Inherent</u> Risk Score</td><td>5</td><td>4</td><td rowspan="2">No change</td><td>20</td><td rowspan="2">8</td></tr>
<tr><td><u>Residual</u> Risk Score: Sept 23</td><td>4</td><td>4</td><td>16</td><td>Risk Appetite: Seek</td></tr>
<tr><td colspan="9">Key Update on Actions – Sept 2023:
See mitigating actions.</td></tr>
<tr><td colspan="6">Key Controls:</td><td>In Place</td><td colspan="2">Assurances:</td></tr>
<tr><td colspan="6">Integrated Care Group regularly reviews workplan</td><td></td><td colspan="2">Reporting Virtual Ward uptake through to Devon Urgent and Emergency Care (DUEC) Programme Board</td></tr>
<tr><td colspan="6">Publication of Community First Framework</td><td></td><td colspan="2">Community services waiting list now included in Integrated Quality and Performance Report (IQPR) to Board</td></tr>
</table>

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Control Gaps	Assurance Gaps
Community Provider Collaborative to be established	Limited community metrics through to Board via the IQPR
Primary and Community Care Model programme to be agreed across system	

Mitigating Actions:	Action Owner	Action Status	Planned Completion Date
Community Provider forum to be established to share best practice, learning and agree how to take community workplan forward.	Su Smart	Complete	June 2023
Out of hospital actions to be incorporated into Urgent and Emergency Care (UEC) Improvement Plan and report into Unscheduled Care Board.	Jo Turl	Complete	September 2023
Acute Respiratory Infection (ARI) hub business case to be developed and funding decision made by Devon Investment Group (DIG).	Jo Turl / Lorraine Webber	In Progress	Mid-September 2023
Admissions avoidance business case to be developed with Devon Collaborative Board and funding decision made by DIG.	Jo Turl	In Progress	Mid-September 2023
Action plans and trajectories to increase referrals into Urgent Community Response (UCR) teams received by providers and being monitored weekly.	Jo Turl / Lorraine Webber	In Progress	October 2023
Action plans and trajectories to increase referrals into Virtual Wards received by providers and being monitored weekly.	Jo Turl / Lorraine Webber	In Progress	October 2023
Identify and agree key actions from New Models of Care programme relating to End of Life (EoL), Falls and Frailty.	Jo Turl	In Progress	End September 2023

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<table>
<tr><td colspan="6"><u>Make More Efficient Use of Our Resources</u>
Corporate Objective 9:
Move out of System Oversight framework (SOF4) – including delivery of a balanced system financial plan.</td><td>Director Lead:
Bill Shields, Chief Finance Officer (CFO)</td></tr>
<tr><td colspan="6" rowspan="3">Risk
If the NHS Devon fails to obtain commitment from all partners in the ICS to achieve financial balance. This will undermine our ability to move greater resource to prevention and our ability to exit the NHS England System Oversight Framework Level 4 status (SOF4).</td><td>Principal Assurance Committee:
Finance & Performance Committee (FPC)</td></tr>
<tr><td>Devon Challenge: (5) Economic Resilience</td></tr>
<tr><td>ICS Strategic Goal:
Enhancing productivity and value for money - We will make the best use of our funds by maximising economies of scale and increasing cost effectiveness.</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Move</td><td>Risk Score</td><td>Target</td><td rowspan="2">Joint Forward Plan Enabling Programme: Finance</td></tr>
<tr><td><u>Inherent</u> Risk Score</td><td>4</td><td>5</td><td rowspan="2">No change</td><td>20</td><td rowspan="2">8</td></tr>
<tr><td><u>Residual</u> Risk score:
Sept 23</td><td>4</td><td>4</td><td>16</td><td>Risk Appetite: Open</td></tr>
<tr><td colspan="7">Key Update on Actions – Sept 2023:
The final plan for 2023/24 was agreed at the start of May 2024. This describes an in-year delivery of £42.3m deficit for the system as a whole. The plan is reliant on a Cost Improvement Programme (CIP) plan of £212.2m against NHS Devon resources of £2.599m, representing 8.3%.
The overall CIP is based on organisationally owned targets of £152.7m and for which organisations are corporately responsible. In addition, there is a further £59.5m of system wide collaborative schemes for which the system is jointly responsible for delivery and against which a risk share agreement that ties in all organisations.
The plan is part of wider recovery trajectory and Long-Term Financial Plan (LTFP), that indicates a recovery to system balance over three years.
The key financial requirements to enable exit from SOF4 include:</td></tr>
</table>

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A shared unambiguous view of the drivers of the deficit – a process was commenced in February 2023 with the outputs forming an integral part of the 2023/24 financial recovery plan and informed the collaborative elements of the shared CIP plan.

Productivity – has been a focus of the 23/24 operating plan with a requirement to fully include and model all opportunities from Getting It Right First Time (GIRFT) / High Value Low Complexity (HVLCS) / One Devon Elective Pilot.

The key measures for exit will be against:

- Performance against system savings plans and trajectories;
- Significant improvement in underlying recurrent position (linked to CIP delivery);
- Productivity back to 2019/20 levels as a minimum;
- Meet the financial plan for the quarter; and
- Reconfirm the exit run rate.

These measures will form part of the system performance and SOF4 reporting and will inform the risk to exit as described in this risk.
The system will not exit SOF4 in 2023/24, the risk score remains at 4 x 4 = 16.

For an update on actions as at September 2023, please see the 'Mitigating Actions' table below.

Key Controls:	**In Place**	**Assurances:**
Financial Recovery Plan		Financial Recovery Plan reported to Finance & Performance Committee in April and May 2023
Newly appointed Executive Director of Finance		Finance Committee report re. risks and mitigations by way of base case, upside, and downside
NHSE dedicated support (team)		System Exec oversight
'Triple Lock' now in place		System Director of Finance (DoF) meeting
Case for Change endorsed by region and signed off by ICS Execs	TBC	System Improvement Assurance Group
Peninsula Acute Sustainability Programme Plan to April 2023	TBC	SoF Metrics included within the Integrated Quality and Performance Report (IQPR)
Control Gaps		**Assurance Gaps**
NHSE Recovery Plan sign off		ICB missing key performance targets
Urgent & Emergency Care (UEC) Strategy		SoF4

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Mitigating Actions:	Action Owner	Action Status	Planned Completion Date
Development of Medium Term Finance Plan (MTFP), this sets out the scope and scale of the challenge to deliver financial balance during the strategic medium term. The model has been developed locally, in collaboration with Deloitte, and is understood and owned by all the NHS partners in the system. This is the strategic plan setting out the challenge rather than a delivery plan. The model allows for stress testing should current year delivery fall short of plan.	Bill Shields		28.09.2023
Independent review of forecasts and likely outturn and delivery against agreed CIP targets, both Business As Usual (BAU) and collaborative strategic. Agreement reached with NHSE to engage Paul Mapson to carry out this independent review, which will give assurance on the level of risk in the current year delivery plans.	Bill Shields and System DoFs		October 2023
System Recovery Task and Finish Group established. This is an action focussed meeting to maintain pace and focus, grip and control, rapid escalation and resolution of issues and blockages.	Bill Shields		September 2023
Scoping of a procurement for consultant support to Phase 4 which will provide additional support in areas of high benefit such as procurement, workforce, out of hospital services. and digital enablement, in addition to the continuation of support to CIP delivery, and support to the delivery of the system recovery programme.	Kirsty Denwood		October 2023
Development of the risk sharing reporting to ensure there is a common understanding of how the risk sharing will impact on individual organisational positions, minimising any opportunities for omission or double counts in the forecast. Consistency of reporting, better articulation of risk review.	Kirsty Denwood		September 2023
Testing with each CIP scheme Senior Responsible Officer (SRO), the validation of current year forecast delivery, the route to cash, the timing of delivery to ensure the forecast and risk at system level is robust and well understood. Testing the opportunities for in year recovery and stretch delivery. Meetings are in the process of being arranged during September and early October 2023.	Sarah Brampton & Kirsty Denwood		September 2023 / October 2023
Delivery of the system-wide CIP programme for 2023/24.	Bill Shields		On-going
Delivery of finance and activity trajectories.	Bill Shields		On-going
Develop a capital programme that aligns and supports delivery of the operational plan/to include technology advancements/digital agenda etc.	Bill Shields		2024/25

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ICS Infrastructure Strategy.	Bill Shields		December 2023

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<table>
<tr><td colspan="6"><u>Make More Efficient Use of Our Resources</u>
Corporate Objective 10:
Develop a workforce strategy to ensure resilience of key services.</td><td colspan="2">Director Lead:
Paul Renshaw, Director of Workforce Strategy</td></tr>
<tr><td colspan="6" rowspan="3">Risk:
If the One Devon Health & Care System does not produce an agreed system wide workforce strategy and deliver a coherent strategic workforce numerical plan that meets the health and care needs of the population, is affordable and can be delivered by system partners, then it will continue to have high costs and be unable to ensure resilient, safe, and effective services. As a consequence, One Devon Health & Care System will continue to fail to meet statutory constitutional targets.</td><td colspan="2">Principal Assurance Committee:
People & Culture Committee (PCC)</td></tr>
<tr><td colspan="2">Devon Challenge: (8) Varied education, training, employment opportunities, workforce availability and wellbeing.</td></tr>
<tr><td colspan="2">ICS Strategic Goal:
Enhancing productivity and value for money.
We will have enough people with the right skills to deliver excellent health and care in Devon, deployed in an affordable way.</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Move</td><td>Risk Score</td><td>Target</td><td colspan="2">Joint Forward Plan Enabling Programme: Workforce</td></tr>
<tr><td><u>Inherent</u> Risk Score</td><td>4</td><td>4</td><td rowspan="2">No change</td><td>16</td><td rowspan="2">6</td><td colspan="2"></td></tr>
<tr><td><u>Residual</u> Risk Score:
Sept 2023</td><td>3</td><td>4</td><td>12</td><td colspan="2">Risk Appetite: Open</td></tr>
<tr><td colspan="8">Key Update on Actions – September 2023:
The One Devon Workforce Strategy was approved by the NHS Devon Board in May 2023 and work is ongoing in implementing the strategy themes and principles across System partners.
The strategic workforce numerical plan associated with this is being developed in collaboration with the NHS Devon Finance Team, Deloittes, NHS England Workforce, Training and Education (NHSWT&E) and Devon health providers; we expect a detailed plan for health providers to be produced and socialised by the end of Quarter 3 of 2023/24. Ongoing engagement with primary and social care is in place to support the collation of primary care and social care workforce planning data to enable this to be added to the strategic workforce numerical plan by end of Quarter 4 of 2023/24.</td></tr>
</table>

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A key enabler of the delivery of the workforce strategy and associated workforce plans will be the redesign of service pathways across the Devon System. Clinical engagement is key in delivering both the service redesign and the associated strategic workforce numerical plans required to deliver the new ways of working.

The strategic workforce planning tool (named SWIFT) continues to be developed and will be launched in Quarter 3 of 2023/24 within Devon health providers. Subject to further funding being secured for further development of the planning tool, further rollouts will be planned for primary care and social care in the 2024/25 financial year.

Key Controls:	**In Place**	**Assurances:**
Workforce Strategy designed and approved		Workforce Strategy Steering Group in place which oversees the development and implementation of the workforce strategy and associated workforce plans. Progress reported through to Executive Workforce Group and People & Culture Committee.
5 Year workforce plan (expected Quarter 3 of 2023/24)		Workforce Strategy Steering Group in place which oversees the development and implementation of the workforce strategy and associated workforce plans. Progress reported through to Executive Workforce Group and People & Culture Committee.
Workforce dashboard		Workforce report and dashboard created and in use from end of July 2023 for NHS providers.

Control Gaps	**Assurance Gaps**
Learning and Education Strategy - to be approved at People and Culture Committee in July 2023 and NHS Devon Board in September 2023.	

Mitigating Actions:	**Action Owner**	**Action Status**	**Planned Completion Date**
A revised approach to collating the required data to inform the strategic workforce numerical plan for health providers has been designed, approved, and implemented. Workstreams are on track to deliver the plan by agreed deadline.	Mark Sowden		31.12.2023

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Ongoing engagement with primary care and social care to source workforce planning data so that the data can be included in the strategic workforce numerical plan to enable full System workforce planning.	Mark Sowden		31.03.2024
Clinical engagement with health provider Chief Medical Officers (CMOs) and Chief Nursing Officers (CNOs) planned throughout Quarter 3 and Quarter 4 to support socialisation and approval of strategic workforce numerical plans as well as to ensure those plans are aligned to the required clinical service / pathway redesign and new ways of working required. This engagement work is being supported by NHS Devon CMO & CNO.	Paul Renshaw / Mark Sowden		31.12.2023 for socialisation and approval of plans. Ongoing engagement thereafter to ensure alignment to service redesign and delivery of plans.
Oversight and progress reporting in place to monitor progress and delivery of plans. Oversight includes provider Executive / senior management attendance at meetings as well as ongoing engagement with provider leads.	Mark Sowden		31.03.2024
The development of our own strategic workforce planning tool (SWIFT) will be a key enabler in supporting health providers in developing robust workforce plans as well as enabling ongoing monitoring of delivery progress. The SWIFT tool will also standardise workforce planning processes and the outputs of the tool will help inform talent pipelines and new ways of working models.	Mark Sowden		31.12.2023 'go live' within health providers.
Workforce dashboard only showing NHS data at present. Meeting with Local Authorities (LA's) and Primary Care to agree plan for getting appropriate data from respective markets into wider dashboard by the end of 2023/24.	Mark Sowden		31.03.2024

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<table>
<tr><td colspan="6"><u>Make More Efficient Use of Our Resources</u>
Corporate Objective 11:
Maximise the use of digital technology and data so it [care] is evidence based and outcome focused.</td><td>Executive Director:
Bill Shields, Chief Finance Officer (CFO)

Director Lead:
Malcolm Senior, Director of Digital Transformation</td></tr>
<tr><td colspan="6">Risk:
If we fail to resource and work collaboratively towards the common priorities presented in the Digital Strategy, we will not be able to maximise the benefits afforded by the advances in digital and data. Specifically the NHS Devon Digital Team are driving system improvement and collaboration in the following areas:
▪ The digital contribution to exiting Segment 4 of the National Oversight Framework (NOF4)
▪ The delivery of unified and standardised digital infrastructure and applications to support the clinical model
▪ The delivery and development of shared care record capability
▪ The development of the digital citizen and improving digital inclusion
▪ The delivery of a shared digital target operating model for the delivery of digital services.</td><td>Principal Assurance Committee:
Finance & Performance Committee (FPC)

ICS Digital Vision:
Invest in a digital Devon: People will only tell their story once; first contact will be digital where appropriate and more advice and help will be available online. We want to make the most of advances in digital technology to help people stay well, prevent ill-health, and provide care.</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Move</td><td>Risk Score</td><td>Target</td><td rowspan="2">Joint Forward Plan Enabling Programme: Digital and Data</td></tr>
<tr><td><u>Inherent</u> Risk Score</td><td>4</td><td>4</td><td rowspan="2">No Change</td><td>16</td><td rowspan="2">8</td></tr>
<tr><td><u>Residual</u> Risk score: Sept 23</td><td>3</td><td>4</td><td>12</td><td>Risk Appetite: Seek</td></tr>
<tr><td colspan="7">Key Update on Actions – September 2023:

The Digital Strategy was approved by the NHS Devon Board in March 2023.

The NHS Devon Digital Team and the Integrated Care System (ICS) Devon Technical Design Authority are supporting the system recovery activity.

£85m has been allocated to Devon Partnership NHS Trust (DPT), University Hospitals Plymouth NHS Trust (UHP) and Torbay and South Devon NHS Foundation Trust (TSDFT) to complete their digitisation journey.

Channel 3 Consultancy are supporting activity on the Target Operating Model, Shared IT Services and Review of Referral Services. A specification is being developed for Phase 4 implementation.</td></tr>
</table>

ANNEX B&C

Whole system digital workshops held to bring ICS organisations, critical suppliers, and NHS England (NHSE) together to progress the delivery of the digital strategy.		
Key Controls:	**In Place**	**Assurances:**
Digital Strategy		Highlight reports to Finance and Planning Board
Digital Transformation Board		Assurance reports to Finance & Performance Committee
NHS Devon		Involvement of NHSE across governance levels
Single Technical Design Authority		
Control Gaps		**Assurance Gaps**
Over reliance on provider digital resources who have other competing local priorities		
A culture of whole system thinking across the ICS has yet to be achieved		Competing local priorities
		Lack of financial resources*

Mitigating Actions:	**Action Owner**	**Action Status**	**Planned Completion Date**
Ready to launch business case for the future development of the shared care record to support the enablement of wider access to the shared care record so that patient information is accessible to all those involved in direct care.	Malcolm Senior		Sept 2023
Channel 3 Consultancy providing support by producing business case for a Target Operating Model supporting a more efficient and resilient shared IT service and contributing to our exit of NOF4.	Malcolm Senior		30.09.2023
Channel 3 Consultancy providing support by producing a business case for Shared Service Desk supporting a more efficient and resilient shared IT service and contributing to our exit of NOF4.	Malcolm Senior		30.09.2023
Channel 3 Consultancy providing support by producing an initial Review of Referral Services supporting a more efficient referral service for Devon and contributing to our exit of NOF4.	Malcolm Senior	Complete	31.08.2023
Professional provider support requirement being specified for Phase 4 implementation activity. Linked to the implementation of the business change associated with the Channel 3 business cases above.	Malcolm Senior	Complete	Mid-Sept 2023

ANNEX B&C

Through Organisational Change Phases 1 & 2, consideration will be given to the impact of workforce reductions on each team's ability to deliver their objectives and ultimately, those of NHS Devon.	Piers Tetley	Ongoing	TBC

ANNEX B&C

<table>
<tr><td colspan="7"><u>Improve Services and Reduce Unwarranted Variation</u>
Corporate Objective 12:
Minimise our negative impact on the environment and ensure services are green / sustainable.</td><td colspan="2">Director Lead:
Andrew Millward, Chief Communications & Corporate Affairs Officer</td></tr>
<tr><td colspan="7" rowspan="2">Risk:
If NHS Devon does not embed the principles for Healthier Planet, Healthier People then it will not ensure that it is as green and sustainable an organisation as possible in order to contribute to the NHS target of reaching net zero by 2040 (for emissions it controls directly and by 2045 for those it can influence (such as the supply chain)). The consequence will be that we fail in our responsibilities to tackle the impact of the climate emergency on the health of the population and for future generations.</td><td colspan="2">Principal Assurance Committee:
Finance & Performance Committee (FPC)</td></tr>
<tr><td colspan="2">Devon Challenge: (2) Climate Change</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Move</td><td>Risk Score</td><td>Target</td><td colspan="2" rowspan="2">ICS Strategic Goal:
We will create a greener and more environmentally sustainable health and care system in Devon, that tackles climate change, supports healthier living (including promoting physical activity and active travel).</td></tr>
<tr><td><u>Inherent</u> Risk Score</td><td>4</td><td>4</td><td>No change</td><td>16</td><td rowspan="2">8</td></tr>
<tr><td><u>Residual</u> Risk Score: Sept 23</td><td>4</td><td>4</td><td>↑
(Previously Scored 12)</td><td>16</td><td colspan="2">Joint Forward Plan Enabling Programme: Green Plan</td></tr>
<tr><td colspan="7">Key Update on Actions – Sept 2023:
NHS Devon’s Green Plan was written with contributions from acute trust partners and general practice. This provides a framework to support the individual partner Green Plans. The plan is now being revised to reflect the Joint Forward Local Plan consultation. Key actions that cut across both documents are,
• More NHS Devon staff will make greener journeys to work;
• NHS Devon will be a paper free organisation by 2028; and
• More products and services are bought locally promoting the concept of the Devon Pound across the One Devon Health and Care System its partners.</td><td colspan="2">Risk Appetite: Seek</td></tr>
</table>

ANNEX B&C

Key Controls:	**In Place**	**Assurances:**
Estates / Sustainability Lead meetings taking place		Action log produced
Control Gaps		**Assurance Gaps**
Resources and Capacity: No resources have been identified to support the implementation of the Green Plan. There is currently no dedicated strategic resource at a One Devon Health and Care System level for the Green agenda		Formal governance arrangements not in place and no formal route to the NHS Devon Board
NHS Devon's Green Plan does not currently have an associated delivery plan		The Green Plan is currently being reviewed to reflect the sustainability ambitions within the Joint Forward Local Plan

Mitigating Actions:	**Action Owner**	**Action Status**	**Planned Completion Date**
Clarity of responsibility for this function will be considered through the organisational change programme (Phase 1 and 2).	Piers Tetley	TBC	TBC
Devon Green Plan / Joint Forward Local Plan Action - More NHS Devon staff will make greener journeys to work. (40% increase in the number of staff making greener journeys to work).	Darin Halifax	Ongoing	March 2028
Devon Green Plan / Joint Forward Local Plan Action - NHS Devon ICB will be a paper free organisation by 2028.	Darin Halifax	Ongoing	March 2028
Devon Green Plan / Joint Forward Local Plan Action - More products and services are bought locally promoting the concept of the Devon Pound across the One Devon Health and Care System and its partners across NHS Devon (Increase of 50% more products and services bought locally).	Darin Halifax	Ongoing	March 2028

ANNEX B&C

<table>
<tr><td colspan="6"><u>Develop Our Culture and How We Operate</u>
Corporate Objective 13:
Develop and embed a new culture for the ‘One Devon’ system and create stronger relationships built on integration and trust.</td><td colspan="2">Director Lead: Andrew Millward, Chief Communications & Corporate Affairs Officer</td></tr>
<tr><td colspan="6" rowspan="2">Risk:
There is a risk that the organisational change work being undertaken by the NHS Devon to enable it to meet the required 30% running cost reduction distracts staff from focusing on the transformational change required to improve the provision of care and services for the people of Devon. There is also a risk that the restructure has a knock-on impact of the work underway to strengthen system working as part of the ‘One Devon’ partnership.</td><td colspan="2">Principal Assurance Committees:
Executive Strategy & Transformation Group; and
People & Culture Committee (PCC)</td></tr>
<tr><td colspan="2">ICS Overarching Goal:
One Devon will strengthen its integrated and collaborative working arrangements to deliver better experience and outcomes for the people of Devon and greater value for money. (extract from the Devon Plan).</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Move</td><td>Risk Score</td><td>Target</td><td colspan="2" rowspan="2">Joint Forward Plan Enabling Programme: System Development</td></tr>
<tr><td><u>Inherent</u> Risk Score</td><td>5</td><td>5</td><td rowspan="2">Scores Updated to Reflect Risk to the ICB Specifically</td><td>25</td><td rowspan="2">6</td></tr>
<tr><td><u>Residual</u> Risk Score: Sept 23</td><td>4</td><td>5</td><td>20</td><td colspan="2">Risk Appetite: Seek</td></tr>
<tr><td colspan="8"><u>Key Update on Actions – September 2023:</u>
▪ Organisational Change: On the 22nd July 2023 Phase 1 of organisation change consultation for the Executive and Senior Leadership Team (SLT) launched. This is due to complete by the end of September 2023.
▪ Improving care and services for people of Devon through adoption of outward mindsets – continuing to rollout the 12 month programme.
▪ Completion of 2023 System Diagnostic and Integrated Care System (ICS) Maturity Framework Assessment.
▪ Provision of development support to South, East, and North Local Care Partnerships (LCPs).</td></tr>
<tr><td colspan="6">Key Controls:</td><td>In Place</td><td>Assurances:</td></tr>
<tr><td colspan="6">Organisational Change Oversight Group</td><td></td><td>-</td></tr>
</table>

ANNEX B&C

Control Gaps	Assurance Gaps
-	-

Mitigating Actions:	Action Owner	Action Status	Planned Completion Date
Organisational change programme split into two phases with Phase 1 focused on the Senior Leadership Team (SLT).	Piers Tetley	Close to Completion	Early October 2023
Communications Plan in place to ensure that staff are kept up to date in relation to proposed changes and that they are appropriately engaged.	Sam Cush	Ongoing	N/A
Organisational Change Phase 2 due to follow Phase 1, with a focus on the rest of the organisation, in order to ensure that organisational leaders own proposed new organisational structures.	Andrew Millward	Not Yet Commenced	31.03.2023

ANNEX B&C

<table>
<tr><td colspan="6"><u>Develop Our Culture and How We Operate</u>
Corporate Objective 14:
Develop a system operating model, so we are clear on system decision making, local care partnership accountability and development of a more locally based, citizen led approach to planning and delivering services.</td><td>Director Lead:
Nigel Acheson, Chief Medical Officer (CMO)</td></tr>
<tr><td colspan="6" rowspan="2">Risk:
If NHS Devon does not set clear timescales and expectations for the development of the system operating model as a result of the inertia (inactivity) caused by operational pressures, then some partners will become disengaged and unable to focus on wider system objectives. The consequence will be a break down in trust between partners, which will undermine the relationships needed to fully develop an integrated care system.</td><td>Principal Assurance Committee:
ICS Executive Strategy and Transformation</td></tr>
<tr><td>ICS Aim:
Creating an environment for success - Integrated System Development Programme.</td></tr>
<tr><td></td><td>Likelihood</td><td>Impact</td><td>Move</td><td>Risk Score</td><td>Target</td><td rowspan="2">Joint Forward Plan Enabling Programme: System Development</td></tr>
<tr><td><u>Inherent</u> Risk Score</td><td>4</td><td>4</td><td>No change</td><td>16</td><td rowspan="2">6</td></tr>
<tr><td><u>Residual</u> Risk Score:
Sept 23</td><td>3</td><td>4</td><td>↓
(Previously Scored 16)</td><td>12</td><td>Risk Appetite: Seek</td></tr>
<tr><td colspan="7">Key Update on Actions – Sept 2023:
Operating Model delegations meeting took place on 25th August 2023, including NHS Devon, Local Care Partnership (LCP) and Primary Care (PC) members. Actions include development of delegation process and Memorandum of Understanding (MoU). Follow-up meeting being arranged.</td></tr>
<tr><td colspan="5">Key Controls:</td><td>In Place</td><td>Assurances:</td></tr>
<tr><td colspan="5">Operating Model agenda items at Senior Executive Team (SET)</td><td></td><td>All partner Board approval of Devon Operating Model</td></tr>
<tr><td colspan="5">LCP Development Meeting</td><td></td><td>One Devon Health and Care System maturity assessment</td></tr>
</table>

ANNEX B&C

Control Gaps	Assurance Gaps
Delay in NHS Devon Exec agreement of vision and timescales for implementation	
Development and Delegation Framework – dependent on the above	
Plan and timeline for adoption of additional responsibilities – dependent on the above	

Mitigating Actions:	Action Owner	Action Status	Planned Completion Date
NHS Devon to share updated Operating Model presentation with System Management Exec, LCPs, and PCs.	Warwick Heale		Nov 2023
NHS Devon to co-produce with LCPs and PCs a delegation framework to include: governance (formally approved Terms of Reference (ToRs), membership, reporting etc.); assessment of capacity and capability (including that provided by transfer of staff to new body). May use elements of the One Devon Health and Care System Maturity Assessment.	Warwick Heale		Dec 2023

ANNEX B&C

Scoring Methodology.

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 x Likelihood (I x L)

		Likelihood				
		1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
Severity	5 Catastrophic	5	10	15	20	25
	4 Major	4	8	12	16	20
	3 Moderate	3	6	9	12	15
	2 Minor	1	4	6	8	10
	1 Negligible	1	2	3	4	5

Good Governance Institutes Framework definitions:

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

END OF DOCUMENT

NHS Devon Integrated Care Board

Freedom to Speak Up (FTSU) Annual Report and policy update

Date of meeting	Date report produced
04 October 2023	31 August 2023

Author(s)		Report approved by	
Name and title:	Philippa Harding, Company Secretary Alison Wilkinson, Associate Director of Transformation	**Name and title:**	Jane Milligan, Chief Executive Officer
Phone:	01392 675 116	**Date:**	27 September 2023
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 annual report sets out the work of the Freedom to Speak Up FTSU Guardians over the preceding twelve months.

There have been three FTSU Guardians working within NHS Devon, supporting staff and others to raise concerns that they feel unable to raise through other available routes.

The Guardians work includes raising awareness of Speaking Up and providing a way that individuals can raise concerns anonymously. Confidentiality is maintained as far as possible.

The Guardians are supported in their roles by a named Executive and Non-Executive Lead.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
The Audit and Risk Committee discussed this report at its meeting on 26 September 2023 and endorsed it.

Key recommendations and actions requested
1. The Board is asked **note** the work that has taken place during the past year;
2. The Board is asked to **reflect** on the themes coming through from the concerns raised, actions taken and learning
3. The Board is asked to **comment** on the plans for future work and any areas of omission.
4. The Board is asked to **approve** the proposed amended FTSU policy.

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	
Health inequalities	
Workforce	
Resources and finance	
Legal	

Digital and Data	
Engagement and consultation	

3

Freedom to Speak Up (FTSU) Annual Report and policy update

Introduction

1. Having an open and responsive culture, where all staff feel confident and able to speak up when things go wrong, is one of the key elements of ensuring a safe and effective workforce.

2. Effective speaking up arrangements help to protect patients and improve the experience of workers. The NHS understands that the main reasons workers do not speak up are because they fear they may be victimized or because they do not believe anything will change and the NHS Devon Integrated Care Board (ICB) has a responsibility to ensure that this is not the case. This is further reflected in the NHS People Plan, which aims to ensure everyone feels they have a voice, control and influence.

3. In order to continue to embed a culture of “speaking up” the ICB’s predecessor organisation, NHS Devon CCG, developed and published a “Freedom to Speak Up” Policy, in October 2019 and appointed a number of Freedom to Speak Up Guardians across the organisation, to help support this agenda through providing an independent and impartial source of advice to staff at any stage of raising a concern.

4. The FTSU Guardians retained their roles on transfer to the ICB, which has provided valuable continuity in terms of this agenda.

The Work of the FTSU Team

5. During the last year good progress has been made in embedding the FTSU agenda.

6. The FTSU Guardians have made two presentations as part of the staff briefing, firstly to publicise Speak Up Month in October 2022, to raise awareness of the role of the Guardians and how support can be accessed, and more recently in a combined update with the Staff Partnership Forum, Health and Wellbeing Champions and Mental Health Champions.

7. During Speak Up Month, members of the team and NHS Devon executives and non-executives made pledges in relation to speaking up and these were shared with staff through the staff briefing and on social media.

8. As staff returned to office-based working in greater numbers, posters have been put up in all NHS Devon offices, raising awareness of Speaking Up and of how to contact the FTSU Guardians.

9. During Speak Up Month specifically, but also continuing since, FTSU Guardians have ensured that they have a visible presence in NHS Devon's offices.

10. Several articles have been included in the weekly staff bulletin and each of the three FTSU Guardians have now been subject of a profile in the bulletin.

11. The team has continued to meet on a monthly basis with the Executive and Non-Executive FTSU Leads joining the meetings. The Associate Director of Human Resources and Organisational Development has also been invited to attend some of the monthly meetings, providing case studies and training and latterly to discuss progress with developing joint training for the Guardians, HR team and Staff Partnership Forum (SPF).

12. The joint training was undertaken in July 2023 and work continues to develop tools for FTSU Guardians and SPF representatives to use to better signpost and support individuals who speak up. Joint meetings are planned, to share high level, anonymised intelligence and to help the teams to provide a more joined-up approach.

13. Improvements have been made to the processes for recording cases raised with the FTSU Guardians, for example:

    - A tribunal in which one of the Guardians was involved led to changes in the notes taken, to reflect that all notes can be used in any legal action, by either party, and that notes must be kept for a minimum of 7 years (as they constitute patient records).
    - Security of any files, emails and notes has been improved, with a secure shared directory now managed by the team, in addition to the shared email space and Teams site.

14. As detailed above, work has begun with the SPF, HR team and others to set out the most appropriate routes for signposting individuals to ensure that they get the right support, as staff can raise issues with a number of teams.

15. As part of a project for a leadership academy course, one of the FTSU Guardians developed and published an anonymous survey, asking people what they know about FTSU and whether they would feel comfortable speaking up. The feedback from the survey was analysed and is helping the team to tailor our approach going forward. Regular 'pulse' surveys are planned going forward, which will include questions regarding speaking up.

16. The FTSU Guardians, Executive and Non-Executive leads and Associate Director of HR and OD, in conjunction with the NHS Devon Chair, jointly completed the national self-reflection tool and used responses to develop an improvement plan to address the gaps. This will frame our work going forward.

17. The Guardians supported NHS Devon's Health and Wellbeing Champions in a second round of wellbeing checks.

Themes From Concerns

18. Over the previous four years the numbers of concerns raised has been increasing and this has continued into 2023/24:

Concerns raised	
2019/20	0
2020/21	4
2021/22	5
2022/23	12
2023/24 5 months to 31/08/23	7

19. Specifically, between September 2022 and August 2023, fifteen individual concerns have been raised with the Guardians. Some of the main themes that have emerged during this time are:

- Behaviour – there have been eight concerns raised about behaviour, both internal to NHS Devon, whereby senior leaders were perceived as not demonstrating NHS Devon's values, and regarding staff and leaders in external partner organisations. With regard to the internal behaviour, where staff members have been willing, concerns have been discussed with the appropriate executives/senior leaders and action taken. However, several of those who have approached the team have specified that they are raising the concern for awareness only and that they wish to take no further action, either for fear of recrimination or because they do not believe that it will make a difference. Those relating to external organisations have been taken forward by senior NHS Devon leaders.

- Lack of good governance/process, in relation to HR processes (e.g.: recruitment, return from long term sick leave) and other NHS Devon processes, such as procurement. This has been raised with relevant senior leaders and, as a result, a reminder has been issued to all staff regarding NHS Devon's procurement policy and the Associate Director of Human Resources and Organisational Development has been asked to review the training given to those with line management responsibility in the application of HR policies.

- There was one concern raised regarding a patient safety issue in a provider organisation, which was referred to the Patient Safety and Quality team for investigation and has resulted in a service review.

FTSU Policy

20. Every NHS organisation should have a FTSU policy in place so that those who work in the organisation know how to speak up, who they can speak up to and what will happen when they do. Policies should be designed to be inclusive and support resolution by managers wherever possible.

21. NHS Devon's current FTSU policy was "rolled over" from NHS Devon Clinical Commissioning Group and in late 2022/early 2023, the FTSU Guardians were asked to review the policy, both to reflect that we are now a new organisation and to reflect the recent publication of an updated national FTSU Policy document, which is recommended as the minimum adopted by all NHS organisations.

22. The new policy was reviewed by the HR team and the Staff Partnership Forum, prior to going to Remuneration Committee and the Audit and Risk Committee before its presentation to the NHS Devon Board.

Board oversight

23. To date, the NHS Devon Board's Remuneration and Internal ICB Workforce Committee has taken an active lead in supporting the FTSU Guardians to embed FTSU into the new organisation. Going forward the Audit and Risk Committee will take a more formal oversight role in relation to this work.

24. It is proposed that this more formal oversight involves receiving reporting and assurances in relation to:

Assessment of cases

- The number and types of cases being handled by the FTSU Guardian
- Analysis of trends, including whether the number of cases is increasing or decreasing, any themes in the matters being raised (such as types of issue, particular groups of workers who speak up or areas of the organisation in which matters are being raised more or less frequently than might be expected), and information on which groups of workers are, or are not, speaking up
- What has been learnt and what improvements have been made as a result of workers speaking up
- Potential patient-safety or worker-experience issues

- How speaking-up matters fit into a wider patient safety or worker experience context, to help build a broader picture of the speaking up culture, barriers to speaking up, potential patient safety risks, and opportunities to learn and improve.

Action taken to improve speaking up culture:

- Actions taken to increase the FTSU Guardians' visibility and promote all speaking-up channels
- Actions taken to support any workers who are unaware of the speaking-up process or who find it difficult to speak up
- Assessments of the effectiveness of the speaking-up process and individual case handling, including user feedback, pulse surveys and learning from case reviews
- Potential improvements following reports of workers feeling they have suffered detriment for speaking up
- Actions taken to improve the skills, knowledge and capability of workers to speak up, to support others to do so, and to respond to the issues they raise effectively.

Recommendations

- Recommendations for any required action, with data and other intelligence presented in a way that maintains confidentiality.

Plans for next year

25. The following actions are planned for the year ahead:

- Once the revised FTSU policy has been approved by the NHS Devon Board, this will be launched through a staff briefing session, as part of Speak Up Month.

- The team will use the Improvement Plan developed from completion of the self-reflection tool to further embed a speak up culture and break down barriers to speaking up.

- Closer working with Staff Partnership Forum and other NHS Devon wellbeing teams, for triangulation of themes & trends.

- Contribute to the launch of regular 'pulse' surveys.

- NHS Devon must also respond to the recent NHS England guidance for ICBs on speaking up – this can be found at NHS England » Integrated care

boards, integrated care systems and Freedom to Speak Up and is reproduced below as Appendix A.

- NHS Devon will also need to develop a response to the NHS England letter regarding the recent verdict in the Lucy Letby trial; this is available at NHS England » Verdict in the trial of Lucy Letby or in Appendix B.

- Consideration will need to be given to determining what the requirements are for FTSU work with primary care going forward and how this can be supported.

Conclusion and Recommendations

26. The Board is asked to:

- Note the work that has taken place during the past year;
- Reflect on the themes coming through from the concerns raised, actions taken and learning;
- Comment on the plans for future work and any areas of omission; and
- Approve the proposed amended FTSU policy.

Appendix A

Integrated care boards, integrated care systems and Freedom to Speak Up

Freedom to Speak Up is one way of ensuring our NHS people have a voice that counts, which is central to our NHS people promise. The following information clarifies the expectations of integrated care boards (ICBs) and integrated care systems (ICSs) in relation to Freedom to Speak Up.

Context

In June 2022, NHS England and the National Guardian's Office published an updated Freedom to Speak Up guide and improvement tool to support organisations with delivering a speaking-up culture for their workers. In addition, an updated national Freedom to Speak Up policy was published. These documents apply to primary care, secondary care and more widely in health and care systems.

What integrated care boards should do

As you agree on ICS-level outcomes for all organisations in your ICS, it's important to think about how Freedom to Speak Up will support the delivery of those outcomes in terms of worker voice, worker experience and patient safety. ICBs have a great opportunity to ensure speaking up routes are available for all workers in NHS healthcare providers across the ICS. This must include access to a Freedom to Speak Up guardian(s) at organisation, place and/or system level. Appointing an executive and non-executive lead for Freedom to Speak Up within your ICB will provide leadership for that work. Specifically:

Freedom to Speak Up for ICB workers by 30 January 2024:

- ICBs must ensure their own ICB staff have access to routes for speaking up including Freedom to Speak Up guardian(s), and associated arrangements. Some of you may have adopted legacy clinical commissioning group arrangements and, as NHS organisations, ICBs are expected to adopt the new national policy and use the guide and improvement tool to map the plan for the next three years.

Freedom to Speak Up for primary care workers over the next 18 months:

- ICBs should think about primary care workers across the ICS having access to routes for speaking up, including access to a Freedom to Speak Up guardian(s) who is registered with and trained by the National Guardian's Office. Please note:
    -
    - There are relatively very few trained and registered Freedom to Speak Up guardians that support primary care workers. Even where guardians are in place, levels of speaking up (both reported and not reported to the National Guardian's Office) remain extremely low.

- Building on the report by the National Guardian's Office in 2021, NHS England and the National Guardian's Office are working with those guardians already in place to better understand the practical challenges of Freedom to Speak Up in primary care and create a menu of support for organisations and ICSs.
- NHS England is working with a small number of ICBs who already have work underway to address this, so that the learning from their experience can be documented and shared.

Freedom to Speak Up across the ICS over the next 18 months:

- ICBs should start to think about:
  - How they will gain assurance that all NHS organisations across the ICS have accessible speaking up arrangements, in line with the guidance and policy recently published, considering the different barriers that workers face when speaking up and actions to reduce those barriers.
    - NHS England has asked that all NHS trusts adopt the policy and apply the guide and improvement tool over the next 18 months and have provided assurance to their public boards by the end of January 2024.
  - How they might share good practice and learning across the ICS about speaking up culture improvements.
  - The systems they will put in place to capture and measure speaking up data.

What next?

Based on our ongoing work with primary care and ICBs referenced above, NHS England and the National Guardian's Office plan to share further information by 31 March 2024 about the precise expectations of ICBs in regard to Freedom to Speak Up for primary care workers and across their system.
Please note:

- If ICBs are considering appointing a Freedom to Speak Up guardian now as a point of escalation for staff across the ICS, we suggest they get in touch with NHS England's Freedom to Speak Up team for guidance and support.
- Should an ICB decide to appoint a Freedom to Speak Up guardian to support staff that work in organisations across the ICS, we would advise you to think about whether this role should be separate from a Freedom to Speak Up guardian role that supports ICB staff.
- Once an ICB has appointed a guardian through fair and open recruitment processes, please contact the National Guardian's Office to access the appropriate training and support. ICBs will need to consider the resources (time and support) that the guardian will need to meet the needs of the workforce.
- When you have appointed a guardian, please ensure they complete their training and are added to the directory on the National Guardian's Office website.

- Please get in touch with the National Guardian's Office to share your learning and reflections nationally on implementing freedom to speak up.
- Please email the National Guardian's Office to sign up to their newsletter and keep up to date with latest developments.

Appendix B

Classification: Official
Publication reference: PRN00719

To:

- All integrated care board and NHS Trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - clinical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc

- NHS England regional:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - workforce, training and education regional directors/regional heads of nursing

Dear colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and

will cooperate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.
That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked Integrated Care Boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.
This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard, NHS Chief Executive
Sir David Sloman, Chief Operating Officer, NHS England
Dame Ruth May, Chief Nursing Officer, England
Professor Sir Stephen Powis, National Medical Director, NHS England
Date published: 18 August, 2023
Date last updated: 18 August, 2023

Freedom to Speak Up Policy

POLICY INFORMATION

Document Status:	Final Draft
Version:	V3
Effective date	TBC
Date last ratified:	TBC
Date of last review at staff partnership forum	16/02/2023
Review date:	3 years from effective date
Author:	Alastair Harlow, freedom to speak up guardian Marina Junaram, freedom to speak up guardian
Associated Guidance Document	N/A

Document Change History:		
Version	**Date**	**Comments (i.e. reviewed/amended/approved)**
3	14.12.2022	Policy updated and taken to FTSU group for review. Approved by SPF in Feb 2023.
2	10.08.2020	Policy updated. Approval received from AO and SP
1	21.10.2019	Document made live following approval.

PLEASE REFER TO THE NHS DEVON INTRANET TO ENSURE THAT YOU ARE VIEWING THE LATEST VERSION OF THIS POLICY. FOR THIS REASON, PLEASE REFRAIN FROM SAVING OR PRINTING THIS POLICY.

NHS Devon Values

Developed by staff, our values shape who we are, how we work and help us to make the right decisions on behalf of people in Devon.

One Devon

- We collaborate with staff, partners, patients, families, carers, communities and professionals to develop the right services for our population
- We think and act for our population, while recognising local needs
- We share information, skills and resources
- We value and protect our climate, and work in a sustainable way that reduces our carbon footprint

Quality in everything we do

- We develop safe, effective and accessible services that put patients at the centre
- We make decisions that are evidence-based, cost-effective and innovative
- We recognise achievements and celebrate success
- We take pride in our work, learn when things go wrong, and support people to speak up

Respect for all

- We treat people with respect and compassion
- We listen to people to understand their priorities, needs, and abilities, and involve them in decisions that affect their lives
- We are proactive with our health and wellbeing and our colleagues
- We champion equality, diversity and inclusion, and challenge inequalities
- We are open, honest and transparent

Everyone is a leader

- We lead by example and with integrity
- We are kind, caring and empathetic
- We support people to learn and develop
- We demonstrate leadership and expect to be held accountable for our actions and performance
- We are responsive, consistent and professional

ORGANISATIONAL INTENT

NHS Devon Integrated Care Board (referred to as NHS Devon) is passionate about ensuring our staff are treated fairly, with respect and dignity so that we maintain a diverse, flexible and motivated workforce which is high performing and delivers high quality outcomes.

We want our employees to be focussed on making a positive contribution and reaching their full potential at work, both at individual and team level.

We recognise there may be times when individuals feel they wish to 'speak up' about a concern at work and this policy is intended to inform individuals of how they can do this.

This policy aligns to all policies relating to our Employee Life Cycle, which is an important part of developing our culture of ownership and responsibility.

We welcome speaking up and we will listen. By speaking up at work you will be playing a vital role in helping us to keep improving our services for all patients and the working environment for our staff.

This policy is for all our workers. The NHS People Promise commits to ensuring that "we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to understand the hopes and fears that lie behind the words".

We want to hear about any concerns you have, whichever part of the organisation you work in. Across the NHS we understand that some groups in our workforce feel they are seldom heard or are reluctant to speak up; you could be an employee, secondee, agency worker, bank worker, or apprentice. We also know that across the NHS, individuals with disabilities, or from a minority ethnic background or the LGBTQ+ community do not always feel able to speak up.

This policy is for all workers, and we want to hear all our workers' concerns.

RESPONSIBILITIES

In accordance with NHS Devon Values everyone has both a shared and personal responsibility to prevent and eradicate wrongdoing at work. All colleagues should ensure NHS Devon values are appropriately upheld.

All colleagues will promote a culture of openness that welcomes the opportunity to address and resolve concerns.

NHS Devon Executive Team and Board are responsible for:

- receiving and reviewing feedback and reports on Speaking up complaints;
- ensuring that recommended actions following investigations are prioritised and actioned;
- providing an organisational culture where employees are encouraged to raise concerns and are supported when they do.

Managers are responsible for:

- having honest and open conversations with employees;
- acting upon all concerns raised by employees in a professional and timely manner;
- making every effort to protect the identity of the employee(s) raising the concern, if requested;
- maintaining appropriate documentation and confidentiality throughout the process;
- ensuring compliance with relevant legislation, policy and NHS Devon values;
- ensuring the person raising a concern is communicated with through the course of the process;
- seeking HR support and advice as required.

Freedom to Speak up Guardians are responsible for:

- working independently to support speaking up;
- being an expert in all aspects of raising and handling concerns;
- offering support and advice to employee who wish to raise a concern or are handling concerns ensuring feedback is given to the employee member raising a concern;
- monitor any concerns that have been raised;
- safeguarding the interests of the individual raising a concern;
- identifying common themes to help inform organisational learning;
- taking an objective view;
- ensuring concerns are escalated as appropriate;
- ensuring confidentiality regarding staff who speak up and wish to remain anonymous
- reporting to the board and externally (Lead Guardian);
- completing such reports as required.

Employees are responsible for:

- reporting illegal or unethical conduct through the appropriate routes immediately or at the earliest opportunity;
- disclosing when instructed to cover up wrongdoing, regardless of the persons level of authority;
- being clear that you are raising a concern in line with NHS Devon's Freedom to Speak Up policy, outlining your perceived key issues or risks;
- respecting the right of colleagues who raise concerns;
- engaging with the internal process in the first instance with open and honest communications;
- ensuring compliance with relevant legislation, policy and NHS Devon values;
- seeking HR advice as required.

Human Resources are responsible for:

- developing, supporting and coaching Managers;
- providing professional HR advice to managers to ensure they comply with organisational and legislation;
- responding appropriately to any concerns raised;
- ensuring compliance with relevant legislation, policy and NHS Devon values.

All parties should also familiarise themselves with the Standards to Business Conduct policy which has a number of close links to this policy.

WHAT CAN I SPEAK UP ABOUT?

You can speak up about anything that gets in the way of patient care or affects your working life. That could be something which doesn't feel right to you: for example, a way of working or a process that isn't being followed; you feel you are being discriminated against; or you feel the behaviours of others is affecting your wellbeing, or that of your colleagues or patients.

Speaking up is about all of these things.

Speaking up, therefore, captures a range of issues, some of which may be appropriate for other existing processes (for example, HR or patient safety/quality) utilising other policies (Fair Treatment policy, Attendance policy etc). These policies are available on the Devon ICB intranet.

Whichever route you choose, as an organisation, we will listen and work with you to identify the most appropriate way of responding to the issue you raise.

You can raise a concern individually or as a group of employees about risk, malpractice, wrongdoing, illegal or dishonest practices within NHS Devon.

Some examples of concerns raised in the public interest include (and are not restricted to):

- criminal offenses or activities;
- unsafe patient care;
- unsafe working conditions;
- lack of, or poor, response to a reported patient safety incident;
- covering up wrongdoing;
- financial mismanagement or corruption;
- suspicion of fraud (which can be reported to the local counter-fraud team);
- a bullying culture (across a team or organisation rather than individual instances of bullying).

For more examples, please see the Health Education England video.

WE WANT YOU TO FEEL SAFE TO SPEAK UP

Your speaking up to us is a gift because it helps us identify opportunities for improvement that we might not otherwise know about.

We will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up.

WHO CAN SPEAK UP?

Anyone who works in NHS healthcare. This encompasses any healthcare professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, apprentices, junior doctors, locum, bank and agency workers, and former workers. We are aware that in Devon ICB not all of these professional groups will be represented, but we will be able to signpost to the appropriate body to ensure your voice is heard.

WHO CAN I SPEAK UP TO?

Speaking up internally

Most speaking up happens through conversations with supervisors and line managers where challenges are raised and resolved quickly. We strive for a culture where that is normal, everyday practice and encourage you to explore this option – it may well be the easiest and simplest way of resolving matters.

However, you have other options in terms of who you can speak up to, depending on what feels most appropriate to you.

- Senior manager or executive with responsibility for the subject matter you are speaking up about.
- The patient safety team or corporate governance team, where concerns relate to patient safety or wider quality.
- Local counter fraud specialist (where concerns relate to fraud). Concerns regarding fraud or corruption can also be raised with the ICB Chief Finance Officer.
- Concerns in relation to matters such as information, recording keeping, communications, IT can also be directed to the ICB Senior Information Risk Owner (SIRO) or the Caldicott Guardian.
- Our Freedom to Speak Up Guardians. The guardians will ensure that people who speak up are thanked for doing so, that the issues they raise are responded to, and that the person speaking up receives feedback on the actions taken. You can find out more about the guardian role here. The team can be contacted on d-icb.ftsug@nhs.net.
- Our senior lead responsible for Freedom to Speak Up.
- Our non-executive director responsible for Freedom to Speak Up.
- Our HR team - d-icb.hr@nhs.net.
- A member of the Staff Partnership Forum, your Trade Union or professional body.

Details of current post holders and email addresses are included at Appendix A.

For independent advice on whistleblowing, protection or how best to raise a concern call the National Whistleblowing Helpline on 08000 724 725 or visit the website www.wbhelpline.org.uk.

Speaking up externally

If you do not want to speak up to someone within NHS Devon, you can speak up externally to:

- Care Quality Commission (CQC) for quality and safety concerns about the services it regulates – you can find out more about how the CQC handles concerns here.
- NHS England for concerns about:
    - GP surgeries
    - dental practices
    - optometrists
    - pharmacies
    - how NHS trusts and foundation trusts are being run (this includes ambulance trusts and community and mental health trusts)
    - NHS procurement and patient choice
    - the national tariff.
- NHS Counter Fraud Authority for concerns about fraud and corruption, using their online reporting form or calling their freephone line **0800 028 4060**.

NHS England may decide to investigate your concern themselves, ask your employer or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their oversight of the relevant organisation. The precise action they take will depend on the nature of your concern and how it relates to their various roles.

Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters, such as a concern from an individual about feeling bullied.

If you would like to speak up externally about the conduct of a member of staff, you can do this by contacting the relevant professional body such as the General Medical Council, Nursing and Midwifery Council, Health & Care Professions Council, General Dental Council, General Optical Council or General Pharmaceutical Council.

WHAT IS A "PROTECTED DISCLOSURE"?

A protected disclosure is defined in the Public Interest Disclosure Act 1998. This legislation allows certain categories of worker to lodge a claim for compensation with an employment tribunal if they suffer as a result of speaking up. The legislation is complex and to qualify for protection under it, very specific criteria must be met in relation to who is speaking up, about what and to whom. To help you consider whether you might meet these criteria before raising a concern, please seek independent advice from the Protect or a legal representative.

HOW SHOULD I SPEAK UP?

You can speak up to any of the people or organisations listed above in person, by phone or in writing (including email).

The most important aspect of your speaking up is the information you can provide, not your identity

You have a choice about how you speak up:

- **Openly:** you are happy that the person you speak up to knows your identity and that they can share this with anyone else involved in responding.
- **Confidentially:** you are happy to reveal your identity to the person you choose to speak up to on the condition that they will not share this without your consent, unless

legally compelled to as part of a legal process. This extends to the other members of the guardians and lead guardian.

- **Anonymously:** you do not want to reveal your identity to anyone. This can make it difficult for others to ask you for further information about the matter and may make it more complicated to act to resolve the issue. It also means that you might not be able to access additional support you need and receive any feedback on the outcome.

In all circumstances, please be ready to explain as fully as you can the information and circumstances that prompted you to speak up.

ADVICE AND SUPPORT

- Local support is available to you via the Employee Assistance Programme https://intranet.devon.icb.nhs.uk/staff-information/health-and-wellbeing-support.
- Our Freedom to Speak Up Guardians Alastair Harlow (aharlow1@nhs.net) and Marina Junaram (marina.junaram@nhs.net). You can find out more about the guardian role here. The team can also be contacted on d-icb.ftsug@nhs.net
- You can access a range of health and wellbeing support via NHS England:
    - Support available for our NHS people.
    - Looking after you: confidential coaching and support for the primary care workforce.
- NHS England has a Speak Up Support Scheme that you can apply to for support. You can also contact the following organisations:
    - Speak Up Direct provides free, independent, confidential advice on the speaking up process.
    - The charity Protect provides confidential and legal advice on speaking up.
    - The Trades Union Congress provides information on how to join a trade union.
- The Law Society may be able to point you to other sources of advice and support.
- The Advisory, Conciliation and Arbitration Service gives advice and assistance, including on early conciliation regarding employment disputes.

WHAT WILL WE DO?

The matter you are speaking up about may be best considered under a specific existing policy/process; for example, our process for dealing with bullying and harassment (the NHS Devon Fair Treatment policy). If so, we will discuss that with you. If you speak up about something that does not fall into an HR or patient safety incident process, this policy ensures that the matter is still addressed.

What you can expect to happen after speaking up is shown in Appendix B.

Resolution and investigation

We support our managers/supervisors to listen to the issue you raise and take action to resolve it wherever possible.

Where an investigation is needed, this will be objective and conducted by someone who is suitably independent (this might be someone outside your organisation or from a different part of the organisation) and someone who has, or is willing to be trained in investigations (which may be provided through the HR team for those who need it). It will reach a conclusion within a reasonable timescale (which we will notify you of), and a report will be produced that identifies any issues to prevent problems recurring.

Any employment issues that have implications for you/your capability or conduct identified during the investigation will be considered separately, utilising a specific policy such as the fair treatment policy.

Communicating with you

We will treat you with respect at all times and will thank you for speaking up. We will discuss the issues with you to ensure we understand exactly what you are worried about. If we decide to investigate, we will tell you how long we expect the investigation to take and agree with you how to keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others and recognising that some matters may be strictly confidential; as such it may be that we cannot even share the outcome with you).

How we learn from your speaking up

We want speaking up to improve the services we provide for patients and the environment our staff work in. Where it identifies improvements that can be made, we will endeavor to ensure necessary changes are made, and are working effectively. These changes will be shared back with you (if possible). Lessons will be shared with teams across the organisation, or more widely, as appropriate.

Review

We will seek feedback from workers about their experience of speaking up. We will review the effectiveness of this policy and our local process annually, with the outcome published and changes made as appropriate.

SENIOR LEADERS' OVERSIGHT

Our most senior leaders will receive regular reports at the Audit and Risk Committee, providing a thematic overview of speaking up by our staff to our FTSU guardians.

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 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 the HR team or your line manager.

An impact equality assessment has been conducted in regard to this policy. A copy is available from HR on request.

Appendix A

Speaking up internally - contact details

- Patient safety team - d-icb.nursingdirectorate@nhs.net
- Corporate governance team - D-ICB.governance@nhs.net
- Local counter fraud specialist – Sandra Bell (sandra.bell19@nhs.net)
- ICB Chief Finance Officer - Bill Shields (bill.shields2@nhs.net)
- ICB Senior Information Risk Owner (SIRO) - Andrew Millward (andrew.millward@nhs.net)
- Caldicott Guardian (d-icb.caldicottguardian@nhs.net)
- Freedom to Speak Up Guardians –
    - Alastair Harlow (aharlow1@nhs.net)
    - Marina Junaram (marina.junaram@nhs.net).
    - FTSU team email (d-icb.ftsug@nhs.net)
- Non-executive director responsible for Freedom to Speak Up - Kevin Orford (k.orford@nhs.net)
- HR team (d-icb.hr@nhs.net)

Appendix B:

What will happen when I speak up?

We will:

Thank you for speaking up

•

Help you identify the options for resolution

•

Signpost you to health and wellbeing support

•

Confirm what information you have provided consent to share

•

Support you with any further next steps and keep in touch with you

Steps towards resolution:

Engagement with relevant senior managers (where appropriate)

•

Referral to HR process

•

Referral to patient safety process

•

Other type of appropriate investigation

Outcomes:

The outcomes will be shared with you wherever possible, along with learning and improvement identified.

Escalation:

If resolution has not been achieved, or you are not satisfied with the outcome, you can escalate the matter to the senior lead for FTSU or the non-executive lead for FTSU.

Alternatively, if you think there are good reasons not to use internal routes, speak up to an external body, such as the CQC or NHS England.

NHS Devon

NHS Devon Integrated Care Board

Committee Chair's Report - Audit and Risk Committee

Date of board meeting	Dates of committee covered in this report
04 October 2023	12 July 2023

Chair	
Name and title:	Graham Clarke, Non-Executive Member

BAF updates or escalation

- The Board Assurance Framework (BAF) was received and noted. Future development of the BAF would include the mapping of delivery and enabling programmes from the Joint Forward Plan and the underlying risks associated with the organisational change process. The next iteration of the BAF would include timelines on progress and action updates.
- Assurance that the BAF is working adequately and effectively in managing the principal risks to the achievement of the Integrated Care Board's (ICB) strategic objectives will be via internal audit review of the BAF would review how risk were being considered by each Board Committee, as well as looking at the management and escalation of corporate risks that sat outside the BAF.

Risk register review updates/escalation

- N/A

Integrated Quality, Performance and Finance Report (please provide summary of discussion for Board assurance)

- N/A

Reports received, discussed, and noted

- Declaration of Interest update report was received and noted.

- Internal Audit update report was received and noted.
  Progress against the 2022/2023 Audit and Assurance Plan and Value-Add Plan included six final and two draft reports. It was highlighted that, since the report was written, a further two reports had been finalised and the report of the Integrated Care Board (ICB) strategy review was currently in draft form. Therefore, four audits remained, the progress of two of which was being impacted by the availability of ICB staff to support the work.

  The Better Care Fund audit (requested by the Board) will be scheduled following assurance at the Finance Committee of the work being undertaken in this area by the Finance team.

- Head of Internal Audit Opinion (HIAO) was received and noted.
  The final opinion was confirmed as limited. The Director of Audit and Assurance Services emphasised that the ICB had made significant progress in the right direction for a satisfactory opinion for 2023/24. She suggested that NHS Devon was not an outlier in terms of the challenges that it had experienced in the development and embedding of its systems of internal control.

- Single Risk Management System plan was received and noted.
  The high-level plan for a new risk management system was presented. The plan included the articulation of risk management system requirements, learning from other organisations who had implemented systems, the procurement process and dedicated risk management training with colleagues across the organisation. The importance of ensuring a system approach to risk management was emphasised.

- Data Protection Framework and Strategy was received and noted.
  Key changes to the framework were highlighted which included minor amendments to roles and responsibilities and reporting functions.

- Information Governance update report was received and noted.
  A moderate risk rating had been given following the internal audit of the DPST Toolkit. The organisation achieved 95% compliance for IG mandatory training and all Board members are compliant.

- Annual SIRO report was received and noted.
  The internal Data Security Protection Toolkit (DSPT) audit showed moderate assurance with eight out of the ten assertions receiving substantial assurance.

  The DSPT review with the DPO and SIRO took place on the 28th of June 2023 and was successfully published on that date with all mandatory assertions being completed.

- Committee Effectiveness Review Process was received and noted
  The process led by the governance team would ensure that the Audit and Risk Committee would receive the outcomes of all Board Committee reviews once completed and it would be the responsibility of the Committee to then provide feedback to the Board in relation to the effectiveness of these Committees.

  Consideration was requested to delaying or not undertaking these reviews. At the least it was suggested that the Finance and Performance and Remuneration Committee reviews should delayed, see table below.

Committee	Review opens	Review closes	Review presented to committee
Primary Care Commissioning Transition Committee	22 June	9 July	13 July
Finance and Performance Committee	31 October	14 November	28 November
People and Culture Committee	28 August	11 September	20 September
Quality and Patient Experience Committee	23 January	6 February	21 February
Remuneration and Strategic Workforce Committee	14 August	28 August	7 September
Audit and Risk Committee	18 July	01 August	11 October
Audit and Risk Committee	13 March - full suite of committee reviews to be reported ahead of Annual Report (members report)		
NHS Devon Board	3 April – via Audit Committee Chairs report.		

- External Audit Plans were received and noted.
  The summary for the Clinical Commissioning Group (CCG) M1-3 2022/23 and the ICB M4-12 2022/23 annual accounts, would include
  - The presumed risk associated with revenue and expenditure would be rebutted Management override would be reviewed for abnormal patterns.
  - Going concern in terms of disclosures and any cut off into the ICB.
  - Regularity will be reviewed.
  - Materiality has been set at a 2% level and anything over £300,000 limit will be reported to the organisation.
  - Only significant weakness is required to be reported

- Counter Fraud update report was received and noted.
  The Government's Counter Fraud Functional Standard Return (CFFSR) showed NHS Devon having achieved an overall "green rating".

Committee decisions

- Approval of the Data Protection Framework and Strategy

Escalation to the Board – for information

- KPMG are now in place and working to audit the accounts in line with the agree timeframe.
- ASW highlighted there would be an increased risk of fraudulent activity taking place whilst the organisation is going through the organisational change and taking on new commissioned services.
- Potential impact of the organisational change and running cost reductions on audit activities.

Escalation to the Board – for action

- The Board are asked to discuss and agree if the timelines for the committee effectiveness reviews are appropriate.

Recommendations for the board

- None

Recommendations for other committees

- The Finance and Performance Committee is asked to assure the Audit and Risk Committee on the progress of work related to the Better Care Fund.

Terms of reference or other committee effectiveness issues

- None

NHS Devon

NHS Devon Integrated Care Board

Committee Chair's Report - Audit and Risk Committee

Date of board meeting	Dates of committee covered in this report
04 October 2023	01 September 2023

Chair	
Name and title:	Graham Clarke, Non-Executive Member

BAF updates or escalation

- N/A

Risk register review updates/escalation

- N/A

Integrated Quality, Performance and Finance Report (please provide summary of discussion for Board assurance)

- N/A

Reports received, discussed, and noted

- **2022/23 Annual Reports**
  The report provided information about the approach taken to the production and submission of the 2022/23 M4-12 Annual Report and Accounts for NHS Devon Integrated Care Board (ICB), as well as the submission of the 2022/23 M3 NHS Devon Clinical Commissioning Group (CCG) Annual Report and Accounts. It also provided information about the draft findings of an internal

audit review of invoices related to international recruitment which indicated a significant internal control issue that should be recorded in the NHS Devon ICB Annual Report.

- **2022/23 Annual Accounts**
  The committee received confirmation that the accounts remained consistent with discussions over the year.

- **NHS Devon Clinical Commissioning Group Month 1-3 2022/23 – Independent Auditor's Report and NHS Devon Integrated Care Board Month 4-12 2022/23 – Independent Auditor's Report**
  It was confirmed there were no control recommendations; however, there was an observation in relation to the fact that the SBS accounting system allowed journals to be self-approved. It was noted that NHS Devon ICB had a process in place to undertake a retrospective review of journal approvals; however, KPMG was not able to rely on this review. Associate Director of Finance confirmed that the control issues related to self-approving journals would be corrected once the new financial system had been implementation in 2024/25.

Committee decisions

- Noted the draft findings of the ASW review of invoices related to international recruitment and that the final report of this review will be presented to the Audit and Risk Committee meeting in October 2023.
- Agreed that the draft findings of the ASW review indicated a significant internal control issue that should be recorded in the NHS Devon ICB Annual Report.
- Noted the actions already taken and proposed further actions taken in response to the draft findings of the ASW review.
- Approved the draft NHS Devon CCG Annual Report for onward presentation to the NHS Devon Chief Executive Officer for approval.
- Approved the draft NHS Devon ICB Annual Report for onward presentation to the NHS Devon Board for approval at its meeting on 06 September 2023
- Approved the draft NHS Devon CCG Annual Account for onward presentation to the NHS Devon Chief Executive Officer for approval.
- Approved the draft NHS Devon ICB Annual Account for onward presentation to the NHS Devon Board for approval at its meeting on 06 September 2023

Escalation to the Board – for information

- N/A

Escalation to the Board – for action

- N/A

Recommendations for the board

- To approve the NHS Devon CCG Annual Report.

- To approve the NHS Devon ICB Annual Report.
- To approve the NHS Devon CCG Annual Accounts.
- To approve the NHS Devon ICB Annual Accounts.

Recommendations for other committees

- N/A

Terms of reference or other committee effectiveness issues

- None

NHS Devon

NHS Devon Integrated Care Board

Committee Chair's Report - Audit and Risk Committee

Date of board meeting	Dates of committee covered in this report
04 October 2023	26 September 2023

Chair	
Name and title:	Kevin Orford, Independent Non-Executive Member

BAF updates or escalation

- The Board Assurance Framework (BAF) was received and noted. The BAF continues to develop and there has been an increased focus on the articulation of BAF risks and the actions in place to mitigate them.
- The Committee was assured that the BAF continues to improve; however it was highlighted that a key next step would be to ensure that Board Assurance Committees had the opportunity to scrutinise BAF risks prior to their presentation to the Board. It was emphasised that the BAF must be a live document that can be used to structure and inform both Board and Committee business,

Risk register review updates/escalation

- The Committee received an update on the recent review of the NHS Devon Risk Management Policy and an update on the ongoing work to develop risk management systems and processes within NHS Devon. The proposed Risk Management Policy, which the Committee endorsed, is presented to the Board elsewhere on the agenda for this meeting.
- Work continues on the procurement of a new automated risk management system. However, until such a time as this can be procured, the Committee

was informed that the organisation ceases using the web-based Corporate Risk Register system that is currently in place, in favour of using a manual spreadsheet system. This would be a centralised master spreadsheet held by, and updated by, the Corporate Governance team with information provided by the wider organisation (e.g. teams, directorates etc.). The Committee was assured that this was an appropriate short-term step to improve the accuracy of and engagement with risk management activities within NHS Devon.

Integrated Quality, Performance and Finance Report (please provide summary of discussion for Board assurance)

- N/A

Reports received, discussed, and noted

- Declaration of Interest update report was received and noted.

- External Audit update report and 2022/23 Annual Report was received and noted.

  The Annual Report summarised external audit work in relation to both the 3-month CCG audit and the 9-month ICB audit, presenting conclusions against our significant risks, and commentary against the Value For Money (VFM) domains. In line with the organisation's NOF4 status, significant weaknesses were identified in relation to financial sustainability and governance. These are being addressed through the System Recovery Programme and work by the Governance team on risk management systems and processes and also by amendments to the Internal Audit Plan to increase audit time related to governance, financial systems and procurement processes, which were agreed by the Committee. (see detail below)

- Review of losses and special payments – an oral updated was provided to confirm that there were no issues to report to the Committee.

- Counter Fraud Interim Report was received and noted.

  The report covered the period July 2023 to September 2023 and set out the counter key and emerging risks and anti-fraud activities for this period.

- Internal Audit Update Report and revised Audit and Assurance Plan were received and noted.

  Good progress has been made against the Internal Audit Plan to date. The Committee agreed extensions to a number of open actions, in order to enable appropriate implementation of the recommended work. In light of the findings of external audit and the Head of Internal Audit Opinion for 2022/23, the Committee had asked Internal Audit and Executives to review

the appropriateness of the plan for the remainder of the year. The Committee approved the following proposed changes to the plan:

Audit Area	Amendment
Assurance Framework and Risks Management	Review of NHS Devon's risk arrangements t be split in two - part 1 to will review the new policy/procedures/ processes (September/October), and part 2 to consider their implementation/application (Q4).
Governance Review	Increased days. Review of governance arrangements to be undertaken on an iterative basis as work is undertaken to refresh NHS Devon governance core governance framework.
Financial Systems	Increased days. To enable increased samples sizes and to consider payment controls in more detail. To undertake more specific testing around the use of certain suppliers highlighted during the special review, recently undertaken, to establish whether related companies have supplied services to NHS Devon.
Single Tender Waivers	Additional review.
HR policy compliance absence, mandatory training etc	To include People Plan Implementation review.
Delivery of Joint Health and Wellbeing strategies and Joint Strategic Needs Assessments	To be conducted as a high-level review in 2023/2024.
Patient, Carer and Resident Engagement	Moved to take place in 2025/2026 to accommodate changes above.

The Committee also received the following reports of internal audit reviews completed since its last meeting:

- Payroll (2022/2023) – Satisfactory Assurance
- People Plan Implementation Oversight (2022/2023) – Satisfactory Assurance
- ICB Strategy (2022/2023) – Significant Assurance
- Single Tender Waiver Review (2023/2024) – Limited Assurance – the Committee received a detail management response to this report and took assurance from the proposed actions to address the recommendations raised by Internal Audit.

The Board will be aware that Internal Audit has also undertaken a special review of invoices relating to international recruitment. This report did not

receive an assurance rating. It is proposed that a further independent review should be undertaken to build on the findings of the work undertaken by Internal Audit. The Committee considered the findings of Internal Audit, the actions already taken in response and endorsed the proposed independent review.

- Information Governance Update report was received and noted.
  Work has commended on reviewing the content of the 2022/23 Data Security and Protection Toolkit (DSPT) with a view to moving across into the 2023/24 version. Meetings will shortly be arranged between the IG consultant and Delt/IT to start reviewing the IT assertions and to arrange agreed dates for collection of evidence. The key change to the 2023/24 DSPT is to the training requirement which now no longer requires organisations such as NHS Devon to achieve 95% compliance for IG training but to determine their own scrutiny through a training needs analysis and to also demonstrate IG awareness for staff.

- Policy Framework Refresh was received and noted.
  The Governance team has proposed a new Policy for the Development and Management of Procedural Documents, which the Committee agreed to recommend to the Board. The Committee took assurance from the work undertaken by the Governance team to review the status of the organisation's non-clinical policies and the actions that will be taken to ensure that they are brought into good order. The Committee was also content with the proposed approach to the approval of the organisation's clinical policies.

- Care Quality Commission (CQC) preparedness report was received and noted.
  The Committee was provided with the information that is available in terms of the CQC's approach to assessing Integrated Care Systems (ICSs) and the manner in which NHS Devon will be ensuring its readiness for this assessment. Specifically, that:
  - Executive Owners and Leads should be allocated to each Quality Statement;
  - Executive Owners and Leads should undertake a baseline assessment of NHS Devon using CQC's existing key lines of enquiry (KLOEs) for providers as a proxy whilst KLOEs for ICSs are being developed;
  - Where possible, the plans to address any areas of weakness should be implemented by 31 December 2023; and
  - Colleagues from Cornwall and Isles of Scilly Integrated Care Board should be invited to undertake a peer review of the work being carried out to ensure NHS Devon's readiness.

  The Committee noted that there were risks to the target date of 31 December 2023, as this was a stretch target, but that this meant that there would be room for slippage. Consideration was given to the implications of reviewing ICBs as a proxy for ICSs.

- Freedom to Speak Up Annual Report and Policy Update was received and noted.

The Committee noted the Annual Report and endorsed the proposed update to the Freedom to Speak Up Policy. Further information about this is elsewhere on the agenda for this meeting.

Committee decisions

- None

Escalation to the Board – for information

- Amendments to the Internal Audit Plan are designed to address the weaknesses identified in relation to the organisation's systems of internal control
- Work is being undertaken to strengthen policy frameworks, but it will be important to ensure compliance with these.

Escalation to the Board – for action

- The Board is asked to consider the policies that are being presented to it separately.

Recommendations for the board

- The Committee recommends that the Board approves:
  - Risk Management Policy
  - Policy for the Development and Management of Procedural Documents
  - Freedom to Speak Up Policy

Recommendations for other committees

- None.

Terms of reference or other committee effectiveness issues

- None

NHS Devon Integrated Care Board Meetings in Public - Action Log						
Action Ref	**Date of Meeting**	**Action - issue to be addressed**	**Target Date**	**Lead**	**Progress on action**	**In progress / Completed**
26	21.12.2022	The Devon Audit Chairs' Forum to hold a risk review workshop and feed back to the Board, via the Audit Committee Chair's Report	Feb-23	Graham Clarke Ann Cooper	05.07.23 - Workshop held with Devon Audit Chairs on 1 June 2023 and upate included in Committee Chair's update on 07.06.2023. **REQUEST TO CLOSE**	**Completed**
29	15.02.2023	Include a SEND update on the Board forward planner for review	Mar-23	Nigel Acheson / Jo Turl	27.09.2023 - Outcome of SEND inspections included in Chief Executive's Report to the Board on 04.10.2023 **REQUEST TO CLOSE**	**Completed**
38	03.05.2023	Cost of Living Fund report be shared from One Devon Partnership Chair when available	Jul-23	James McInnes	Circulated to NHS Devon ICB Board members 18 July 2023 **REQUEST TO CLOSE**	**Completed**
41	03.05.2023	The Board to be updated on progress of engagement at the Never Event group via the Quality & Patient Experience Committee	Jun-23	Hisham Khalil	05.07.2023 - Update provided to Board at its meeting on 07.06.23 - completed. **REQUEST TO CLOSE**	**Completed**
43	05.07.2023	A detailed response to be provided to the Board as to compliance around health checks for children in care and the number of children placed outside of Devon.	Aug-23	Naomi Chapman	29.8.2023 Included within papers supporting Children & Young People's Deep Dive included in the Board development session on 06.09.2023 **REQUEST TO CLOSE**	**Completed**
36		Discharge funding evaluation to be presented at a future meeting of the Board.	TBC	Anthony Fitzgerald	27.09.2023 - The Winter Plan (considered by the Board on 06.09.2023 and 04.10.2023) includes detail of how funding is being allocated to initiaves which support discharge improvements. **REQUEST TO CLOSE**	**Completed**
31	15.02.2023	Accountability Framework Standard Operating Procedure to be included on the forward planner	Mar-23	Susan Masters / Philippa Harding	03.03.23 - This work will form part of the governance review and be brought back to a future meeting of the Board.	**In progress**
35		Development session in April to cover the Advisory Committee on Resource Allocation (ACRA) formula and the way it works	Apr-23	Philippa Harding	27.09.23 - Was not included withing the development day agenda, the scheduling of this item will be considered and included on the Forward Planner. 05.04.23 - Included in the preparation for the development day.	**In progress**
37	03.05.2023	Chief Delivery Officer to review the orthopaedic pathway and barriers to an efficient, cost effective and user-friendly pathway. Review of specialist physiotherapist pathway to be brought back to a future Board Meeting.	Jul-23	Anthony Fitzgerald	29.08.2023 The orthopaedic pathway is in the process of being reviewed as part of the One Devon Elective pilot building on the work that Jwas completed last year using the methodology used for the spinal pathway review. The pathway is about to be reviewed and an update will be circlulated to Board members once the review has been completed.	**In progress**
39	03.05.2023	Update to be provided on the progression of the IQPR to include further metrics such as health inequalities	Jun-23	Anthony Fitzgerald/ Nigel Acheson	27.09.2023 - Performance indicators in respect of Health Inequalities will be considered by the Population Health Improvement Committee and an update will be provided to the Board.	**In progress**
40	03.05.2023	A report be made to a future meeting of the Board in respect of the health inequalities being experienced by patients on waiting lists	Jun-23	Anthony Fitzgerald	27.09.2023 - This issue will be considered by the Population Health Improvement Committee and reported on to a future Board meeting.	**In progress**
42	03.05.2023	Standing item to be included on the Board agenda to provide assurance around the recovery position	Jun-23	Jodie Howland	27.09.2023 - The recovery position is included within the ICS Finance Report which is presented to the Board. Further reporting to be determined.	**In progress**
44	05.07.2023	Summary report of the National Advisor for Care Leavers to be circulated to the Board for information.	Aug-23	Steve Brown	27.09.2023 SB waiting for the formal response from the National Advisor, once this is received it will be circulated to the Board.	**In progress**